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

Wednesday, 11 April 2018

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

THE COURT USHER: [9:32:14] All rise.

The International Criminal Court is now in session.

PRESIDING JUDGE SCHMITT: [9:32:38] Good morning, everyone.

Could the court officer please call the case.

THE COURT OFFICER: [9:32:42] 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: [9:32:53] Thank you very much.

I ask for the appearances of the parties.

For the Prosecution, Ms Adeboyejo first.

MS ADEBOYEJO: [9:33:01] Good morning, Mr President, your Honours.

Benjamin Gumpert, Colleen Gilg, Beti Hohler, Pubudu Sachithanandan, Colin Black,

Julian Elderfield, Hai Do Duc, Kamran Choudhry, Jasmina Suljanovic,

Shkelzen Zeneli, Maya Talakhadze, and Ramu Fatima Bittaye.

PRESIDING JUDGE SCHMITT: [9:33:24] Thank you very much. You really needed

a list today that you had to read out, I think.

And for Legal Representatives of the Victims, Ms Massidda first.

MS MASSIDDA: [9:33:32] Good morning, your Honour. My apologies, I was stuck in traffic, but just in time, the time that the Prosecution introduced the entire team I can count on two or three minutes before I arrive. Good morning. For the Common Legal Representative team appearing today, Orchlon Narantsetseg, Caroline Walter and Paolina Massidda.

PRESIDING JUDGE SCHMITT: [9:33:52] Thank you.

And for the other team, Mr Mawira.

MR MAWIRA: [9:33:53] Good morning, Mr President, your Honours. For the Legal Representatives, Mr James Mawira and Maria Radziejowska.

PRESIDING JUDGE SCHMITT: [9:34:01] Thank you very much.

And for the Defence, Mr Ayena.

MR AYENA ODONGO: [9:34:03] Good morning, Mr President and your Honours. Today I am assisted by Chief Charles Achaleke Taku, Ms Abigail Bridgman, we have Eniko Sandor, Morganne Ashley and Mr Santiago Montoya.

PRESIDING JUDGE SCHMITT: [9:34:29] And your client.

MR AYENA ODONGO: [9:34:31] And of course it goes out saying, Mr President, our client Mr Dominic Ongwen is in court.

PRESIDING JUDGE SCHMITT: [9:34:39] Thank you very much. And Mr Montoya is a new face in the courtroom.

MR AYENA ODONGO: [9:34:44] Yes, he is a new face and one of our young fellows helping us.

PRESIDING JUDGE SCHMITT: [9:34:49] Thank you.

Welcome, Mr Montoya.

The Prosecution is now calling as its next witness, in Germany we would say its expert, Mr Weierstall.

Good morning, Mr Weierstall. On behalf of the Chamber I would like to welcome you in the courtroom.

WITNESS: UGA-OTP-P-0447

(The witness speaks English)

THE WITNESS: [9:35:06] Good morning, Mr President, your Honours. Thank you very much for the warm welcome.

PRESIDING JUDGE SCHMITT: Mr Weierstall, there should be a card in front of you with the solemn undertaking and we have the habit here that the expert, the witness reads this card out aloud and that is the swearing-in ceremony, so to speak. So please read it out *loud.

THE WITNESS: [9:35:26] I solemnly declare that I will speak the truth, the whole truth and nothing but the truth.

PRESIDING JUDGE SCHMITT: [9:35:30] Thank you very much. Before we start with your testimony we have a few practical matters to have in mind when you give your testimony. You are well aware that everything we say here in the courtroom is written down and interpreted. And to allow for the interpretation you have to speak clearly and at a slow pace, slower than I am doing at the moment, preferably I would say. Speak into the microphone, of course, and only start speaking when the person who has asked you questions has finished.

If you have any questions yourself, you can raise your hand, I will give you then the word.

We can start now with your testimony. Ms Adesola Adeboyejo has the floor.

MS ADEBOYEJO: [9:36:10] Thank you, Mr President, your Honours.

QUESTIONED BY MS ADEBOYEJO:

Q. [9:36:16] Good morning, Professor Weierstall.

A. [9:36:19] Good morning.

Q. [9:36:19] By way of housekeeping I am going to be putting questions to you today covering six broad topics: Your professional qualifications, some procedural matters regarding the expert report and tendering it before this Court, the six guiding questions you raised in your report, the extracts from evidence that this Court has heard, and then finally I will ask you questions about your concluding remarks. You can feel free to refer to the binders beside you there. Those were provided by the Office of the Prosecutor. And at the appropriate time I will ask you to look at the relevant binders.

Please can you tell the Court your full names.

A. [9:37:07] Yes, of course. My name is Roland Weierstall and I am professor for clinical psychology and psychotherapy at a medical school in Hamburg, it's a private university. And I am state licensed psychotherapist.

Q. [9:37:24] And if I can just take you to binder 3 in the first binder. So there is binder 1 and 2. Let me take you to tab 3.

PRESIDING JUDGE SCHMITT: [9:37:44] Although we have an electronic file, we still stick sometimes to paperwork and this largely depends on having Judges who have only experience with analogue working and of course under these circumstances it makes things easier if you refer to a binder and we do not have to put everything on the monitor. So this means that experts and witnesses sometimes really have to work here in the courtroom.

Ms Adeboyejo.

MS ADEBOYEJO: [9:38:16] Thank you, Mr President.

Q. [9:38:18] Tab 3. And that's your report that contains your curriculum vitae, isn't it, Mr Witness?

A. [9:38:26] Yes, it is.

Q. [9:38:29] For the record, it's 0280-0674.

So you have just told us, Professor, that you are a professor of clinical psychology and psychotherapy. Could you tell us what's the difference between a clinical psychologist and a psychiatrist?

A. [9:38:55] Well, in Germany the system is like this: We, as a -- you can call yourself maybe a clinical psychologist after you finished your master's degree, for example, in psychology and then you have an emphasis on clinical psychology during your studies. But if you later want to diagnose people and also work with patients and also want to offer psychotherapy, for example, then in Germany you need a qualification for this. So only with a master's degree you are not allowed in Germany to give diagnosis and that's the reason why afterwards you need additional qualifications.

And I have two of them. I'm, on the one hand, licensed as a state licensed psychotherapist, which means that I have this qualification, this extra qualification that you need. And there's an additional, I think, your Honour, you might know it, the Heilpraktikergesetz in Germany which allows, which is also another qualification for an alternative practitioner to also diagnose and treat people with mental disorders or with disorders that need psychotherapeutical assistance. And that's the difference. And that's my qualifications that I have. And this is independent of the lecturer qualifications that I have. I also have the venia legendi, which is the university lecturer qualification in Germany, which gives me the right to teach psychology --

THE INTERPRETER: [9:40:26] Your Honour, could the witness please be asked to

slow down.

MS ADEBOYEJO: [9:40:31] You would have to go a bit slower, please, Witness.

THE WITNESS: [9:40:34] Please excuse.

MS ADEBOYEJO: Because the Acholi translation is trying to catch up with all these concepts.

PRESIDING JUDGE SCHMITT: [9:40:40] So you commit this offence, this deed like anybody else or everyone here has done already.

But the question I think was what the difference to psychiatry is.

THE WITNESS: [9:40:52] Yes, that's what I wanted to say. And the difference to psychiatry is that I studied psychology and that is not that I studied medicine and for being a psychiatrist you need to have, you need to have studied medicine before.

MS ADEBOYEJO: [9:41:06]

Q. Thank you. Now I see that you have published quite a number of research papers in your CV, so we are still looking at tab 3, which is your curriculum vitae. Have you worked with rebel groups before?

A. [9:41:20] Before when? What do you mean?

Q. [9:41:22] Well, you have included in your curriculum vitae that you had some experience and I wanted you to share that with the Chamber.

A. [9:41:31] We did lots of research with former combatants in different former crisis regions, as you can also see in my curriculum vitae, for example, in Rwanda, in Uganda, in Burundi, South Africa, for example. And my group was the first to systematically investigate former rebels and combatant groups in terms of the processing of violence cues.

Q. [9:41:59] And in the footnote, the very first footnote of your report I see that you have referred to randomised controlled trial. Can you explain what this term

means?

A. [9:42:14] Okay. Randomised controlled trial means that when you want to find out in experiment, for example, if your type of treatment you offer is superior to a different type of treatment. So, for example, assume that we want to offer trauma therapy and we want to prove that it really works, then we would pick a number of traumatised individuals and then randomly, which means by chance, assign them to the new treatment that we want to offer and the other type of treatment that is standard in clinical care, for example. And then we compare them in the end and see is our new treatment superior or is it not superior? And that means a randomised controlled trial and that's important because it is international standard or the most important standard when you want to get evidence for the, for the validity of the treatment you offer.

Q. [9:43:17] Thank you, Professor. Now let's, still looking at your curriculum vitae, you also talked about the publications. I want to focus especially on the publication "When combat prevents PTSD symptoms - results from a survey with former child soldiers in Northern Uganda". Could you tell us a bit about that, please.

A. [9:43:45] Okay. The research question is -- is it okay if I say some more words regarding this point?

PRESIDING JUDGE SCHMITT: [9:43:53] Yes, of course. And if it becomes a little bit lengthy, I will interrupt you.

THE WITNESS: [9:43:59] Okay. Thank you, your Honour.

Okay, so the idea of our research was that first we only had few data that showed us that former child soldiers that we were working with in Uganda, that they didn't suffer from so intense symptoms of PTSD than we would have expected them to suffer from. So we know that there is a clear dose-response relation between the

number of traumatic events we experience and probability to suffer from post-traumatic stress disorder, which means that, for example, if I would have experienced 10, 12, 15, different traumatic events, then I would have a higher probability to develop a post-traumatic stress disorder than compared to someone who maybe only have experienced two or three. And then you can estimate, depending on the number of traumatic events you have experienced the probability to suffer from PTSD; and then we find a gap, a difference between victim populations and first, and first interviews or first pilot studies with former child soldiers where we didn't find these high rates of PTSD.

So when I say PTSD, it means post-traumatic stress disorder. And so this was something where we say, okay, there must be or there might be a difference in the processing of violence cues, because the victims and the perpetrators, they all face the same traumatic cues or potentially traumatic events, so every perpetrator is also confronted with seeing that people, also seeing dead bodies, seeing people being shot or being stabbed, but we thought, okay, if they see the same things, why don't they suffer from similar intense PTSD symptoms?

So there must be a protective mechanism that prevents them from getting traumatised by the things they see. So that was the original research question where we started.

MS ADEBOYEJO:

Q. [9:46:15] Okay.

A. [9:46:16] And may I just add another thing regarding this particular paper or publication?

PRESIDING JUDGE SCHMITT: [9:46:18] Yes, please.

THE WITNESS: [9:46:19] Okay. And so this, the Ugandan publication you are referring to, was one of the first systematic studies that we did, and there we

compared former abducted child soldiers from the LRA compared to age-matched controls, which means other male participants that haven't been abducted by the LRA but that were also raised in Uganda, and we were interested to see how the relation between the number of traumatic events they experienced and the PTSD symptomatology is moderated by their, by different processing of violence cues.
And now I come to the conclusion of what the results tell us. The results tell us that when we find high levels of appetitive aggression, which concept I also refer to in my report, which means that they process violence cues in a different way, they process violence as being appealing maybe or being also sexually arousing, for example.
We have these patients or these clients or participants that report also violence to be sexually arousing and that they wanted to, they were really seeking for violence after they committed atrocities, we found that people with high levels of this appetitive aggression suffer less from PTSD and this --
THE INTERPRETER: [9:47:48] Your Honour, I do apologise for interrupting, but could the witness please slow down.
MS ADEBOYEJO: [9:47:54]
Q. Can I just ask you to slow down again, because the Acholi interpreters are finding it different to catch up with you.
A. [9:48:00] okay. And basically that is what was the main result, that we saw that the appetitive processing of violence cues on the one hand really exists. It affects the relation between traumatic experiences and the PTSD level.
And also one finding that also might be important for this particular case is that we didn't find individuals with high levels of appetitive aggressive behaviour, so those who report to enjoy violence, for example, and low levels of PTSD, and we also don't find people with low levels of appetitive aggression and high levels of PTSD, which

means we only get access to those people who are at the borderline to psychopathology, which -- and we conclude that for those who are still functioning properly, that they don't have any motivation, for example, to demobilise or to take part in these examinations because they are still functioning.

Q. [9:49:13] Okay. I would ask you to observe those pauses that I spoke of earlier, and I will come back to this question of appetitive aggression. I have some questions on that specifically.

But I am still dwelling or focusing on your curriculum vitae. And aside from your work as a full professor of clinical psychology, I note that you have also conducted some research and you have written some reports as an expert, as an expert witness for use in court. Can you tell us about this very briefly.

A. [9:49:55] Okay. Very briefly I have worked in for forensic assessments, I did forensic assessments for a court and -- or yeah, I did it.

PRESIDING JUDGE SCHMITT: [9:50:11] And, of course, the follow-up question suggests itself, what kind of courts have these been? Germany, for example, in Germany?

THE WITNESS: [9:50:21] Germany, a German court. It was for the Landegerichte. I don't know the proper translation, the Landegerichte.

PRESIDING JUDGE SCHMITT: [9:50:29] No. He says higher -- no, regional court. Higher regional court would be Oberlandesgerichte.

