International Criminal Court

Trial Chamber IX

Situation: Republic of Uganda

In the case of The Prosecutor v. Dominic Ongwen - ICC-02/04-01/15

Presiding Judge Bertram Schmitt, Judge Péter Kovács and

Judge Raul Cano Pangalangan

Trial Hearing - Courtroom 3

Tuesday 20 March 2018

(The hearing starts in open session at 9.32 a.m.)

THE COURT USHER: [9:32:29] All rise.

The International Criminal Court is now in session.

PRESIDING JUDGE SCHMITT: [9:32:40] Good morning, everyone.

Good morning, Mrs Mezey.

Could the court officer please call the case.

THE COURT OFFICER: [9:33:01] Thank you, Mr President.

The situation in Uganda, case, The Prosecutor versus Dominic Ongwen, case reference ICC-02/04-01/15.

And we are in open session.

PRESIDING JUDGE SCHMITT: [9:33:07] Thank you.

For the appearances much the parties, Mr Black.

MR BLACK: [9:33:10] Good morning, your Honour. Colin Black for the Office of the Prosecutor, Ben Gumpert, Colleen Gilg, Paul Bradfield, Shkelzen Zeneli, Julian Elderfield, Maya Talakhadze, Pubudu Sachithanandan, Kamran Choudhry, Jasmine Suljanovic, Yulia Nuzban, Adesola Adeboyejo and of course our case manager, Ramu Fatima Bittaye.

PRESIDING JUDGE SCHMITT: [9:33:39] Thank you very much, Mr Black.
And for the Legal Representatives of the Victims, first Mrs Massidda.
MS MASSIDDA: [9:33:45] Good morning, Mr President, your Honours. For the Common Legal Representative team, Orchlon Narantsetseg, Caroline Walter, Innocent Mpoko, Laura Mahecha and myself Paolina Massidda.
PRESIDING JUDGE SCHMITT: [9:33:59] Thank you.
And Mrs Hirst.
MS HIRST: [9:34:01] Good morning, your Honours. Megan Hirst and James Mawira.
PRESIDING JUDGE SCHMITT: [9:34:05] Thank you. And for the Defence, Mr Obhof.
MR OBHOF: [9:34:08] Good morning, your Honours. Today we have counsel Krispus Ayena Odongo; co-counsel Chief Charles Achaleke Taku; our assistant to counsel, Ms Abigail Bridgman; our case managers, Michael Rowse and Tibor Bajnovic; and our consultant, Ms Eniko Sandor; and Mr Ongwen is sitting in the back behind us today.
PRESIDING JUDGE SCHMITT: [9:34:26] Thank you very much, Mr Obhof.
On behalf of the Chamber I have to inform the parties and participants of events that took place yesterday evening, I would even dare say late evening. Yesterday evening via email the Defence requested that the Chamber adjourn the proceedings in order for the accused to receive a second medical examination from Professor de Jong. This request was rejected by way of email decision that same evening.
The Defence sent their request ex parte, but the other participants have an important interest in seeing both the Defence's request and the Chamber's decision.
By the end of tomorrow, Wednesday, 21 March, the Defence is to send a proposal for

redactions to the email exchange in question. This proposal is to be sent to the Chamber, who will then apply all appropriate redactions and send the exchange to the participants.

The exchange will eventually be filed in the public record by virtue of the email decision procedure specified in decision 700.

So this I think is the fairest -- with regard to fairness, the best what we can do at the moment. And no further interventions on that are required and needed and even wished, so to speak.

What I wish to do is to make some remarks also on this material drawn from the courtroom proceedings that have been put to the witness. This material, or better is to word it this way, this compilation of material has been provided to the Defence since January. It cannot have been -- come to a surprise that it is being put to the expert. Furthermore, it cannot be a surprise because it is material from the record. It is material from the largely publicly available record. Most of us have been present when this was said, have experienced what has happened in the courtroom. And the Chamber, which is under the obligation to establish the truth, is also under the obligation to make sure as far as possible to provide experts, psychiatrist experts especially, with as broad a factual basis for the expertise as possible and this means that no one, no party, no participant can select, can choose the facts and evidence to be presented to an expert because it might be supportive for their cause or shield, on the other hand, facts in evidence from the expert that they might think might perhaps not support their cause.

This is what I wanted to say. And perhaps an additional remark. I'm coming from a civil law system, perhaps it might be of interest for somebody here in the courtroom how it is handled there.

In a civil law system, in Germany especially, a psychiatrist expert is expected to be present during the whole proceedings, has access, and is appointed by the Court, and also has access to all of the files. And if the expert can be not present during certain proceedings, can be excused, of course, and if something important happens, the presiding judge in the next hearing informs the expert what has happened and might be of interest, factual interest, evidence-based interest for the expertise of the expert.

So what we have here with this material drawn from the courtroom proceedings is, let me put it this way -- I'm too quick I see.

What we have here with this material drawn from the courtroom proceedings is, I would not say the minimum, but is something that we as a Chamber think is essential to provide an expert with a basis for her, in this case, for her expertise.

So this is -- and it has been known, as I have said since a long time, that this would be done, such a compilation, and that it would be put to the expert.

Unless somebody wants to say something additionally, we proceed now with the questioning of the expert and I give Mr Black the floor.

MR TAKU: [9:38:58] May it please the Court.

PRESIDING JUDGE SCHMITT: [9:39:00] Mr Taku, but shortly, please.

MR TAKU: [9:39:02] Very short, your Honour. With regard to the issue we will be making a comprehensive filing with the intention of seeking for continued evaluation, whether it's an incident or not, for the future of the entire proceedings, periodic assessments that may inform the Court and help your Honours in having the background about the conditions, personal circumstances and conditions, mental health situation of the accused for the entire proceedings, not just for a specific incident. We will be making that filing, I think the Court will look at it on the merit.

PRESIDING JUDGE SCHMITT: [9:39:38] Of course everything, of course, Mr Taku,

you know that, everything the Chamber receives will be not only noted, this is a typical word in this environment, noted, but noted has always a little bit the notion of you lay it aside and perhaps you don't really read it, but we, and I think you know that, this Chamber reads everything and takes everything into consideration, of course, only if we think that it is worth to be taken into consideration.

Mr Black, please.

MR BLACK: [9:40:11] Thank you, your Honour. On that I would just say, I don't know if the Defence intends to file it inter partes, but we would have a strong interest to receiving that and having an opportunity to comment.

PRESIDING JUDGE SCHMITT: [9:40:23] That is -- since we have this sometimes, allow me the strange mixture, a little bit of we have to establish the truth here, as we sit here, on the one hand, and then we have this more party-driven structure, we have to find a compromise that serves all the purposes that we have to serve, according to the Statute and the Rules. And in that sense, of course, it would be absolutely -- we would absolutely endorse that this is inter partes. And this was also the reason why the Chamber ordered that this email exchange from yesterday evening should be made as far as possible public -- not public, inter partes, inter partes procedure.

Mr Black.

MR BLACK: [9:41:17] And just to add, your Honour, I didn't mean to exclude the legal reps from that. When I say inter partes, I meant parties sand participants as you --

PRESIDING JUDGE SCHMITT: [9:41:25] You know I think you understood the word parties in a more broader sense in that event.

But, Mr Black, now it's your turn.

MR BLACK: Thank you.

PRESIDING JUDGE SCHMITT: And the turn of Mrs Mezey.

WITNESS: UGA-OTP-P-0446 (On former oath)

(The witness speaks English)

QUESTIONED BY MR BLACK: (Continuing)

Q. [9:41:34] Good morning, Professor. Thanks for being back with us this morning. I think we completed looking at the chart, so we don't need to look at that again. I'm going to move to my final sort of broad topic which is to ask you a few clarifying questions about your conclusions.

For these next questions, please assume with me that there are at least two kind of distinct factual questions that could be relevant here. The first is: Did Mr Ongwen suffer from a mental disease or disorder in 2002 to 2005?

And then second: If he did, did that disease or disorder affect his capacity to appreciate the nature of his conduct, the unlawfulness of his conduct, or to control his conduct?

Do those two questions --

A. [9:42:27] Yes, I understand.

Q. [9:42:28] So let me ask you first a couple of questions about that first question. In your report, which is tab 2 of the binders, which I see you still have before you, you conclude in paragraph 103, which is the ERN ending 0811, that based on the evidence you reviewed, there is no evidence to support a diagnosis of any of the three mental illnesses we discussed yesterday, PTSD, depressive disorder, or dissociative disorder, or other significant mental illness. Is that still your opinion today?

A. [9:43:09] Yes, it is.

Q. [9:43:10] Now that sounds to me like you are indicating an absence of evidence, but did you identify anything which affirmatively suggested to you that he did not

have one of those disorders in 2002 to 2005?

A. [9:43:28] I think it's difficult to put it that way. I would look for evidence of symptoms, evidence of distress, evidence of dysfunction that could point to the presence of a mental illness or disorder, and in all the material that I have seen, I have not found any evidence of behaviours or symptom, signs that might indicate mental illness.

Q. [9:44:05] In paragraph 58, for example, of your report, you remark on Mr Ongwen's apparent ability to give detailed reports of attacks during his time in the LRA. Is that -- does that just suggest an absence of evidence or is that actually inconsistent with him having a mental illness at that time?

A. [9:44:29] Well, it is inconsistent with certain kinds of mental illnesses, so as I was explaining yesterday, the ability to give a detailed account of one's actions would negate the presence of a dissociative state because one would not be able to recall and describe behaviours committed during a dissociative state.

If one is looking at other kinds of mental illnesses, however, it might be possible to retrospectively describe in detail what one was doing, what one was feeling, and what was happening around you. So, for example, an individual suffering from a depressive disorder of a mild to moderate severity would still be consciously aware of their environment and would still be able to know what they were doing and to describe what they were feeling and to have recall subsequently as to their actions.

So it is impossible to make a blanket statement. Having a mental illness does not necessarily render you incapable of conscious awareness or control or the ability to know the difference between right or wrong. It would depend on the type of mental illness and the severity of the condition at the time.

Q. [9:46:16] Thank you for that explanation. You accept in your report that

Mr Ongwen has suffered psychological trauma during his time in the LRA; is that right?

A. [9:46:27] I do.

Q. [9:46:30] Could you explain again why the fact of that trauma is not enough to conclude that he had a mental illness or disorder at that time?

A. [9:46:43] Essentially, the experience of trauma does not inevitably lead to psychiatric illness. PTSD, which is the most frequently described psychiatric disorder arising following trauma, only occurs in around 10 per cent of individuals who have experienced life-threatening trauma. So the experience of a trauma does not inevitably equal psychiatric illness.

Similarly, other psychiatric conditions may arise following trauma. Depressive disorder, alcohol and substance misuse, anxiety disorders are all at an increased risk following trauma, but again it is not inevitable and it will depend on many other factors, including the individual's personality, vulnerability factors, for example, a family history of depression. It will depend on other environmental factors.

So coming back to your question, the experience of trauma cannot and should not be equated with psychiatric illness. Indeed, the majority of victims of trauma both childhood and adult do not experience any diagnosable mental illness subsequently.

Q. [9:48:41] Thank you. One bit of housekeeping, I failed to give the full ERN for a report, which is tab 2, UGA-OTP-0280-0786.

Professor, that clearly I think answers the first question that I put to you. So let me turn briefly to the second.

Imagine for a moment that the Judges disagree with you and they do accept the suggestion by the Defence experts that one or more of those three illnesses was present in Mr Ongwen between 2002 and 2005. In your opinion, based on what you

have seen in this case, would there then be sufficient basis to conclude that he had been incapacitated in the ways that are relevant, that his ability to appreciate the nature of his conduct or the unlawfulness of his conduct or to control his conduct was therefore affected?

A. [9:49:51] No, I don't think there would have. And again based on all the materials I have seen, including the transcripts that were discussed yesterday, all the evidence points to Mr Ongwen having control over his actions, being aware of what was happening, being able to express an intention to act in certain ways, so having agency and control. And all of those features are incompatible with the presence of a serious mental disorder.

Q. [9:50:41] And thinking about this case in particular, there are four charged attacks in the case, one that happened in October of 2003, another in April of 2004, one in May of 2004, another in June of 2004. Does the timing of those four distinct attacks impact upon the likelihood that he might have been, for example, dissociating during all of them?

A. [9:51:14] Well, it would be highly improbably to suggest that there was a continuous and ongoing mental abnormality between those four attacks, from the first to the last of those attacks, that was ongoing, or that a mental abnormality occurred coincidentally with each of those four attacks, that that description would be, frankly, psychologically incoherent.

And in response again to -- to the relationship between mental disorder and the attacks, there, when one is looking at the relationship between, for example, dissociation and behaviour, behaviour that is planned, behaviour that appears to be motivated and premeditated is highly unlikely to represent the sort of automatic motiveless actions that are typically associated with a dissociative state or other

severe mental health conditions.

And referring back to the attacks, all four of the attacks, and confirmed by many of the extracts from the transcripts, appear from the accounts to have been determined and carried out through the instructions of Mr Ongwen. So they appear to have been planned and premeditated, rather than impulsive and out of the blue, if I can put it that way.

Q. [9:53:34] As you know, there are also a few other charges which continue over time, forced marriage and slavery, and use of child soldiers charges.

MR OBHOF: [9:53:47] Objection, your Honour. I'm wondering where slavery is located.

MR BLACK: [9:53:51] Did we not argue enslavement?

MR OBHOF: [9:53:54] But this would be located to the camps specifically.

MR BLACK: [9:53:58] Fair enough. Thanks. It's not important to my question, so I --

PRESIDING JUDGE SCHMITT: [9:54:02] Indeed. Indeed, what you -- you know better what your point - I think I know your point - but it's about, I think, confirmed charges that have a sort of duration.

MR BLACK: [9:54:14] Exactly, your Honour. Thank you. And sorry, if I was imprecise.

PRESIDING JUDGE SCHMITT: [9:54:19] Okay, Mr Obhof.

MR BLACK: [9:54:21]

Q. [09:54:21] Professor, my question for you is, you talked about conduct that's planned, premeditated. What about conduct that's ongoing on a day -- that happens on a daily basis over months or years? What's the likelihood of that kind of conduct being committed by someone in -- who is dissociating, for instance? Or what's the

likelihood that the person could have been dissociating every day throughout those months or years?

A. [9:54:47] It would be entirely implausible, in my view.

Q. [9:54:51] What about the prospect that PTSD or depressive order had caused that kind of daily conduct or incapacitated the person from understanding the nature of what they were doing every day, is that plausible?

A. [9:55:07] No, there would be no -- there is no logical, or connection between those disorders and the symptom of those disorders and the behaviours that you are describing.

Q. [9:55:25] We have now come to my last question and I would ask you to look at your report again at tab 2. And turn to paragraphs 118 and 119, please. That's the page with ERN 0815. The public doesn't have access to your report so I would ask you if you could, slowly, to read those 2 paragraphs out loud.

A. [9:55:56] "I have identified no evidence of mental illness or disorder that would have removed or seriously compromised the mental element of Mr Ongwen's actions during the period covered by this legal action, that is, between 2002 and 2005. "There is also no psychiatric reason related to current or past mental illness or disorder, to suggest that Mr Ongwen was: incapable of appreciating the nature of his conduct

Incapable of appreciating the unlawfulness of that conduct or incapable of controlling his conduct to conform with the requirements of the law."

Q. [9:57:06] And as you --

MR TAKU: [9:57:13] Your Honours, if I could. I think -- I wonder whether the Court would permit conclusion of opinions on legal issues, legal conclusions, which only the Court can. She can give an opinion on the facts presented to her but not

on the law.

PRESIDING JUDGE SCHMITT: [9:57:24] Mr Black, shortly, if you want. No, but if this were so it is correct what you are saying. So in the end the legal conclusions will be drawn by the Chamber, that is correct.

Mr Black.

MR BLACK: [9:57:37] Thank you, your Honour.

Q. [9:57:38] And, Professor, focusing on the psychiatric reasons which you refer to, as you sit in Court today, including the things that we have seen and discussed in Court, do these two paragraphs still accurately reflect your expert opinion in this case?

A. [9:57:52] Yes, they do.

Q. [9:57:53] Thank you for your time.

No further questions, your Honour.

PRESIDING JUDGE SCHMITT: [9:57:58] Thank you.

Mrs Massidda, I don't think that you will have questions.

MS MASSIDDA: [9:58:02] No, your Honour. Considering what happened yesterday, and the fact that the Prosecution has covered the two areas that I would like to cover, we have no question for this witness. Thank you.

PRESIDING JUDGE SCHMITT: [9:58:12] I would not assume that Mrs Hirst neither.

MS HIRST: [9:58:18] No, no questions from us, Mr President.

PRESIDING JUDGE SCHMITT: [9:58:20] Thank you.

Then I would give Mr Obhof the floor for your questioning.

And still, Mr Obhof, during the time you are arranging I am telling you the following, we have lost a little bit of time, so -- but we would want to finish today, so you perhaps can indicate in the course of your questioning how long it will last so we

could perhaps then shorten the lunch break or extend half an hour or whatsoever. When you can foresee it, so take your time.

MR OBHOF: [9:58:59] I think I can finish today in normal time, but I will let you know at the end of each session.

PRESIDING JUDGE SCHMITT: [9:59:05] Yes. Simply to indicate what we are planning.

QUESTIONED BY MR OBHOF:

Q. [9:59:13] Morning, Doctor.

A. [9:59:14] Morning.

Q. [9:59:14] Do you prefer to be called doctor or professor?

A. [9:59:17] Doctor is fine.

Q. [9:59:18] Okay. Now, under your instructions in paragraph 18 under the heading "Expertise of Author" you indicate that you -- international work as the International Criminal Court. Can you explain to the Court what prior experience before this case you have had with the ICC?

