1 International Criminal Court
2 Trial Chamber IX
3 Situation: Republic of Uganda
4 In the case of The Prosecutor v. Dominic Ongwen - ICC-02/04-01/15
5 Presiding Judge Bertram Schmitt, Judge Péter Kovács and
6 Judge Raul Cano Pangalangan
7 Trial Hearing - Courtroom 3
8 Thursday, 21 November 2019
9 (The hearing starts in open session at 9.32 a.m.)
10 THE COURT USHER: [9:32:39] All rise.
11 The International Criminal Court is now session.
12 Please be seated.
13 PRESIDING JUDGE SCHMITT: [9:32:57] Good morning, everyone.
14 Could the court officer please call the case.
15 THE COURT OFFICER: [9:33:05] Good morning, Mr President, your Honours.
16 Situation in the Republic of Uganda, in the case of The Prosecutor versus
17 Dominic Ongwen, case reference ICC-02/04-01/15.
18 And for the record, we are in open session.
19 PRESIDING JUDGE SCHMITT: [9:33:18] Thank you.
20 I ask for the appearances of the parties, the Prosecution first, please.
21 MR GUMPERT: [9:33:24] Ben Gumpert representing the Prosecution.
22 We me today Colleen Gilg, Colin Black, Adesola Adeboyejo, Beti Hohler,
23 Yulia Nuzban, Grace Goh, Jasmina Suljanovic, Kamran Choudhry and Pubudu
24 Sachithanandan. Oh, and Nikila Kaushik, sorry.
25 PRESIDING JUDGE SCHMITT: [9:33:44] Thank you.

1 And for the representatives of the victims, please.
2 MS MASSIDDA: [9:33:47] Good morning, Mr President.
3 For the common Legal Representative team, Ms Ana Peña, Ms Caroline Walter, and
4 I am Paolina Massidda.
5 PRESIDING JUDGE SCHMITT: [9:33:57] And Ms Sehmi.
6 MS SEHMI: [9:33:58] Good morning, Mr President, your Honours. On behalf of
7 the Legal Representatives for Victims, Anushka Sehmi, and with me is James Mawira.
8 PRESIDING JUDGE SCHMITT: [9:34:06] Thank you.
9 And then for the Defence, Mr Obhof.
10 MR OBHOF: [9:34:09] Good morning, your Honours. Today we have Beth Lyons,
11 Tibor Bajnovic, Eniko Sandor, Krispus Charles Ayena Odongo, Michael Rowse,
12 Chief Charles Achaleke Taku, Roy Titus Ayena, Gordon Kifudde, myself Thomas
13 Obhof. And Dominic Ongwen is in Court.
14 PRESIDING JUDGE SCHMITT: [9:34:27] Thank you very much.
15 And we also note that we have two experts here in the courtroom,
16 Professor Weierstall and Dr Akena.
17 And of course most importantly I would like to welcome Professor Ovuga here in the
18 courtroom. On behalf of the Chamber you are going to testify before the
19 International Criminal Court. Good morning to you.
20 I think, Professor Ovuga, you heard me, yeah, but we couldn't hear you because the
21 microphone was not on.
22 WITNESS: UGA-D26-P-0042
23 (The witness speaks English)
24 THE WITNESS: [9:35:15] I'm sorry. Good morning, your Honours.
25 PRESIDING JUDGE SCHMITT: [9:35:18] Thank you very much.

1 We have to issue a short oral decision in private session.

2 For that we go shortly to private session for perhaps two or three minutes.

3 (Private session at 9.35 a.m.)

4 THE COURT OFFICER: [9:35:42] We are in private session, Mr President.

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16 (Open session at 9.38 a.m.)

17 THE COURT OFFICER: [9:38:44] We are back in open session, Mr President.

18 PRESIDING JUDGE SCHMITT: [9:38:52] Thank you very much.

19 Mr Ovuga, there should be a card in front of you with a solemn undertaking to tell

20 the truth. Could you please make this undertaking by reading the card out aloud.

21 THE WITNESS: [9:39:10] I solemnly declare that I will speak the truth, the whole

22 truth and nothing but the truth.

23 PRESIDING JUDGE SCHMITT: [9:39:15] Thank you very much.

24 I have a few practical matters, you know them already I think. You have followed

25 on Monday, at least large parts of the testimony of Dr Akena on Monday and

1 Tuesday, and you saw that sometimes there is an issue that we tend to speak too
2 quick here in the courtroom. So we would ask you to answer in a relatively slow
3 pace so that the interpreters can follow. That's the first thing.
4 And the second is if you need a break, please raise your hand so that we get to know
5 that, so you don't have to sit here and think you don't feel comfortable or don't feel
6 well and need a break and we don't know this. Please tell us, as in one instance
7 Mr Akena has also done it.
8 THE WITNESS: [9:40:04] Your Honour, you don't have to worry about whether I
9 will speak too fast because by nature I am a slow speaker, and I hope I will not send
10 people to sleep.
11 PRESIDING JUDGE SCHMITT: [9:40:18] That, let me put it this way, that was quite
12 an encouraging start. Perhaps I have talked about my problems than about yours,
13 spoke about fast talking and speaking.
14 I give now the floor the Defence and I assume it will be Ms Lyons.
15 MS LYONS: [09:40:45] Good morning, Professor Ovuga. And also to Dr Akena
16 and Professor Weierstall.
17 There's one more housekeeping matter, legal housekeeping matter we should deal
18 with upfront, which is the 68(3), your Honour.
19 PRESIDING JUDGE SCHMITT: [9:41:04] Of course.
20 MS LYONS: Yes, okay. So let me start there.
21 PRESIDING JUDGE SCHMITT: Yes. You know it's -- you could --
22 MS LYONS: [9:41:06] I was waiting for you to do it, but I'm happy to do it.
23 PRESIDING JUDGE SCHMITT: [9:41:11] No. No, no, no.
24 MS LYONS: [09:41:11] It's my evidence.
25 PRESIDING JUDGE SCHMITT: But it's interesting, by the way, an interesting