THE WITNESS: [9:50:31] Okay. No. It was the --

PRESIDING JUDGE SCHMITT: [9:50:32] The regional court.

THE WITNESS: [9:50:33] -- the regional court in Konstanz.

PRESIDING JUDGE SCHMITT: [9:50:35] Okay.

THE WITNESS: [9:50:37] And then I was also asked to write a report, and this was

paid by a private person whose son was charged for some offences, and I have also written a report there, but the conclusion was that the hypothesis the father had wasn't true, and so he didn't bring it or presented it in court.

MS ADEBOYEJO: [9:51:04]

Q. [9:51:05] Okay. Thank you very much, Professor.

Now we are still on tab 3, which is open in front of you, and I just want to ask you if you -- of course that's a question I have to ask anyway, whether you recognise this record and the appendices to this report?

A. [9:51:27] What do you -- could you please repeat the question.

Q. [9:51:29] The appendices to the reports.

A. [9:51:30] Yes.

Q. [9:51:31] That's tab 3, your report.

A. [9:51:34] Yes, yes.

Q. [9:51:36] Do you recognise it? Is it your report?

A. [9:51:37] This is my report.

Q. [9:51:38] Okay. And is that your signature --

PRESIDING JUDGE SCHMITT: [9:51:40] May I just shortly.

This is absolutely correct what you are doing, Ms Adeboyejo. But an expert or also a witness coming from a civil law background is not used to do that. So I assume Mr Weierstall simply thinks yes, this is a report, yes, this is a report, continue. But in this legal environment, so to speak, and I think it is absolutely okay, there is a process of authentication and this is being done now.

Please continue, Ms Adeboyejo.

MS ADEBOYEJO: [9:52:15] Much obliged to you, Mr President.

Q. [9:52:18] And this will be your signature on page 28 of that report, isn't it,

professor?

A. [9:52:24] This is my signature, correct.

Q. [9:52:26] And did you write this report truthfully and to the best of your knowledge and recollection?

A. [9:52:30] I have written this report truthfully and I did my best to answer all the questions honestly.

Q. [9:52:43] Okay. And do you object to this report being used by the judges when they are determining this case?

A. [9:52:51] Yes.

Q. [9:52:52] Do you object to it?

A. [9:52:54] No, no.

PRESIDING JUDGE SCHMITT: [9:52:55] No, no. It has to be clear for the record.

THE WITNESS: [9:52:59] Sorry.

PRESIDING JUDGE SCHMITT: [9:52:59] I simply assume there is a misunderstanding, but of course we have to have, really for the legal requirement of Rule 68(3), we have to have the correct answer.

MS ADEBOYEJO: [9:53:08] Yes.

PRESIDING JUDGE SCHMITT: [9:53:09] I would not say the right answer, but the correct answer. So you have to ask the question again, please.

MS ADEBOYEJO: [9:53:15]

Q. [9:53:15] I have put the question, but I will put it again as the Presiding Judge has directed. Do you have any objection to the judges using your report when they are determining this case?

A. [9:53:27] No.

MS ADEBOYEJO: [9:53:29] Okay. Now, Mr President, your Honours, this would

be the questions.

PRESIDING JUDGE SCHMITT: [9:53:34] Indeed, with the answer "No", yes. With the answer "No", the legal requirement of Rule 68(3) is indeed fulfilled, yes.

MS ADEBOYEJO: [9:53:44] Much obliged, yes, your Honour.

PRESIDING JUDGE SCHMITT: [9:53:46] To at least strive to be precise.

MS ADEBOYEJO: [9:53:51] That's correct. Thank you, your Honour.

Q. [9:53:54] I will move now to the substantive questions as I spoke to you about. We have heard previous evidence in this courtroom about the classification of mental disorders through the DSM-5 and the ICD-10. Can you tell the Court what these are?

A. [9:54:13] Yes, of course. The ICD as well as the DSM are both classification systems that we use in psychology, psychiatry and medicine to determine if certain disorder really can be diagnosed or not. So there are criteria defined, and we have to see if this criteria are fulfilled, and then if they are fulfilled, we are allowed to diagnose.

Q. [9:54:46] And in your case when writing this report, which of them had you referred to?

A. [9:54:50] I referred to the ICD, because it is usually in Germany we use the ICD and we also once made a, made a -- did some research on which classification systems are used in Europe, and we found out that most European countries also refer to the ICD. But it's also possible to translate the -- from ICD to DSM.

Q. [9:55:23] Did you at any time have reference recourse to the DSM?

A. [9:55:27] Yes, I actually do it when we are writing up research papers, for example, because usually they are published in international and also American journals and we also, we always try to publish them in American journals, because

then we sometimes reach a broader readership, and they are used to DSM.

Q. [9:55:58] Now, I understand there were three principal sources of information you used in coming to your conclusions in your reports, and that was the report by Professor de Jong?

A. [9:56:09] Yes.

Q. [9:56:10] Yes, okay. And there was also a report by Professor Ovuga and Dr Akena, isn't it?

A. [9:56:16] Yes, that's true.

Q. [9:56:17] And also there were various types of information that were given to you, video materials, clinical records, other such materials, isn't it?

A. [9:56:27] That's correct.

Q. [9:56:27] Now, did you have an opportunity to examine the accused person in person?

A. [9:56:34] No, we didn't have the opportunity, and I also didn't have the opportunity.

Q. [9:56:38] And why didn't you have the opportunity?

A. [9:56:41] We asked if we get the opportunity to personally interview or clinically assess Mr Ovuga -- I'm sorry, Mr Ongwen, pardon -- and this request was refused.

Q. [9:57:03] Now let's go to the six guiding questions --

A. [9:57:08] Yes.

Q. [9:57:09] -- which you have used to structure your reports. The judges have a full copy of your report, but I will take you through those guiding questions and then I will ask you some supplemental questions and your observations on them, okay.

So your guiding question one was: Has Mr Ongwen being exposed to one or

multiple traumatic events? And that was in page 24 of your report.
So my first question to you along this line is, can you define "trauma", what do you mean by "trauma"? Can you define it for us?
A. [9:57:53] Yes, of course I can define it for you.
So a trauma or there is an official class -- or, so what the trauma is is officially written down in the classification systems. So you can find the definition in ICD as well as in DSM.
And in the DSM-IV -- so therefore you must know that there are different versions of the DSM, and since a few years we are now using DSM-5, but before we used DSM-IV.
And in the DSM-IV definition we have two criteria that have to be fulfilled. On the one hand, it is the objective aspect, which means that you have to face or you have had to face an incident or something that happened which where you may be confronted with seeing other people -- another person dying or seeing another person being seriously harmed or if this also happens to you.
And then on the subjective level, while this happened, you must have experienced extreme feelings, for example, of helplessness or horror. And now it changed in the DSM-5, and in the DSM-5 now they deleted the subjective criterion and only refer to the objective criterion.
But I personally totally disagree with this definition because I don't think that there is objective trauma. I think it is only the subjective processing of what you have experienced is the thing that matters.
Q. [9:59:47] But I see that in your definition in the report you have referred to what you call in page 5, you have referred to what you called aversive details. You said a person could by being -- by witnesses -- or witnessing or by being exposed to aversive details. Could you tell the Chamber what you mean by that term "aversive

details"?

A. [10:00:12] Yes. What I mean with the term "aversive details" is that it refers to what I mean with the subjective nature of trauma. So if there's anything that I experience as disturbing, where I would say "this arouses these feelings of helplessness or horror inside of me", then these are aversive details, so things that really bother me. And this could be very different things for some people, and I think this really depends on the subjective experiences of the particular person, which means, for example, that you could witness a car accident and it might be disturbing for you and I could witness it and it's not disturbing for me. So the processing might differ between different people and therefore it means that the aversive nature of the trauma depends on the processing.

Q. [10:01:09] Yes. Thank you very much for that, Professor.

And would it be right then, or would I be correct to say that this issue of trauma was the least controversial of the issues you had to deal with when you were looking at these materials, you know, the fact that trauma was actually suffered?

A. [10:01:30] Yes.

Q. [10:01:31] And you would also agree with me that essentially all the sources I referred to earlier - de Jong, Akena, Ovuga and materials - concur that, and you were able to reach a conclusion and your conclusion is to be found, to this guiding question, in page 24 of your report. And I was wondering if you could read that conclusion to us to your guiding question 1.

PRESIDING JUDGE SCHMITT: [10:02:02] I think that is not necessary because we have this process of Rule 68(3).

Okay, I thought there was a problem. I think we have this process of Rule 68(3). This means, to explain it also for the expert, that the complete report that you have

given is part of your evidence today in the courtroom, legally. So I would not ask the expert to read out something. I am not, I am not very fine with it. I think this is unnecessary. You can ask additional questions; for example, it might be interesting inter alia what the experts says to the material provided to him, I think we will come to that later on. But you won't have to ask him to make a reading lesson here. If you ask questions and he wants to explain it with his own words, yes, but not let him read it out.

MR GUMPERT: [10:03:08] Your Honours, I take my life in my hands, metaphorically, to seek to persuade you to the contrary. Of course your Honours are fully aware of what he's written and it is in evidence, but that passage is very short and there is considerable public interest, not only those in the public gallery, but I suspect many thousands of people watching outside. The amount of time consumed would be very small. The benefit to those who have a legitimate interest may be significant.

PRESIDING JUDGE SCHMITT: [10:03:46] Yes, but -- I agree with you, in part. I don't agree in the manner you would like to elicit the information. Why not ask the expert simply: What were your findings? What was your conclusion with regard to this first guiding question number 1? And if he himself wants to take the same, wants to use the same words, that's fine. But to ask him to read part of the report I think is, also defies a little bit the meaning of Rule 68(3). But I agree with you that the information is of course of interest, of high importance, and it should be provided also publicly, but we are only talking about the way in which we elicit this information. Now we have talked so long, we would have read it out several times. Mr Taku, no, we don't -- it's --

MR TAKU: [10:04:44] No, I just wanted to say that --

PRESIDING JUDGE SCHMITT: [10:04:42] Short, please, Mr Taku.

MR TAKU: [10:04:43] Yes. The report which is a public report, will surely be published, and therefore the material can be available to the public in many other forms than coming to read here and to alter the rules which your Honours have applied in these proceedings.

PRESIDING JUDGE SCHMITT: [10:05:00] I have already decided now; so now I take over, Ms Adeboyejo.

So for the first guiding question: What was your conclusion regarding the potential trauma that Mr Ongwen might have gone through?

THE WITNESS: [10:05:18] So my first conclusion was that I have no doubts that living in this war scenario might have resulted in being confronted with potentially traumatic events that later in life could have also resulted in a development of a psychopathological disorder.

PRESIDING JUDGE SCHMITT: [10:05:43] Thank you.

Please continue, Ms Adeboyejo.

MS ADEBOYEJO: [10:05:46] Thank you, Professor.

Q. [10:05:50] You have used the term "psychopathological" --

A. [10:05:54] Yes.

Q. [10:05:54] -- and I want to bring your mind back to that. Could you tell the Chamber what you mean by that term in particular?

A. [10:06:01] Yes. For me, it's important to not say the development of a trauma-related disorder as we know that different psychopathologies, which means the development of also, for example, addiction, the development of schizophrenia, the development of a personality disorder and a particular trauma disorder like PTSD, could all have been the consequence of being exposed to adverse events. That's why

I refer to the term "psychopathology" and not trauma disorder.

Q. [10:06:40] Thank you, Professor, that's clear.

Now to your second guiding question, which was whether Mr Ongwen suffered from a major trauma-related mental disorder during the period between 2002 and 2005; and if yes, which disorder applies to his specific case. At page 11 of your report, that's 0280-0684, you make reference to the report of Professor de Jong, where Professor de Jong describes Mr Ongwen and gives a detailed account of some aspects of his life in the LRA and his current position. Professor de Jong describes him as suffering from intrusive thoughts, nightmares and loss of hope for the future, doesn't he?

A. He does.

Q. [10:07:41] Yes, okay. If we also turn to pages 16 and 17 of your report, you make reference to the reports of Dr Akena and Professor Ovuga and their report also gives further details on the mind and the life of Mr Ongwen while he was in the LRA, doesn't it?

A. [10:07:58] That's correct.

Q. [10:07:59] Now in the light of all of this information, you came to a particular conclusion on this second guiding question. What was your conclusion?

A. [10:08:12] My conclusion was that from my perspective it's not possible to come to the conclusion or it -- from -- let me, sorry, let me rephrase it.

I think it, by the way the, the statements of Mr Ongwen are quoted in the reports of Professors de Jong and Ovuga, I think that it could be possible that Mr Ongwen suffered from a mental disorder during the -- his time in the LRA, and it could have been possible maybe that there were some signs of the -- of a mental disorder, but none of the material that I have been provided supports this, that there's a real, or that

the diagnosis that could have been potentially diagnosed in this time, that there is not sufficient evidence that this was -- could have been really diagnosed --

Q. [10:09:28] So --

A. [10:09:29] -- and so --

Q. [10:09:32] So I can --

A. [10:09:33] Especially, yes, especially, sorry, if I may add this, especially I think there is really always a big difference is that, that what was confusing while reading the reports because the period we are referring here is the period between 2002 and 2005. And many of these symptoms that are reported here refer to the current psychopathological status and there is not much evidence provided that these symptoms have already -- have really been present in the past and especially not in the period between 2002 and 2005.