A. [9:59:41] I'm sorry, which paragraph is that?

Q. [9:59:43] Paragraph 18.

A. [9:59:56] My paragraph 18?

Q. [9:59:57] Or, sorry, 16. My fault. It's a typo. I'm sorry.

A. [10:00:09] I'm just trying to find the sentence, if you excuse me.

PRESIDING JUDGE SCHMITT: [10:00:12] I can help you. It's largely at the end of this paragraph: "I have extensive experience as an expert witness" and from then on.

THE WITNESS: [10:00:21] Yes. Yes. The International Criminal Court I put down for the purpose of this proceeding, this is my only experience at the International Criminal Court.

MR OBHOF: [10:00:34]

Q. [10:00:37] Thank you, Doctor. During your career how many child soldiers have you worked with?

A. [10:00:44] None.

Q. [10:00:51] How many persons, individuals have you worked with that have lived, as the Prosecution might describe, in a state of war for 27 years?

A. [10:01:05] For 27 years, that's a very specific question. I have certainly worked with individuals, assessed individuals, treated individuals who have been within war situations, both as combatants and also as civilians. Twenty-seven years, I am not sure I am able to give you an exact answer to that.

Q. [10:01:38] Now, the Prosecution also requested that if you needed more information that you could ask for further information. Did you request any such further information from the Prosecution?

A. [10:01:58] At any time, the -- the main request that I put to the Prosecution was to be able to assess Mr Ongwen.

Q. [10:02:12] Now, per your instructions at page 0820 in your report -- which is tab 2, while referring to her report for the rest of the day -- indicated that you could discuss Acholi culture and that you can -- you could consult other experts. Which experts did you consult about Acholi culture?

A. [10:02:43] I had telephone conversations with Dr Cathy Abbo, who I understand is going to give evidence later to the Court, who I would regard as being -- certainly I am not an expert on the culture, but I would regard her as being more of an expert, and in our discussions that was one of the topics we briefly described. My role in the Court primarily is as an expert mental -- as an expert witness in mental health, and I hope I've been clear that that is where my expertise lies, and specifically in

relation to psychological trauma, post-traumatic stress disorder and the impact of abuse. With Acholi -- I was fortunate to have, with the other two experts appointed, one mental health professional who I do consider has that expertise, and the other mental health professional who I considered had expertise certainly in relation to working with child soldiers.

Q. [10:04:11] Does it help, Doctor, to know that Dr Cathy Abbo is a Japadhola from Tororo, which is about 400 or 500 kilometres away from Gulu, quite a few hundred kilometres away from Acholiland? So you would still consider her an expert knowing that she does not actually come from that culture?

A. [10:04:36] I think that's a question you would need to put to her.

MR OBHOF: [10:04:40] Could the court usher please pull up Defence tab 1, that's UGA-D26-0015-0080.

A. [10:04:59] I'm sorry, I have difficulty finding that.

Q. [10:05:00] Sorry, there is a thinner binder.

PRESIDING JUDGE SCHMITT: [10:05:03] The thin, the thin one.

MR OBHOF: It would be the first tab.

PRESIDING JUDGE SCHMITT: [10:05:09] Otherwise it would be difficult to distinguish, but you take this thin one.

MR OBHOF: [10:05:31]

Q. [10:05:32] Now, Doctor, yesterday the Prosecution asked you about a few instances of possible torture upon Mr Ongwen, being arrested, being caned, being beaten, and you said that that could cause PTSD. Now you are seeing from the photographs there, it's from Mr Ongwen's leg, an injury which happened approximately November of 2002. Could an injury like this in which somebody would have been in what the LRA call sickbay for months or even a year, could this

trauma have caused PTSD?

A. [10:06:19] You cannot make any assumptions about an individual's mental state, or their perceptions of a trauma or their processing of a trauma, simply by reference to a physical injury. But I -- I remain of the view and I would say, as I said yesterday, that any experiences of torture in which the individual is frightened, they feel helpless, feel that their life is under threat, could potentially result in a psychiatric disorder.

Q. [10:07:13] Doctor, were you also aware that Mr Ongwen's parents were murdered by both the NRA and the LRA?

A. [10:07:27] I was.

Q. [10:07:28] Doctor, are you aware of the spirit -- sorry, spirituality element in the LRA?

A. [10:07:39] I have read about this. I think it was within the -- some of the information that I was sent to prepare for the case.

Q. [10:07:50] Now, how are you aware that Mr Ongwen's parents were murdered?

A. [10:07:57] I would have to go back, but, by recollection, by recollection I think his mother was killed when he was running away. I would have to look at this again. I seem to recall that one of them was certainly killed. The other parent, it wasn't entirely clear what had happened to them.

Q. [10:08:31] Are you aware that the Acholi belief that if you kill someone that person's spirit can inhabit your mind?

A. [10:08:44] I don't believe I was aware of that.

Q. [10:08:49] Now, beyond the discussion in Dr de Jong's report, did you receive any other information about Mr Ongwen's childhood?

A. [10:09:06] I apologise to the Court, it is difficult for me to recall because I was sent all the documentation that I have referred to in my report. Within that

documentation there is some description of Mr Ongwen's background, and I think certainly my colleague, Dr Abbo, has gone into a bit more detail in -- in outlining that. Certainly exploration of childhood and development and upbringing would be part of a mental state examination, which I was unable to do. The information that I recall seeing was that Mr Ongwen had had a relatively stable, happy, secure family life until he was abducted -- up until the period he was abducted.

Q. [10:10:18] Did you have, other than what the Prosecution provided, any information about the spiritual aspects of the LRA used when fighting the SPLA, the NRA, or the UPDF?

A. [10:10:50] I did. And I'm afraid I'm unable to recall the details, but I do remember that it formed quite a large part of the material and the description of the culture within the LRA but was also -- I took into account the fact that it was also combined with, certainly for Mr Ongwen, quite a strong religious belief. And there are descriptions of Mr Ongwen spending a lot of time praying, and I think reading the Bible, so there was clearly a mixture, a cultural mix in which he read the Bible, but was also highly influenced by cultural beliefs and the particular belief system held within the LRA at the time.

Q. [10:11:57] But these materials you are referring to are the ones which were provided by the Prosecution or discussed with the other co-experts; is that correct?

A. [10:12:08] All the materials that I have relied on are referred to and are included in the documents here.

Q. [10:12:17] Did you read about -- anything about technicians, controllers, the Yard, Camoplast or Air Stiblis?

A. [10:12:30] I did not.

Q. [10:12:36] And, sorry, I take the longer pauses to help the people in the booth.

Did the Prosecution give you information about these specific rituals concerning fighting and that these rituals were under the strict instructions of Joseph Kony? Sorry, strict control.

A. [10:13:05] I read, as I say, I read all the material that was provided to me. I was aware of there being strong spiritual and ritualistic processes that operated within the LRA that Mr Ongwen subscribed to.

Q. [10:13:32] Now paragraph 37 of your report, and I believe you explained this in detail yesterday as well with the Prosecution, you suggested that it's generally regarded as crucial for any forensic medical or psychiatric examiner to familiarise themselves fully with all relevant material before carrying out an assessment of this nature. Do you believe the -- knowing now about a lot of the issues that have arisen about the spiritual beliefs and how you do not know some of these very common things withinside the LRA, maybe the packet in which the Office of the Prosecutor supplied did not fully apprise you of all the necessary spiritual and cultural beliefs in Acholi and in the LRA?

A. [10:14:30] Well, there are two issues there.

First, not to take the paragraph out of context, I make this comment in reference to Professor de Jong who states -- who carried out two interviews and wrote his report without seeing any of the papers related to the case. And I suggest in the following paragraph that that would seriously compromise his opinion because of the importance of ensuring that your opinion is not solely based on the account given by the defendant, and that there is an attempt to challenge any inconsistencies or discrepancies.

The second issue is that I do not consider that I needed to be aware of every single belief system and ritual that was performed within the LRA in order to understand

that there was a spiritual -- a strong spiritual and cultural element affecting the LRA at the time, and needing to factor this in when considering both the question of whether a mental disorder was present, but also how that mental disorder may have expressed itself, given that cultural context.

Q. [10:16:20] But does it help, though, that de Jong himself, who had worked in northern Uganda, understood the concept of what the Acholi call cen, and that he actually wrote about it in his report and took that into context as part of the spiritual beliefs of the Acholi?

A. [10:16:44] My concern is about the lack of access to any documentation by Professor Jong which I consider seriously undermined his conclusions. I accept he may have been aware of the Acholi culture, but that does not equate to completion of a full and comprehensive forensic assessment which then would allow you to be able to interpret what you see and to make a valid diagnosis.

Q. [10:17:25] Now, notwithstanding Defence objections to intercept evidence towards reliability, enhancements, weather conditions, distorting voices, possible malfeasance by the GoU -- which I think you understand, your Honour.

PRESIDING JUDGE SCHMITT: [10:17:45] Shortly, Mr Obhof. As I already said yesterday, it's perfectly clear that what is put to an expert, especially what is put to an expert are hypothesis by the parties. Yesterday -- also these transcript material, it's not -- it does not reflect the established truth, it simply reflects what has been said in this courtroom and the expert gives her opinion under the assumption that this has been said and this might be correct, and that is the same what you are doing now from your side.

MR OBHOF: [10:18:19]

Q. [10:18:22] Did you listen to the audio recording intercepts that the Prosecution

provided?

A. [10:18:30] I listened to some video -- some audio recording, video recordings. Can you refer to -- can you tell me exactly what you are referring to?

Q. [10:18:45] Well, firstly, it would be in the Prosecution binder in tabs, if I'm not mistaken, starting at tab 33 in the thick binders. Or we can turn to, sorry, your report, page 0825 and the letter H of your report, Doctor, where it talks about the Koc-Ogako attack.

A. [10:19:37] Yes.

Q. [10:19:37] Did you listen to these?

A. [10:19:38] I listened -- I listened to -- I read everything that the lawyers sent me.

Q. [10:19:49] Now, I assume you do not speak Acholi?

A. [10:20:03] No.

Q. [10:20:06] What non-word cues or emotions could be deducted from those recordings?

A. [10:20:18] Sorry, could you repeat the question?

Q. [10:20:21] What type of non-word cues or emotions would you be listening for in these recordings?

A. [10:20:33] Generally, when one is listening to recordings, you would look at the fluency of somebody's speech, the form of their speech, the content of their speech, whether or not their speech varies in terms of tone, varies in terms of speed, their reactivity. You would also be looking for any -- in terms of the content, you would be looking for anything that suggests a discontinuity or disruption with the current sense of reality or sense of consciousness.

Q. [10:21:33] Now regardless of the, again, the dispute about the actual recordings themself, which is of no concern to you, did the Prosecution explain that Acholi is

a tonal language and that changes of tone and pitch are actually how they form words and that the same word like "Labongo" and "Labongo" are actually two different names of two different people, whereas it's different than what you would ascribe to a Germanic language?

A. [10:22:09] Well, I think it's fair to say I did not receive any tutoring in the Acholi language and I was not aware of that. In considering the evidence, it may be worth saying that I placed more weight or less weight on certain materials than other -- than others. Some material was more instructive in terms of either suggesting an absence of mental disorder, or what I was looking for is whether there appeared to be anything that could suggest abnormal mental processes, abnormalities in behaviour, again, that could raise the possibility of a mental disorder. So this -- the list is, of course, a comprehensive list of all the material, but some of it, I have to say, was less directly connected to what I was being asked to consider, which is is there evidence of a mental illness or mental disorder, particularly during the time frame that we are considering, and, if so, what impact might that have had on his actions and his ability to understand his actions or control his actions.

Q. [10:23:58] So in your report, though, you didn't ascribe to the weight which these audios or the transcripts may have given to your final determination, did you?

A. [10:24:12] No, I -- that was not, in my view, particularly necessary. What I was looking for in all the evidence is, as I say, material that would either appear to support the notion that Mr Ongwen had a mental illness, was mentally unwell or, indeed, material that appeared to be consistent -- sorry, that appeared to be inconsistent with that argument, that is, material that appeared to suggest the contrary, that he was rational, coherent, and functioning in a mentally normal way.

Q. [10:25:13] Still on these audios, and more towards the report that Mr Black

talked about earlier today, did the Prosecution inform you that for the majority of these reports that Mr Ongwen allegedly made, that he was not present at the attack and he was merely reporting what others had told to him?

A. [10:25:38] I don't believe we had that conversation.

MR BLACK: [10:25:46] Your Honour, objection. If he wants to put a hypothetical, but if he is -- purports to describe the evidence, I think he has to do it in a way that is more accurate than that.

PRESIDING JUDGE SCHMITT: [10:25:57] Yes, it was -- I also thought it was a little bit unspecific, because there is of course also material that is allegedly related directly to Mr Ongwen, meaning that it is alleged that he is speaking. So you would -- but I think it's not such an important point that we need to go through all the material one by one to specify it, in my opinion. I think it's not necessary. But your objection is correct, I would sustain it.

Continue.

MR OBHOF: [10:26:27] I will just go through a few, your Honour.

Q. [10:26:31] Did the Prosecution inform you that it is not alleged that Mr Ongwen went to the attack at Lukodi?

A. [10:26:45] I wonder if I could ask, because there are several different attacks. I was sent this material a year ago. I have reviewed some of the material, but it would help me if you are going to refer to a specific incident, if you could direct me to that incident and then I can refresh my mind as to what that was and comment on it.

Q. [10:27:12] I could even make it easier, your Honour.

The Prosecution only alleges that Mr Ongwen went to the Odek attack.

MR BLACK: [10:27:23] Objection, your Honour. It may be that we can't agree on what the evidence says, but, you know, we do allege that he was at Pajule, that he

was at Odek. I may not remember all of them. It might be we could move forward if he puts hypotheticals to the witness, as one might to an expert, rather than describing what the evidence or the allegations are.

MR OBHOF: [10:27:43] Your Honour, Mr Ongwen is not alleged to have reported about Pajule.

PRESIDING JUDGE SCHMITT: [10:27:47] But is this really -- I think we can sense that the witness has not been fully informed about when and where Mr Ongwen was allegedly directly present or is only reporting. I think this seems to be relatively clear. But, Mrs Mezey, what would you want to say?

THE WITNESS: [10:28:14] Thank you, your Honour. If it would help, clearly my understanding is the question of Mr Ongwen's involvement in the acts. The facts of the case are a matter for the Court, they are not matters that directly affect me and, as an expert, I would not wish to comment on his -- the extent of his direct involvement with those acts.

In terms of assessing his mental state, which is what I am here to advise the Court on, it makes no difference whether Mr Ongwen was physically present at the attack being alleged, or was ordering the attack, or was at a distance from the attack in terms of assessing his mental state and his mental responsibility for his actions at the time.

PRESIDING JUDGE SCHMITT: [10:29:16] So, Mrs Mezey, you have foreseen the question that I wanted to put to you to clarify that. And, with this answer, I think we simply can continue to the next point.

MR OBHOF: [10:29:25] Well, let me explain further. The question is, she made statements about his ability to recall and recount stuff inside a report in a place where he was not to try to show his mental state. If somebody came up and handed me a piece of paper, I could very easily read that on a radio and not have to remember

anything, and my mental state the day before or two days would not be indicative.

PRESIDING JUDGE SCHMITT: [10:29:56] But If this is so, Mr Obhof, then directly go to this specific incident that you mean and ask the witness.

MR OBHOF: [10:30:06] We'll come back to that. Mike's looking at it right now.

PRESIDING JUDGE SCHMITT: [10:30:10] You can also, if you want -- for example, if you want to be specific you can do this also after the coffee break, for example, so your team has enough time to really figure this out. But now I think it would help the expeditiousness of the proceedings if you would proceed.

MR OBHOF: [10:30:24]

Q. [10:30:26] Now, in your report you have highlighted some abstracts from the clinical notes at the detention centre that you considered significant in terms of providing an insight into the description of Mr Ongwen's mental state. I have a few questions related to those and why you chose.

At paragraph 26, from December 2015, you wrote down:

"Complains of nightmares" -- I'm assuming -- "every day last week, which affect functioning during the day ... gives the impression of adolescence ... remarkably talkative, relaxed ... average intelligence."

Now, can you tell me the significance of this passage?

A. [10:31:24] Well, any accounts of -- by mental health professionals, any contemporaneous account by mental health professionals about Mr Ongwen's functioning, mood and mood -- and symptoms is relevant, because it gives you an insight into a possible -- his mental state.

The relevance of this entry was nightmares, I've noted, which clearly Dr Verbruggen had also thought about, is a symptom, can be a symptom of post-traumatic stress disorder, particularly when they are severe and persistent and recurrent.

The fact that he appears to be talkative and relaxed and there is no other note of any other mental abnormality, no emotional problems, no cognitive problems, no other symptoms of mental illness noted is -- I have included that because it's what we would see as being a lack of coherence in terms of his presentation that doesn't fit, so that if somebody has PTSD, for example, and has nightmares, you would not expect them to be relaxed and talkative and able to engage. So I thought that was important.

Q. [10:33:24] Now, you didn't explain the "gives the impression of adolescence ...", the significance of that part to the entire selection which you chose?

A. [10:33:36] "Gives the impression of adolescence ..." is perhaps the least immediately relevant to the mental state. I could have just carried on with my dots. Adolescence, I think somewhere else he is referred to with a slightly more pejorative term, as being slightly infantile, maybe, childlike. That could be interpreted in any way. But you're correct, it doesn't immediately give you an insight into a particular mental health condition.