1 question if we could have already done away with this when we had Mr Akena, but
2 we have two experts here and now Mr Ovuga has only be sworn in, so I think to be
3 here on the safe side procedurally we do, we exercise this again.
4 You could have different opinion, Mr --
5 MS LYONS: Oh, no --
6 MR GUMPERT: [9:41:34] I would only say, the document, as I understand it, is in
7 evidence under 68(3). And although it was written by two people, that doesn't have
8 any retroactive effect, so I would suggest it unnecessary. And let me put on the
9 record (Overlapping speakers)
10 PRESIDING JUDGE SCHMITT: [9:41:52] No, that should be on the --
11 MR GUMPERT: [09:41:52] No objection.
12 PRESIDING JUDGE SCHMITT: [09:41:53] Yeah, it's perfectly --
13 MR GUMPERT: (Overlapping speakers)
14 PRESIDING JUDGE SCHMITT: [09:41:54] Of course you can assume that we
15 thought about this, the Chamber, before.
16 MR GUMPERT: [9:41:57] Sorry.
17 PRESIDING JUDGE SCHMITT: [9:41:59] No, no, no, not sorry. It's absolutely you
18 can, you can discuss this, but you can also argue of course that the report, we have
19 two experts which stand for the report and we always say it's -- it becomes part of
20 their testimony, yes?
21 And if we say it becomes part of their testimony, it's a good argument to say we have
22 to give Mr Ovuga also the chance to express explicitly that he stands for the report.
23 So this would be the other argument I have, but --
24 MR GUMPERT: [9:42:31] You have the better of me. I concede.
25 PRESIDING JUDGE SCHMITT: [9:42:34] Ms Lyons.

1 MS LYONS: [9:42:36] I didn't mean to, to -- anyway, I'll do it. Okay.
2 QUESTIONED BY MS LYONS:
3 Q. [9:42:38] Now, we have, we have been discussing - and I will just say what they
4 are - yesterday the four reports that were jointly produced by you and Dr Akena.
5 And they're at tabs 6, 7, 8 and 9.
6 PRESIDING JUDGE SCHMITT: [9:43:02] Ms Lyons, what we can do, we can shorten
7 the procedure.
8 MS LYONS: [9:43:06] Okay.
9 PRESIDING JUDGE SCHMITT: [9:43:07] I think Mr Ovuga is very well aware of his
10 four reports. You can simply, you can shorten this. This would be possible, I think.
11 MS LYONS:
12 Q. [9:43:16] I will shorten this by asking: These reports bear either your electronic
13 signature or a typed signature that it's from you; is that correct?
14 A. [9:43:29] Correct.
15 Q. [9:43:30] Now, these reports all predate your testimony today and I have to ask
16 you is there anything you need to amend or change or correct in these reports?
17 A. [9:43:45] Not any I think of now.
18 Q. [9:43:48] Okay. And the last question, Professor Ovuga, is do you have any
19 objections to the placing of these four reports into evidence?
20 A. [9:43:57] No.
21 PRESIDING JUDGE SCHMITT: [9:44:00] Fine. Please continue.
22 MS LYONS: [9:44:02] Your Honour, pursuant to Rule 68(3) the Defence moves again
23 for the four reports, the brief report, first report, second report and supplementary
24 report to be placed in evidence for this case.
25 PRESIDING JUDGE SCHMITT: [9:44:19] Via -- yes. I think there is no objection by

1 the Prosecution, so we can assume that this has been procedurally and correctly done
2 via Rule 68(3).
3 You can proceed now with questioning.
4 MS LYONS: [9:44:31]
5 Q. [9:44:32] Now, in front of you there is probably a plethora of paper, as we say.
6 There are two binders. One is a binder 1 and one is binder 2. Most of the
7 documents we'll be using are in binder 1. Binder 2 was compiled based on the
8 bibliography of your second report. I will use a few of those articles. I will let you
9 know, but it's really there for your convenience and reference in case you want to give
10 some evidence and refer to something that is in there. You don't have to, but it's up
11 to you. It's for your convenience; that's why it's there.
12 Right now I'm going to deal with your CV, as I did with Dr Akena, and a few pointed
13 questions on methodology. And then I'm going to try to place my focus on the
14 second psychiatric report. That doesn't mean we won't refer back maybe to the first
15 or other reports, but really that's what we're going to focus on and some of the issues
16 associated with that report.
17 And I will also ask you in a few minutes to define briefly a few of the terms that
18 appear in the second psychiatric report.
19 So let me start with your CV. Now the CV we have in binder 1, there are -- there's a
20 summary bio sketch at 3.1, which is a two-pages summary of your bio. And then
21 there's a longer 28-page CV starting, for the record, at UGA-D26-0015-0856 and
22 ending at 0883.
23 I'm going to ask you a few questions. Unfortunately, we have limited time and we
24 won't go through all 30 -- 28 pages. But I will try to highlight, ask questions which
25 highlight what may be relevant for the case and if I'm missing something, feel free to

1 let me know.

2 Now, first of all, can you tell us a little personal information: Where you were born,

3 where you live and what languages you speak, please.

4 A. [9:47:28] I was born in a small village, Ogolo village in Adjumani district,

5 West Nile region of Uganda in 1946. Currently, I live (Redacted)

6 (Redacted)

7 Q. [9:48:07] Okay. And can you also tell us what languages you speak or -- yeah,

8 what languages you speak and understand.