Q. [10:10:11] Now, the other doctors have actually come up with a diagnosis of three mental disorders, one of which you have referred to earlier, PTSD, and also a major depressive disorder, MDD, and other specified disorder, dissociative disorder, during the period 2002 and 2005.

A. [10:10:33] Mm-hmm.

Q. [10:10:35] So we are going to look at that seriatim, so to speak, starting with PTSD. What would be your own brief definition of PTSD?

A. [10:10:46] My brief definition exactly matches the official definition and this means that PTSD is characterised mainly by three main symptom: One is the intrusions, so that I have memories and nightmares about the incidents that happened; the other thing is the hyperarousal, which means that I am constantly in a more aroused state, that I am -- for example, that I easily startle; and the next big thing is the avoidance, so people that have experienced traumatic experiences, they tend to

avoid trauma reminders.

And we have to add that in the DSM-5 there now have also been other symptoms included that somehow match or are related to symptoms of depression. But either it doesn't matter if you diagnose people according to DSM-IV or DSM-5, if you really have a severe post-traumatic stress disorder, then you should come to the same conclusion whether you use DSM-IV or DSM-5, even if there's a not a hundred per cent overlap between the two classification systems.

Q. [10:12:06] Okay, all right. Now, what about major depressive disorder, what would be the main characteristics of that?

A. [10:12:13] The main characteristics of major depressive disorder is that you have a loss of interest in things, on the one hand, that you have a loss of motivation and it's usually accompanied by various other symptoms like, for example, loss in sleep quality, people don't sleep anymore, they have ruminations which prevent them from sleeping. They might have changes in their weight, they can lose weight, they can gain weight. They have a loss of sexual interest. And the number of additional symptoms affects the severity of the diagnoses. So the more symptoms are fulfilled by a patient, the higher the level of -- the severity of the disorders coded.

Q. [10:13:07] I will come to that later. Now the last term is the other dissociative, other specified dissociative disorder.

A. [10:13:16] Mm-hmm.

Q. [10:13:16] Could you tell us briefly what this term means?

A. [10:13:19] Yes. Dissociative disorders usually look like as if a patient suffers from a neurological disorder. So, for example, that there are memory deficits, there are -- that it could happen that, for example, people have amnesia, they don't remember what has happened in the past or in a certain episode, for example. Or it

could also happen that they report not having feeling in their, in their legs or in their arms and that resembles a neurological disorder, but we don't have a neurological, really, manifest physical impairment. And it could also covers, for example, multiple personality disorder. I mentioned this because it is reported also in the, in the report by Professor Ovuga and his colleague. And is a very broad variety of different symptoms that can be categorised in this category, and, yeah, but they all look more or less like an impairment of the integrity of normal functioning of cognitions, senses and mind-body integrity.

Q. [10:14:40] Right. So I'm still on page 11 of your report where you have used the term "differential diagnosis" and that's, that's in the middle of the paragraph, the very first paragraph. Could you tell the Chamber what you mean by this term?

A. [10:15:07] Okay. Yes, what I mean with differential diagnosis is that, assume you don't sleep and it's difficult for you to sleep, then this could have different reasons. So on the one hand if you are traumatised, then maybe you don't want to sleep because you fear that bad things could happen to you during the night. When you suffer from depression, you don't sleep because you maybe have rumination, you have worries and then you think about how bad life is and this prevents you from sleep. If you take drugs, for example, cocaine, then you don't sleep because you are in a hyperaroused *state.

So there are different reasons why a person can suffer from certain symptoms and we have to, when we really want to make a diagnosis, let's say the diagnosis of PTSD, then we have to exclude alternative diagnosis. And, for example, also here when we talk about nightmares, then the nightmares could either be the consequence of trauma, which means that really things that happened in past come into my mind, or it could also be that it's a more psychotic disorder, for example, where I fear things, for

example, that monsters are in my bedroom but this is not really the truth, but it could also cause nightmares. So this means when you really want to make a diagnosis like the ones that are suggested in the reports by Professor de Jong and also in the report by Professor Ovuga, then you also have to consider alternative explanations and you have to rule them out.

PRESIDING JUDGE SCHMITT: [10:17:10] (Microphone not activated). Excuse me, a short interpretation. I am informed that still it might be a little bit too quick, especially the answers, Mr Weierstall, frankly speaking. So you simply would still to have slow down a little bit more.

Ms Adeboyejo.

MS ADEBOYEJO: [10:17:32] Thank you.

Q. [10:17:33] Thank you, Professor.

Now, would there be any overlap, then, between the symptoms of PTSD, MDD and *other specified dissociative disorder?

A. [10:17:51] Yes, there can be and I now really try to speak a bit slower and I apologise that I always have the tendency to rush a bit because I always want to present you all the information I have.

Yes, for example, when you read research papers on -- and you find, then you always find high correlation, which means a high relationship between depression and PTSD. And when you, for example, really have a closer look on how these diagnoses were, or how it took part that these, that people came to these diagnoses, then many people tend to overlook that there is an overlap in the symptoms, which means that, as we, as I already said before, difficulties of sleeping can either be trauma related and a symptom of PTSD, or it could be a consequence of depression. And now when you really want to make, give a clear -- or make a clear diagnosis, then you have to

differentiate it and you have to ask the person: Why don't you sleep? What is it that prevents you from sleeping? And only then I am able to really either put it on this or the other side.

Q. [10:19:34] Okay. So if I understand you correctly, to be able to arrive at a convincing diagnosis of any of these conditions, you would have to undertake this differential diagnosis?

A. [10:19:53] Absolutely. And this is something that always have to be done and this is something I also teach my students because you should not make the mistake and overlook a very important other aspect. And this means if I have the hypothesis that someone suffers from PTSD, it could also be, for example, that hyperarousal is a consequence of drugs or that hyperarousal is a consequence of any medical issue. So this means if I really want to come to a valid conclusion, then I would have to consider all alternative explanations and only then I can say, okay, this is really a depressive disorder, for example.

Q. [10:20:46] And what would be your observations then on the reports by Professor de Jong and Ovuga, Akena on these aspects, what would be your observations?

A. [10:21:01] My observation is that this is missing in both reports. So if you have a theory, a good theory always tries to falsify the hypothesis, and this is a very important aspect. So if I had the hypothesis that Mr Ongwen suffers from PTSD and depression, then I can't only try to find evidence for my hypothesis, but I also have to consider all the alternative explanations. And this, as far as I can tell from the information that I have and the information that is presented or given in the documents, I don't see that this has been done, that alternative diagnosis have been considered.

And also where I have doubts is that the validity of the symptoms has been proven, because this is the most important aspect. You have to really find out is it plausible that this symptom matches the symptoms, how the symptom, in a way how it is classified in the classification system and only if this really matches, if the statements of my clients, my clinical impression and also maybe in the responses I gave in the standardised questionnaire, only if these match then I would say in such an important case like this one it's justified to, to name the symptoms, name the symptom depression or sleep disorder.

Q. [10:23:01] And that would, that would be actually what you refer to then as, we have heard this in this court, as triangulation, isn't it?

A. [10:23:11] Correct.

Q. [10:23:12] Now, would it be fair then to say that there are indications in both the objective descriptions in the clinical records and in the accounts given by Mr Ongwen of the three experts of the symptoms, symptoms of mental illness? Can I repeat the question?

A. [10:23:33] Please.

Q. [10:23:33] I think you were distracted by the water.

Would it be fair to say that there are indications in both the objective descriptions in the clinical records and in the accounts given by Mr Ongwen to the experts, to the other three experts, of the symptoms of mental illness?

A. [10:23:56] Mm-hmm.

Q. [10:23:57] Would that be fair, would it be fair to say that?

A. [10:24:00] Whom do you mean with the three experts?

Q. [10:24:04] I mean Professor de Jong, Professor Ovuga and Dr Akena.

A. [10:24:09] Yes.

Q. [10:24:09] That would be yes?

A. [10:24:10] Yes.

Q. [10:24:11] Okay. Now, do these symptoms, because you used the word "manifest" mental disorder, the symptoms that they have, they have expressed in their reports that they have seen with Mr Ongwen, do they support that there was manifest mental disorder?

A. [10:24:33] I don't think that they support that Mr Ongwen really suffered from a manifest disorder, and what I mean with manifest is that it really can be diagnosed according to the classification system. Because this requires, for example, in the case of depression, that the symptoms of an, I don't know, let's say an impaired mood is not only there once in a while, but that it maintains over at least, for example, two weeks.

And also in the case of PTSD, we have to consider here, for example, for how long are these symptoms present and is it, for example, a PTSD or is it an alternative diagnosis? Because you can also develop changes in your personality in the aftermath of a trauma and this is a very, very important other diagnosis that could have been, that could have been applicable here, but this wasn't already considered.

And so this is what I meant before, yes, there are some hints that speak, or that could be related to a *symptom, but I don't think that there is sufficient evidence that diagnosis really fulfilled.

Q. [10:26:05] And in fact if we still focus on page 11 of your report, this is what you were referring to when you were talking about uncertainties.

A. [10:26:15] Mm-hmm.

Q. [10:26:16] And mismatches, isn't it?

A. [10:26:19] Mm-hmm.

Q. [10:26:20] All right. Let me ask you about your observations on that aspect. First of all, I think you calculated --

PRESIDING JUDGE SCHMITT: [10:26:28] Wait a moment, Ms Adeboyejo. Obviously Mr Weierstall wants to have the word.

MS ADEBOYEJO: Yes.

THE WITNESS: [10:26:36] Sorry. There's one aspect I just want to add, because I think -- and thank you, Mr President, for allowing me to add something. I think the problem is that the report always mixes the past and the present. And I can of course on the one hand, I don't know, find sleeping disorders, for example, today in Mr Ongwen and the psychopathological assessment also refers to this. But the problem is this doesn't have to do anything with the past and there is not much information given on the past in both of the reports and this is something that I don't understand because I thought it was about past incidents and not about the present mental health status that could have been completely different from the things that have happened before.

PRESIDING JUDGE SCHMITT: [10:27:36] May I shortly, Ms Adeboyejo. So it's absolutely correct what you are saying and I think we really should focus today and tomorrow on the past. We are talking about the time from 2002 until 2005. And the current mental status of Mr Ongwen is, in that respect, only relevant if it gives us hints about the past.

Please, Ms Adeboyejo.

MS ADEBOYEJO: [10:28:10] Thank you, Mr President.

Q. [10:28:13] Let me take you to page 17 of your report where you had calculated the number of dissociative episodes which on his own account Mr Ongwen can be expected to have experienced during the period from 2002 to 2005, and that's the last

bullet point on page 17.

A. [10:28:49] Mm-hmm.

Q. [10:28:49] What issues did this raise for you, Professor?

A. [10:29:07] What I wanted to show is that, or what I wanted to express is that I was on the one hand very surprised that we really received such a concrete answer so that he suffered from eight episodes in such a long period, because I, in my whole career I never talked to any patient that could have given an exact number and say it really happened eight times in such a long period. This was the first thing that there were, I would say, this -- I was a bit surprised why, why it was only eight. Then I thought, okay, if eight episodes occurred in 25 years, that means one or two or three episodes in the period between 2002 and 2005. And even if it was the case that during these three episodes things happened that maybe could have affected the mental health, or the health status or the mental status of Mr Ongwen while committing one of the accused incidents, then there is still a lot of time where these potential dissociative symptoms are not present.

And that's a very important thing for me, because I think that when we assume that an impaired mental health status was or had affected Mr Ongwen's behaviour in the period between 2002 and 2005, then this mental health status should have been, or this affected mental health status should have been stable over time and should have been there at least all -- either all the time or at least always during these incidents that are now part of this trial.

Q. [10:31:34] In fact, if we are still dwelling on paragraph 3.2.2 of your report, you also make reference to the interpretation in the Defence report of Mr Ongwen's feelings about his current condition as a sign of depression. What are your observations in this regard?

A. [10:32:02] Which bullet point are you referring to?

Q. [10:32:05] 3.2.2.

A. [10:32:06] Yes.

Q. [10:32:08] I am still on page 17.

A. [10:32:09] Okay.

Q. [10:32:09] And I am looking at where it talks about in bullet point 1 and 2.

A. [10:32:17] Okay, okay. So I refer to -- I think you mean this, that Mr Ongwen, or that I quote here, that Mr Ongwen repeatedly experiences bad thoughts and vivid visions of his friends who lived with him in the bush but died; is it correct?

Q. [10:32:44] Yes. But it starts with the paragraph "In their report, Dr Akena".

A. [10:32:53] Okay, yes. Okay, when I -- it starts with the two words that are presented in the report of Professor Ovuga, and there I was surprised that he, on the one hand, talks about two different mental -- let's say mind states in the client, but that he only explores the one that is metaphorically sitting on the left side, and this is the one that suffers, and not the other side, the other side is mentioned in a few lines but not further explored.

And I would have wished that this, that this right side would have received more attention, because this means that it could on the one hand side been possible that Mr Ongwen suffered from a PTSD during his time in the LRA and also in the period between 2002 and 2005 or that there were at least some, some symptoms present.

But if there was also another side, then this stresses the point I made before, then this means that the disorder can't have been there all the time. And this is something I am missing.

And the bad thoughts and the vivid memories, I don't think that this is uncommon. We did -- I told you in the beginning that we did research now with thousands of

different former combatants, and of course many of them report that the experiences they met, some of them were really, yes, let's say, really you can say traumatising or that they still dream about them and they still have intrusions, and still when they are reminded on what has happened, that some of them start to cry.