Q. [10:34:26] Now, you have written a bit about adolescence in your past; is that correct?

A. [10:34:32] I have done, yes.

Q. [10:34:35] And are there psychiatric or psychological issues that are specific to adolescence?

A. [10:34:44] No. I am not a child and adolescent psychiatrist. Again, Dr Abbo has more experience in that area. And we are not talking about an adolescent, we are talking -- I'm being asked to consider an adult man in his thirties.

Q. [10:35:07] Speaking of the infantile reaction, at paragraph 29 of your report: "Hunger strike since yesterday, after being denied telephone contact with aunt.

Needs ritual performed to remove the curse... infantile reaction to hissing own anger."

Now, again, could you explain the significance of choosing this selection, please?

A. [10:35:44] Yes. Well, hunger strike could mean many things. So what you would be wondering about is whether somebody is genuinely striking, which implies that they are -- they're denying themselves food in order to obtain some sort of preferable treatment or benefit or to express anger about a particular issue. If you see somebody going on a hunger strike, you would also need to question the possibility that they may not be eating because they are depressed. So loss of appetite, loss of weight is a symptom of depression; it can be a symptom of depression and it can also be an early sign of somebody who is actively suicidal that they start to deny themselves food.

However, you cannot necessarily infer that there is a mental illness present when somebody goes on a hunger strike. It can be a completely rational and instrumental decision and, in this case, the view of Dr Verbruggen was that Mr Ongwen was refusing food in a slightly childish way to express anger about what was going on.

Q. [10:37:29] And did you place any significance on the fact that he needed rituals performed to remove the curse?

A. [10:37:40] I -- I took that to be consistent with his belief system and his cultural background; not a symptom of mental illness.

Q. [10:37:54] I'm going to be referring to Defence tab number 5 in the thin binder, Dr. So UGA-D26-0015-0197.

A. [10:38:16] Sorry, "00"?

Q. [10:38:18] It's 0197. Have you read this article by Drs Ovuga and Abbo?

A. [10:38:35] I don't -- I don't think I've actually read this one. I don't think I have. If I haven't referred to it in my report, then I haven't.

Q. [10:38:49] No problem. Do you know they discussed that the issues of cen and orongo are actually manifestations -- possible manifestations of PTSD in the Acholi culture?

A. [10:39:08] No, I haven't read the article.

Q. [10:39:12] Now in discussion of the infantile reaction to his own anger, would it be significant to your forensic evaluation if Mr Ongwen has shown a childlike disposition throughout the years, not just in these few clinical notes that you noted?

A. [10:39:55] Not really. I mean, there are -- outside a psychiatric context, there are many adults who display somewhat immature or childlike responses in a variety of situations; it -- I would not consider it to be particularly significant. The one thing I would mention is that Mr Ongwen did have a psychological assessment which measured (Redacted). Now I think one has to treat that test with a degree of caution because not all psychometric measures are validated, particularly in translation, and also when they are conducted with individuals who are under a -- under stress; it may be more difficult for them to engage in that evaluation. But what -- what I would say, and it does relate to your question, is that (Redacted). is a mild -- it represents a mild learning disability in that only around 10 per cent of a population would be expected to have an (Redacted).

Again, a heavy degree of caution must be exercised because -- not just because of the cultural context, but also because the important issues that Mr Ongwen's education was completely disrupted because of his abduction. I mention that because if it was correct, then that might be an explanation for perhaps a slightly more childlike quality that one or two people have referred to and -- and the fact that Mr Ongwen may have more difficulty in articulating feelings of anger or outrage or conflict, and therefore they get expressed perhaps more readily as emotions. But again, there are

other reports that describe Mr Ongwen as a very intelligent man. I am aware that he's writing, I think, a diary or a book about his life and that would not appear to be entirely consistent with somebody who is operating at this low-intellectual level. So I apologise for the long answer, but the idea about being childlike, I think more relates to perhaps intellectual capacity rather than the presence or absence of any active mental illness.

PRESIDING JUDGE SCHMITT: [10:43:02] Shortly, Mr Obhof, since it is the Defence questioning, I did not intervene, but you know best what should be discussed in open session and what should be discussed in private session. You know, you have a -- I only wanted simply to address it shortly, and I think you have a plan; so I'm sure -- but I wanted to make sure, so to speak.

MR OBHOF: [10:43:30] I have one more question in public and then actually it says "confidential" on my page.

PRESIDING JUDGE SCHMITT: [10:43:35] Okay, so I had sensed it at least a little bit correctly. So please continue.

MR OBHOF: [10:43:38]

Q. [10:43:41] Is it typical of a heterosexual male within his mid-twenties to do the following act: Act like a girl, wearing dresses and creating fake breasts, and consider that especially in light of a -- or, as the Prosecution described it, in a war-type, military-type situation. Would that be a normal?

A. [10:44:14] It would be entirely wrong for me to comment on that. I'm not an expert in normal heterosexual men, I'm afraid. And certainly, again, one would need to take the cultural context into it and what people around thought and felt and believed was the cause of that behaviour, but I would not consider myself to have expertise to comment on that.

MR OBHOF: [10:44:45] So we don't need to go to private session; we're skipping over those questions.

PRESIDING JUDGE SCHMITT: [10:45 11] "We don't need", you said?

MR OBHOF: [10:45:15] Do not need.

PRESIDING JUDGE SCHMITT: [10:45:17] We do not need.

MR OBHOF: [10:45:23]

Q. [10:45:36] Now I'm going to paraphrase from paragraph 35. I'm going to -- at least inform me if I am not -- paragraph 38, pardon me. So please inform me if I'm not giving the gist properly where you say in relation to Dr de Jong's report: "In the absence of ..." reviewing relevant background material about the individual "there is a risk of uncorroborated hearsay assertions being reported as assumed facts." Would that be correct with the part I inserted, Dr?

A. [10:46:24] Yes.

Q. [10:46:26] Now in compiling your report, did you not talk or not discuss elements because you considered them to be uncorroborated hearsay?

A. [10:46:40] I'm sorry, could you repeat that.

Q. [10:46:41] In writing your report --

A. [10:46:43] Yes, yes.

Q. [10:46:44] -- did you not discuss certain issues or certain facts because you considered them to be uncorroborated?

A. [10:46:56] I think you're -- you're describing two different scenarios. The information I was sent was information I understood would be considered by the Court. As I said before, the facts of the matter are for the Court to determine; not for me. In terms of what I say about Professor de Jong, I am merely commenting on the need -- as I set out in paragraph 37, when you are conducting a forensic psychiatric

examination -- to ensure that you have all the material available to you. Clearly, the account given by a defendant in a matter such as this is going to be heavily influenced by their own subjective view and the potential benefits on them in terms of presenting themselves in a certain way.

Q. [10:48:10] But did you consider uncorroborated hearsay when writing your report?

A. [10:48:22] Well, if you can direct me to the particular uncorroborated hearsay that you're referring to, that would be helpful. I am aware that there were certain materials that had greater -- a greater factual basis, if you like, than others and needed to be considered differently.

So, for example, the evidence from the medical records that I briefly summarised, they were facts as far as I was concerned. There were other matters, such as in the transcripts that I was sent that were matters that had been heard in Court, but it was for the Court to determine whether or not those facts were to be accepted as truth. What I was being asked to do as a psychiatrist was merely to consider if they are true. Is there anything within that material that would either -- that would assist the Court in either determining whether Mr Ongwen had or has a mental illness or, indeed, would appear to negate any suggestion of mental disorder, which is what I did.

PRESIDING JUDGE SCHMITT: [10:49:45] Mr Obhof, I would not object if you go straightaway to the specificities that you perhaps have in mind.

MR OBHOF: [10:49:54] I don't know; I think she actually answered my question.

PRESIDING JUDGE SCHMITT: [10:49:57] Okay, good. Yes, even better.

MR OBHOF: [10:49:58] And if we do have a few more, we'll follow up during the next session.

Q. [10:50:10] Now in paragraph 44 of your report, you state: "There is also no

evidence that Professor de Jong attempted to challenge Mr Ongwen when he was reporting unusual symptoms, for example seeing double" cups of coffee, or -- "double coffee cups", sorry, "or when there was evidence of inconsistency." Now if you believe that someone is profoundly traumatised or psychologically unstable, is it professionally common to push hard on that person as one might do in a normal cross-examination?

A. [10:50:51] I think -- I think one has to and one does. You have to do it sensitively. And I think -- I think Professor De Jong saw Mr Ongwen, in fact, on two separate occasions, if that's correct. I don't think then you can, if you like, recoil from discussions that are going to be quite difficult or distressing to an individual if those discussions are necessary in order to be able to understand their mental state.

Q. [10:51:48] Now, Doctor, were you aware of the mandate of Dr de Jong?

A. [10:51:57] If Dr de Jong has set it out at the beginning of his report, I would have read that. I cannot recall what he says in his report.

Q. [10:52:09] I'll just remind you. And this is actually from the Trial Chamber, it's a targeted psychiatric examination of Mr Ongwen conducted by an expert appointed by the Chamber.

The purpose of this examination was twofold, to make a diagnosis as to any mental condition or disorder Mr Ongwen may suffer at the present time, and to provide specific recommendations on any necessary measures, treatments that may be required to address any such condition or disorder at the detention centre.

This is at Prosecution tab 19.

Now, considering that he was primarily focused on diagnosing, is it necessary to write down every small detail in which a patient discusses with you to report to the Chamber about possible mental issues and possible medications to take?

A. [10:53:20] Well, one still needs to undertake a rigorous and comprehensive psychiatric examination. My understanding is Mr Ongwen was not Dr de Jong's patient. He is not the treating psychiatrist. He was appointed by the Court Chamber to advise Chamber on mental health issues. In fact, Professor De Jong goes further because he does talk about mental disorder which is not just his current mental health and treatment needs in the here and now, but talks about his mental state over a prolonged period of time. So he goes beyond his instructions, if I can put it that way. Given the forum in which Dr de Jong was operating and how he was instructed, I would still expect him to follow rigorous -- the rigorous approach that is expected of conducting a forensic psychiatric examination of this nature.

MR OBHOF: [10:54:44] Your Honour, I think this would be actually a logical break.

PRESIDING JUDGE SCHMITT: [10:54:48] Then we have the break until 11.30.

MR OBHOF: [10:54:51] I think I'm on time for two one and half hours.

PRESIDING JUDGE SCHMITT: [10:54:54] I assume that. I think you would have alerted me if was otherwise.

So we have five minutes more than normally.

THE COURT USHER: [10:55:03] All rise.

(Recess taken at 10.55 a.m.)

(Upon resuming in open session at 11.29 a.m.)

THE COURT USHER: [11:29:48] All rise.

PRESIDING JUDGE SCHMITT: [11:30:11] Mr Obhof, you have the floor.

MR OBHOF: [11:30:15] Thank you, your Honour.

Q. [11:30:21] Good afternoon -- or, sorry, good morning.

A. [11:30:43] Morning.

Q. [11:30:45] Doctor, at paragraph 46 of your report --

THE COURT OFFICER: [11:30:54] ERN, please. Thank you.

MR OBHOF: [11:30:56] Yes, I'm getting to that. At page 0797.

Q. [11:31:05] You discuss how Professor de Jong --

A. [11:31:13] Sorry, could you give me just one moment?

Q. [11:31:17] No problem.

A. [11:31:17] Which tab is it?

Q. [11:31:19] It's tab 2.

A. [11:31:21] 0797 you said?

Q. [11:31:23] Yes.

A. [11:31:24] Okay.

Q. [11:31:28] You state that "Professor de Jong occasionally uses psychiatric terminology in a way that would not be generally accepted by the majority of psychiatrists. For example, he describes the beliefs that Mr Ongwen developed when he was a member of the LRA, such as those relating to spirits, as representing part of a delusional system. Such ideas might objectively appear to be strange or irrational, however they do not meet the definition of delusional beliefs, as they would have been common to others who shared Mr Ongwen's sociocultural background and in which he and others had been indoctrinated over the years." Now, Doctor, at page 5 of Professor de Jong's report he discusses this, that the "Psychiatric diagnostic (classification) systems distinguish voices, visions and thoughts that are part of the meaning system of a religious subgroup" --

A. [11:32:51] I'm sorry, could you give me the tab only?

Q. [11:32:53] Tab 5. Very sorry, Doctor.

A. [11:32:57] And the --

Q. [11:32:58] It would be on page 5.

A. [11:33:00] Page 5.

THE COURT OFFICER: [11:33:05] And the ERN page, please. Thank you.

MR OBHOF: [11:33:09] There is no ERN.

PRESIDING JUDGE SCHMITT: [11:33:11] I'm not so sure. I have here an ERN, UGA-D26-0015, and on page 0050. Or I might be wrong, but I have at least. And it appears to me it would start at 0046 and you want to refer to 5505.

MR OBHOF: [11:33:44] Your Honour, this is with Dr de Jong's report, which only you have access to the full copy. The original one is an annex to a Registry filing.

PRESIDING JUDGE SCHMITT: [11:34:00] I won't contradict you, but I really would like to insist that, since we are talking about perceptions and what people see and not see, I see here an ERN number at least. But of course continue. We know where you want to be.

MR OBHOF: [11:34:25]

Q. [11:34:25] It's in footnote 5, sorry, on page 5, where he discusses the distinction where he says: "Psychiatric diagnostic (classification) systems distinguish [between] voices, visions and thoughts that are part of the meaning system of a religious subgroup or a religion and hence do not qualify as psychopathological. In the case of the LRA this apparently is a complex issue."

Now, is it fair to say, as the doctor wrote in the footnote, that the identification of delusional thoughts is complicated by religious and cultural beliefs?

A. [11:35:16] I don't quite understand what Professor de Jong is saying here. But essentially a delusional -- you cannot diagnose delusions if they simply represent beliefs that are shared by others within that individual's socioculture or religious background. So the criticism sometimes is of western psychiatry that they will diagnose or label somebody as being psychotic or psychiatrically ill because they

misunderstand the meaning or nature of the experiences that they are reporting. So they may not be comprehensible to somebody in western society, but if they are shared by and considered to be accepted, acceptable by people from that same sociocultural context, it is inappropriate to define -- well, they do not represent delusional beliefs and do not represent any aspect of a psychiatric disorder.

Q. [11:36:45] But Dr de Jong noted that and he spent, if I'm not mistaken, three pages of his reports, page 20 to 22, discussing some of the cultural beliefs, specifically he discussed cen.

A. [11:37:06] Well, with great respect to Professor de Jong, I think he is incorrect. He appears to be saying two different things, in fact. At the bottom of page 4 he says "There are no delusions except for those that belong to the LRA's collective religious delusional system." That would not be recognised as representing -- that is not recognised within psychiatry.

If these beliefs are part of a generally shared accepted belief system, then they cannot be described as delusions and cannot be described as representing a mental illness.

Q. [11:38:01] So if somebody truly thought he was talking to the spirit of Juma Oris Debohr, or some spirit, and truly believed that and would hear the voices and be able to recite what was going on, then that person is not delusional?

A. [11:38:22] Well, one cannot be absolute. One would need to look at the context. One would need to look at whether other people from his same background, from the same cultural context consider those beliefs and those experiences to be abnormal and bizarre, or whether they agree that those kinds of experiences are reasonable and are understandable and are commonly shared. If the latter, then they do not represent mental disorder. If the former, then one would need to actually look further to see whether they could represent an aspect of mental illness.

Q. [11:39:16] So then it could be completely normal to somebody based upon their culture, based upon their sociological -- on sociological findings that somebody could talk with people who have been dead for 10, 15, 30 years, truly believe that, and so that would not be considered a delusion or some kind of mental disorder because their culture believes it even though they honestly hear voices or see the images?

A. [11:39:53] You would need to look at as an individual context. Again, just to repeat, even if you or I might find those experiences difficult to explain, and unusual, they do not necessarily represent a mental illness. So again one would have to put that within the context in which they are occurring, and one would also need to look at other features that you would expect to be present in somebody who was mentally disordered. So in the absence of any other impairment to that individual's functioning, in the absence of any clinical distress, one would hesitate to suggest that those experiences alone are indicative of a mental disorder or a delusional system. One symptom in itself does not necessarily lead one to conclude that there is a mental illness. It's a constellation of symptoms and signs, behaviours, interactions that actually allow you to put them together to decide whether or not that person is mentally well or mentally unwell.

Q. [11:41:26] So could these beliefs, these delusions tell people or ask people to do certain actions?

A. [11:41:43] Well, delusions don't talk to people. Could you just -- I think maybe what you're referring to are hallucinations, or are you referring to delusions?

Q. [11:42:00] Well, let's go with hallucinations because that was next on my list.

A. [11:42:06] Right. Hallucinations, that's a -- they are a recognised symptom associated with a severe psychotic illness. I mentioned yesterday the hallucinations that can be associated with a depressive disorder and those hallucinations are

generally auditory hallucinations. So the person experiences voices from the external space and the voices tend to talk to them in individuals who are depressed and they tend to be congruent, they are congruent with the mood disorder, so that they are typically critical, blaming, abusive voices. That would be consistent with a psychotic illness. They may in some circumstances even instruct somebody that they need to kill themselves because they are so worthless, they do not deserve to live.

In the psychotic, the hallucinations associated with a schizophrenic illness are slightly different. For example, in paranoid schizophrenia, the voices, again, they come from an external space, but they tend to comment on the individual. They give a running commentary on how that person is moving, how they are looking, what their expressions are, but they may also be instructive. So they may also instruct the individual to commit certain acts, again, which are congruent with their feelings of paranoia and threat.