9 A. [9:48:17] I speak fluently only two languages. The one we are using.

10 Q. [9:48:25] English?

11 A. [9:48:25] English. And my own Madi language. I had hoped I would learn

12 Lingala, but I did not have the opportunity to learn Lingala.

13 Q. [9:48:43] And Madi is M-A-H-D-I?

14 A. [9:48:48] No M-A --

15 Q. [9:48:49] A?

16 A. [9:48:50] -- D-I.

17 Q. [9:48:51] Oh, M-A. Okay, I have it. M-A-D-I. Okay. Thank you.

18 Now, could you tell us a little bit about your educational background.

19 A. [9:49:04] After going through primary education, secondary education, I studied

20 medicine in Makerere University and graduated in -- in March 1976. After

21 internship of one year and post-internship fieldwork, I came back to do postgraduate

22 training in psychiatry in 1978 and graduated in February 1981.

23 Then, after some long period of working, and in the -- in the interests of developing

24 the department of psychiatry, I enrolled for a doctoral programme at Karolinska

25 Institute in 2002 and completed in 2005, graduating a year later in 2006, in -- PhD,

1 joint PhD at Makerere and Karolinska Institute in suicide prevention, suicidology and
2 psychiatric epidemiology. Thereafter I have been engaged in conducting the
3 research and training and administration.
4 Q. [9:51:05] Could you tell us, tell the Court what your current position or positions
5 are.
6 A. [9:51:14] I retired from active practice and active teaching at the rank of dean of
7 faculty of medicine at Gulu University in August 2017. Nevertheless, I continue to
8 support young colleagues like Dr Akena and others outside this court in doing
9 publications and also in formulating research projects.
10 But otherwise, I also support one of my children in the implementation of his
11 agricultural research field -- fieldwork with sweet sorghum, which he invented
12 beginning at his MSc level. And it shouldn't be surprising that from medicine, I'm
13 also supporting someone in the field of agriculture because in my life, I started as a
14 peasant farmer from a peasant family. And it is -- I thought it was appropriate that
15 after retirement I go back to farming.
16 Q. [9:53:12] Thank you. Now, could you just very briefly tell the Court what
17 positions or some of the positions that you've held at Makerere both as an academic
18 teaching and also in terms of administrative positions.
19 A. [9:53:37] I worked as head of department of psychiatry. I was a member of the
20 faculty board; I was a member of the university senate; and I also served as a member
21 of the examinations irregularities committee whose job was to ensure adherence to
22 ethical standards in the administration and conduct of exams in all faculties and
23 departments at the university; and on two or three occasions, I actually chaired that
24 committee.
25 Q. [9:54:38] Now, in your career, could you explain briefly some of the areas -- first

1 of all, have you conducted research? And assuming you have, a few of the areas,
2 could you highlight them for us, please?
3 A. [9:54:58] My research field has been -- all my research interest has been wide,
4 spending the full spectrum of medicine from parasitology to psychiatric research,
5 social sciences research and public health research.
6 So I can't say -- well, let me revise that. In the course of my studies, I developed one
7 particular screening test that Dr Akena kept referring to. It is a screening instrument
8 to detect suicidal individuals at population level.
9 I also developed a clinical test of responsibility in order to make an objective
10 assessment of the level of responsibility, criminal responsibility and culpability of
11 suspects.
12 There was a third instrument which I developed for purposes of develop -- of
13 describing the impact of trauma that former child soldiers or abducted children were
14 going through at a government rehabilitation school outside Gulu town. And this
15 was a modification of previous trauma scale which has been used in Eastern Europe,
16 in Afghanistan, in Vietnam -- sorry, in Cambodia and so on.
17 This was a shortened version of the aforementioned screening to determine the
18 severity of PTSD as related to the number of traumatic experiences that children or
19 adults were exposed to in their -- at specific periods in their lifetime.
20 Q. [9:57:56] Now, without going into too -- we'll have a chance to go into more
21 detail a little bit later on this, but let me just ask you now briefly, you mentioned three
22 screening instruments that you developed. Could you tell us if you used any of
23 these in this case? And if you didn't, why you didn't.
24 A. [9:58:26] The most appropriate ones would have been two. The one which I
25 said I used when I was studying former abducted children at a government

1 rehabilitation school, we didn't use it because, one, I had not validated it, although
2 some other researcher had interest in validating it, I'm not sure if she did. The other
3 one I could have used was the suicide detection instrument. We didn't do it, we
4 didn't use it because the ideas of suicidality were obvious in -- in the case of
5 Prosecutor versus Dominic Ongwen.
6 It was too obvious that a screening stool -- sorry, a screening tool should not be used.
7 Q. [9:59:56] On that point, when you say too obvious, if I may ask a half leading
8 question? Okay.
9 PRESIDING JUDGE SCHMITT: [10:00:05] Let's hear it first.
10 MS LYONS: [10:00:07] Okay. Let's hear it first.
11 Q. [10:00:09] What I want to ask: Does that mean that you didn't think it was
12 necessary? Could you explain the obvious --
13 PRESIDING JUDGE SCHMITT: [10:00:16] No problem with this wording.
14 MS LYONS: [10:00:18] All right.
15 Q. [10:00:19] Okay. So I'm interested in the suicide detection, you're saying that it
16 was too obvious. What exactly do you mean? Was it not necessary? Would it not
17 have provided information to you? We're all laypeople and your terminology, even
18 though it's common language, your terminology may not be understood by all of
19 us -- or by me, at least, speaking for myself in terms of this.
20 A. [10:00:51] Well, an individual tells you that they are, they are fed up of life, they
21 see no meaning in life, life is a burden and the best place for them to be would be with
22 the dead, and they go on to narrate episodes of how they attempted to kill themselves.
23 So here I think it would be a waste of our -- it would have been a waste of our very
24 valuable time to sit and take the client in the case of Prosecutor versus Dominic
25 Ongwen through a 35-item screening tool, and yet there was quite a lot of other