But this is only, again, only one, one aspect. And this doesn't necessarily mean that I completely suffer from a full-blown PTSD. Just being reminded of bad things has an effect, okay, but what does it tell us?

Q. [10:35:32] Thank you, Professor.

Let me move to page 18 of your report and the first bullet point there where you noted the number of suicide attempts which Mr Ongwen reports having made while he was with the LRA. What would be your observations on this?

A. [10:35:53] I was very surprised to hear that Mr Ongwen really reports eight suicide attempts, because when you have -- or usually when you are faced with people suffering from severe depression and that have acute suicidality, then I can be sure that when they leave the room, they will kill themselves and they will manage to kill themselves, and that we really have to try hard to prevent these people from really committing suicide.

And eight serious attempts is quite a surprising number, because I think if it is really true that Mr Ongwen had the wish to die and he really made this decision, then I think it's for me very uncommon why he survived all the eight attempts. And this was something I also realised where I would say the severe -- it doesn't match with the clinical picture of a severely depressed individual.

And it is the same with, for example, that in the beginning of the report, it is said that all the interviews took, lasted several hours. When I do a clinical assessment with a severely depressed individual, then maybe after 10, 15 minutes, my patient or my

client will be exhausted, especially when you talk about trauma, for example. And these were some concerns I had and some mismatches that I think were in the reports that I have written and that's why I thought it important to mention them here as they influence the conclusion that I can draw in the end.

Q. [10:38:09] Thank you, Professor.

Let me take you now to your guiding question three, which was: Does Mr Ongwen necessarily have to suffer from the experiences he might have made, or could it also be possible that he maintained his general level of functioning and adapted to the violent environment? And this is the guiding question where the issue of appetitive aggression comes into play.

You had already attempted to explain this to the Chamber when we started, but perhaps slower and more briefer.

PRESIDING JUDGE SCHMITT: [10:38:58] No, no, no. He has attempted it in a more abstract general way.

And now simply, Mr Weierstall, you can summarise for us, summarise, I underscore, what your findings are in that respect with respect to your guiding question number 3 and specifically with respect to the person of Mr Ongwen.

MS ADEBOYEJO: [10:39:24] Much obviously, Mr President.

THE WITNESS: [10:39:28] Okay. To summarise it, appetitive aggression means that it is possible that violence cues that can cause trauma-related disorders in, mostly in victims populations, that they can also be processed as appealing or rewarding in perpetrators. This is something we have found in a large proportion of former combatants in former crisis regions, in different crisis regions transculturally, and this is not related to a disorder, because we find, let's say, 30, almost sometimes 40 per cent of the perpetrators, former perpetrators reporting this appetitive

aggression.

And this is important because this stresses the point I made before, that trauma always depends on the processing and the subjective experiences; and if I don't experience an event, like say seeing someone being killed, if I don't experience horror, then why would I suffer from this later?

And this means that only because Mr Ongwen had been exposed to potentially traumatic events, this doesn't imply that he also suffers from PTSD. It could also have been that he processed the experiences he met in a different way, and we find that people high in appetitive aggression are the more functional individuals, which means when I adapt to the violent environment, then I don't suffer from symptoms. Of course this doesn't exclude the possibility that I suffer from seeing my comrades being killed or losing a good friend or also being wounded. That's not the point. But it means that there are potential mechanisms that allow an individual to also adapt to a violent environment without developing symptoms.

MS ADEBOYEJO:

Q. [10:41:56] Thank you, Professor.

Now, without going into the question now of whether that process of appetitive aggression applies in this case further, I want to look at the various sources of information that you had available to you to answer that guiding question 3. And I will start with the clinical records from the mental health professionals, those who have day-to-day care of Mr Ongwen. And I want to consider some of the examples chronologically as you stated in your report, particularly from page 23.

And on 28 September 2015, it was reported, "The mood is neutral with appropriate affect; there is no suicidality."

On 30 November 2015, it was reported, "Stable, no mental health conditions; some

symptoms of PTSS."

On 21 December 2015, it is reported: "Laughs a lot, has a glint in his eye when he does. Remarkably talkative compared to the previous consultation. Is friendly and behaves correctly. Appears relaxed. Impression of above-average intelligence."

On 15 September 2016, "The longer the interview continues, the more cheerful he becomes and he laughs and makes jokes."

On 23 September 2016, "He will assume the role of 'being stupid'" in inverted commas.

On 12 October 2016, "In my opinion, he has a realistic view of the future. I will not call it pessimistic. I find it healthy that he is thinking about his life and what he has done."

And, finally, 28 October 2016, "He makes a bright impression."

Professor, what do these records overall suggest about his level of psychosocial functioning, what I have just read?

A. [10:44:27] Again, these quotes refer to the present mental health status, and I think we also here have to differentiate between the past and the present. But all these quotes you are referring to, and I think there are a number of them, there are many other different quotes that I could find in the documents that were provided to me, they support quite a, I would say, high or a good integrated level of psychosocial functioning. And to me this also doesn't match, in my opinion, the diagnosis of a severe depression and a PTSD, because even if we stick to the past, there are some other quotes given where it is said that Mr Ongwen took care of others, for example. And sometimes when you have people with severe depression, they wouldn't be in a position to take care of others, because for them it's even difficult to get up in morning. Or if you suffer -- have people suffering from PTSD, they will tell you, I

feel detached from others. It's very difficult for me to have loving feelings for my child because I have really, my general level of how I experience emotions is totally impaired and this all doesn't fit together.

Q. [10:46:14] Thank you, Professor.

If we turn to page 11 in your report where you were referring to the report by Professor de Jong, that's at para 3.1.3, that's the last paragraph of that page 11, was there any information contained in Professor de Jong's report that helped you to come to any opinion about Mr Ongwen's level of psychosocial functioning during his time in the LRA?

A. [10:46:58] Do you allow me to have a look in my documents?

Q. [10:47:02] Yes.

PRESIDING JUDGE SCHMITT: [10:47:02] That's at the bottom of 11 and then on the top of page 12.

THE WITNESS: [10:47:12] But, your Honours, if I understood you correctly, you wanted me to refer to the report of Professor de Jong, right? Correct?

MS ADEBOYEJO: [10:47:20]

Q. Yes. Well, I was asking you if there was any information contained in Professor de Jong's report that helped you to come to an opinion about Mr Ongwen's level of psychosocial functioning. But you've referred to it in page 11 of your report.

A. [10:47:34] Yes. Do you also want me to quote something from the report of Professor de Jong additionally to what I have written in my own report, or can I just answer free?

Q. [10:47:45] I think you can just answer freely.

A. [10:47:47] Okay. Yes, there were different paragraphs in the report of Professor de Jong where I think there was sufficient evidence that spoke for an intact or at least

not disturbed level of psychosocial functioning.

Q. [10:48:13] In fact, there is mention, isn't there, of his promotion in the LRA, Mr Ongwen's promotion in the LRA. If we look at that, I am still looking at that last paragraph of your page 11, where it talks about "Mr Ongwen was promoted several times which 'happened through fighting'" and that's referring to page 11 of the de Jong report. So what would be your observations, what's the significance of this?

A. [10:48:41] The significance is the trauma-related avoidance, because people that suffer from PTSD tend to avoid trauma reminders. If I see, for example, a car accident in the street here I would try everything to avoid walking through the street because whenever I walk through the street I would be reminded of the things that happened. So if I suffer from PTSD and have bad memories from seeing people being killed, then I would try everything to avoid more trauma reminders. And this means that this also impairs my ability to fight.

People that suffer from PTSD, they are not functioning properly. Also in the military, if you have someone who suffers from PTSD, you wouldn't send him to the front line because he will make mistakes, he will suffer from hyperarousal, which means that he is not able to follow orders, which means that he is not even able to control a weapon when you have a shaking hand because of your anxiety symptoms and this means, for me, my conclusion was that when he -- and there are some other quotes where it was said that he, Mr Ongwen, was a good fighter and this was also the reason for promotion, then this means that or for me the consequence or my conclusion was that then he couldn't have suffered from severe PTSD symptoms or severe depression because this would have prevented him from acting out this behaviour.

Q. [10:50:34] There is also mention of his observance of the LRA's rule system, in page 12 you made mention of that. What's the significance of that? That's page 12

of your report. Very first line of page 12.

A. [10:50:56] Yes.

Q. [10:50:56] In other words, he survived by following the rules. What would be the significance of this?

A. [10:51:03] On the one hand, following the rules, I think, from what I -- from what I know from the different studies we have done in the various post-conflict regions, surviving in an armed force, especially under these conditions, is very *tough. And also adjusting to the rules, also being so smart to guide others and also not being, I don't know, also, yes, also killed maybe by your own comrades just because you don't follow the order, means that you at least have to know the orders, you have to follow them. And as far as I can tell from the experiences I made with other, with other former combatants is that you really have to be rather smart to then also be promoted.

Q. [10:52:14] Still on that, dwelling on that, page 12, it's also reported -- Mr Ongwen is also reported to have been good at using different types of ammunition and that he was a diplomat. What, what would be your observations on this?

A. [10:52:32] Well to --

Q. What's the significance?

A. -- be a diplomat means, for me, what I associate with being a diplomat means that you have to have a concept of a theory of mind, so you have to, on the one hand, understand what one person experienced and how he feels and also another person, and then I have to do some reasoning on a meta level and then see how we can find a diplomatic way and let's say, for example, integrating two different perspectives on one issue. And this means that I have to feel empathy with one person and the other

person, because otherwise I couldn't act in a diplomatic way. And this also means that I must have at least sufficient cognitive abilities to plan my behaviour in a certain way to achieve certain goals.

Q. [10:53:36] Thank you, Professor. I want to now turn to the reports by Professor Ovuga and Akena.

I'm keeping an eye on the time so that I will finish this aspect, Mr President.

And I would like you to comment on the information contained in their report, so I will make some cites.

And in page 18 of your report you are referring to the Defence report which cites some witnesses to whom its compilers had spoken who had known Mr Ongwen while he was in the LRA. If you look at page 18, he is described -- Mr Ongwen is described as being diligent, fearless, kind, likeable and being a good administrator.

What significance would you attach to this description?

A. [10:54:35] For me this stresses exactly the things that I already mentioned before, especially being fearless stresses that this completely contradicts the diagnosis of a fear-related disorder like PTSD. PTSD is dominated by the fear and which means that I, I am constantly fearing that bad things are happening again. So the fear from the past is something that bothers me today, so then I can't be a fearless person. It would be exactly the opposite.

And the same is with being a good administrator and being likeable, this means for me, on the one hand that you have the ability to adequately socially interact with other people and on the one hand also, for example, guide other people, I don't know, maybe give them advices, that's my interpretation here, but it could also be other explanations what is meant here, but this also contradicts the diagnosis of a major, especially of a severe depressive disorder, because a severely depressed individual,

wouldn't be possible, wouldn't behave or to match this description.

Q. [10:56:02] Now still on page 18, "It is reported that Mr Ongwen feels 'deep remorse, guilt and self-blame'" regarding his view of the morality of what the LRA was doing while he was with the LRA. What's the significance of this?

A. [10:56:30] For me this quote is significant because the question was if some moral reasoning is possible for Mr Ongwen. And then feeling remorse and feeling guilty means that he must have at least an idea of right and wrong and otherwise if I don't have this distinction between what is good and what is bad and what should be done and what should be avoided, then I wouldn't also feel remorse. Why would I feel guilty if I don't think that anything I have done isn't correct? So this means that I need a concept of right and wrong.

Q. [10:57:17] Now, also going to page 19 now of your report, you make reference to the Defence reports about Mr Ongwen is cited as being hard-working, hard-working soldiers receive rapid promotion. Again I will ask you, what's the significance you attach to this?

A. [10:57:50] The significance is the hard-working and it also stresses the point I also made before that hard-working, for me, doesn't match severe depression. It's not possible. And especially that's the issue we now have with all the refugees coming from war-affected countries, that we say we have to help them to overcome PTSD symptoms, as with the PTSD symptoms and with the severely impaired mental health status they are not able at all to work and do a regular job and they are not able to take care of their children and have regular psychosocial functioning, and that's why we need to offer psychotherapy to them in order to overcome these issues. You see. And that's -- and the question I have is: Why should this have been different in the case of Mr Ongwen, that on the one hand he suffers from the same symptoms,

but doesn't face the same impairments? This doesn't match for me.

Q. [10:59:00] And finally for this guiding question, in page 25 you came to a conclusion and you set it out. Could you tell the Chamber what was your conclusion then on this guiding question 3?

A. [10:59:26] Based on the points we already talked about now and in the past minutes, I think, for me, it's plausible if Mr Ongwen says that he -- that some of the experience he made bother him. I don't -- I think this is not possible -- I think this is possible and, for me, it's also -- it also matches all the experiences I made with other former combatants or army members that say, "Whenever I am reminded of bad things that happened to me or my comrades, it makes me feel sad, it makes me feel depressed. And I try to avoid these reminders."

But I think even this is something that also affected Mr Ongwen in the period between 2002 and 2005. This doesn't exclude that the level of functioning, from my opinion, was sufficiently intact, or was -- otherwise he wouldn't have made this career. And I think he also wouldn't have survived in this war scenario. And this is what I mean when I refer to the research we did with the former Ugandan LRA soldiers, that we didn't find these individuals that were highly traumatised but didn't have less -- low symptoms or low levels of appetitive aggression, because we have been told that we will never get these individuals as they didn't survive. You need to adapt to this -- to a war scenario in order to survive.