So I apologise, that was a long answer and I've forgotten what the question was. So the short answer is, yes, in certain conditions, namely, paranoid schizophrenia, individuals may experience what's -- what's sometimes called command hallucinations, voices telling them to do things.

Q. [11:44:36] So this would also be indicative of somebody talking to their parents that had deceased in 1987 and the parents telling that person to kill himself and join them in the afterlife?

A. [11:44:52] Not, not necessarily. It's, it's quite a complicated business assessing hallucinations and what a lot of people experience is something we call pseudo-hallucinations, which is the experience of almost having a voice in your head, a running commentary in your head which, which represents almost a visualisation

of your own thought processes or your belief system. That is not indicative of a psychotic illness, but is actually an extreme version of what many of us experience in normal day-to-day lives. From time to time, people will almost carry on conversations with themselves or with another person in their mind which they know is part of themselves rather than an external body that is affecting their mind or influencing their behaviour.

So again, after that long answer, the short answer is, again -- following bereavement, for example, a very, very common response, a very common experience is for people to describe conversations with their -- with their loved one. This is more common following traumatic bereavement, but it happens after normal bereavement, that they have a sense of that person, they can hear that person's voice in their head. That represents a normal grieving reaction. It does not represent a serious mental illness or a psychotic process.

Q. [11:46:41] So you're saying they just talk in their mind. What happens when the person actually verbally talks to the person, not merely in their mind but actually voices those -- voices their opinion, his or her opinion to the hallucination to where people around them can hear the living being speaking?

A. [11:47:05] Well, again they don't necessarily demonstrate a mental illness or a psychotic process. And again, a corollary would be, for example, in people who hold very religious, strong religious beliefs and who feel that they are talking to God. They may have those conversations in real space. They may have a real sense of having those conversations and even hearing the voice of God.

Now, those kinds of religious experiences, one would hesitate to simply dismiss or -- or define or label as representative of a mental illness. Clearly they are not. So what you are describing is very much a normal aspect of certain kinds of a religious

and a cultural context, an aspect of normal behaviour, normal mental processing, rather than representing, again, a mental illness, an abnormality of mind.

Q. [11:48:12] So it would be normal for somebody to go through the grieving process - or I believe you used "bereavement" - 29 years after the action happened and 26 years after the person found out about the death?

A. [11:48:28] Well, one would need to look at actually what he was saying and what the evidence was for that. I'm -- I haven't read anything that suggests that these are experiences that are particularly persistent, constant, continuous, troubling or distressing to Mr Ongwen or that affect his mental functioning; and therefore, my view is that whether or not he has those experiences, they don't represent, they don't represent a mental illness and are not suggestive of a mental illness.

Q. [11:49:17] Now we're going to page 0799, which is paragraph 51 of your report, Doctor. Now you discuss the PHQ-9 and you state that: "It should" not -- "It should be noted that this measure was not developed or validated on a non English speaking population."

Have you read any reports about the validation of the PHQ-9 in any -- in Uganda?

A. [11:50:07] Not specifically in Uganda, no.

Q. [11:50:11] There would be another document in the small binder, the Defence binder, tab 11, UGA-D26-0015-0281. For those people who are not familiar with Uganda, Lugandan, or the people of Buganda, is the area around and north of Kampala. So in the report they discuss it being moderately helpful in detecting depression in persons from Uganda, specifically noting the people of Buganda. Also in that report, Doctor, they talk about a one Dr Akena, who did a similar study in 2013 on using the PHQ-9 for HIV patients in Kampala. Would it help, Doctor, if you had time to read this during the break before we discuss it?

A. [11:51:35] I think that's fine. I accept it if -- if that's -- I'm not sure when it was printed, when it was published, but I would accept that it has been used.

Q. [11:51:52] If I'm not mistaken, it was 2016 for the publication for this – for tab 11.

Now, is there any indication whether or not Dr de Jong would have known of this report before issuing the PHQ-9 test to Mr Ongwen?

A. [11:52:15] The -- I have no idea. You would have to ask him.

Q. [11:52:30] Now on the same page, 0799 and your paragraph 52 of your report, Doctor, you note: "Nor does" -- Dr de Jong -- "comment on the fact that Mr Ongwen was assessed as having mild symptoms of depression in June 2016, by the psychologist, as measured using the Hamilton Rating Scale ..."

And again, the explanation in footnote 6 of Dr de Jong's report goes on to state that: "Recognizing ... facial" -- "depressed facial expression is not easy for clinicians without extensive clinical experience in Africa or with African immigrants. The British psychiatrist Carothers mentioned even in the 19fifties that Africans seldomly manifest depression. Though his explanation was racist - he attributed his observation to less developed frontal lobes - it was and is often difficult for non-Africans to recognize the depressed mood. We know from epidemiological studies that depression in Africa is as prevalent as elsewhere."

Now, is that last sentence true about depression being around the same -- about as prevalent in Africa as elsewhere?

A. [11:54:12] Yes. Could, could I ask the Court if I could just very briefly, and I will answer that question, just return to the paper that was mentioned, the PHQ?

Q. [11:54:24] Yes.

PRESIDING JUDGE SCHMITT: [11:54:25] I think since, since you are sitting here

and are here to provide evidence and yes, do that, please.

THE WITNESS: [11:54:35] That's -- that's very kind. I just wanted -- having just seen the paper, just to draw attention to the Court, and I'm afraid we're back on the thin bundle, bundle 10. I think I'm stepping outside my expert role here, but bundle 10, that is the paper I was directed to in 2016.

MR OBHOF: [11:54:59]

Q. It's tab -- I believe it's tab 11.

A. [11:55:02] I'm sorry, it is tab 11. I apologise.

Q. [11:55:06] That's okay.

A. [11:55:08] Just to say, of course, I have not read the full paper, but I have noted the conclusions of the paper, which says something very similar to what I say in my report, that is the conclusion at the end of the abstract, which says: "The usefulness of the PHQ-2 in this rural population should be viewed with caution." That's a "2". But also the first sentence: "The Luganda translation of the PHQ-9 was found to be modestly useful in detecting depression."

That's, that's not very convincing, I have to say, as a clinician, and only performed slightly better than PHQ-2. So just to -- just to return to really what I was saying is that one has to be a bit careful in diagnosing something on the basis of a measure such as a PHQ-9.

Coming back to your question about facial expression, and I haven't opened Dr de Jong's report, I'm not sure when Dr Carothers wrote the report that you're referring to, I think it's quite historical, isn't it?

Q. [11:56:35] In the 1950s.

A. [11:56:37] The 19 -- very historical. Psychiatry has developed quite a long way since 1950, including the development of transcultural psychiatry, a much

greater awareness of the manifestations, how psychiatric illnesses express themselves and present themselves across different cultures. And there are a lot of other papers that have been written about this.

Certainly what I would say is that there are -- in various African languages there are far fewer words for depression than in western, western languages. And where there is no vocabulary to describe emotions it's very, very difficult then to elicit emotions or to be sure that you're describing what other people might consider to represent depression. It does not mean that depression does not exist. Clearly, clearly it does. But one has to be extra sensitive and careful about ensuring that you are capturing the behaviours, the emotions, the symptoms that one would normally need to -- one would normally need to have in order to make a valid diagnosis.

PRESIDING JUDGE SCHMITT: [11:58:18] And we have of course the difficulty that has been mentioned several times in the past days that we have first of all perhaps a state of mind currently and then we have to go back in time for -- certain legal conclusions that would have to be made in the end by the Chamber, but we would have to go back in time 15 years ago, for example, to try to discover what the mental state of a person might have been at that time. And that is --

THE WITNESS: Yes.

PRESIDING JUDGE SCHMITT: -- or has to be distinguished and that might pose even more difficulties.

THE WITNESS: [11:58:52] I agree. My -- if I could just say some of the experience I've had has been in Kenya, and I was instructed as part of the Kenyan emergency group litigation, and this involved interviewing a large number of Kenyans, Africans who had experienced very significant trauma and abuse, alleged, during the emergency rule. The examination of these individuals obviously needed to take into

account both their cultural context, but also the fact that we were talking about events that had happened around 30 years ago, 40 years ago probably. And so it is, it is an area that I have thought quite a lot about and had some experience in.

MR OBHOF: [11:59:55]

Q. [11:59:58] Well, thinking about these cultural issues and said earlier -- we said earlier facial expressions, isn't this something that Dr de Jong, who has worked quite extensively in Uganda, might have been keen and aware of, especially considering he noted it inside of his report, so he would have been aware of certain expressions in Uganda, certain facial expressions, body expressions which would lead to issues dealing with depression?

A. [12:00:29] Is there any particular part of the report that I could have a look at?

Q. [12:00:42] I don't know, if I remember correctly, it was in his CV. And like I said, he does talk about this issue on footnote 6.

PRESIDING JUDGE SCHMITT: [12:00:51] I personally think, I read the report thoroughly, I would also not label a certain page or something like that, but you derived this from his CV and from his background.

So it's a hypothesis that is put to you simply under the assumption that indeed he has this experience.

THE WITNESS: [12:01:13] Yes. I completely respect Professor de Jong's experience in that area. It's very difficult to -- it's very difficult to assess from his report the extent to which Mr Ongwen's facial expressions and behaviours during the interview were -- informed his diagnosis and formulation of what was going on.

Most of the time both he and others have described Mr Ongwen as being friendly, relaxed, talkative, and there hasn't been much description, I couldn't see much description in his report, I don't recall it, of facial expression per se. In fact what

Professor de Jong is describing is what any psychiatrist would be expected to do in a mental state examination, which is to, which is to consider the person's facial expressions, their eye contact, their body posture, their behaviour. So there is really no difference, I would suggest, from what Professor de Jong is saying from normal expected psychiatric practice and that would be regardless of where your client or patient is coming from.

MR OBHOF:

Q. [12:02:44] But de Jong did note, did he not, that this was merely a mask, that this was merely something in which he was trying to hide his feelings?

A. [12:02:57] Well, that is a hypothesis and speculation on the part of Professor de Jong, but I have seen no evidence to see, to show that he tried to test out that hypothesis with Mr Ongwen.

Q. [12:03:17] But he did note that he understood some of the -- that he has experience there and that he, at least from the way it reads, that he does understand at least some type of body language or some type of cues you would say to identify that somebody is merely masking their true intentions and has an outwardly, friendly demeanour but yet is depressed inside?

A. [12:03:46] As I said yesterday, it would be helpful if Professor de Jong would be able to provide an explanation or a motive as to why he feels that that might be the case.

In practice it is very difficult for people to either mask their symptoms because they -- in severe mental illness you do not have control over your thought processes and behaviours and feelings. You often don't have insight into the fact that you have a problem with your feelings and behaviours and so you therefore don't feel the need to control them.

But also given the fact that Mr Ongwen was seeing a mental health professional who I think he perceived as being on his side or at least friendly to him, who was there to assess his mental state, who was there to consider his needs, it would be very difficult to understand why Mr Ongwen would feel the need to mask those symptoms when in all other respects he appears to be entirely open with Dr de Jong about nightmares and about other experiences that he is having.

PRESIDING JUDGE SCHMITT: [12:05:08] I have a general question in that respect that interests me. If it would be easy to mask your feelings as a patient, your state of mind, wouldn't this mean for your profession that a lot of the basis for psychiatric expertise would be destroyed?

THE WITNESS: [12:05:29] Well, it might, be I think the bigger problem in forensic work is the risk of people exaggerating or faking symptoms in order to excuse themselves or avoid responsibility.

PRESIDING JUDGE SCHMITT: [12:05:52] May I shortly. If you want, it goes both ways. If you want to answer both ways, that would be interesting I think.

THE WITNESS: [12:05:59] The faking? It's again faking, faking of symptoms is very well described. It's very common. It's quite difficult, unless you have read a lot of books and are very clever and are very persistent, it's quite difficult to fake convincingly over a period of time. You can occasionally produce symptoms that look like mental illness, but to maintain that is almost impossible. And there have been a number of experiments in fact that have described individuals who have tried to dissimulate psychiatric illnesses and have given up after a few days or weeks because it is so difficult. So psychiatrists are quite, quite good usually at picking up non-genuine complainants.

In terms of masking symptoms, the area that that has been described in as sometimes

being in fact with middle-aged men, in relation to depression, that is, that is the one condition where masking of symptoms has been described and that is thought to relate to certain somewhat macho, if I can use that word, but macho notions of what it is to be mentally ill, what it is to be a man, that you cannot be weak, you cannot show your emotions, you cannot be dependent on other people. And in a certain group of men it's been suggested that they will often mask their symptoms because of fear of losing face.

There is no literature I have read on masking post-traumatic stress disorder symptoms. It just does not exist. For various reasons. It may be that that post-traumatic stress disorder is a disorder that people quite like to have in a way because it identifies the problem as being outside the individual rather than inherently due to your own weakness or inability to, inability to cope.

I have also not found it -- not much evidence on individuals being able to mask symptoms of severe mental illness of any kind, particularly psychotic illnesses because -- probably because the individual themselves does not have insight into the fact that they are mentally ill and also because they simply do not have that agency and ability to control their symptoms.

So hopefully psychiatrists won't be made redundant, but the inclination of most people is that they will talk about symptoms.

And the final point is that it is not just what the people say, what people say about their symptoms, it is how they behave and if their behaviour is congruent. So somebody may not talk about depression, but if they are not eating, if they are losing weight, if they are staying awake at night because they can't sleep, if they are restless and agitated, they look as if they are mentally ill even if they do not wish to disclose those symptoms directly to you. And so one would need to actually use other

sources to make a diagnosis rather than necessarily just relying on the individual's self-report.

MR OBHOF: [12:10:31]

Q. [12:10:32] I'm going to read a small passage from Dr de Jong's report. "Although his mood seems" --

PRESIDING JUDGE SCHMITT: [12:10:37] Where are we?

MR OBHOF: [12:10:38] Page 5, sorry, "normofore" on tab 5 "... the undertone is depressed, and he suffers from anxiety. He tends to hide his depressed mood in a culturally congruent manner in order not to embarrass others, and sometimes laughs to cover up emotions."

Q. Now, are these some of the undertones, some of the issues that one must look whilst somebody is self-reporting and talking, as laymen would say, reading between the lines?

A. [12:11:11] I find it -- I did find it quite difficult to understand what the basis of Professor de Jong's speculation was, on what evidence was he making that suggestion, because if you are faced with somebody who is cheerful, talkative and relaxed, you cannot simply infer that actually they are deeply depressed, they are merely hiding their symptoms, unless there is some evidence from other sources which appear to confirm that hypothesis. It is -- also would be wrong to make that inference without showing in your report that you have attempted to raise that with the individual and explore that hypothesis.

Now, I have not seen anything in Professor de Jong's report to suggest that he did and therefore it looks somewhat speculative.

If I may add one other point very quickly, which is that when I read these reports I did put in a request for the handwritten records and I understand that that was not

felt to be appropriate by the Court, which I completely understand. But one of the reasons I made that request is because I felt that I needed in my own mind to try and separate out what were Professor de Jong's views and speculations, hypotheses about what Mr Ongwen was thinking and feeling as opposed to what Mr Ongwen himself was directly reporting. And also to what extent the complaints of symptoms were spontaneously reported by Mr Ongwen or to what extent they were responses or to prompts or suggestions by Professor de Jong. And again that would help one to interpret and understand exactly what had led Professor de Jong to draw these conclusions.

Q. [12:14:03] Thank you. On page 0800 of your report, Doctor, at paragraph 56 you write that "I am not convinced that Mr Ongwen currently, or has ever, manifested other core post-traumatic symptoms such as significant distress, hyperarousal, re-experiencing or dissociative symptoms or poor concentration." Could you explain to the Court what hyperarousal is?

A. [12:14:51] Yes. Hyperarousal is feeling on edge, being unable to relax, being constantly in a state of alert, being very sensitive to environmental threat, perhaps being easily startled so that if there is a noise or something unexpected, that individual looks frightened, looks aroused.

Q. [12:15:23] How about avoidance?

A. [12:15:26] Pardon?

Q. [12:15:27] Avoidance, sorry. Could you explain what avoidance is?

A. [12:15:31] Avoidance?

Q. [12:15:32] Yes.

A. [12:15:33] Again, as I mentioned yesterday, it's one of the core -- it's a core feature of post-traumatic stress disorder and it relates to the avoidance of memories,

thoughts, feelings, situations, behaviours that are reminiscent of the original trauma.

Q. [12:15:54] So a type of avoidance would be say somebody starts having bad dreams or bad memories and in order to expel those, such a person reads the Bible or maybe writes in his notebook, would those be ways of avoiding --

A. [12:16:12] No, no, that would not be post-traumatic avoidance.

Q. [12:16:17] So what would be avoidance then if (Overlapping speakers)?

A. [12:16:19] Post-traumatic avoidance would be a refusal to talk -- in Mr Ongwen's case, a refusal to talk about any of his experiences and manifestation of extreme distress and agitation if he was having to talk about them. What people who are traumatised do is that they absolutely try and avoid any reminders of the trauma because of the sense of being overwhelmed and out of control.

Q. [12:16:51] So you could also consider a type of avoidance is telling his psychiatrists or psychologists he does not want to meet with them, whether it be so he doesn't have to talk about his experiences?

A. [12:17:05] Well, it's avoidance, but it's not post-traumatic avoidance, I would say. There is ample evidence that Mr Ongwen is more than willing to talk about his experiences in the LRA. He has talked a lot about his experiences to both Professor de Jong and to Dr Akena and in other settings. He's written about his experiences. There is no cognitive avoidance post-traumatic. People avoid in a general sense for all sorts of reasons, but they are not necessarily pathological.