1 damning information that we were looking for.
2 PRESIDING JUDGE SCHMITT: [10:02:10] I think that answers -- (Overlapping
3 speakers)
4 MS LYONS: [10:02:15] Yes, yes. Yeah.
5 PRESIDING JUDGE SCHMITT: [10:02:17] It's to be understood that the expert didn't
6 think it would be of additional value under the circumstances.
7 MS LYONS: [10:02:23] Yes, I understand. Thank you.
8 PRESIDING JUDGE SCHMITT: I think this is (Overlapping speakers)
9 MS LYONS: Thank you, your Honour. All right.
10 Q. [10:02:25] Now I want to ask a little bit more specifically about a few
11 experiences and then a few questions related closer to this case and the work.
12 What -- do you have any experience in forensic psychiatry and, if so, briefly what is
13 that experience? For how long? In what capacity?
14 A. [10:02:59] My experience in appearing in the courts started way back when
15 I was an intern. That was in 1976. But I would not call that strictly forensic
16 psychiatry because it was general related to what I did for someone who was
17 involved in a bicycle accident.
18 The real forensic psychiatry work started when I was working for the ministry of
19 health of Kenya in their national mental hospital where I was attached to the forensic
20 unit. And there what I did was to, on daily basis, assess clients, make diagnosis,
21 provide care and then also make reports.
22 Some of the reports I wasn't called to go and present in person, but there were others
23 where I appeared in the high court of Kenya, both in Nairobi and in Nakuru. The
24 locations were determined by where the jurisdiction of the particular cases were.
25 Then I was moved to begin psychiatric services in western Kenya, in Kakamega

1 Regional Hospital where I rehabilitated general mental health services and I again
2 examined a few suspected offenders. Then I visited prisons where I examined and
3 provided advice on the health of prisoners. There I wasn't required to make reports,
4 but just to provide advice after examining.
5 Then after four years I went to the Transkei Homeland of South Africa. There the
6 forensic work was more intense. I was the only black psychiatrist in the hospital and
7 I worked with colleagues, one colleague from this country who was also a psychiatrist,
8 one colleague from Germany but a year later he left, and then the rest of my
9 colleagues were medical officers under our supervision. And I conducted -- sorry,
10 I was again in charge of the forensic unit in that hospital called Umzimkulu Mental
11 Hospital. And I assessed suspected offenders on that unit, wrote reports and then
12 provided face-to-face presentation of my findings.
13 So I would say all my practice life from 1981 as a psychiatrist I have engaged in doing
14 forensic psychiatry work.
15 Q. [10:07:41] Thank you.
16 Now, could you talk a little bit about what work you may have - generally talk
17 about - what work you have dealing with, right now, dealing with the war, the war in
18 Uganda and the ex-LRA. We're not asking details, but just generally. Are you
19 doing any work now in this area and can you describe generally what it is to the
20 Court?
21 A. [10:08:24] I did work when I was at the university, but I also saw a few former
22 child soldiers who had been rescued or who reported to have escaped when I was at
23 the department of psychiatry of Makerere University. But after, after my departure
24 from active teaching at Gulu University I have also stopped providing active care.
25 But I do have vivid memories of some of the clients that I saw. Some were priests,

1 others were laypeople, others were, as I said, formerly abducted children. The full
2 range.
3 And then occasionally I also attend to victims of domestic sexual assault in the form
4 of incest and what I can tell you is, whether domestic or field trauma, the
5 presentations are remarkably, they're remarkably similar.
6 As you said, I will not describe the details. If you need any details, I will request for.
7 PRESIDING JUDGE SCHMITT: [10:10:19] I understand. But at the moment we are
8 still in general matters.
9 MS LYONS: [10:10:23] Yes.
10 PRESIDING JUDGE SCHMITT: [10:10:24] And perhaps also as an explanation to
11 everyone, or a reminder, better to say, that we are going to focus on the charged
12 period. Of course, we also perhaps have to talk about other periods if they have
13 influenced this or you can make conclusions from them to the -- back to the charged
14 period, but we are really trying to elicit information what might have been the case,
15 the state of Mr Ongwen during 2002 until 2005.
16 MS LYONS: [10:11:00] No, no. Absolutely.
17 Q. [10:11:02] I just have a few more questions on your background because I think
18 it -- I think it is useful to, as we have done with each our experts, to just finish up on
19 this.
20 Could you tell us how you professionally got involved in the Ongwen case, briefly.
21 A. [10:11:32] One morning I came from home to my office and I found a
22 handwritten paper, A4 foolscap paper, with two names on. The two names, or the
23 owners of the two names, expressed the wish to see me and they did not hide why
24 they wanted to see me, and that was that they needed my help to make an assessment
25 of the suspect in the Prosecutor versus Dominic Ongwen and make a report to the

1 Court.
2 I thought through it and then rang them on the telephone number they left behind.
3 And then we fixed an appointment and they came.
4 I listened to them, and my first answer to them was in the form of a question: "Does
5 he know English?" They said no. I said, "In that case, I disqualify myself." And
6 I was, I was quite serious when I said it. They said, "No, no, no, don't disqualify
7 yourself. The fact that you want to disqualify yourself is the more reason why we
8 need, we need you." I said, "If the suspect doesn't talk English and I don't speak
9 Acholi-Luo, how shall we communicate?" And then we went around and around.
10 I suggested some Luo-speaking names in my department and then in the department
11 where Witness 0041 is.
12 PRESIDING JUDGE SCHMITT: [10:14:19] That's Mr Akena, we can -- we want
13 to -- Mr Akena, I think you agree we want to take you out of the anonymity here.
14 MR AKENA: Absolutely, sir.
15 THE WITNESS: [10:14:35] Okay, with your permission, where --
16 PRESIDING JUDGE SCHMITT: [10:14:37] Of course.
17 THE WITNESS: [10:14:40] -- where Dr Akena is, all the names were no, no, no.
18 And then I said, "Well, can you try Dr Akena?" And when -- as soon as I mentioned
19 Akena, I could see their faces light up. So they then kind of negotiated that since
20 I was going to work with Dr Akena, then he would provide the translations and then
21 there should be no problem. So that was how I got involved.
22 But apart from the language, apart from the language problem, there was also a
23 personal problem, just like Dr Akena laboured to explain. In fact, when you asked
24 him the question, I wasn't in the courtroom, but when I watched the video, I saw he
25 was holding his head like this. And when he lifted his head up, I thought he would