Q. [11:01:30] But if I understand you correctly, it is highly unlikely, though, that the level of functioning was severely impaired. Is that what I understand you to be saying, Professor?

A. [11:01:47] Yes. This is exactly what I would say, because if you suffer from severe depression or if you suffer from PTSD, and especially if you suffer from any

sort of dissociative disorder, then this highly affects your level of functioning. For example, if you would *dissociate and you, for example, lose the control of your senses, this really increases the chance that you won't survive a war scenario, especially not for a period of such a long time. And that's my opinion -- or, that's not only my opinion, but that's the conclusion I would come to depending on my experience as a mental health expert and someone who has worked in these, in these -- with these populations.

Q. [11:02:44] Thank you, Professor.

MS ADEBOYEJO: Mr President, that is the time for the break.

PRESIDING JUDGE SCHMITT: [11:02:49] Indeed. Indeed, this is time now for a break. And I think it's a little bit after 11 o'clock. I trust everyone to be here at 25 to 12. This is a little bit an odd time, 25 to 12, but I trust everyone to understand what I mean; five minutes past half past, so to speak.

THE COURT USHER: [11:03:14] All rise.

(Recess taken at 11.03 a.m.)

(Upon resuming in open session at 11.38 a.m.)

THE COURT USHER: [11:38:48] All rise.

PRESIDING JUDGE SCHMITT: [11:39:07] And obviously the "Please be seated" has not referred to Ms Adeboyejo, who has still the floor.

MS ADEBOYEJO: [11:39:13] Thank you, Mr President.

Q. [11:39:16] So, Professor Weierstall, we are going now into the guiding question 4, which is: What mental disorder precisely would have accounted for the lack of Mr Ongwen's capacity to appreciate the nature and quality of the wrongfulness of the accused's conduct and his ability to control his behaviour and what hypothesised underlying psychological mechanisms would have caused this lack?

Before we took the break, we were looking at the three disorders that the other experts had identified, PTSD, MDD or other specific dissociative disorder. Is a diagnosis of any of these three disorders per se sufficient to determine if an individual had insight into his behaviour at a particular time or was able to control it?

A. [11:40:19] No. You want me to say a few more words?

PRESIDING JUDGE SCHMITT: [11:40:26] It's not -- you can if you want --

MS ADEBOYEJO: [11:40:27] If you want.

PRESIDING JUDGE SCHMITT: [11:40:28] -- if you want, but it would not be necessary because I think we have also the report on the table. But if you want, of course you can elaborate a little bit on it.

THE WITNESS: [11:40:41] Okay, Mr President, your Honours, maybe if I talk too much, then please tell me. I was a bit unsure if sometimes my answers are a bit too long and so I wasn't sure if I can say some more words.

PRESIDING JUDGE SCHMITT: [11:40:54] As I already said, I would interrupt you if I think. And perhaps you would also sense some impatience on the Bench.

THE WITNESS: [11:40:56] Okay.

PRESIDING JUDGE SCHMITT: [11:41:00] Please continue.

THE WITNESS: [11:41:02] Okay. Yes, well, I had this guiding question in mind because I thought, okay, assume that he suffers or suffered in this period from a mental disorder. What could have been this disorder and how could have this affected the ability to, I don't know, get the insight into the wrongfulness of the nature of the conduct and the ability to control the behaviour?

And for the post-traumatic stress disorder, this doesn't necessary impair the ability to get the insight of the wrongfulness and neither does it affect the ability to control behaviour, unless you, for example, suffer from flashbacks. For example, flashback,

which means that the people relive the traumatic event they have faced. And there it can happen that afterwards people -- the fact that individuals reported that they have some kind of amnesia afterwards and they can't remember what has happened in between.

But even this applies in this particular case and that Mr Ongwen suffered from flashbacks, then for me again it's highly unlikely that during these flashbacks where he relived past experiences, conducted any other planful behaviour, so this is regarding, this is my point regarding the PTSD symptoms.

Regarding the depression, depression is not at all associated with a loss of reference to the reality and not compared to psychotic disorders. For example, it can be that as part of an affective disorder which includes depression, but also manic disorders, that you can also experience psychotic symptoms, like you, for example, get the impression that you have supernatural powers or that you are -- you have to order that God told you, for example, to behave in a certain way. This is something that can be part of an *affective disorder, but then it also is closely then linked to psychotic disorders, to schizophrenia, for example.

And then if this would have been the case, then I would have expected that these differential disorders would have been discussed in the report, and this is not the case.

And the only possible, for me, the only possible, depending on the -- and when always I say "opinion", I mean in line with the best of my knowledge and the scientific evidence that is available at the moment. The only possible for, at least for me convincing explanation would have been the dissociative disorder, because we know, for example, when you consider the disorder of dissociative fugue, that people suddenly appear in another place and they can't remember how they got there, and

afterwards they also can't tell you, for example, how they -- what has happened in the time in between. And so in this time period, of course things can happen that someone cannot explain and where I would expect that this person was or also wasn't in the position to control his or her actions, but --

PRESIDING JUDGE SCHMITT: [11:45:01] Now I am interrupting.

THE WITNESS: [11:45:02] Okay.

PRESIDING JUDGE SCHMITT: [11:45:03] I think we should really focus on the issues here --

THE WITNESS: [11:45:03] Okay.

PRESIDING JUDGE SCHMITT: -- at stake; on the time frame we have mentioned --

THE WITNESS: [11:45:11] Okay.

PRESIDING JUDGE SCHMITT: [11:45:13] -- 2002 until 2005; on the specificities that might relate to the accused Mr Ongwen and so on.

Ms Adeboyejo, please continue.

THE WITNESS: [11:45:24] Okay.

MS ADEBOYEJO:

Q. [11:45:25] Thank you, Professor. I would come back to some of the concepts that you mentioned just now. But now I want to point your attention to page 7 of your report, and especially paragraph 2.2. And in the sixth to seventh line you refer to "a certain severity of the symptomatology is required in order to impair a person's volitional control".

And I wanted to know what your observation is on this particular term, what do you mean?

A. [11:46:10] Yes. While symptoms can vary, even if you suffer from depression, symptoms can vary, they can be severe at one time and less severe at another time,

and this is what I mean, that the disorder really impairs your ability to control yourself or to have insight in the wrongfulness of your actions. Therefore, you need a certain severity of the disorder in order to have these really severe impairments.

Q. [11:46:44] All right. If we go to page 12 then of your report, you have noted that Professor De Jong speaks of various dissociative experiences which Mr Ongwen told him he had undergone while he was with the LRA.

And just to make it clear to you, he speaks about complaints that started in 1998, after he was abducted. That is in page 23 of Professor de Jong's report. And you are referring to it at the first bullet point in paragraph 3.1.4 of page 12 of your report.

So you if look at your report, page 12, paragraph 3.1.4, and I'm looking at the first bullet point under that paragraph. Have you seen it?

A. [11:47:54] Mm-hmm.

Q. [11:47:56] Okay. And so you were referring to Professor de Jong's report. Do these accounts by Professor de Jong, do they give us an insight into any link between dissociation and the commission of offences?

A. [11:48:12] No. I don't think so, because the explanation how these symptoms are related to the behaviour, this is not given. So even if Mr Ongwen suffered from dissociative experiences or symptoms, maybe not already a disorder, then this -- I think I would have expected that the link to the behaviour is outlined, and this is not done. And so I don't think that this is plausible why the dissociations affected behaviour.

Q. [11:48:48] Professor de Jong also speaks of various recollections by Mr Ongwen of his own disciplinary or protective functions as a commander. So you have at page 14 of his report, Professor de Jong's report, which you have referenced in page 13 of yours, so just to avoid you having to go back and forth, if you look at page

13 of your report, the first paragraph, you were referring to Professor de Jong's report where it says there's a hint that Mr Ongwen was indeed able to tell right from wrong. It is described that he punished soldiers who tortured and killed civilians. These are some of the examples.

What would be the significance of this?

A. [11:49:40] I think the significance is that if I protect mothers and children and if I engage in saving other people's life, then I would expect that this person has a meaning of the value of life and the value of different individuals in a group. And for me, this is important as this stresses that this was not severely impaired, at least if this -- if he still was affected by a dissociative disorder, then still the link is missing how this all fits together. So all the reports that I -- that were available don't explain the underlying model, how this all fits together, and then none of them helps to overcome this contradictions.

Q. [11:50:50] Now, let's turn to the report of Dr Akena and Professor Ovuga. And they also make assertions about Mr Ongwen's capacity to understand and control his conduct. So we are going to examine some of the material and to see what your observations are.

If we turn to tab 7 of the binder in front of you, of binder 1, yes, tab 7.

A. [11:51:39] Okay.

Q. [11:51:39] All right. And if we go to page 12 and paragraph C of the defence report, page 12, paragraph C.

A. [11:51:51] Mm-hmm.

Q. [11:51:51] You would see that there was a discussion there with regards to neurological damage, yes?

A. [11:52:01] Mm-hmm.

Q. [11:52:01] And you've made reference to this in page 19 of your report. Do you want to -- could you talk us through what your observations are concerning the neurological damage being referred to here. So that is page 19 of your report.

A. [11:52:26] Page 19, yes, I'm just trying to find page 19. Okay.

Q. [11:52:43] The ERN for tab 7 is UGA-D26-0015-0015 at 0004. All right. So what would be your observations on the issue of neurological impacts which you discussed there?

A. [11:53:12] The reason why I made this point in my report is that of course we know that people suffering from trauma disorders also -- or at least some of them have altered, let's say some of them suffer from altered brain functioning, where you can detect deviant responses to, for example, fear cues; and you can validate them with neurological measures.

But this point, this point C in the report that you were mentioning on page 12, this is quite speculative, because it doesn't tell us anything about the specific case of Mr Ongwen.

So all these results that are reported here always refer to group data, which means that of course I can explain a bit of the individual variation between different individuals, but it doesn't necessarily mean that in the individual case we have an impairment.

So even if I find high impact on trauma on brain functioning in many traumatised individuals, it doesn't necessarily have anything to do if trauma left an -- has had an impact on the neurological functioning in this particular case.

Q. [11:54:51] "This particular case" meaning Mr Ongwen?

A. [11:54:54] Meaning Mr Ongwen.

Q. [11:54:55] Okay, all right. You also used another term in page 19, going back to

your discussion of the Defence report, and that was the longitudinal reference data.

A. [11:55:08] Mm-hmm.

Q. [11:55:09] Could you tell the Chamber what you mean by that so that that is also clear.

A. [11:55:13] If we want to say that traumatic experiences have impaired Mr Ongwen's brain functioning, then we would have needed longitudinal data, which means data from how was the brain -- how did the brain look like before the incidences happened and how did it look afterwards, and what would have I expected in the normally developing brain if I assume that we here have an abnormal development.

And so I would have to make, I would have to make additional diagnostic assessments in order to determine if we really find alterations in brain functioning in the case of Mr Ongwen. And even here, even if we would find alterations in the brain functioning, let's say we do an EEG assessment, for example, and then we find he differs from what we would expect within the statistical range within the normal individual, and let's keep it in brackets or in "the normal", then we still can't conclude how his specific brain functions or the wires between the different areas in the brain really affect the behaviour.

So there are so many steps in between from coming to the point that we have or we can observe neurological alterations to the individual case, and so many parts that I *have to explain and to consider that for me this link is not there. It's -- I don't see that there is any evidence for -- that was in the reasoning that is provided in the other report.

Q. [11:57:15] And is there any data also?

A. [11:57:18] No.

Q. [11:57:20] Now incidentally the Defence report here is referring to the work of Thomas Elbert et al, that's what I made you read in tab 7, the binder 1, because they were making reference to Thomas Elbert, who are the authors of the report that is being cited. Would you happen to know who this Thomas Elbert et al, who they are?

A. [11:57:47] Of course I know, because I'm one of the et als and Thomas Elbert and I were the ones who, who started this research and the research idea comes from the two of us.

Q. [11:58:06] All right. And that takes me back then to the issue of appetitive aggression which you had explained earlier because this is also referred to in the defence report in the same tab 7, page 12, but this time in section (d). The Defence report makes reference to this concept, but I want to ask you whether you agree with the opinion that they have expressed in that section?

A. [11:58:36] I also highlighted in my report that I disagree with the understanding of the concept of appetitive aggressive behaviour because the way how it is used here is, in the way I understand the report, that it is used to collect arguments that speak for an impaired ability to have an insight in the wrongfulness of the accused incidents and also to behave in a way that I want to behave. And what we wanted to show was the concept of appetitive aggressive behaviour is exactly the opposite. We wanted to show that it is possible to adapt to a violent environment and to also adapt to a war scenario without suffering from mental health consequences. So that's why I don't understand the reasoning and I don't understand why the reference is made to our work in this particular way.

Q. [11:59:54] In other words, it's actually opposite of the conclusion that your work --

A. [11:59:59] Exactly. It doesn't support, it doesn't support the conclusions in the report of Professor Ovuga.

Q. [12:00:10] Okay. Let's also move to subparagraph (e), section (e) of the Defence report, which refers to a multiple personality disorder, and that you have discussed in page 20 of your report. Let's start by you explaining what is meant by multiple personality disorder?