Q. [12:17:52] Where has Mr Ongwen written, could you let me know? I'm wondering because I've never seen it. Where has he written about all of his experiences?

A. [12:18:04] I may have got that wrong. I know he's writing a diary, is my understanding, if I can check with the Court.

Q. [12:18:12] I know there was --

A. [12:18:13] Because he wants his experiences to be known about in the future. That is my reading of what happened.

Q. [12:18:19] I know there was a miscommunication where somebody once said that, and you are correct, but it is a diary which was asked by a psychologist and a psychiatrist for him to write to help cope with his problems. Just so you can understand.

A. [12:18:36] I understand and that's fine. But I have been struck, I think Dr Lafrandt also notes no avoidance symptoms, I think it's Dr Lafrandt or Dr Verbruggen, in the medical records. Again the fact that without avoidance symptoms you cannot diagnose PTSD, and the fact that somebody is willing to talk about, to think about their experiences, and even more importantly that they do not break down when talking about their experiences, they do not psychologically dissociate or become incapable of continuing, that demonstrates that there is no post-traumatic avoidance.

Q. [12:19:40] Let's talk a little bit about the dissociation. Do you remember reading in de Jong's report about the New Year's Eve fireworks?

A. [12:19:48] I do.

Q. [12:19:49] How would you classify that for a person to believe while he's in The Hague for almost a year to think that the UPDF was coming to attack him on the beaches of Scheveningen?

A. [12:20:01] Well, again, that's a self-report by Mr Ongwen, and I'm afraid that -- I think there may have been a reference in fact to nightmares as well in the medical reports, if I'm correct, but I think one does have to regard self-report with some scepticism. That's my first comment.

The second comment is that again a single symptom does not represent a disorder. If fireworks -- I don't know how common fireworks were in Uganda and it would depend on how familiar he was, but actually fireworks can sound remarkably similar to gunfire and I would not be at all surprised if Mr Ongwen found the experience somewhat disorientating and disturbing. But in and of themselves they do not necessarily represent an abnormal psychological -- abnormal psychological processes or post-traumatic stress disorder.

Q. [12:21:16] You also say in paragraph 61 of your report that "in the absence of clinically significant distress ... and impaired functioning ... the full disorder cannot be diagnosed." And I removed the "not present in Mr Ongwen".

A. [12:21:39] Yes.

Q. [12:21:41] Now, how can you be so certain without interviewing Mr Ongwen?

A. [12:21:49] I don't think I'm expressing certainty in that in that paragraph and I'm being -- trying to be careful about distinguishing current evidence - and there is quite a lot of current evidence, particularly from the medical records, psychological records that I've read since Mr Ongwen's detention - and historical diagnosis. And again the historical diagnosis, for the historical diagnosis I've relied on all the material I've been sent, looking at the transcript, hearing the audio recordings and the video material. Is there evidence that there was significant distress there? Was it reported by anybody in the field, any of his comrades, his wife, his wives? And was there evidence of impaired functioning associated with a mental disorder? So that would be the historic aspect.

Since his detention here, he has been distressed from time to time, of course, but that distress has been entirely proportionate to and explicable by his current circumstances. It does not represent, in my view, necessarily a mental disorder,

1 although he -- from time to time he has had some depressive symptoms. And it
2 certainly, as I said before, doesn't give you any indication as to how he might have
3 been 20 years ago.
4 Q. [12:23:47] Could you also explain what impaired functioning truly means,
5 with examples, impaired functioning for the purpose of post-traumatic stress
6 disorder?
7 A. [12:23:59] Impaired functioning in certain areas, so in social relationships it
8 would include -- it could include social withdrawal, it may include not seeing friends,
9 not wanting to go out, a loss of interest in your usual activities or hobbies. It may
10 include arguments and difficulties with family members. It would affect
11 concentration, so it would affect your ability to function in education, so to
12 concentrate at work, to perform -- to continue with your studies. It would affect
13 your work, your relationship with your colleagues, your ability to concentrate, to
14 remember, to process information. So essentially the activities that most of us take
15 for granted on a day-to-day basis in our interactions and our day-to-day activities
16 would be extremely difficult for an individual with a serious mental health condition.
17 Q. [12:25:15] Some example could be somebody sitting in their room and crying
18 and not socialising with others?
19 A. [12:25:23] That, that -- if somebody is crying you would need to explore their
20 mood state. People cry for all sorts of reasons. It doesn't necessarily indicate that
21 they have a mental illness. It's a normal emotion. You can't infer anything from
22 that and that is not actually what I'm talking about in terms of social functioning.
23 So for Mr Ongwen, for example, if he -- I think he was learning -- he was going to
24 education classes, for example. So if he was unable to attend education, if he was
25 unable to concentrate in the education class, if he was unable to learn, again, not just

because he didn't want to but because he simply could not focus on what was being said to him, he could not process the information, he could not concentrate or retain it, and if that represented a change in functioning, then that would be an example of impaired, impaired functioning associated with a mental disorder.

Q. [12:27:09] At page 0804 of your report, Doctor, paragraph 71, you state there's no indication of a dissociative episode, avoidance or excessive anxiety in long interviews with Dr de Jong and that is -- and that would be expected. Does this -- does this observation drive your conclusion that Mr Ongwen may be malingering?

A. [12:27:56] It drives my conclusion there is no evidence currently for mental disorder, that he is not currently mentally ill, at least was not mentally ill at the time he was assessed by Professor de Jong.

Q. [12:28:15] But as you stated, especially in relation to dissociative disorders, yesterday, that people with dissociative disorders do not exhibit continuous dissociation; is that correct?

A. You would not expect to see continuous state of dissociation over a period of days or months or years.

Q. [12:28:38] It would be areas of hours, maybe a day?

A. [12:28:42] Dissociative reaction is generally minutes, could be, could be a bit longer, minutes or hours, but not longer than that.

Q. [12:28:56] Now, is it ever the case that the dissociation occurs largely in response to specific stimuli?

A. [12:29:06] Yes.

Q. [12:29:08] At page 0802, paragraph 64, you discuss about there being no information about Mr Ongwen's alcohol or psychoactive substance. Now when you

were writing your report, did you consider any of those factors or did you assume that he has none?

A. [12:29:44] Professor de Jong doesn't provide information, but information is provided in other reports and it's in line with I think Mr Ongwen's religious beliefs that he does not drink and does not use drugs.

Q. [12:30:02] When you wrote your report, did you use that as your determining factor, that he did not -- sorry, not determining factor. Let me start over. When you wrote your report, did you do that under the assumption that he did not use alcohol and did not use psychoactive substances whilst in the LRA and whilst at the detention centre?

A. [12:30:27] Well, that is normally something I would have questioned him about, so this is hearsay, but everything I read suggested that drugs and alcohol were not a feature. So the reason I mention it in 64 is simply to note the fact that if you are going to make a diagnosis of dissociative disorder, it is important to take that into account. And there was no evidence in Professor de Jong's report that he had considered that.

Q. [12:31:02] Would it also be considered that you're not allowed to have alcohol at the detention centre, not allowed to have drugs at the detention centre?

A. [12:31:14] I'm not -- sorry, I'm not sure of the question.

Q. [12:31:18] Well, you keep speaking in possibilities and that you're not allowed to have alcohol or psychoactive drugs, illegal psychoactive drugs in the detention centre. So would it necessarily be required for him who is making a diagnosis for the here and now, not for 2002 to 2005, but for the here and now, would that be necessary to write in his report that Mr Ongwen does not use alcohol and does not use psychoactive drugs?

A. [12:31:52] Yes, I wasn't entirely clear from Professor de Jong's report about the timeline because from time to time he seemed to be talking about a longstanding diagnosis, at other times he seemed to be talking about a diagnosis in the here and now.

And I'm sure security is much tighter here, but certainly in many prisons it is possible to get alcohol and drugs into the prisons, unfortunately. They can have an impact on the individual's mental state.

I am not suggesting that alcohol or drugs were important, but I'm simply noting the fact that if Professor de Jong is going to make the diagnosis which is not a here and now diagnosis, it implies a chronic longstanding, enduring condition, it would have been helpful and necessary to have explored or explicitly excluded the possibility that these kinds of symptoms had been precipitated by alcohol or substance misuse.

Q. [12:33:13] You also state about how you were trying to -- about how the -- you were unsure of the diagnosis he was talking about in the previous years of while he was in the LRA. Isn't getting a patient's history and trying to figure out how long something has been happening or if it happened in the past part of the diagnosis for the here and now?

A. [12:33:37] It is.

Q. [12:33:38] So I'm just wondering, why would you find it unusual that he was trying to find maybe that he had PTSD or dissociative disorder?

A. [12:33:45] No, it's not that I find it unusual. I find it -- I'm commenting on the fact that it is impossible to tell from Professor de Jong's report what the chronology was of these conditions and whether he is talking about something that's current or something that's historical, and if historical, what's been the cause of that illness over the years?

Q. [12:34:15] Page 0805 of your report, paragraph 76, you note that only Dr Akena visited Mr Ongwen. Does it help you to know that Dr Ovuga actually visited Mr Ongwen five times in November of 2016 -- or, sorry, October, at the end of October 2016?

A. [12:34:54] Well, it would be helpful to have known the methodology of the report writer. Normally if you write a report you are an independent expert and you write a report based on your own mental state examination of all the material and your interpretation and formulation of the case.

In the way I read it, it was quite difficult to work out the methodology, but it appeared to me that Dr Akena had seen Mr Ongwen on five or six occasions and that there had been some telephone discussion and contact between him and Professor Ovuga, but I was left somewhat unclear as to what their respective roles were in terms of writing the report and formulating the opinion.

Q. [12:35:49] So two doctors visit a client, we'll say. Are they expected to write individual reports or could they write a joint report?

A. [12:36:01] Are you saying they both visited together, is that --

Q. [12:36:03] Yes, they did.

A. [12:36:04] -- what you're telling me? Yes.

Well, the -- I suppose the closest experience that I would have is as -- it would appear that Professor Ovuga is the more experienced and senior of the two doctors. If I carry out an assessment with a senior trainee, for example, which is maybe equivalent to this, and we would both see the individual together, I think it would be made clear, first of all, who is taking the responsibility for providing an opinion. But more than that, it will have to be made clear with whoever was instructing the psychiatrist involved who was being instructed and whose opinion was being sought because this

is not a collective opinion that's being gauged, it is the opinion of an individual expert.

So although I might be involved in supervising a trainee in an assessment, if they are the doctor who is being instructed and engaged, ultimately it is their independent professional opinion that they are giving themselves. If a case is particularly complex or difficult, I might take a junior doctor with me for training purposes, but I would write the report if I was being instructed to give my opinion.

Q. [12:37:46] You also mention about not seeing Dr Akena's CV. For one, is it necessary to submit a CV in such a report?

A. [12:38:00] Well, I suppose I'm just reflecting a degree of confusion about the methodology, whose opinion I'm reading. If I'm reading Professor Ovuga's report, then, yes, it would be helpful to see Professor Ovuga's CV. If it's Dr Akena who is writing the report, I would want to see his. Again, it appeared as if it was Dr Akena who was conducting the mental state examination, but clearly what you're telling me is that that is not the case.

Q. [12:38:48] So is it necessary to have a CV?

A. [12:38:50] I think it is necessary to -- I think it's helpful to have a CV because you can then understand what the basis of that individual's opinion is. One can assume if somebody is appointed by the Court, that they have an expertise, but it does help to put that expertise into perspective.

Q. [12:39:13] Did you ask the Prosecution for a copy of their CVs?

A. [12:39:17] I think I may have had a conversation at some point and wanted to know what their backgrounds were.

Q. [12:39:25] Did you know there's a record of their CVs on file with the Registrar here at the Court?

A. [12:39:34] I don't think I do.

PRESIDING JUDGE SCHMITT: [12:39:36] I think Mr Gumpert has shortly misunderstood the background of the question, like me, for a second or two, but I think now we are on the right page.

Meaning, Mr Obhof, that I think, Mr Gumpert, you have understood it shortly that if you were asked to provide a CV, you were asked to provide a CV to the expert, which of course is not the case.

No, it's just to -- please continue.

MR OBHOF: [12:40:11]

Q. [12:40:15] Doctor, what's the generally accepted sequence of questioning in a psychiatric examination?

A. [12:40:38] Are we talking about the mental state examination or the full psychiatric examination?

Q. [12:40:48] Let's start off with the mental state.

A. [12:40:51] The mental state examination is fairly standard. First heading is appearance and behaviour. And that touches on what you were talking about earlier, which is the person's presentation, eye contact, posture, interactions. That's appearance and behaviour.

Secondly, you're looking at their speech, the form and content of their speech and whether there are any abnormalities in the form or content or flow that are suggestive of mental illness.

You then conduct, carry out a number of questions relating to mood. I'm not going to go through all the questions. These are just broad headings. So exploring depression, exploring hypomania, exploring anxiety, agitation, restlessness.

You then use questions to explore their thinking, gain the form of their thinking, the

content of their thinking, thought disorder, which is to do with the sequencing of their thinking, whether they are experiencing any abnormal thoughts such as delusions, whether they are having any abnormal experiences such as hallucinations. This is a brief description.

And then the final, the final areas is cognitions and that can vary, but essentially you're looking at whether somebody is cognitively intact. So you're particularly looking at areas of attention, of concentration, of memory, of perceptions, of ability to process and retain information.

Q. [12:42:45] Now, what kind of examination would you do if you were doing it say for a criminal trial at the ICC of an accused?

A. [12:42:57] You carry out the same process. The mental state examination is a part, as I said, it's the equivalent of a GP or a physician putting a stethoscope to your chest, listening to your chest and trying to diagnose a chest complaint. It's the equivalent. It sits within the full psychiatric examination, which explores the person's whole life in terms of their family history, personal history, mental health and physical health history, forensic history, alcohol and drug use, sexual history. So it builds up an entire picture of the individual and their functioning as far as one can.

Q. [12:43:59] Now, in your letter -- did you ever receive a letter of instructions from the OTP in how to conduct an examination if you were to conduct an examination on Mr Ongwen?

A. [12:44:14] I cannot remember receiving a letter of that kind.

Q. [12:44:20] Is it your understanding that Mr Ongwen has almost no formal education?

A. [12:44:29] From the age of around 10 I understand that's the case, yes.

Q. Could you explain how it is that somebody with no formal education who lived in the bush for approximately 27 years and somebody who arrived at the detention centre essentially unable to communicate with anyone would have a means of determining how to game the system or fake, be a malingerer.

A. [12:45:13] I think people are -- I don't think you need a formal education in order to malinger or to fake. In a way it's common sense, appearing depressed, talking about things that are strange or incomprehensible or worrying, behaving in certain ways that are going to bring attention to you or cause concern. One does not need a formal education. That's the first thing I'd say.

The second, second issue is looking at how these kinds of symptoms develop because I'm aware that Mr Ongwen has been in detention for two years. He has also been seen by a number of mental health experts, both as part of his treating team, but as part of the ongoing examination, forensic examination. And however careful we are as mental health professionals, sometimes there is a tendency to suggest symptoms or to, through direct questioning, to prompt certain responses, and certain responses by a defendant may then elicit a reaction from the examiner or from others that they then recognise as being helpful or sympathetic to their cause. And so people do learn over a period of time what responses are likely to result in secondary gain for them and what responses are perhaps less desirable.

So particularly, and this is no criticism at all of the psychiatrists involved, but particularly if you see an individual over five or six sessions when you are actively probing symptoms of post-traumatic stress disorder, symptoms of dissociation and depression, it is very likely that the individual will understand and realise that these are symptoms that are being sought and might be helpful.

Q. [12:47:52] So how would one ever diagnosis PTSD if it would be faked so

much? I mean you said that issues are hard, you know, the signs are hard to fake, all of them, sorry.

A. [12:48:06] They are. Are you talking about current or in the past?

Q. [12:48:10] Let's start off with current.

A. [12:48:13] Well, in -- currently where there is an incentive, if you like, to manufacture symptoms, what you are trying to do is to not simply rely on what the person tells you, but to look at how they are behaving and, you know, where those behaviours are inconsistent with or incompatible with a diagnosis of PTSD. So if somebody tells you that they are constantly on edge, constantly in a state of fear, they think they are being attacked every day and yet they are able to sit in the room with you for two or three hours, they appear relaxed they're joking, they're friendly, there is no abnormality, there is no evidence of distress or dissociation, then one has to seriously question the self-report because the disorder is not manifest in the room with you.

Q. [12:49:36] If I remember correctly, yesterday you talked about historical, so we won't have to go back into that.

I'm sorry for keep going over, I didn't put ERN page numbers, so I have to check every single time I talk about a new paragraph.

It is ERN 0806 and at paragraph 83. You notice that it was not clear as to whether there was any discussion between the two experts, the Defence experts, which I'm assuming when you said the experts, whether or not it was clear whether or not Dr Ovuga and Akena, am I correct? Or do you mean de Jong and --

A. [12:50:51] Whether Professor de Jong and Professor Ovuga and Dr Akena talked to each other.

Q. [12:51:00] Okay. Now is it generally okay for experts to talk to one another

before they do an examination?

A. [12:51:09] Not really. I would say there would be a conflict, potential conflict of interest and a potential undermining of that individual's independence as a professional expert. My view would be that you would need to consider material, conduct your examination and come to an independent view as to diagnoses before you speak to the other expert, if that is then required by the Court.