1 break down. But he wriggled himself out of it. So it was the same experience, that
2 was partly the reason why I was declining.
3 My family in the village was personally affected. My first cousin was abducted.
4 He escaped because he claimed he was a Sudanese refugee. And they tested him in
5 Arabic and he could fluently -- he answered fluently and that was when they released
6 him and said, "Okay, you go back."
7 I had the husband of my first cousin's sister killed brutally in a granary together with
8 other villagers. There is -- there was a community in one of the trading centres
9 bordering one of the districts of the LRA operation. They were attacked twice and
10 an SOS was sent to me to come and help the community and when I -- on one
11 occasion when I was providing counselling services, a 65-year-old man broke down
12 in public crying and vowing that what the LRA had done, even the unborn child will
13 not forget. And he was saying this with tears in his eyes. Quite uncalled for in my
14 culture.
15 So there was these -- there were these series of personal experiences just like
16 Dr Akena went through, I also went through. And it was a tough decision to accept
17 the request of the two lawyers to support the Defence team.
18 But what finally won was that of my calling. As a medical practitioner, as a
19 psychiatrist, it does not matter who one is attending to or is being asked to attend to.
20 We are all human beings, we all have hard times, hard feelings and I, as a medical
21 practitioner, as a psychiatrist swore to help even my enemies when I can.
22 And here, I would like the Chamber to accept my underlining the fact that even one's
23 enemies or even my enemies I have to attend to them without prejudice, without hard
24 feelings in order to give relief to them, in order to prevent them from dying, in order
25 to prevent them continuing to suffer. And that was why I accepted eventually.

1 Otherwise, I wasn't going to accept.
2 PRESIDING JUDGE SCHMITT: [10:21:09] Thank you.
3 Ms Lyons.
4 MS LYONS: [10:21:11] Yes.
5 Q. [10:21:13] Thank you very much.
6 It's -- it's hard for me to follow now that presentation.
7 You know Dr Akena obviously. Just for the record, do you know Dr Abbo, and how,
8 if you know her?
9 A. [10:21:35] Dr Abbo trained and graduated in psychiatry when I was head of
10 department and I was the only teacher in the department. So I know her very well.
11 We have collaborated in the research in publications together. The next question
12 you might want to ask is, if or how I felt when she became an expert from -- for the
13 Prosecution. That has nothing -- has had no effect on our collaboration. We have
14 never talked about what she did, what I did. We are simply continuing our old
15 mentor, mentee relationship as usual.
16 Q. [10:22:47] Thank you for that addition, really. Let me also ask you along the
17 same lines, Professor de Jong, do you know him? Did you ever consult with him?
18 Your colleague answered a question about the report, did you read his report before
19 you did your reports? Do you know anything about him?
20 A. [10:23:12] All I can say is that I read a book that he wrote about depression when
21 I was doing my postgraduate training in psychiatry. I have never seen him. I have
22 never met him. I have never written to him. I don't know him personally.
23 Q. [10:23:46] Now, what I would like to do is move on a little bit, but I would
24 like -- the Chamber and the parties and participants all have the extensive CV and I'm
25 skipping over publications and editorials obviously (Overlapping speakers)?

1 PRESIDING JUDGE SCHMITT: [10:24:03] No, I think --
2 MS LYONS: [10:24:04] I think this is enough.
3 PRESIDING JUDGE SCHMITT: [10:24:05] -- that's not necessary (Overlapping
4 speakers)
5 MS LYONS: [10:24:05] Okay, I just want to (Overlapping speakers)
6 PRESIDING JUDGE SCHMITT: [10:24:07] We have it here in the binders and it's
7 really impressive and quite extensive, we can (Overlapping speakers)
8 MS LYONS: [10:24:11] And you know we could spend days --
9 PRESIDING JUDGE SCHMITT: [10:24:11] -- simply (Overlapping speakers)
10 MS LYONS: [10:24:12] I understand. So I want to move --
11 PRESIDING JUDGE SCHMITT: [10:24:15] (Overlapping speakers)
12 Nobody -- nobody will doubt that.
13 MS LYONS: [10:24:17] Okay. Thank you, your Honour.
14 PRESIDING JUDGE SCHMITT: [10:24:20] If you will, you can go to the heart of the
15 matter, so to speak.
16 MS LYONS: [10:24:28] (Microphone not activated).
17 PRESIDING JUDGE SCHMITT: [10:24:29] Microphone, please.
18 MS LYONS: [10:24:31] I'm getting closer to the heart. There's just one question that
19 affects the dealing with the heart, which is on methodology.
20 Q. [10:24:45] Can you very briefly explain whether your cultural understanding of
21 Mr Ongwen's background, including his belief system, has any effect on your medical
22 conclusions?
23 A. [10:25:11] Can you paraphrase it, please?
24 Q. [10:25:15] Sure. What I wanted to know was, I am making the assumption that
25 you have an understanding of the cultural background to some degree of Mr Ongwen.