A. [12:00:31] Multiple personality disorder as also it is already implied by the name of the disorder means that it is possible that individuals also in relation to trauma, especially trauma in early childhood, develop multiple personalities, which means that one personality, for example, could be a very charming person, the other one could be a violent person and the next one could be the good husband, I don't know, whatever you can think of how personalities can look like, and it also can happen that one personality doesn't know anything about the other personality. And because we have -- we here have the deficit in the integrity of the self, therefore, it's summarised or it's located in the classification systems as a dissociative disorder, so this is the dissociation, which means the opposite of an integration of the personality.

Q. [12:01:46] And in your opinion, is there anything relevant to this case? Does the data in this case support anything to do with *multiple personality disorder?

A. [12:02:04] No. I think, as I also have written in my report, that there is too little information available and, in particular, if Professor Ovuga and his colleague tried to, to argue that this particular disorder was relevant or in the case of Mr Ongwen, then they should have presented much more information. Not only on a diagnostics and on a differential diagnosis, but they would have also had to discuss all the different symptoms, how they apply in the specific case of Mr Ongwen and they would have also had to discuss all the alternative explanations that speak against this disorder.

And only I think when they come to the conclusion that there is no alternative explanation than just giving this disorder, then I would say, okay, this convinces me.

Q. [12:03:12] Now, the Defence report also records that - and this you discuss on page 18 of your report - that Mr Ongwen is producing a notebook which he wants to have published so that people will remember him for 200 years to come. That's under paragraph 3.2.3 of your report and it's in the second bullet point. What observations do you have on this?

A. [12:03:50] So I don't want to speculate about the current mental health status. It's just that I was surprised why he has this idea, when he -- when it is hypothesised that he suffers from a major depressive disorder because what we usually -- or what we find in depressed people is that they usually have a problem with self-confidence, they are desperate, and I wouldn't expect someone to have this -- how would you say? I call it narcissistic, I don't want to use a clinical term to -- or in terms of a diagnosis, but I think this also doesn't fit to me. Maybe there are some hints in between the lines, therefore, maybe a different disorder that could have accounted for an impairment of the ability to get insight in the wrongfulness of the, of the acts that were -- that Mr Ongwen is accused for, but this is not discussed and not considered and so there is much information missing.

Q. [12:05:05] In fact, you actually used that word "narcissistic tendencies" and I wanted to ask you what you meant by that when you use that term, "narcissistic tendencies"?

A. [12:05:29] So I was -- when I read all the available information, I was surprised what was the motivation to -- of Mr Ongwen to get promoted in the LRA and what was the driving force behind this career. And I also found, and I would have to look it up in the documents, there's -- at one point it is also said that he also doesn't like to

follow orders here. And, and I thought --

Q. [12:06:11] By "here" what do you mean?

A. [12:06:13] I can, I can try it, if I find it and I will tell you where it is. Where is it? It is in the clinical notes and --

Q. [12:06:39] So in other words by "here" you mean in The Hague?

A. [12:06:43] In The Hague, yes.

Q. In The Hague, okay.

A. If you want, I can look it up in the break.

Q. [12:06:46] No. We can -- let's continue.

A. [12:06:48] Okay. But these are all different aspects that where I was wondering maybe there are some tendencies that Mr Ongwen is maybe convinced that he -- that's very speculative maybe, because I don't have sufficient information, but I thought that maybe there could have been also some kind of being proud to what he achieved while being still in the LRA and there are maybe other -- when it comes to motivation for his behaviour, I assume that there are other alternatives that are more plausible for me rather than the diagnoses that were reported in the, in the reports.

Q. [12:07:44] Assuming for a moment that the intention of the authors of the Defence report was to express the notion that Mr Ongwen's volitional capacity had been removed, and you discussed this in page 20 of your report, is that justified by the available information about his behaviour while he was in the LRA, in your opinion?

A. [12:08:20] No, I don't think so. I don't think so that there is sufficient information available to justify this and the information that I have also doesn't support the conclusions that were made in the reports, in both reports by Professor de Jong and Professor Ovuga and Dr Akena. So based on all the reasoning that I

also presented here already.

Q. [12:08:51] And in the light of all this information, you came to a conclusion in page 26 of your report regarding the guiding question 4, and what was your conclusion on this question?

A. [12:09:10] Yes. As I, this is also written on page 26 in the first paragraph, is that I don't think that none of -- that I think that none of the available sources provides convincing evidence that the mental disorder could have distorted Mr Ongwen's criminal liability in a way to justify the application of Article 31.

Q. [12:09:36] All right. Let's move to question 5.

A. [12:09:39] Okay.

Q. [12:09:40] Which is the question of how likely is it that Mr Ongwen suffered from a mental disorder that remained constant at a level over the period of several years in a way that Article 31 is applicable or how likely is it that the severity of the symptoms fluctuated in a systematic way so that they were only present in a severe form when Mr Ongwen allegedly conducted criminal behaviour and what could have been a potential trigger for such fluctuations? So we are going to start with the clinical records from the mental health professionals in The Hague. And there are a couple of those records that you made reference to in page 24 of your report, if you look at paragraph 3.3.4, 3.3.4. Do you think you could point those out, 3.3.4, that the one dated --

A. [12:10:52] Yes.

Q. [12:10:54] -- 18 April 2016.

A. [12:10:57] Yes. Basically, to sum it up, Mr Verbruggen mentioned in his clinical notes that there are symptoms -- symptom fluctuations which are also quite normal, which I would usually expect in people with a mental disorder.

Q. [12:11:18] And what would be the fluctuations that he refers to?

A. [12:11:25] He refers to the symptoms of depression, and with the nightmares I assume that he refers to PTSD because nightmares are not a symptom of any other mental disorder.

Q. [12:11:36] Okay. And if we look at Professor de Jong's report, you found no useful information on this guiding question in his report?

A. [12:11:43] Correct.

Q. [12:11:43] Thank you. All right.

Now let's look at the Defence reports, there are two pieces of information I want to ask you about. The one is that does the information contained in the Defence report tell us about the fluctuation in respect of episodes of dissociation and suicidality? You discuss that in page 18 of your report. If I point you specifically to paragraph 3.2.3 of page 18, and the second to the last bullet point. So what does the information tell us about the fluctuation in respect of episodes of dissociation and suicidality?

A. [12:12:33] Yes. So when you link this information to the calculations I made when I tried to understand how many episodes of dissociations did Mr Ongwen suffer from in the period between 2002 and 2005, then when I assumed that he suffered from dissociations eight times, and that is in the period that is referred to, and if I assume that he suffers eight times from acute suicidality, then this is clear hint for me that there were fluctuations in the symptoms, which means that severe -- for example, a severe depressive disorder couldn't have been present in such an intense way for the whole period between 2002 and 2005, I think this is highly unlikely. Because then I would have expected a different picture. Then I would have expected that suicidality was present every day and every day there must have been someone

preventing Mr Ongwen from committing suicide. And then I would have also expected that, for example, that he suffered from severe nightmares and flashbacks every day, but this would have prevented him from giving orders or from going to the battlefield, because then I would have expected him to only sit somewhere in a hut dissociating, but not being able to function in any regular way.

Q. [12:14:24] Capacity. Right. Thank you. The second question is: What does the information in the Defence reports -- let me take you to page 20 of your report, because that's where you discuss the issue of his weight loss.

A. [12:14:40] Mm-hmm.

Q. [12:14:43] If you look at paragraph 3.2.5, that last paragraph, "it is reported that Mr Ongwen has lost 3 kilograms over the month". What does this information tell you? What's the significance?

A. [12:15:03] The significance is that the reasoning in the report by Professor de Jong was that the weight loss can be seen as a symptom of severe depression, because, as I said in the beginning, depressive -- a depressive disorder is -- can be associated with a loss of weight or also gain of weight. But I think if he really stopped eating because he -- because of depressive symptoms, then -- and this for -- over a course of many years -- then he would be in a totally different physical constitution, physical appearance, because -- and that's the reason why I conclude that maybe he stopped eating. I cannot prove this. But this, in my opinion, is not -- does not in any way support the idea of a MDD diagnosis between 2002 and 2005.

Q. [12:16:17] So in the light of all this information you had come to a conclusion concerning this guiding question 5, isn't it? And it's in page 26 of your report. And what was your conclusion, Professor?

A. [12:16:35] Well, my conclusion is that there we cannot assume that -- or, based on the information that we have, I can't come to the conclusion that the severity of any mental health problem was so stable over -- in the period between 2002 and 2005 that it justifies the application of the Rome Statute that we are now discussing. And I think -- and even in the very unlikely event that there were symptom fluctuations and the symptoms were always very intense in these moments where the incidents happened where Mr Ongwen is accused for, even if in this highly unlikely event that you don't find in any scientific literature - and I also, when I have written my report, I tried to refer to the knowledge that is available - then this must have been outlined by the examiners to somehow make -- give us a plausible explanation how these symptom fluctuations correspond with the accused's offending behaviour. So I can only come to the conclusion that it doesn't -- it's not justified, the conclusions that you find in the reports of Professor de Jong and Professor Ovuga and Dr Akena.

Q. [12:18:26] All right.

And the final guiding question you give, Professor, was: What are the assessment methods which might provide the closest *approximation to the true mental health status of Mr Ongwen during the period between 2002 and 2005, and how coherent is this reconstructed picture and how probable are the different interpretations presented in the available sources? Now, in looking at this question, you discuss the issue of dissimulation. So first of all I want to ask you about that term, what do you mean by the term "dissimulation"?

A. [12:19:17] So what I mean with dissimulation means that if I want to pretend that I suffer from a certain disorder, then of course I can start reading books and clinical reports and then I can try to behave as if I were in an individual suffering from such an disorder. That's what I mean with dissimulation.

And this can -- and the result is that when you later --so after I learned how a traumatised individual behaves and how a traumatised individual would respond in a standardised questionnaire, then of course I can give the answers and make my -- and mark the answers that match this diagnosis, but this means that I don't suffer from the diagnosis, but that I'm just pretending because I might get an advantage out of having this one or the other disorder.

Q. [12:20:22] And how is an expert able to determine whether or not the person being examined is dissimulating?

A. [12:20:31] Yes. An expert who is writing a report and who -- who must consider dissimulation, and especially in the forensic setting we have to consider that dissimulation could be important. So when it comes that we -- that a certain case is discussed in Court, or, for example, when you get some benefits from your health insurance or from your employer because you suffer from a disorder that might have been caused by your job, for example, then we must consider this. And this means that on the one hand we have standardised questionnaires, like the one that have all -- ones that have also been used by Professor de Jong, for example, so we know that these are validated. And if we exclude dissimulation, then we know that these questionnaires give us quite a good estimation of the mental health status of the affected person. But if I assume that dissimulation could be -- could be an important aspect that affects the answers given by the client, then I would then do the face-to-face interview and see if I find contradictions. And if I -- and then if I find these contradictions, then I would have to discuss them and see where do they come from. Why is there a mismatch between, for example, my clinical impression or the way how my client behaves in psychiatry or in this -- or I would ask, for example, relatives, I would try to get other sources that help me to validate the responses I get

from a questionnaire and this has to be discussed.

PRESIDING JUDGE SCHMITT: [12:22:31] May I shortly, please.

And since we are dealing here with criminal proceedings or proceedings in a criminal case, what importance might have evidence that is on the record?

THE WITNESS: [12:22:44] Dear, Mr President, can you please rephrase the question.

PRESIDING JUDGE SCHMITT: [12:22:48] No, no, I mean the following: You say -- you provided us with some information how you possibly might identify dissimulation. What importance could the evidence that has been given in a courtroom, for example, during hearings play in assessing if there is dissimulation or not? Evidence by witnesses, by other experts, whatsoever, documents available.

THE WITNESS: [12:23:15] Well, it's very important in court to consider dissimulation, and it's also very important to -- if I got your question correct, I think we -- we know that even memories can change.

PRESIDING JUDGE SCHMITT: [12:23:39] I think you have not understood my question. You have mainly in your answer -- you have mainly referred to, as a source of information to the client, as you said. But there might be a client and an accused and anybody else in this world does not live solely, he lives in a social environment, and he has lived also in the past in a certain social environment, and other persons might have observed this person. So my question would be: How important can be sources of information that derive from such persons, what we call evidence in the courtroom?

THE WITNESS: [12:24:21] Yes, thank you, Mr President, for reframing – rephrasing it.

It's absolutely important, because we meet other people that have lived with the -- in this case with the accused person to report their impression of the client. And if they

think the results that we -- or that the reports, if they really match their experiences, and therefore I think for me therefore it was important also to have the access to the different sources here, ones -- the two and by the three examiners on the one hand, then the -- also the clinical notes, for example, of Ms Verbruggen, and all this information has to be considered when we want to come to a final decision.

PRESIDING JUDGE SCHMITT: [12:25:16] Thank you very much.

Please, Ms Adeboyejo.

MS ADEBOYEJO: [12:25:21] Thank you.

Q. [12:25:21] And in your experience how common is it for there to be the practice of dissimulation in forensic populations?

A. [12:25:33] I think it, it depends, because I think that there are some people that think it might be better to have a mental -- a diagnosis of a mental disorder and going to a psychiatric hospital in Germany, for example, compared to going to prison. Yes. So I think dissimulation is -- it can be quite -- can be common and it always depends -- but it always depends on the individual motivation of the person we are talking about. And so I don't think that I can give a general answer, but I think if it comes to responsibility for accused's offences, then I think dissimulation can be a very important aspect that has to be considered.