Q. [12:51:48] Did you talk to Dr Abbo or Dr Weierstall before writing your report?

A. [12:51:57] No.

Q. [12:51:57] Did you make any alterations after talking to them -- sorry, please go ahead.

A. [12:52:03] I may have had a conversation -- in fact, if I can correct that, we had a brief telephone conversation simply to introduce ourselves to each other. We did not discuss at all our views on Mr Ongwen or have any discussion about the material that we'd been provided with.

PRESIDING JUDGE SCHMITT: [12:52:29] I think we have to -- indeed you have incorporated this in paragraph 15 of your report, this is 0789. And if Mr Obhof would not have brought it up, so to speak, I would have done it in this context. Perhaps you can elaborate a little bit more on what it means to "discuss our involvement in this case".

THE WITNESS: [12:52:51] Yes, I can. I was not familiar with Dr Abbo or Dr Weierstall or their backgrounds, and I think in terms of our own methodology, we thought it would be helpful just to understand the perspective of each other, where we were coming from in preparing the report and what aspects we felt we had the necessary expertise specifically to comment on.

So the discussion really was around what our relevant experience and expertise had been, what our thoughts were about the areas that we thought we could appropriately comment on and an idea about the time scale and what our methodology would be in terms of reading the material and at that stage hopefully interviewing Mr Ongwen.

It was probably about -- we spoke for about 30 minutes and it was helpful in terms of understanding Dr Abbo's experience as a child and adolescence -- in child and adolescent work and also with victims of trauma and Dr Weierstall's experience particularly with boy soldiers and my experience, which I felt was specifically in the area of forensic psychiatry and the assessment and diagnosis of mental health conditions associated with offending.

PRESIDING JUDGE SCHMITT: [12:54:33] Thank you.

I think you are indulgent with me, Mr Obhof.

MR OBHOF: [12:54:38] Of course. It happens at least once a term where you read out my next question.

Q. [12:54:44] Did you ever ask the Prosecution to find out that in fact de Jong and the Defence experts did not talk to each other and in fact from what we know de Jong never even had their reports?

A. [12:54:56] No, I don't think I did.

Q. [12:55:00] So why was it important for the three different experts to know the backgrounds of each other?

A. [12:55:15] Are you talking about myself and Dr Abbo and Dr Weierstall?

Q. [12:55:23] That's correct.

A. [12:55:24] I think it's just because it helped again contextualise what I was doing and because our names had been -- we had been instructed together essentially

as a team, was my understanding, and at some point I anticipated that the three of us might be required to discuss our opinions so simply, for the simple reason I think of really just introducing ourselves, understanding what our experience was and familiarising ourselves with each other's work. But there was no particular purpose outside that or gain or influence over what we were going to then -- the opinion that we were then going to give.

PRESIDING JUDGE SCHMITT: [12:56:24] I think Professor Weierstall addresses this in his report a little bit more specific. I don't have the ERN number, but I have the wording and I put it to you, so to speak, Mrs Mezey. He explains at paragraph 1.3 that "All experts agreed to not exchange their clinical hypotheses and methodological approaches prior to writing up their individual reports in order to exclude potential biases and remain as objective as possible". So this is what is incorporated in Professor Weierstall's report.

THE WITNESS: [12:57:07] Yes.

PRESIDING JUDGE SCHMITT: [12:57:09] Would you agree from your recollection?

THE WITNESS: [12:57:11] Absolutely I would agree with that, yes.

MR OBHOF: [12:57:17]

Q. [12:57:25] But did you know when writing your report that Dr Akena is from the same ethnic group as Dominic and understands the local cultures, languages, expressions and rituals? Did you understand this when you were reading the report?

A. [12:57:46] I think I did. I think I read that somewhere.

Q. [12:57:53] Did you also understand that Dr Ovuga is from a neighbouring culture, a similar but slightly different culture as Mr Ongwen, or ethnicity I

should say?

A. [12:58:09] I think I was aware of that. I couldn't provide you with the details though.

MR OBHOF: [12:58:17] I think this is good for lunchtime.

PRESIDING JUDGE SCHMITT: [12:58:19] I agree. But can you tell us if after the lunch break a normal session would be sufficient for your questioning?

MR OBHOF: [12:58:31] I would just ask if we can come in at 2.20. So it's not really an extended session. I should be able to finish in 90 minutes, but I want to have that 10-minute buffer just in case.

PRESIDING JUDGE SCHMITT: [12:58:42] I think we could even continue, extend a little bit beyond 4 o'clock because 2.20 is a little bit odd. We are not used to it. You know we are all, the people, we are accustomed to certain procedures here and time schedules and to change this might be too complicated.

Lunch break until 2.30.

THE COURT USHER: [12:59:12] All rise.

(Recess taken at 12.59 p.m.)

(Upon resuming in open session at 2.30 p.m.)

THE COURT USHER: [14:30:47] All rise.

PRESIDING JUDGE SCHMITT: [14:31:10] Good afternoon, everyone.

Good afternoon, Ms Mezey.

And, Mr Obhof, you still have the floor.

MR OBHOF: [14:31:21] Thank you, your Honour.

Q. [14:31:25] Good afternoon, Doctor.

A. [14:31:26] Good afternoon.

Q. [14:31:26] Had to get rid of the gum, sorry.

Now, in paragraph 85 of your report at 0807, you say that the absence of observations of tearfulness and retardation, amongst other things, contribute to your conclusion that Mr Ongwen does not have a major depressive disorder.

Now, we mentioned this brief earlier, but you didn't note at tab 44, at Defence document D26-0015-0140, where it says -- where the clinical notes read that: "He occasionally feels so angry and desperate that he has to cry."

Now, does sitting alone and crying or even crying in one room represent tearfulness?

A. [14:32:32] Crying is, I would say, the same as tearfulness.

Q. [14:32:43] Now, also at paragraph 55, you say there is no evidence of sleep disturbance?

A. [14:32:51] Sorry, paragraph 85?

Q. [14:32:54] Correct.

A. [14:32:55] Yes.

Q. [14:32:56] That there's no evidence of sleep disturbance. Now I am having trouble understanding this when your own report notes a number of occasions and problems of sleep, merely, paragraphs 27, 28, 29, 30 and 50, and also the clinical notes have no fewer than at least 13 areas, 13 different notes in which they talk about sleep disturbances. If I get the clinical note from 22 to 16, where they say that Mr Ongwen has barely slept for two weeks and that they actually started him on -- and I'm sorry, I am going to mispronounce this, promethazine.

A. [14:33:50] Yeah, no, that's correct.

Q. [14:33:51] So it does appear that there are sleep issues with Mr Ongwen?

A. [14:33:57] There are certainly reports of sleep disturbance between 2015 and when the records end, 2016.

Q. [14:34:06] And just so everyone knows, what is a circadian rhythm in terms of

a human body, in layman terms?

A. [14:34:19] I think I can only explain it in layman terms. I mean, it's a natural body rhythm in terms of the wake/sleep cycle and times of the day or night when the body is more or less alert, essentially.

Q. [14:34:34] And so there are issues when people are sleeping opposite; so when they are sleeping during the day and being awake at night, excluding those who work at night. So is that normal for people to be going back and forth? Say, sleeping at night and then a few weeks later, sleeping during the day and then a few weeks later, sleeping at night?

A. [14:34:56] I'm not a sleep expert, but it's not particularly usual.

Q. [14:35:03] Now you also notice where the -- as I just said, the detention centre did attempt to administer sleeping pills or drugs for sleeping for Mr Ongwen?

A. [14:35:26] Mm-hmm. Sorry, Yes. Yes.

Q. [14:35:36] Now, at the same paragraph, at 85, you say there is no evidence of weight loss. Where you say:

"Indeed many of the symptoms of depressive disorder are explicitly negated, as being currently present, for example Mr Ongwen is described by the clinical psychologist ... as having gained weight."

A. [14:36:03] Yes.

Q. [14:36:04] Now isn't the side effect of some antipsychotics weight gain?

A. [14:36:09] He's not on anti-psychotic medication. Well, he was put on promethazine, but that weight gain is not a particular side effect of promethazine.

Q. [14:36:20] How about antidepressants like melatonin or SSRs -- SSRIs?

A. [14:36:28] Melatonin is not associated with weight gain.

THE INTERPRETER: [14:36:32] Your Honour, could the counsel pause so that the

interpretation could be done properly, thanks.

PRESIDING JUDGE SCHMITT: [14:36:38] I think you have heard it, Mr Obhof.

MR OBHOF: [14:36:41] Yes, sorry, booth.

THE WITNESS: [14:36:46] There are one or two antipsychotic medications that are particularly associated with weight gain, but Mr Ongwen has not been prescribed those medications.

MR OBHOF: [14:37:02]

Q. [14:37:02] How about SSRIs?

A. [14:37:04] Okay, an SSRI is, refers to a group of anti-depressant medication. I am aware that he was referred at one point during his detention an antidepressant medication, an SSRI, called citalopram. According to the records, he stopped taking that within a very short period of time. Citalopram is not particularly associated with weight gain.

Q. [14:37:50] What happens to -- well, not just generally men, but of human beings in general once they start hitting their 30s?

A. [14:38:02] I'm afraid you're asking me a question, which is not my area of expertise.

Q. [14:38:07] It's no problem. So do people, generally their metabolism slows down, Doctor?

A. [14:38:12] That is not my area of expertise.

Q. [14:38:14] So your area of expertise isn't general knowledge?

A. [14:38:18] As a medical doctor, people's metabolism changes all the time. It can change according to the food they ingest, whether they have caffeine, whether they have alcohol, whether they have drugs, according to their age, according to their weight, according to all sorts of things.

Q. [14:38:38] Now, would somebody's metabolism increase or decrease if they went from a very highly active lifestyle living in the bush and eating very little food to transitioning to a sedentary lifestyle while eating food very rich and very heavy, i.e., very high in calories?

A. [14:39:02] If -- if people are eating food, which is very rich and high in calories and if they're sedentary, then they would be expected to gain some weight. They would be expected to gain weight.

PRESIDING JUDGE SCHMITT: [14:39:13] And, Mr Obhof, allow me the remark, I don't think that we really would need an expert for this conclusion.

MR OBHOF: [14:39:24] I learned that at 36.

PRESIDING JUDGE SCHMITT: [14:39:26] I think there are some people here in the courtroom who are beyond this 30-year-old threshold, so to speak.

MR OBHOF: [14:39:38]

Q. [14:39:43] Now you mentioned caffeine, what would drinking a lot of caffeine do to the metabolism?

A. [14:39:50] It can increase your metabolism.

Q. [14:39:53] Okay. Did you also notice in the Defence expert reports -- report, OTP tab 7, at page 0006 and 0007, where they noted that Mr Ongwen had lost three kgs in the month leading up to their visit?

A. [14:40:14] Yes, I --I'm afraid I don't have the page. This was a self-report as far as I'm aware. In the records, there are references to him gaining weight. I haven't seen any charts. One would normally want to look for charts which document physical -- people's physical state, including height and weight, because weight can be an indicator of better or poorer functioning in terms of people's mental health.

Q. [14:40:53] Now, paragraph 87 on ERN 0807, you say that the Defence experts

"...defend their diagnosis of severe depressive disorder by stating that Mr Ongwen is merely 'covering up ... the intense emotional turmoil he experiences almost daily'. Thus they appear to be disregarding evidence that contradicts their clinical opinion, without setting out the justification for adopting this counterfactual approach."

And this is the second time we've heard something similar from a different set of medical doctors who independently met with Mr Ongwen.

Why are you so easily dismissing their reports, both of whom independently -- both reports which independently came up and said that he is masking his true emotions?

A. [14:41:59] Because I think one has to go with what one knows is likely and probable within psychiatric presentations. If you are confronted by all the signs and symptoms that appear to deny, deny the existence of any current clinically significant disorder, then it is simply, in my view, perverse to disregard all those signs and symptoms and to suggest that they are merely a mask for an individual's true feelings, or beliefs, which they have simply refused to express or been unable to express.

So this is, for that reason, I say it is very surprising to me and difficult to understand why this alternative hypothesis has been put forward when the obvious conclusion to draw is that there is no current mental illness present because there are no signs or symptoms obvious that would justify such a diagnosis.

Again, I would say that there isn't evidence from the report that Dr Akena or Dr Ovuga have actually tested out this hypothesis by putting it to Mr Ongwen or that Mr Ongwen himself has expressed difficulties in admitting to acknowledging these feelings of constant turmoil and distress.

Q. [14:43:57] Now on that same page, you also state that -- paragraph 86:

"The authors themselves also appear to negate a diagnosis of depressive disorder by observing that Mr Ongwen is a 'cheerful, humorous individual ... emotionally tough,

resilient and able to withstand challenges and life's adversities'."

Now, all other things being considered, if Mr Ongwen did have a depressive disorder and if he did later take medications, would that lead to an improvement in his day-to-day life?

A. [14:44:42] Could you -- I -- I'm not sure what you're asking specifically. If somebody has -- if somebody has a depressive disorder --

Q. [14:44:53] Mm-hmm.

A. [14:44:54] -- and they are treated for that depressive disorder so that they no longer have a depressive disorder, one might expect their functioning to improve? So their interactions and their ability to engage fully in day-to-day activities.

Q. [14:45:12] Yes.

A. [14:45:13] Is that what you're asking?

Q. [14:45:15] Yes, Doctor?

A. [14:45:18] In general, yes. But what I am referring to in this -- in paragraph 86 is the fact that somebody with a depressive disorder does not present clinically as cheerful, tough, talkative, resilient and outgoing. They present as withdrawn, inward looking, sometimes very angry, unable to communicate and fragile. So the description in the report is entirely at odds with the conclusion that is reached with regard to the presence of a current depressive disorder.

Q. [14:46:12] So is it possible that an individual can have certain manias while still being highly depressed?

A. [14:46:23] Can have certain?

Q. [14:46:26] Manias? M-A-N-I-A-S.

A. [14:46:34] I'm not sure with a mania is.

Q. [14:46:39] Certain desires, certain loves, certain things they like to do. Sorry,

like a manic state. A manic state. Can an individual have a manic state while still being highly depressed?

A. [14:46:59] No. A manic state is essentially the flip side of a depressive disorder; so what you see in depression, you see the opposite, essentially individuals who are hypomanic.

PRESIDING JUDGE SCHMITT: [14:47:15] And, of course, we know that there is also a mental illness that is called, I don't know the English word exactly, but it is a combination of manic depression.

THE WITNESS: [14:47:25] Bipolar affective disorder.

PRESIDING JUDGE SCHMITT: [14:47:28] Yes, so you would word it this way.

THE WITNESS: [14:47:31] And people would swing from one mood state to the other, but they tend not to coexist at the same time in the same individual.

MR OBHOF: [14:47:41]

Q. [14:47:41] I was wondering, I was watching television last night and one of my favourite movies came on, Mrs Doubtfire, and everybody knows that on 11 August 2014, one of the most cheerful, humorous individuals ever to live hung himself with his belt, in part because of depression. So is it possible to present a cheerful humorous, friendly, outgoing atmosphere but yet still be depressed?

A. [14:48:20] Well, I -- I won't comment directly on Robin Williams because it would be unprofessional and inappropriate. But as I said earlier, I mentioned this issue about masked depression and the fact that with the depressive disorder, particularly in adult men, there may be a wish to try and cover up symptoms of depression, to put on an act in order not to worry other people, in order not to seem weak or vulnerable. That can happen.

I think that's all I can offer in terms of that question.

Q. [14:49:11] That's okay. Now at paragraph 88, you state again: "The authors refer to Mr Ongwen's 'deeply ingrained suicidal urges', without explaining why, over the two year period he has been detained, there has only been one impulsive act of self-harm."

If the court officers could please pull up Defence tab 3, UGA-D26-0015-0167, and the video is not to be shown to the public.

PRESIDING JUDGE SCHMITT: [14:49:57] Then we -- then if this is the case, we have to go shortly to private session --

MR OBHOF: [14:50:01] Okay.

PRESIDING JUDGE SCHMITT: [14:50:02] -- I would suggest. Private session for how long, Mr Obhof? How long will it be? The question can be put in open session, then?

MR OBHOF: [14:50:09] I have three questions. Yes, three questions in private session.

PRESIDING JUDGE SCHMITT: [14:50:16] Okay, then we go to private session for a couple of minutes, I would say.

(Private session at 2.50 p.m.) (Partially reclassified into public)

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(Redacted). Again, one cannot simply make a diagnosis based on viewing a series of behaviours or single acts.

Q. [14:54:42] But these would be factors when determining whether somebody is depressed or suicidal?

A. [14:54:53] Absolutely. I think one always needs to consider that. I -- I work in -- I've worked in prisons for many years, I've worked in secure units for many years. Acts of self-harm, sometimes we call them parasuicide, acts of extreme behavioural disturbance when people are smashing doors, breaking windows, wrecking their bedrooms or their cells, banging their heads against walls. Again, such behavioural disturbances are common. They can be a manifestation of the extreme stress and difficulties confronting individuals who are incarcerated over a period of time. They can be a manifestation of mental disorder, personality

disorder or mental illness or they can just be a reflection of people's extreme frustration and anger at being detained.

So again, one would need to have, we talked about differential diagnosis, one would need to have all of these possibilities open to one, and again look at how long these instances lasted for; what the person themselves says about them; what are the other aspects of their behaviour or interactions or mood, presentation that might suggest a more functional mental illness that might need treatment or perhaps the extent to which such behaviours are instrumental and rational and are designed, if you like, in order to achieve some goal.

So, again, they are disturbed behaviours, but how far that takes you in terms of being able to diagnose a mental health -- a mental illness, I think is -- is much more qualified.

PRESIDING JUDGE SCHMITT: [14:56:59] So Mr Obhof, we can go back to open session, you are aware of this?