1 You are not from the north, but you understand the way the Acholi system works, the
2 belief system. You've detailed your work with clients, you know, you've worked in
3 Gulu in the north, you've done clinical practice. So I want to know if this
4 understanding, if it affects your medical conclusions or how you deal with the
5 understanding. Does it help you? Does it not help? Does it have no effect on
6 your medical conclusions in respect to Mr Ongwen?
7 It's a general question. I don't know if I've clarified it. If I haven't, I'll move on
8 but ...
9 A. [10:26:20] Cultural, cultural explanations of mental illness vary from one group
10 to another. The cultural belief systems of the Acholi and the Madis are the same or
11 they are similar. We believe in supernatural forces. We believe in witchcraft. We
12 believe in explaining our misfortunes on evil spirits, but that is the cultural
13 explanatory model that we have to explain our distress nature.
14 We do make use of this in understanding the complaints that people bring forward,
15 they come with to us. But we know how to elicit the symptoms of mental distress,
16 mental illness or mental disorder.
17 So the cultural belief systems help us to understand a client like the suspect in
18 Prosecutor versus Dominic Ongwen. We understand him because his belief systems
19 are similar to what we also hold. But it does not affect the way we make our
20 conclusions because we will -- we engaged him in going around and around and
21 around in talking about his difficulties.
22 Q. [10:29:05] And can you also just tell us, just tell us the community from which
23 you come, how far is that from an Acholi community, just distance wise?
24 A. [10:29:22] We share a border.
25 Q. [10:29:24] You share a border?

1 A. [10:29:27] Yeah.
2 Q. [10:29:27] Okay. Thank you.
3 I had one question under methodology -- we're still in the methodology area. It
4 deals with the DSM-5. Maybe you heard some of the testimony yesterday or saw it
5 on the video.
6 Could you tell us, just very briefly, what the status of a diagnosis called complex
7 PTSD is within the DSM-5 now, and what is the debate that led up to whatever the
8 situation now is?
9 A. [10:30:23] The status as reflected in the literature is that complex PTSD is a form
10 of post-traumatic stress disorder that results from an individual having been exposed
11 to several episodes and some of the episodes -- or most of the episodes having been
12 severe over a long period of time.
13 So, in effect, the number of times the severity of experiences of trauma gives rise to a
14 whole complex, complex picture of a disorder arising from the trauma, and this
15 picture sometimes presents, especially in the earlier days, in DSM-III, DSM-IV and
16 much earlier, the complex nature of PTSD included presentations of psychosis,
17 personality derangements, dissociations, alcohol and drug addiction all mixed up
18 together so that it became difficult for clinicians at that time to say, oh, this is simple
19 PTSD. This appears to be something more than just simple straightforward PTSD.
20 Q. [10:32:42] Thank you. Now, my understanding is that it isn't recognised in
21 DSM-5. This was a point that was brought out during the testimony of Dr Mezey
22 who said it was not a formal diagnosis. She talks about this, for the references - you
23 don't have to go there, I can quote it if I'm permitted to - tab 8, binder 1, T-162,
24 pages 27 to 28.
25 Dr Mezey says this condition, quote, "was never adopted a formal diagnosis because

1 it was felt that it lacked the validity and consistency to warrant a diagnostic
2 classification."
3 And my question is your reaction to this statement.
4 A. [10:33:46] My reaction is reflected in my long but vague answer.
5 Q. [10:33:56] Okay.
6 A. [10:33:58] I agree with her because, as I said, it is a mixed bag of presentation of
7 different features of -- or features of different forms of mental illness. So it would
8 have been funny to have put it under a diagnostic category without further work.
9 The DSM-5 is already undergoing work to revise it, and who knows, complex PTSD
10 might in the future appear in the -- but otherwise, other than what I have said,
11 psychiatry is one of the disciplines of medicine which is full of controversy. Theories
12 are coming up every now and then. Every theorist presents their ideas as the ideal
13 idea to replace idea B. So psychiatry is a very, very, can I say, sometimes a confused
14 field and -- because people do not readily agree. But as I said, who knows, complex
15 PTSD might appear.
16 In fact, to add, there is a book written by Judith Lewis Herman who first talked about
17 complex PTSD in her book. And one of the differentials she talked about are
18 borderline personality disorder, which of course, as I said earlier, appear to be a
19 component of complex PTSD. Schizophrenia, bipolar disorder, they are all mixed up
20 there.
21 But I agree, the long -- the short of the long is that I agree with the doctor.
22 Q. [10:37:00] All right.
23 PRESIDING JUDGE SCHMITT: [10:37:01] But it was long, it was not so vague that
24 you said it would be, and it was also quite interesting, frankly speaking.
25 Ms Lyons, please proceed.

1 MS LYONS: [10:37:12]
2 Q. [10:37:13] Along the same lines, in the binder, and this is at binder 1, tab 24,
3 there's some -- a questionnaire on the ICD-11 which you are one of the three
4 coauthors of this.
5 Your Honours, for the record, this is what we -- this was in one of our emails.
6 And I just -- I wanted -- you're welcome to take a -- to find it if you want to look at it --
7 PRESIDING JUDGE SCHMITT: [10:37:45] I'm sure --
8 MS LYONS: [10:37:46] He knows it.
9 PRESIDING JUDGE SCHMITT: [10:37:48] I'm sure he knows --
10 MS LYONS: [10:37:49] Right. Okay.
11 PRESIDING JUDGE SCHMITT: [10:37:49] -- exactly what you are talking about.
12 MS LYONS: [10:37:50] Okay. Okay. I'm sure.
13 PRESIDING JUDGE SCHMITT: [10:37:52] Without having a look. It's this article in
14 the Journal of Psychiatry.
15 MS LYONS: [10:37:57] Right, exactly.
16 Q. [10:37:59] ICD-11 "Trauma Questionnaires for PTSD and Complex PTSD:
17 Validation among Civilians and Former Abducted Children in Northern Uganda".
18 And I just have one question about the conclusion in the "Abstract". It says:
19 "Based on its findings the study concludes that the ICD-11 tools for PTSD and
20 C-PTSD", meaning complex PTSD, "both appear to be valid as suggested by both
21 discriminant and convergent validation of the tools. However" --
22 PRESIDING JUDGE SCHMITT: [10:38:41] Could you please give the exact page
23 number of -- just for the clarity of the record.
24 MS LYONS: [10:38:46] Yes. This is on the first --
25 PRESIDING JUDGE SCHMITT: [10:38:48] But we don't have to search for it