Q. [12:26:27] Thank you, Professor.

Now let's turn to tab 5, which will be Professor de Jong's report, tab 5, and page 5 of that tab. And in page 5 we see that Professor de Jong records how he applied the Hopkins Symptom Checklist-25, and that the answer Mr Ongwen gave amounted to an average score of 3.12. And this is a standard, standardised set of questions testing for depression and anxiety, isn't it?

A. [12:27:14] Mm-hmm.

Q. [12:27:17] Okay. From his notes in his report, he says that this score for Ongwen, 3.12 is over the internationally accepted cut-off score for diagnosing a mental illness, isn't it?

A. [12:27:39] That's correct.

Q. [12:27:40] And at page 6 of his report, he also records that he applied the patient health questionnaire number 9 --

A. [12:27:46] Mm-hmm.

Q. [12:27:47] -- which is a standardised test operating in a similar way for depression, isn't it?

A. [12:27:53] Yes, correct.

Q. [12:27:54] Okay. And there he records that Dominic Ongwen gave a score of 24 out of a maximum 27, isn't it?

A. [12:28:03] Mm-hmm.

Q. [12:28:05] And then furtherer down at the same page he records applying the Harvard Trauma Questionnaire for PTSD, and he notes that war-exposed populations around the world mention that they have directly experienced *or witnessed on average 11 of the 24 trauma categories asked about.
But it seems from Mr Ongwen's answer that he had directly experienced all 24 of these categories, isn't it? So in other words, his replies indicate the maximum trauma exposure possible?

A. [12:28:43] Correct.

Q. [12:28:48] So which will mean then that the scores represent consistency with diagnosis of severe PTSD and severe depression, doesn't it?

A. [12:29:00] That's correct.

Q. [12:29:02] Now, let's close that tab and go back to your report then, tab 3. And

if you look at page 14 of your report, I will put this question then to you. Do these questionnaires show that Professor de Jong investigates the possibility that Mr Ongwen was, as you've been explaining to the Court, dissimulating in any way? Is this reflected in these questionnaires?

A. [12:29:56] No, this is not reflected. And when you also have a look at psychopathological assessment and a general impression that you can find in the report of Professor de Jong, then he should have realised that there is a massive mismatch between the answers given in the questionnaires and the clinical pictures during the interviews. So he should have realised this, and I think it would have been very, very important to address this in the report.

As I told you in the beginning, I do not believe that a highly or very severe depressed individual would behave during the interview in the way how it is reported in the documents.

Q. [12:30:53] And by that you are referring to the references to the joking and the laughing that were referred to earlier?

A. [12:30:59] To joking and to laughing or, for example, one major symptom of a depressive disorder is a lack of concentration. And with a severely depressed individual, you're even not -- that it's even not possible to do psychotherapy with them because they can't concentrate. They are disturbed by other things, and you can't do two or three hours assessment with them and they, while they are always following your answers and giving proper responses, that doesn't match.

And that's the only -- so this means that I can only come to the conclusion that even if you have discourse in the standardised questionnaires, they don't match the clinical picture, and so this must be a consequence of dissimulation, because you will find if you compare the clinical picture as far as I can get it from the documents I have, when

you compare this to other severely depressed individuals that you find in the clinic that have the same scores, the clinical picture doesn't match in any ways.

But, sorry, may I add this? Still I think that 24 traumatic events that he experienced, this list or the list of the different events, I have no doubts that this is possible, but it depends on the processing.

And that is what you also do during the trauma assessment, assessing the different traumatic events you have experienced has nothing to do with the diagnosis. This is just an independent thing which helps you as an examiner to then refer to the traumatic events when you do the trauma assessment. So these are two separate things.

Q. [12:33:03] Thank you for that clarification.

PRESIDING JUDGE SCHMITT: [12:33:06] Shortly we are reminded by the interpreters that we should have a little pause between questions and answers.

MS ADEBOYEJO: [12:33:15] Thank you, Mr President.

Q. [12:33:20] Now, in page 6, so I'm sorry I have to turn you back again to tab 5 on page 6 where Professor de Jong then concludes that there is no indication for psychopathy, what does the Professor have to say about the possibility of Mr Ongwen having dissimulated or manipulated the process?

A. [12:34:09] Well, psychopathy is not a disorder, so you can't diagnosis it. I don't know why he's talking about it. It is possible to assess psychopathic tendencies in an individual, and this can also be related to dissimulation, but I don't think that this paragraph is important for us.

Q. [12:34:56] You yourself note a number of contradictions in some of the observations made by Professor de Jong. Let's turn to page 14 of your report. We will start with the observation that Mr Ongwen made good contact with

Professor de Jong. What would be your observation about this?

A. [12:35:29] Can you please help me, which bullet point is it?

Q. [12:35:39] It's in page 14.

A. [12:35:40] Yes.

Q. [12:35:41] The last paragraph of page 14.

A. [12:35:44] Okay.

Q. [12:35:45] The very last paragraph. It starts with "The report says".

A. [12:35:53] Yes, okay. So when you have -- when you examine a patient with a depressive disorder, and it doesn't necessarily have to be severe, a moderate depression is also sufficient, then you will experience that the fluctuations and the mood aren't there, which means -- and then this is something that you will realise in the contact with the person. So you will feel that it's not -- in German we call it Schwingungsfähigkeit -- I'm sorry that I don't know the proper translations, but it means that I, for example, say something positive and you also go with me, and I say something sad and the mood fluctuates. And this is not possible. And this is, for me, one essential aspect for making good contact. And people suffering from PTSD, one core symptom is the detachment from others, and this is also something that I just can realise in the contact while examining you.

Q. [12:37:04] There is also an observation you have made in the same page 14, but now in the first bullet point where Professor de Jong has concluded, referring to the self-report of Mr Ongwen that "he is honest and tells no lies". What would be your observations on this?

A. [12:37:31] Well, if Professor de Jong comes to the conclusion that or if he accepts that in the statement that he is honest and tells no lies, and that is my impression, that he believes that he is not telling lies, yeah, then if he also assumes that -- so that

psychopathy is not present in the case of Mr Ongwen, this also is important for me because it, to me, it stresses that alternative diagnoses that could be relevant are also not considered because that rather speaks again for the functional -- for the high functionality or level of functioning.

Q. [12:38:30] Now let's, if we look at --

A. [12:38:37] And, sorry, just and I refer to this point because I concluded this methodological approach is not convincing. That's what I mean. If he suffered from psychopathy, then I would still have the impression that he is honest and tells no lies, yeah? So if I come to the conclusion and I want to rule out psychopathy, then I can't only focus on the self-report, this doesn't make any sense.

Q. [12:39:07] I can't rely -- in other words, you cannot rely only on the self-report from the client?

A. [12:39:12] Yes, when you say you don't lie, then I can't conclude that you are an honest person. This type of, this kind of reasoning is not convincing at all. And I can't say it because someone just says "I'm not a psychopath" doesn't mean that you are not a psychopath, because one important aspect of being a psychopath is manipulating and cheating.

Q. [12:39:40] Thank you. Now going to page 15 of your report, Professor, Professor de Jong also observed in the first paragraph of your report that Mr Ongwen gets enthusiastic during the interview. What are your observations on this point?

A. [12:40:06] Well, the observation is that, again, this doesn't match the diagnosis of severe depression. Why would someone who is really depressed get enthusiastic? And if he gets enthusiastic, and we assume that it's maybe a bipolar disorder, where you only -- where you also have manic episodes, then this also would have essentially been, this would have been very essential to discuss this and also include it in the

diagnosis and also in the description of the general psychopathological picture.

Q. [12:40:46] Professor de Jong also noted, still on that same paragraph, that Mr Ongwen will laugh during their sessions. How did the Professor interpret this and what would be your own observations about this?

A. [12:41:05] Yes, the interpretation is that laughing, and this is how I have written it here, it's interpreted as a sign of hiding emotions in a culturally congruent way. And this could be possible, but there are also alternative explanations possible why he is laughing. And for me, the contradiction between the laughing and the depressive disorder is more significant than this culturally explanation. So I think it's absolutely mandatory to explain this contradiction and not just say this might have been a cultural way of dealing with the emotions, because other more significant and more striking explanations are not considered.

Q. [12:42:02] Then going further down there is the Professor's observation that Mr Ongwen is orientated in time and maintains his concentration after hours of interviewing. Is this a significant observation or would you --

A. [12:42:19] Yeah, that's absolutely significant, as I -- I think now I'm starting to -- I'm repeating myself, but it absolutely doesn't match the diagnosis of severe depression or PTSD. And especially I would have assumed that if he currently suffers from dissociative experiences, that these dissociations should also occur during the assessment because when I know that a traumatised individual also suffers from dissociations, then this is a very, very severe symptom, then I have to consider it during my examination because I always have to be very careful to prevent my client or my patient from dissociating, yeah. And this means that the way how I assess the other person must be very careful. And talking about trauma and talking about traumatic incidents, it's a critical issue because I always have the

fear that my patient starts to dissociate and this is something I want to, want to prevent, especially when I'm just doing the diagnosis and when I'm not working with the client in a therapeutic context.

Q. [12:43:45] Now, you also note in your report that the hyperactivity to a wide range of stimuli which Professor de Jong noted is not coherent with the clinical reality presented. Can you explain why. This is your -- this is in the second paragraph of page 15.

A. [12:44:10] Yes, I mentioned this because I think either I respond with hyper-reactivity to traumatised -- the traumatising stimuli or to traumatic use or I dissociate, and I don't see how this goes together. And if we assume that Mr Ongwen suffers from PTSD, and if he is hyperreactive or if he's acting with high arousal in response to confronting him with traumatic cues like, for example, talking about things that have happened, then this means that a dissociation is not taking place in this moment. And if the dissociations are so significant in Mr Ongwen, then I would have also here expected a different picture, especially as I don't see the relation between the PTSD and impaired insights that are discussed.

Q. [12:45:30] Now turning to the Defence report.

Sorry, a matter of housekeeping. The reference for tab 5, there's no ERN, it's filing 702, annex 2. To put that on the record.

Turning now to the Defence report, did that report explore any contradiction such as those we just discussed, all the various explanations advanced, for the suggested health status of Mr Ongwen, in page 21 of your report?

A. [12:46:18] I think in general that there are so many contradictions and I have only given a selection of a few, a few significant contradictions that I found in the two reports, that I think there is so much information missing, and so many points that

would have had to be discussed are not discussed, that I think that the application of the methods and the conclusions that were drawn from the, from the applied methods, this is also very -- dubious is maybe a bit too hard, but it's -- I think it's not justified.

Q. [12:47:08] And in light of all this information, you came to a conclusion in respect of guiding question 6, which -- what would this conclusion be, if I take you to page 27 of your report?

A. [12:47:25] So you want me to refer to page 27 to my response to question 6, correct?

Q. [12:47:37] Yes.

A. [12:47:42] Yeah, I think that the experts that did these examinations, I mean they had sufficient information to be prepared for the -- for valid assessment of the mental health status -- of the current and the past mental health status of Mr Ongwen, and I think that the different methodological issues that arise and that are very important, and I hope that the contradictions and mismatches I outlined in my report, I hope that they stress this point, I think it would have been very necessary to discuss them and to address them also in advance when one prepares these examinations, and this wasn't done properly from my -- in my opinion and that's why I come to this conclusion.

Q. [12:48:47] Thank you, Professor. Now before I come to your overall concluding remarks, I am also keeping an eye on the time, I want to deal with just two matters. If we turn to page 22 of your report, in the light of the various pieces of evidence, you suggest that Mr Ongwen portrays a picture of a Cluster B personality disorder, and you characterise this as dramatic, emotional and erratic. Could you tell us briefly what is a Cluster B personality disorder?

A. [12:49:42] Yeah, well, in a DSM there has always been a distinction between personality disorders and how they can be grouped, and one -- and this is the Cluster B personality, this cluster describes individuals that show very dramatic symptoms and that react in a very emotional way, but that can also maybe aggravate symptoms and maybe dissimulate also symptoms. And I think, for me, this was my first impression. I think that if I would have done these assessments with Mr Ongwen and after the first meeting with him, if this would have been similar to the assessment how it is described here, this would have come to my mind and I would have maybe brought some instruments to verify or fortify if a personality disorder would be more, more plausible.

Q. [12:50:57] And of course you know that under Article 31(1)(a) where you were required to check whether or not Mr Ongwen suffered from mental disease or defect, whether it affected his capacity to appreciate the nature and unlawfulness of his conduct and his capacity to control his conduct, to confirm to the requirements of the law within the period from 2002 to 2005. If, indeed, Mr Ongwen suffers from such a personality disorder that you have just described in your opinion, would this have any significant impact on these issues which the Court will have to consider in respect of Article 31(1)(a)?

A. [12:51:48] I think it's very difficult to consider this because on the one hand none of the other experts focused on these disorders and it's again the same issue as we already spoke about today that just suffering from a certain disorder doesn't mean that it's necessarily -- that it necessarily follows that the capacity to appreciate the nature of the conduct or the unlawfulness or to behave in a certain way, that this is impaired. Still there is the link missing between the mental health status and the consequences of this meant health status. This hasn't been discussed in any of these

documents and this is what really surprises me because I mean, this is the most essential part. It's not the diagnosis, but it's the application of the diagnosis and the consequences for a specific behaviour. And that's also why I came to the conclusion to say why would I do another examination because now all my reasoning is clear and everyone can now prepare himself or herself to behave in a certain way to give the answers that I want to hear, and this makes it very complicated.