MR OBHOF: [14:57:06] Yes, I think there's one further closed -- but I would like to bring it forward --

PRESIDING JUDGE SCHMITT: [14:57:14] Of course, of course.

MR OBHOF: [14:57:15] -- so this way, we can do everything at once.

Q. [14:57:19] And, Doctor, our next area is going to be a little bit about PTSD, and one of the areas I want to discuss, and so we're in private session right now, is the criterion E of irritability or aggression. Could you explain specifically this criterion or this one part of the criterion?

A. [14:57:43] This is part of the hyperarousal cluster which I described yesterday. There are a number of ways in which hyperarousal may be manifested of which anger or aggressive outbursts are one of the, one of the symptoms that -- that is described.

Q. [14:58:05] And it's related to -- the booth.

And it's related to something that triggers them from their past?

A. [14:58:17] Not necessarily. It -- it can be -- there can be a generalised increased level of arousal, so people are generally more irritable, more on edge. They feel they have more difficulty in calming down; they are more easily aroused; they are more argumentative.

(Redacted)

(Redacted)

(Redacted)

(Redacted)

(Redacted). Post-traumatic stress disorder is quite a common diagnosis. It's something like 7 per cent of -- in epidemiological studies about 7 per cent of people have PTSD. There is no strong association or strong connection between a diagnosis of PTSD and aggressive or violent behaviour. So anger and aggression can be explained by hyperarousal, but it's not inevitable or invariable. And in order for that aggression to then be expressed by going on to more serious forms of violence, lethal violence, that would be considered to be highly unusual and would need to be explained as much by aspects of the individual's premorbid personality; for example, a propensity for violence, let's say, as by any specific symptoms of PTSD.

Q. [15:00:29] But, Doctor, we're talking about somebody who is cheerful and outgoing and friendly or as described in these clinical notes as being cheerful and friendly and outgoing.

(Redacted)

(Redacted)

(Redacted)

(Redacted)
(Redacted)
(Redacted)
(Redacted). There are people who have problems with anger and who lose their temper and often do it in a very extreme way. That refers to many of the people we see ending up in prison for violent offences where there is no underlying psychiatric diagnosis or label.
If I could just come back to what you're saying, because actually what you would expect to see in an individual with PTSD is that they lack the ability to regulate their emotions. So they, they are less able to judge their emotional response according to what is going on in the environment.
They respond to the environment as if they are constantly under threat, as if they are constantly at risk of being re-traumatised, and so even if they are in a safe or neutral situation, they may still appear agitated, angry, and -- and aroused.
So coming back to Mr Ongwen, it seems to me that -- that what is being described is an ability to control his emotional responses and to regulate his emotions. He is not constantly angry, aggressive and aroused, but he does become angry when he is in situations that he finds difficult, or challenging, or, or frustrating. And that would appear to negate the idea that this is an automatic post-traumatic response of some kind. But that is completely -- it's irrational, and non -- and sort of usual response to the sort of life stresses that are confronting him at the moment and have been confronting him since he was first detained.
PRESIDING JUDGE SCHMITT: [15:03:42] I think you might guess what I want to say. Open session. I think a lot of what has been said in the past minutes could have been also in open session. But we can later lift it if need be.

Open session.

(Open session at 3.03 p.m.)

THE COURT OFFICER: [15:03:59] We are back in open session, Mr President.

MR OBHOF:

Q. [15:04:15] Going through the other criterion for -- actually, criteria, for PTSD. Criterion A, I don't think there is any doubt that he meets those qualifications; is that correct?

A. [15:04:36] Yes.

Q. [15:04:36] Sorry, they can't --

A. [15:04:38] I apologise. Yes.

Q. [15:04:38] It's a normal human reaction to nod your head, so. Criterion B, nightmares. Did you remember reading about nightmares in the clinical notes?

A. [15:04:49] I did. But nightmares in themselves, everybody has nightmares. They are not unusual. In order to make a diagnosis one needs to look for what is described as severe and persistent nightmares which re-create in some way aspects of the trauma. So I would not, if somebody is having, experiencing nightmares once a week, once every couple of weeks, that would not amount to a clinically significant symptom. If they are having nightmares almost every night that wake them up, where they -- feeling that they are back in the traumatic situation, that is more likely to be of clinical significance.

Q. [15:05:42] Now criterion 3 -- or, sorry, criterion C. Could you explain that a little more in depth?

A. [15:05:55] Yes. I may need to have my DSM-5 in front of me in a moment because it changed from DSM-IV and they have now added an extra criterion. However, the essential element of criterion C relates to post-traumatic avoidance,

which I have already talked about, with is the avoidance of thoughts and memories, feelings related to the trauma, and it also is a behavioural avoidance, so it's the avoidance of any situations that, or circumstances that resemble or remind the individual of the trauma.

Q. [15:06:43] Now criterion D you have the over-negatively thoughts and assumptions about oneself or the world. So would that be something consistent with why does everyone hate me? Why does God hate me? Why are they punishing me?

A. [15:06:58] Yes. An assumption is also to do with a prediction about everything, everything I do will fail because people don't understand me or they are putting up barriers to in some way handicap me.

Q. [15:07:24] How about exaggerating blame of self or others for causing the trauma? Say, blaming Joseph Kony, blaming the UPDF?

A. [15:07:39] Well, again one has to distinguish between what might be a rational, conscious decision to blame other people. And blaming other people is a very common finding, particularly in forensic world. Blaming -- I mean, this particular criteria came from, particularly from work with victims of rape or domestic violence who typically hold themselves responsible in some way for having caused themselves to be victimised, or not preventing themselves from being victimised, and who find it very often hard, often, to direct their anger and blame towards the person who has abused them. So that's what would be described as an inappropriate direction of blame that one sees in many victims of abuse. And I have not seen that feature manifest itself in Mr Ongwen.

PRESIDING JUDGE SCHMITT: [15:08:52] Perhaps you allow me a question. Just when we have all these criterion, isn't it in the end, doesn't it come down when

we look at the single criterion also to an assessment of gravity, how often it turns up, so to speak, how severe it impacts on the individual, plus that in the end you have to have a holistic approach?

THE WITNESS: [15:09:18] Yes.

PRESIDING JUDGE SCHMITT: [15:09:19] Do I understand this correctly? And this is of course, this is not a mathematical equation in the end, what you have doing.

THE WITNESS: [15:09:28] No.

PRESIDING JUDGE SCHMITT: [15:09:28] It's also assessing from your experience and from perhaps your clinical, your clinical and also your forensic experience. Do I understand this correctly?

THE WITNESS: [15:09:41] That that is absolutely correct and, you know, there is a saying one swallow does not make a spring, and so it's very important not to just pluck out individual symptoms as a manifestation of a disorder, absolutely one has to put it all together and to judge that against one's experience, and knowing what is probably and likely in terms of responses to trauma.

MR OBHOF:

Q. [15:10:10] Yes. And I believe that's actually criterion F, is that it's happening over more that than a one-month period.

A. [15:10:19] Yes.

Q. [15:10:25] We have discussed in private session about the irritability and aggression.

Difficulty sleeping. Mr Ongwen has difficulty sleeping?

A. [15:10:40] Currently he has experienced -- there are reports of him having experienced difficulty in sleeping, yes.

Q. [15:11:00] How bad does it have to be for functional impairment, the

last criterion?

A. [15:11:05] There isn't, there isn't a guide in terms of how bad it has to be, but it has to be qualitatively different from how that individual would normally function or behave. So there has to be -- there should be a subjective and an objective view that their functioning is impaired as a result of mental symptoms.

Q. [15:11:36] So is that something that the person would realise himself or is that something that maybe the doctor would realise?

A. [15:11:43] Both, hopefully. So the person might say "I no longer, I am no longer interested in, in seeing people. I no longer enjoy the things I used to enjoy. I can no longer concentrate. I can't read a book. I can't remember what I have watched on television." So they may report those kinds of symptoms. But it may also be observable within the course of your assessment.

Q. [15:12:15] So the assessing doctor might say "We don't think this is good for you," and they might pull the plug on your functional impairment?

A. [15:12:26] I'm sorry, I don't understand the question.

Q. [15:12:28] When a doctor tells you something is bad for you, doctor says "Stop doing this, you need to slow down."

So, say if your doctor said "You need to take a break when you are at work," or "You need to stop going to work once a week. You need to relax." Can functional impairment be caused -- or not caused, but can it be noticed by the doctor but not noticed by the patient.

A. [15:12:53] I am not sure I completely understand the question. The doctor who examines the patient has a snapshot view of the patient over a period of two hours. The doctor would be expected to go to other sources, as well as to enquire of the patient, if there are areas of his day-to-day functioning that he feels he cannot engage

in as he would like to or as he feels he should be able to, and in other sources there may be information about the individual withdrawing, not engaging in activities during the day, not interacting in the way that they normally interact.

So, again, it's usually not just one source of information but several sources of information. And it all comes back to the fact that having a serious mental disorder seriously impacts on your ability to, to think, to concentrate, to interact with other people, to function in a rational and coherent and consistent way.

Q. [15:14:32] Thank you, Doctor.

I am going to move to paragraph 94 and 95 of your report, Doctor. And that's at page 0809. You state:

"An individual would not be expected to have any memory of actions which are conducted whilst in an acute state of dissociation. However, there is ample evidence that Mr Ongwen clearly remembers and is aware and knows of the acts that he is alleged to have perpetrated.

"Insufficient evidence is presented to support a diagnosis of dissociative disorder within this report, as described by Mr Ongwen himself, or as manifested by him during interview."

Now, could you explain the ample evidence you discuss, that he does not have any type of dissociative disorder, especially considering, you say, they last seconds, minutes, maybe an hour or a few?

A. [15:16:02] Well, again, because Professor de Jong is not clear, and Dr Akena is not clear about what form of dissociative disorder they are describing, I am having to tackle all bases, if I could put it that way.

A dissociative disorder which Professor de Jong appears to be referring to, as I said, is a form of personality disorder, it's a chronic, long-term enduring state manifested by

too distinct, at least two distinct personalities, neither of which is aware of the other. The dissociative states or dissociative responses do last for seconds or minutes, maybe a little bit longer. The evidence that I have seen, which is contained both within Dr Akena's report and in Professor de Jong's report, and in the material that I have been provided with, including transcripts, provide a number of examples of Mr Ongwen giving different explanations for his acts, but nevertheless knowing that these acts have occurred.

So, for example, in Professor de Jong's report he talks about - I think it is Professor de Jong - he asks for forgiveness for the acts that he committed, he states that he always tried to stop acts being committed against civilians, that he tried to protect women and children, that he preferred to pray. I think that was the statement.

In a number of the transcripts that were discussed yesterday, there are references to Mr Ongwen clearly and rationally describing either acts that have been carried out with his knowledge or following his orders, or acts that he intends to be carried out. Now, those kinds of descriptions are incompatible with somebody who is in a dissociated state, both because they would not be able to communicate in any coherent way, but also because they would not be able to register or retain or process any of the information, any of the -- any of the events that are going on during the state of dissociation.

Q. [15:19:16] Now the apologies you just remembered, or that you just said, those are generalised apologies over a 27-year period from when he came out, and how he was sorry for what he had done. They are not specific instances. And as you stated, dissociation is -- can be quite, quite quickly, less time than what we are here for the Court.

So, I mean, is it possible, I mean when you are looking at that, to say over a 27-year

captivity in the LRA that these dissociations didn't happen every day, it wasn't all the time but yet still could have been there and present?

A. [15:20:02] I have seen no evidence of -- either in terms of witnesses, witness statements, or in terms of what Mr Ongwen has himself said, or in terms of how he has presented on the recordings to suggest, to show any evidence of dissociation.

Q. [15:20:29] Wasn't just Mr Ongwen a -- wouldn't that just be self-reporting, Doctor? I mean, he has clearly stated this to three separate psychiatrists -- sorry, four separate medical doctors, because there is one report, I can't remember which one, but one report in which he reported of sometimes being in two different -- feeling to be in two different persons in two different bodies?

A. [15:20:50] That in itself is not -- is not necessarily a symptom of dissociation. As I said yesterday, transient feelings of depersonalisation or derealisation, dissociation are very, very common in the general population. Very commonly experienced, and they are not indicative of mental illness. When you say that he told the experts, again, I have been unable to find convincing evidence in either of the psychiatric reports as to the historical presence of dissociative identity disorder, or recurrent dissociative episodes. And these are different from transient feelings of derealisation, that is the world seems slightly hazy somehow, and unreal, or depersonalisation, that is a sort of internal sense of numbing or detachment. If somebody is experiencing a dissociative disorder -- dissociative state in front of you, you know that they are in a state of dissociation because they will -- they will not be in the room with you. In their mind they will not be in the room with you. They will look as if they are responding to something inside their head, and certainly in individuals who have been traumatised they will often look terrified, in a state of extreme arousal. It would be very, very difficult, often, to bring them back to the

current here and now, the current state of reality. It's a very, it's a very dramatic presentation and something that would not be unnoticed or unremarked on by people around if an individual was truly experiencing recurrent dissociative episodes.

Q. [15:23:15] So to the average layman, or maybe somebody from Acholi, this might be, this dissociation could be interpreted as being possessed by spirits? Or witchcraft, sorry, yes.

A. [15:23:37] It is referred to in the DSM-IV that status of possession is close to, akin to being in a dissociative state.

Q. [15:23:56] Doctor, one of the other Prosecution experts, Dr Weierstall - I hope I am pronouncing that right - in his question five felt that was it was important to consider the constancy of mental disorder over the period between 2002 and 2005. He asked himself about symptom fluctuations.

In preparing your report did you consider the possibility that if symptoms were not always present it might be possible to retain some memories at the time yet still experience dissociative states at other times?

A. [15:24:46] You would retain -- I have read Dr Weierstall's report, I agree with Dr Weierstall's statements about fluctuations of these conditions. Certainly, if somebody's mental state is fluctuating, if they are experiencing dissociative episodes from time to time, then events that occur in-between those dissociative episodes would expect to be remembered. There is no reason that the individual would experience any impairment of their memory, or their cognitive functioning, or their sense or agency or motor control, or emotional control outside those dissociative states.

Q. [15:25:44] Doctor, now at paragraph 98, at page 0810, you state that:

"If Mr Ongwen had been suffering from serious mental illness and mental instability,

one would have expected this to have been readily apparent to other fighters and members of the LRA and would, moreover, have been a bar to Mr Ongwen's rapid promotion through the ranks."

Now, given that most of those people around Mr Ongwen would have also experienced the same indoctrination, the same duress, the same trauma, the same problems, and they would have also believed in the same spiritual realms, would it not seem, would Mr Ongwen seem less -- like he had less problems than what he might have seen in a normal population?

A. [15:27:02] No, I don't believe so. I think in a way what I have previously said, I say again, is that belief in a spiritual world is not a mental illness, does not amount to a mental illness, it's part of their cultural religious belief system and context. So, in a way, if one takes that out of the equation, what we are talking about is the presence of other serious mental illness. It seems to me irrelevant the fact that they have all gone through the same trauma, because that doesn't render them unable then to observe behaviours in a fighter that might be dangerous for them or for the fighter, that might prove to be a liability in some way, that are unusual or bizarre or difficult to explain. And yet nobody has identified anything about Mr Ongwen that is different. The only descriptions of him have been of a highly respected, admired and somewhat feared commander within the LRA. I think one of the transcripts referred to this yesterday, somebody who was brave, somebody who fought well. Indeed, Mr Ongwen himself refers to himself being a good shooter and a good fighter.

So if we are talking about serious mental illness we are talking about hallucinations, delusions, loss of weight, loss of appetite, an inability to function, which would include an inability to function as a soldier, as a fighter. Yes, I would expect his

comrades to pick up on that and to have noticed it and commented on it. And yet there is no comment at all about anything that causes them concern or that is suggestive of mental illness.

Q. [15:29:26] And so they might not have thought about it because they might have considered it part of their spiritual realm, part of their religious beliefs, whereas he might have been possessed at one point?

A. [15:29:44] But I don't think there has been any suggestion that flashbacks or severe weight loss or delusional ideas - set aside spiritual experiences - are normal or were being experienced by other fighters, and if those symptoms were present they would have represented very unusual behaviours. There is no reason that they would not, that people would have then described him as somebody who was extremely high functioning, who was extremely tidy, extremely neat, extremely clean, I think is how Mr Ongwen described himself, who was a good fighter, who was a good shot, who led his men well.

Again, those features are incompatible with somebody who is suffering from a serious mental illness. They would not have the capacity to function in that way if they were mentally ill.

Q. [15:31:07] Doctor, did the Prosecution explain to you the disciplinary regime in the LRA?

A. [15:31:30] As I said, I have read all the papers involved that were sent to me. I have read all the material. I am aware that there were punishments meted out, if that's what you're referring to.

Q. [15:31:46] Were you aware that the minor punishments meted out against people was the 100, 200, 300 canings for minor infractions?

A. [15:32:02] I have read about canings and beatings.

Q. [15:32:05] And are you aware that many infractions in the LRA resulted in execution?

A. [15:32:10] I am aware there were executions.

Q. [15:32:16] Were you aware that what we would consider minor infractions were still executed, people were still executed for in the LRA?

A. [15:32:28] It doesn't surprise me, given what I have read. That was my understanding, yes.

Q. [15:32:37] So you are aware that attempting to escape involved the execution of the person?

A. [15:32:42] It could result in the execution of the person.

Q. [15:32:48] Could result?

A. [15:32:52] I believe I have read somewhere that Mr Ongwen tried to stop the execution of, of an individual, or maybe more.