1 (Overlapping speakers)
2 MS LYONS: [10:38:53] Okay. Yes, I'm sorry. This is on the first page. We don't
3 have (Overlapping speakers)
4 PRESIDING JUDGE SCHMITT: [10:38:56] It is on the first page, it should be
5 (Overlapping speakers).
6 MS LYONS: [10:38:58] And it's stamped -- yes, it's stamped, sorry, it's stamped
7 UGA-D26-0015-0779 and I'm reading from the "Abstract" box. Okay?
8 PRESIDING JUDGE SCHMITT: [10:39:11] Thank you.
9 MS LYONS: [10:39:12]
10 Q. [10:39:13] And the last phrase is what I'm interested in: "However, future
11 research can benefit from studying [the] cultural aspects of these diagnoses".
12 And can you say just briefly at this moment a little bit more about what you
13 envisioned as one of the authors as studying the cultural aspects of PTSD and
14 complex PTSD, please.
15 A. [10:39:46] The constructs as appeared in the questionnaire, or questionnaires,
16 were not the constructs of the communities that were studied. Translations were
17 made, but I'm not sure if the translations portrayed the exact concepts that the
18 communities studied would -- it didn't -- the translations did not convey the actual
19 meanings as understood by the studied communities.
20 So when a recommendation is made or was made that future studies are required, it
21 was based on difficulties in helping communities clearly understand what the
22 questions on the questionnaires were after.
23 As I said, we believe in superstitions, supernatural powers, evil spirits, evil-minded
24 enemies, and sometimes putting a question constructed in the western hemisphere or
25 northern hemisphere into the concepts of the Acholi or the Madi or even Baganda

1 would be very, very difficult. So while the ICD-11 and the other were said to have
2 similarities, with retrospect, I do not, I do not really believe that what we measured
3 was what we set out to measure.
4 Q. [10:42:31] Thank you for the explanation.
5 Now, we're going to be focusing on the -- mainly on the second report, but there may
6 be a few questions going back to the first report, or you're free to refer to any of the
7 evidence reports.
8 And what we did yesterday was Dr Akena defined some of the terms and the
9 conclusions in the first report, and I want to highlight two of the definitions that we
10 need before we proceed for the second report. And these were raised by
11 Professor Schmitt and I said we would get to them today, so here they are.
12 We need -- what we would like is -- that's a terrible start of a question. I should
13 learn how to ask questions.
14 What do you mean by dissociative amnesia? And the second question is: What do
15 you mean by symptoms of obsessive compulsive disorder? We need a working
16 definition.
17 PRESIDING JUDGE SCHMITT: [10:43:48] One after the other, please.
18 MS LYONS: [10:43:49] Okay, sure.
19 PRESIDING JUDGE SCHMITT: [10:43:49] The first, dissociative amnesia, please.
20 MS LYONS: Thank you.
21 THE WITNESS: [10:43:54] Thank you, sir. I was going to say the same.
22 MS LYONS: [10:43:58] Okay. Thank you.
23 THE WITNESS: [10:44:00] Dissociative amnesia, before I define it, let me go back to
24 the definition of dissociation or -- and then thereafter dissociative disorder.
25 Dissociation is mainly, but it can also be induced, personally induced, but mainly it is

1 an automatic psychological response mechanism that an individual undergoes in the,
2 in the face of overwhelming traumatic experience. That overwhelming traumatic
3 experience may entail the threat of severe injury or death to oneself or to others. It is
4 associated with horror, fear and a sense of helplessness and inability to escape. So
5 dissociation appears to be a psychological defence mechanism that helps us to cope
6 with that overwhelming encounter.
7 When the dissociative experience develops into a more severe state, then the
8 individual may experience derealisation, which means that the person experiences the
9 surroundings as being unreal, there is an "as if" element.
10 For example, if under your questioning I became overwhelmed and then I told you
11 that it appears as if this entire room is upside down and I'm barely struggling to keep
12 myself upright, that would be an example of derealisation, an "as if" experience of this
13 room being upside down.
14 Sometimes, apart from derealisation, there is also depersonalisation.
15 Depersonalisation means that I experience parts of my body undergoing significant
16 frightening change. For example, again as a reaction to your questioning, supposing
17 I feel as if my right arm is disproportionately very large and very elongated to the
18 point that from where I am seated I can touch that wall. That is, I see this arm, it is
19 as it is, but then I tell you I experience as if my hand is enlarged and long to the point
20 that I can greet, for example, our suspect. That is depersonalisation.
21 Then still on a more severe state let us say now what we wrote about identity
22 disorder. I feel as if there are two persons or three persons in myself and these three
23 persons have different heads all sticking to the same body. This is now what we say
24 dissociative identity disorder. I am one body but I have three heads and I can see
25 the three heads. Although none of you will see. All you need to believe is that I am