Q. [12:53:10] Secondly, I want to move to the aspect of the testimony on the evidentiary extracts, so that would have to do with tab 4. I don't know if you have had a look at this, at these extracts. And that's the document titled "Material Drawn from the Courtroom Proceedings: For Consideration and Possible Commentary." Do you have this document in front of you?

A. [12:53:52] I have.

Q. [12:53:53] Okay, good.

PRESIDING JUDGE SCHMITT: [12:54:06] And you have read those materials.

THE WITNESS: [12:54:07] Yes, I have brought them here and they are coloured. I prepared them.

PRESIDING JUDGE SCHMITT: [12:54:11] Like mine.

So, yes, okay. Please continue, Ms Adeboyejo.

The question would be if we start with this now, let him comment on it now or if we have the lunch break now.

MS ADEBOYEJO: [12:54:20] I'm entirely in your Lordship's hands. I don't know how extensive -- maybe I should ask him how extensive --

PRESIDING JUDGE SCHMITT: Indeed you can do that.

MS ADEBOYEJO: -- he wants to comment on it.

PRESIDING JUDGE SCHMITT: [12:54:29] Yes, okay.

MS ADEBOYEJO: [12:54:30]

Q. [12:54:30] Professor, how extensively would you want to comment on these materials in terms of the extracts? Are you going to speak through each one or do you have particular ones you have selected that you want to speak to? That's just a general question before we come into the specifics.

A. [12:54:52] I think we don't have to do it that extensive because I have some quotes that I marked, but they only stress what I have already said before. So they just provide further evidence, for example, for the functionality of Mr Ongwen that I think was there. I can go through it and tell you what --

PRESIDING JUDGE SCHMITT: [12:55:20] I think we can do it exactly this way, so without questioning the expert. Simply go through them one by one, and when it becomes too lengthy we will have -- simply I interrupt simply and we will have the lunch break.

THE WITNESS: Okay.

PRESIDING JUDGE SCHMITT: Please continue and you don't have to, you know that, of course, you don't have to go back to things you have already said, you can simply say, if so, if so, that things that you have read here match with what you have already said. So please start.

MS ADEBOYEJO: [12:55:53]

Q. May I just, I have one housekeeping issue that when referencing the materials, could you refer to the extracts by the numbers. So in other words, extract number 1, not necessarily the source.

A. [12:56:05] Okay.

Q. [12:56:06] Okay. Please proceed.

A. [12:56:09] Thank you, your Honour, for allowing me to go through it.

So the first quote that I would like to refer to is point 2 but on page number 2. So it's quite a long source. And there it is said, in the lower part it's said, "Now they are pretending that they are sad because they went and killed people, yet they're the ones who killed people." And I thought that this is important because I think I understand if someone now maybe either regrets things or they say I -- I would have -- I want others to give me amnesty, but that this is quite a logical -- a logical motivation now how to deal with the past and how to -- how to now try to put things in the past in a different perspective. And I understand the motivation behind it, but I think for me it was -- it's always an important -- it has always been an important thing to ask myself, is it really the truth that we are examining here and is it really the case that severe mental disorders were present in the past? Or is it that -- is it -- is it now a way to reframe things that happened in the past, but it's just constructed and it wasn't there in the past? And this is why it brought me to the point of dissimulation and why I thought, okay, this really is the point, we have to consider this -- the point of dissimulation. Yes. Then we have the point 3, and there are many aspects where I think that -- that I think are important, for example, that it is said that Mr Ongwen was a person who cared about people, yes. And then that things have changed, yes, through the ranks there were changes, of course, and he had to change his behaviour and he had to adapt to this particular context. But I think, for example, the sentence, "I did not notice anything which was strange" rather supports the impression that I also have that severe mental disorder, and, if it had been that severe, then others would have noticed it. And this is something I can't find in these documents and so this was quite striking for me. We have point 6 on page 4, and there it is said he is very good at it and he knows how to speak to his soldiers. He is very knowledgeable. And this also supports my hypothesis that also interacting with

other people wasn't impaired in a way as I would have expected it in the case that he suffered from the -- one of these disorders that are outlined in the reports of Professor Ovuga, Dr Akena, and Professor de Jong.

Also, point 8 on page 7, at the end of the first paragraph it is said, "... but Dominic did not want us to be killed. He said there is no problem and told us to leave and go to the security of Kony."

And also I think this was a point that convinced me that the moral thinking and the insight into right and wrong, what we have already discussed in the previous session, I think this is supported here.

Then further, also on the point 13, on page 12, there it is said, "Ongwen was taking care of us properly. He used to treat us equally and he used to treat us well."

And when you investigate traumatised individuals, some of the mothers say "I have a child and it was born a few days and a few weeks ago, but I can't feel love for my child because of my trauma." And if really severely traumatised individuals are not able to feel love for their own family, then why would someone with an equally intense trauma disorder feel sympathy and empathy for his comrades and other people in the surrounding that are not as close to him as the family can be? Yes.

So this was -- this is another aspect that I think stresses the points I made before.

I think there are other quotes that match this, like, for example, point 14, page 13, in the middle paragraph it is said that he -- that Ongwen cares about people and has sympathy for people. Yes.

And the same, it is also said on page 15 -- no, sorry, pardon, on bullet point 15 on page 14, the whole paragraph describes Mr Ongwen as a caring individual who was playing with children, for example.

And also why you are -- as you were asking for the psychosocial functioning, and I

think someone with a severe depression is no longer able to play with children and enjoy this, so I think this rather also speaks against the suggested disorders.

I'm almost finished, I think. If we have time, your Honours?

PRESIDING JUDGE SCHMITT: [13:03:15] Yes, of course. Please proceed.

THE WITNESS: [13:03:20] Yes.

One point that surprises me, or surprised me, is point 18. But on page 17, there it is said that when they were talking about other commanders it is said that if they are told to go on mission, they wouldn't go on mission themselves, they would assign this to somebody else and the task would not be done as per the order. And I asked myself, okay, why is it possible for other commanders to not go to a comrade or to a mission, but why then he went? Why did he follow the orders? And this, for me, this also rather spoke for the intact functioning. And if he -- if there is -- if he really -- so when you work with traumatised individuals, many of them try to avoid any -- any trauma reminder and they will do -- some of them would take a big detour to avoid a place that reminds them of bad things that happened. So if there would have been any occasion to avoid going to the battlefield, and then I would have expected him to use this and to keep up this avoiding behaviour, but this is, for me, not visible here.

Yes, and then -- and I think this is the last point I want to make and -- but this is -- this is not related to the question you asked me to answer because we were referring to the period of 2002 to 2005, but because we were talking about his narcissistic tendencies. There, the outburst is reported in point 21 on page 21, and there it is said -- I haven't been here, so I can't really say something substantial, maybe, but that's reported that it's about respect that -- and of -- it's about Mr Ongwen being a soldier and that he wants to be respected. That's what I see here.

So I think the soldier identify may be, from the few instance I find here, it may be, in my view, something that is still -- still be there. And I think that this is the right side described in the report of Mr Ovuga but the side that he did not explore. We only see the victim side, and all the reports only highlight that Mr Ongwen was a victim of the LRA and was abducted as a child. Okay. But this is one side of the story and there could be another story. And also in the reports by -- like in the one of Professor Ovuga and Dr Akena, you find the different side, and it's also mentioned. There might be a right side, but this is neglected. This is the one, this is the side that wants to publish the book, and this is the soldier that wants respect. And I don't -- this doesn't necessarily mean that we can exclude a mental disorder, but it means that there could be an alternative explanation and we should dedicate our attention to it. Because, to come to a final conclusion, it's not only sufficient - and I then I stop - it's not only sufficient to try to find -- to verify my hypothesis, but also try to fortify and exclude alternative explanations, and this is not sufficiently done in any of the reports so far.

MS ADEBOYEJO:

Q. [13:07:35] Right. I have a final question for you, and I promise the Presiding judge that I will sit down.

So if we come to your concluding remarks, Professor, as I understand it, then you drew all the strings of all of these pieces of information together and you came to five conclusions which you have highlighted in page 27 of your report. Do you want to tell us what your conclusions were?

A. [13:08:10] Okay. So my conclusions were based on the guiding questions that we, I think -- yes, that we sufficiently discussed. And the first important thing for me was that I think, okay, it is plausible that Mr Ongwen was exposed to potentially

traumatising events. If you have been in this scenario, then -- and I think there are many, many examples that support this, then he was faced with things that could have potentially been traumatising.

And the next question is, okay, if you experience this, do you also develop mental health symptoms? And I think that we find hints that support that maybe he suffered from one or the other symptom, which doesn't mean that a diagnosis is justified but, for example, intrusions or bad memories, or maybe also if he is affected when he speaks about his past, I think this all is something where I would say, okay, yes, it's plausible that he suffered at least from some symptoms.

And also when we did all the research with the former combatants, it's not that they are all healthy. That's not the point. But the question is when not -- not being healthy doesn't mean that the capacity is fully destroyed. I think that's a completely different story. And so that's why I would say, okay, even if there were symptoms, and even if for a certain period he also fulfilled diagnosis of a mental disorder, this doesn't necessarily imply that the capacity to control, or to appreciate the nature of the conduct, or the unlawfulness, or to control the conduct, that this is not -- well, it doesn't mean that this is impaired. Okay? And --

PRESIDING JUDGE SCHMITT: [13:10:21] I think you can summarise your conclusions even further, because Mrs Adeboyejo has explored with you quite a lot, I think --

THE WITNESS: [13:10:29] Okay.

PRESIDING JUDGE SCHMITT: -- what you have said. So it would be, I think, a little bit of repetition now. So simply summarise it very shortly and I think this is -- you could even refer to that you say the conclusions have not changed, or how they have changed, if they have changed, whatsoever.

THE WITNESS: [13:10:46] Okay. Yes. Please excuse me, Mr President, for being maybe too, too exhaustive.

Yes, to conclude, I don't think that application of the Rome Statute in a way this has been presented here is justified by the documents that I can see, or that I have access to.

PRESIDING JUDGE SCHMITT: [13:11:14] And we have the report as witness evidence on the record via Rule 68(3).

MS ADEBOYEJO: [13:11:23] I'm in your lordships' hands, and I can see that the time is fast spent, but indeed the witness has already indicated his concluding remarks, and that will be all for this witness, Mr President.

PRESIDING JUDGE SCHMITT: [13:11:37] Thank you very much.

I don't assume that Legal Representatives of the Victims --

MS MASSIDDA: [13:11:42] No, your Honour, we don't have question for this witness. Thank you very much.

PRESIDING JUDGE SCHMITT: [13:11:45] Mr Mawira has already indicated, via signs, that you don't have any questions.

MR MAWIRA: [13:11:53] Yes, we do not have any questions for this witness.

PRESIDING JUDGE SCHMITT: [13:11:55] Then, of course, I would ask -- I think Mrs Bridgman is going to question the expert, or is Mr Ayena? I'm not sure.

MR AYENA ODONGO: [13:12:03] Mr President, your Honours, we certainly have questions for this witness, but considering the time now and the fact that we've got to analyse some of his questions -- I mean his answers maybe, and we don't intend to go a long way, in fact --

PRESIDING JUDGE SCHMITT: [13:12:23] I think that it makes indeed sense to stop now for this day --

MR AYENA ODONGO: [13:12:25] Yes.

PRESIDING JUDGE SCHMITT: [13:12:27] -- so you have also a little bit of time --

MR AYENA ODONGO: [13:12:29] Yes.

PRESIDING JUDGE SCHMITT: [13:12:30] -- to look into the material perhaps and to adjust your questioning to what has been said in the courtroom.

So this concludes the hearing for today. We resume tomorrow at 9.30 and starting with the questioning of the Defence. Thank you.

MR AYENA ODONGO: [13:12:48] Much obliged.

THE COURT USHER: [13:12:50] All rise.

(The hearing ends in open session at 13.12 p.m.)

CORRECTIONS REPORT

The corrections marked with an asterisk (*) in the transcript are implemented as follows:

Page 3 line 12:

“load”

is corrected to page 3 line 12:

“loud”

Page 22 line 19:

“sate”

is corrected to page 22 line 19:

“state”

Page 23 line 14:

“the other specific dissociation disorder”

is corrected to page 23 line 14:

“other specified dissociative disorder”

Page 26 line 19:

"symptoms"

is corrected to page 26 line 19:

"symptom"

Page 36 line 8:

"though"

is corrected to page 36 line 8:

"tough"

Page 40 line 2:

"dissociative"

is corrected to page 40 line 2:

"dissociate"

Page 42 line 15:

"effective"

is corrected to page 42 line 15:

"affective"

Page 47 line 21:

"have explain"

is corrected to page 47 line 21:

"have to explain"

Page 49 line 18:

"military"

is corrected to page 49 line 18:

"multiple"

Page 55 line 16:

1 “approximation makes to the true mental”

2 is corrected to page 55 line 16:

3 “approximation to the true mental”

4 Page 59 line 16:

5 “a weakness”

6 is corrected to page 59 line 16:

7 “or witnessed”