Q. [15:33:05] Hold on one second, Doctor.

Again, for the same reason yesterday, your Honour, in confidential, if she would like to continue about this part.

PRESIDING JUDGE SCHMITT: [15:33:16] I think we would not need to do that. We can simply go on.

MR OBHOF: [15:33:20] Okay.

PRESIDING JUDGE SCHMITT: [15:33:21] We can.

MR OBHOF: [15:33:23] Sorry, Doctor.

A. [15:33:24] Yes. I, I cannot tell you, I don't have the figures for how many people tried to escape, how many of them were caught, how many of them were executed. But I am aware of the fact that there was a brutal regime of terrorisation, that people were frightened, that there were punishments being meted out within,

within the LRA. And, and that sometimes resulted in individuals, in the death of those individuals concerned.

Q. [15:34:09] In your readings did you read anything about how if somebody successfully escaped their entire home village could be attacked and destroyed?

A. [15:34:26] Again, I think I may have seen that. It does not surprise me.

Q. [15:34:33] Do you know that even one witness came and testified and said that his village elder, before he was abducted, instructed them not to come home and to stay in the LRA and die in the LRA rather than bring the terror of Joseph Kony on to them?

A. [15:34:53] Again, that seems completely plausible, I accept that.

Q. [15:35:02] Now you mentioned about the -- Mr Ongwen pleading for somebody's life and that essentially he was attempting to go against a direct order of Joseph Kony. Couldn't it also be considered as an attempted suicide to disobey somebody who has repeatedly executed persons who disobey his orders?

A. [15:35:33] Well, it suggests to me that he was not, he was not so frightened of Kony that he was unable to stand up to him. I think it is going too far and is somewhat speculative to suggest that this was a, if you like, masked suicide attempt on his part.

Q. [15:36:03] Now, Doctor, you mentioned rising through the ranks of the LRA. Can you explain to the Court what that means, how does one rise through the ranks in the LRA?

A. [15:36:21] Well, I can't --

PRESIDING JUDGE SCHMITT: [15:36:23] May I shortly.

Mr Obhof, I think this is not, not something where the witness, the expert, - you know, in Germany we would not call her a witness, she is an expert - where she has her

expertise.
You can, if you want, if you think it appropriate, embed this information into a question which touches the expertise of --
MR OBHOF: [15:36:48] Your Honour, the expert has used that phrase several times and --
PRESIDING JUDGE SCHMITT: [15:36:52] Yes, but --
MR OBHOF: [15:36:53] -- if she is using the phrase we would like her to explain what it means to her.
PRESIDING JUDGE SCHMITT: [15:36:58] If you word it like this, what it means to her, she might answer in a general way, that, yeah, whatever she wants to answer. I don't want to answer for her. But the original wording was as if you would want to know from the expert how in the LRA the rank promoting was, she might not know that. But what she understood by this phrase, you can ask her.
MR OBHOF: [15:37:23]
Q. [15:37:23] What do you mean by rise through the ranks of the LRA, Doctor?
A. [15:37:30] Well, what I mean is that he obtained a position, a position of commander - I think one of four commanders, but I may be wrong - which, which meant that he had considerable authority, control and responsibility over a number of men. And that essentially is what I understand by that.
In the transcripts that we looked at yesterday - I think it is number 12 - but I thought there was a very helpful description given by one of the witnesses - I think it is number 12 - somebody who had known Mr Ongwen over a number of years, who had fought with Mr Ongwen and who described the change in his personality from coming from early on in the LRA when he was a fighter with no responsibility, to being, I use the word promoted, to commander. When he took on an authority and

a status and slightly distanced himself from the men, that, that reflected the fact that he was now a more senior person within, within the LRA.

And again, that is something one might expect given the fact that his responsibilities and his status within the LRA had changed. So he became slightly more distant, slightly more of an authority figure and somebody who, who, who gained the respect, I would say, or commanded respect of the men who were fighting with him.

Q. [15:39:27] Now, considering the -- I believe you used "brutal regime" that they used in the LRA, I have a few slight questions about your CV, and that we notice that you have done some good work with battered wives and battered spouses. And one of the biggest obstacles attorneys always face and must overcome to a jury is why didn't they just leave. Isn't that one of the hardest obstacles to prove to a trier of fact?

A. [15:40:18] Yes, that is a question that is often asked.

Q. [15:40:20] Now, considering the extremely brutal regime that the LRA did, and the fact that people couldn't go home because they are worried about their entire villages being destroyed, in a society that the community is placed above the individual, why wouldn't Mr Ongwen just leave? And can you explain the mental problems with somebody not wanting to leave a bad situation.

A. [15:40:59] Well, in fact, my understanding is Mr Ongwen repeatedly tried to leave. Certainly at the beginning. Once he became a commander I think there were fewer attempts to go.

The similarities of battered women I think is -- one can't use that as a comparison that effectively, because the essential point about women in abusive relationships is that they are not only frightened but they are also rendered into a state of extreme helplessness, or learned helplessness where they, they have a sense of, are lacking all

agency over their behaviour and they have feelings of hopelessness and helplessness. They see escape as futile, but they also see their abuser as being all powerful and all controlling and so it doesn't matter what they do, they cannot get out.

Q. [15:42:09] You mean --

A. [15:42:09] Yes.

Q. [15:42:09] I'm sorry. You mean somebody that has spiritual powers that can allegedly read your mind?

A. [15:42:17] Well, clearly Mr Kony, Joseph Kony was the overall commander, was extremely powerful. I think if one is going to suggest that Mr Ongwen is in a similar state to a battered woman, learned helplessness, you would have to demonstrate that he deferred, that he was unable to act or take decisions, or even think for himself, without the agreement or authority of Joseph Kony. That he was completely under this man's control in a way, coming back to battered women, that many women feel their abuser is in complete control of them.

There are examples, and certainly an example that we discussed yesterday, where it seems clear that Mr Ongwen has explicitly gone against Mr Kony's wishes, or what he might have wished, and has stood up to Mr Kony. So it does not suggest to me that he is somebody who is, who is cowered into submission. It suggests that he has remained somebody who retains a degree of autonomy and agency and control and can act on his own authority rather than only acting when he is forced to act because of fear of the consequences.

Q. [15:44:11] Of course, I don't know if you know the setting of the instance we are discussing, that was in 2007 when everyone thought they were going home during the peace talks, it was a time of alleged ceasefire when they were dealing with -- and this is the time when Mr Ongwen went up to Joseph Kony to plead for his father's life

and one of his brother's lives.

But, in a follow up, because you mentioned how Mr Ongwen tried to leave, don't, don't battered women try to leave too sometimes? I mean, don't they attempt to escape and eventually come back because of the, the power that the persons are exerting upon them?

A. [15:45:02] They may do.

Q. [15:45:10] Now considering about these orders, generally speaking,, many of the witnesses have stated that people did not do something until they were ordered by Joseph Kony to do this. Now, this rise through the ranks that you mentioned, a lot of these were suicide missions; Mr Ongwen was injured in his right leg in '96, injured again in his leg in 2002. Do you consider it normal for these people to continue -- for somebody to continuously go on these missions which appear to be hopeless after being ordered by Joseph Kony?

A. [15:45:53] This is, again, not strictly within my expertise. I cannot comment on whether these missions were hopeless or not, that's your view. Some people might say it's -- it's par for the course or at least it's what one takes on and what one embraces and accepts, to a certain extent, when you are part of a fighting unit such as the LRA. People get killed, but that does not necessarily mean that everybody who fights in those missions is seeking death.

Q. [15:46:57] Now starting at page 0810, on paragraph 101, you discuss mood. Without reading it over, I mean it is a rather lengthy paragraph, could you explain to the Court what the difference between mood and affect is?

A. [15:47:31] It's the same, essentially.

Q. [15:47:35] How do you diagnose a mood disorder?

A. [15:47:39] A mood disorder would be depression, or hypomania. Again, you

diagnose it through the process that I have described before and you check out whether that individual is suffering from the symptoms that would be consistent with or coherent with making that diagnosis.

Q. [15:48:26] Doctor, yesterday you mentioned the word duress a few times. Now, what would likely be the logical consequence when somebody is facing staying in the LRA or possibly having an Atiak on their hands? Atiak is a situation in 1995 where approximately 200, that 200 people were killed because Vincent Otti disobeyed an order. Didn't even try to escape, he just disobeyed an order. What would that do on a person's psyche when they had to choose between trying to escape or staying in an organisation to save the lives of hundreds of others?

A. [15:49:20] It's impossible to be general, to generalise how that would affect individuals. It would clearly depend to some extent on the imminence and the credibility of the threat. It would depend on the extent to which the individual felt that they had, again, that they had a degree of control over what was happening, choice over what was happening, whether they had autonomy, whether they had the ability to influence the situation.

Q. [15:50:01] Now, paragraph 113, which starts on page 0813, you state that: "There is evidence that Mr Ongwen both understands and has been able to respond to the charges, on the numerous occasions these have been put to him. He has repeatedly stated that he knows now, and knew at the material time, what he was doing and that his actions were wrong ..."

Can you tell me where you saw that it shows that he said his actions were wrong at the material times?

A. [15:50:46] I can't put my finger on the precise page right now. But I was satisfied from having read the material and watched the transcripts that there were

certainly occasions when he did refer to acts and had asked for forgiveness for having done what he did.

Q. [15:51:15] Now, if it is, assume it possible, the case that Mr Ongwen suffers from dissociation, delusions or perhaps other mental health problems, is it possible that the account that has been allegedly relayed through these reports you examined, could these be confabulated?

A. [15:51:42] I don't understand the question. I'm sorry.

Q. [15:51:46] Simply put, could he be making false memories? Filling in the gaps?

A. [15:52:00] False memories of the incidents? I suppose the first question would be why would he repeatedly talk about acts that were carried out when he knew nothing about them. There are other actions which don't simply rely on what he says but what other people have said he was responsible for doing and was in -- stating his intention to do them.

There are a number of hypotheses in the question, so if he was suffering from a delusional disorder and if he was dissociating, might he have confabulated, in a way that is several hurdles one needs to go through before you get to the end question. I do not consider that there is evidence that he -- would you like me to stop the --

PRESIDING JUDGE SCHMITT: [15:53:03] No, no, no, no, no. It's, you know, in this environment it's important that the judges perceive everything. Thank you.

THE WITNESS: [15:53:12] So I haven't found any evidence that he was dissociating or was mentally disturbed. If, as you say, he was dissociating or mentally disturbed, there is still no reason why he would confabulate or create a false memory. False memories are very uncommon, in any case. But one would have to provide a logical, rational explanation as to what the mechanism was and why he was doing it.

MR OBHOF: [15:53:57]

Q. [15:53:58] At paragraph 15 -- 115, sorry, of your report, Doctor, you wrote: "I do not consider that Mr Ongwen is especially vulnerable. Whilst I note that Mr Ongwen has self-harmed on one occasion in custody, and has also gone on hunger strike, these appear to have respected impulsive and/or rational acts of protest against his current incarceration, rather than indicating severe underlying psychopathology, or serious suicide attempts."

Now, Doctor, isn't there a contradiction between acts that are impulsive and acts that are rational?

A. [15:54:52] No. Impulsivity is a trait that many people have. It may be that they act recklessly, they act without thinking through the consequences, clearly, but that doesn't necessarily mean that they are irrational.

Q. [15:55:18] It doesn't necessarily mean that they are rational either. I mean if you're not thinking through everything clearly, would you be making a rational decision?

A. [15:55:29] Well, many, many of us might be considered to be irrational in that case, because there are degrees to which people are able to reflect on their behaviour, to anticipate the consequences of their behaviour, to articulate exactly what they are thinking and feeling and explain their behaviour.

An impulsive act, for example, if I can refer to the drinking of the detergent which is referred to by the, the doctors at the time as having been an impulsive act and Mr Ongwen himself described it as an impulsive act, I think, which was enacted out of frustration at not being allowed I think a visit I think by an aunt. One would not call him irrational. There is a rationality to what he is doing, there is a reasonable explanation. It appears to be reckless and ill thought out, but he is still able to

explain the reasons for swallowing the detergent and those reasons fall short of being able to diagnose a serious suicidal attempt. So an individual who seriously wanted to die would, would be indicative of a depressive disorder, which you would then expect to see coexisting with other symptoms of depression.

So for Mr Ongwen, not only did he talk about the reason for the act being because he was upset or angry about the lack of visit, but he also recovered remarkably quickly following this act. Again, that would negate an underlying serious mental health condition where you would expect to see ongoing suicidal acts, ongoing dysfunction and distress.

So coming back to your question, I'm sorry I've deviated slightly, yes, you can be impulsive and you can be rational. You may not be behaving sensibly or with, with due reference to the consequences, but you are -- you nevertheless retain a degree of rationality.

Q. [15:58:29] Speaking about impulsive or irrational ideas, did you know that the video I showed you was five or six days after Mr Ongwen drank the detergent?

A. [15:58:46] Yes.

Q. [15:58:47] Do you know why the Prosecution did not give that to you?

A. [15:58:54] I couldn't answer that question.

Q. [15:59:01] Is it rational for a person to refuse a DNA mouth swab because they think whilst they are in The Hague the government of Uganda has secretly met with the Office of the Prosecutor to help poison Mr Ongwen by way of the mouth swab?

A. [15:59:27] It is probably not correct, it is probably not rational, but it is what we might call an overvalued idea that can be seen to have a degree of basis or cogency in the current reality that Mr Ongwen faces. When you are in this situation you are very likely to develop a degree of paranoia about your circumstances and the outside

world and other people's motives.

Q. [16:00:14] In paragraph 112 at 0813 you state that:

"I would argue that the presence of such severe and incapacitating mental disorders would have been incompatible with Mr Ongwen not only functioning adequately, but actively thriving within the LRA for over twenty years."

Can you tell us what your definition of functioning adequately is, Doctor?

A. [16:00:49] Well, he, he created a family life for himself, he had a number of wives, he had children. According to his wives he was a good husband, he looked after them. According to the other fighters he was a good fighter, he was reliable, he was a good shot, he was brave. He, he was feared and respected, both it would appear within the LRA but also by outsiders in terms of knowing that Dominic Ongwen and his men would always fight extremely hard and extremely bravely. So within that context he was -- it was extremely adaptive, he did not stand out. He was not regarded as a liability. He was not seen as vulnerable or fragile or unpredictable. And he survived, which is, which, which I think would take quite a lot of psychological resilience in that organisation and over that period of time.

Q. [16:02:08] Sorry, I am giving them a quick break.

Now at paragraph 116, at page 0814, you state that:

"It is unfortunate that Mr Ongwen has been unwilling to allow myself, or my colleagues within the Chamber of Experts, to psychiatrically examine him. One cannot discount the possibility that Mr Ongwen's refusal to submit to an examination by psychiatrists appointed by the Prosecution is an attempt to manipulate and control the situation, rather than a manifestation of an underlying mental illness."

Now, Doctor, may a person refuse medical treatment?

A. [16:03:03] Yes.

Q. [16:03:06] Did the Prosecution inform you that Mr Ongwen did not refuse to be met by chamber experts?

A. [16:03:14] Professor de Jong and Dr Akena, you mean?

Q. [16:03:17] Well, no. By anybody solely represented by the Judges.

A. [16:03:22] I don't, I don't think I asked the question. I am just aware that Mr Ongwen refused to see myself, Dr Abbo or Dr Weierstall.

Q. [16:03:34] So, Doctor, now knowing that, do you think the highly speculative statement that he meant to manipulate and control the situation is still true?

A. [16:03:47] Unfortunately I do because I think it's no coincidence that Mr Ongwen did not wish to cooperate in seeing mental health professionals who may have been perceived by him as being on the other side or not, not being sympathetic to his cause, whereas he did see the mental health professionals who he believed would listen to what he was saying, would believe what he was saying, and were there to help him, essentially.

Q. [16:04:30] So Dr De Jong, an expert recommended by the Prosecution whom the Chamber appointed after an inter partes discussion between us, so you are saying he would be seen as being not independent but on his side?

A. [16:04:50] Well, I think, as you reminded me earlier, Professor de Jong was there to assess Mr Ongwen's mental state and to recommend treatment. It's unclear what exactly was said to Mr Ongwen about the reasons for Professor de Jong conducting an examination, but that would have felt far less threatening to Mr Ongwen than being seen by three additional psychiatrists after having given his account to Professor de Jong and Dr Akena, who he would, I believe, automatically have assumed would be perhaps a little bit more questioning or a bit more critical of his position.

PRESIDING JUDGE SCHMITT: [16:05:59] Mr Obhof, the time.

MR OBHOF: [16:06:04] I don't know if you received Mike's email, but I said about 10 minutes. But --

PRESIDING JUDGE SCHMITT: [16:06:10] Yes.

MR OBHOF: [16:06:11] Your guess is correct. Your Honour, we are completed with this witness.

Thank you very much, Doctor, and have a safe flight back home.

THE WITNESS: [16:06:20] Thank you.

PRESIDING JUDGE SCHMITT: [16:06:21] Thank you very much, Mr Obhof.

Thank you very much, Mrs Mezey, on behalf of the Chamber for having made yourself available as an expert witness. We wish you also a safe and nice flight back.

This concludes the hearing for today. We resume on Thursday with P-187 at 9.30.

Thank you.

THE COURT USHER: [16:06:52] All rise.

(The hearing ends in open session at 4.06 p.m.)

RECLASSIFICATION REPORT

Pursuant to the Trial Chamber' IX's instructions, ICC-02/04-01/15-497, dated 13 July 2016, the public lesser redacted version of this transcript is filed in the case.