1 telling you my experience that I have three heads.
2 So dissociative amnesia now, after this long explanation, refers to a segment of my
3 memory having been blocked or blotted out of my conscious memory. I am unable
4 to recall significant events about myself, particularly related to the traumatic event.
5 And it can be very distressing, very painful, very disarming in such a way that I may
6 not be able to carry on with my usual duties.
7 If it occurred now, you will find that I will not be able to talk to you, or even if I talk
8 to you, I will tell you things totally, which are -- which have nothing to do with the
9 proceedings in this house.
10 However, dissociative amnesia may not affect certain other elements just before or
11 surrounding, but it only affects that circumscribed personal information, personal
12 memory of events, that is dissociative amnesia. It is another type of a dissociative
13 disorder other than dissociative identity disorder or general dissociative disorder.
14 PRESIDING JUDGE SCHMITT: [10:51:41] And, Ms Lyons, before the break I think
15 we can try to elaborate also the understanding of the expert of OCD I think.
16 MS LYONS: [10:51:51] Sure.
17 THE WITNESS: [10:51:53] Okay.
18 PRESIDING JUDGE SCHMITT: [10:51:53] Yes. This was the second question.
19 I think simply --
20 THE WITNESS: [10:51:57] Yes. OCD, OCD is a term that encompasses two
21 separate disorders but linked. The two separate disorders are linked together.
22 "O" stands for obsessions. Obsessions are repetitive, intrusive, senseless imagines,
23 words, fantasies, and general ideas about oneself and about one's environment.
24 These repetitive experiences in my mind, for example, would again be distressing,
25 they are time consuming, I cannot attend to what meaningful, useful thoughts that I

1 should engage in. They arouse a lot of anxiety, that is, fear without any reasonable
2 cause.
3 And compulsions are kind of -- they neutralise the obsessions. Compulsions are
4 defined as repetitive, involuntary activities that we engage in aimed at neutralising
5 the particular content of the obsessions.
6 Now, let me give an example.
7 We have several doors here and each of them has a knob and each of the knobs -- or
8 the one of interest to me would be this one and I believe that knob has already been
9 touched by several hands and all those hands are contaminated with germs. And
10 I would fear to handle the knob. Unless -- or maybe let there be no "unless". If I am
11 forced to touch the knob to open, as soon as I am out of the room, I run to the nearest
12 sink to wash my hands with antiseptic, with soap, with detergent, sometimes I even
13 scrub with a brush. As soon as I finish, I feel I'm satisfied, but no sooner than having
14 taken three or five steps, the idea of contamination comes back and I run back to the
15 sink to wash.
16 Another example, I said I wanted one, but let me give another example.
17 PRESIDING JUDGE SCHMITT: [10:55:58] I think, I think it would be a good idea
18 perhaps to have a break here, coffee break, because we are close to 11 o'clock. And
19 we can -- it would be good, I think the principle is understood by us, but we can now
20 go on specifically to the report and to the application, so to speak, of these definitions
21 that have been entertained here in the report.
22 So we have now a break until 11.30.
23 (Recess taken at 10.56 a.m.)
24 (Upon resuming in open session at 11.32 a.m.)
25 THE COURT USHER: [11:32:31] All rise.

1 Please be seated.
2 PRESIDING JUDGE SCHMITT: [11:32:51] Ms Lyons, no surprise that you still have
3 the floor.
4 MS LYONS: [11:32:54] Thank you.
5 Thank you, your Honour. Okay.
6 Q. [11:32:59] Moving on, as promised, to the second psychiatric report, which you
7 may, you may know it by heart, but for those who need to find it, it is at binder 1, tab
8 number 8.
9 PRESIDING JUDGE SCHMITT: [11:33:16] And for the specificities --
10 MS LYONS: [11:33:17] Yes.
11 PRESIDING JUDGE SCHMITT: [11:33:18] You want to look into it, it's --
12 MS LYONS: [11:33:21] I'm sorry.
13 PRESIDING JUDGE SCHMITT: [11:33:24] Is the microphone on for the witness?
14 I don't think so. Yes, okay.
15 But, in the meantime, I can tell you, if you would want to go to the specificities,
16 especially the wording of your report, it's tab 8, I think it was. It's in tab 8, we are
17 talking about this. Yes. The report from June 2018.
18 MS LYONS: [11:33:59] And for the transcript, it's report, it's the first cover, ERN is
19 UGA-D26-0015-0948 and it ends on 0982. Getting better on the ERNs, okay.
20 Q. [11:34:24] Now, the first question I have is: From the -- the work that you have
21 done and the reports, can you briefly say is there any relationship between the first
22 and second report or how do you view them?
23 A. [11:34:45] Yes, there is a relationship between the two reports. The second
24 report delved more into some of the findings that we put in the first report, but which
25 we, by "we" I mean Dr Akena and I also felt was not adequate.

1 Fortunately, that was, as he said, brought up by the Prosecution experts. Although
2 he, he felt sorry for, for one of the experts, I do not because, as I said earlier on in the
3 first session, psychiatry is a field of confusion. And not everybody agrees. So I do
4 not personally feel sorry. But, anyway, to answer the question, the second report,
5 and indeed throughout the report we referred to quotes from the first to substantiate
6 what we put down in the second. So the two are related.
7 Q. [11:36:30] Thank you.
8 Now, it was brought to the attention of everybody through a Prosecution pleading
9 that there were, as the Prosecution described, two new diagnoses in the second report
10 that did not appear in the first. And they were identified as dissociative amnesia,
11 which you talked about before break and the symptoms of obsessive-compulsive
12 disorder.
13 My question to you is: Are these new diagnoses and -- or, are these new diagnoses?
14 A. [11:37:26] They may be viewed as new diagnoses, as far as they appeared in the
15 second report, but they are not entirely new. We didn't include them in the first
16 report because we did not have sufficient number of symptoms and we were not
17 satisfied with the descriptive features in the first report.
18 Episodes of loss of memory were reported in the first report -- in the -- in the first
19 psychiatric report. They may not have featured prominently, but we did identify
20 times when Mr Ongwen reported episodes of, for example, loss of memory -- sorry,
21 loss of consciousness, dying and waking up.
22 But other than that, there were no other significant qualifying additional symptoms
23 that we could have added at that time to bring forth a diagnosis of dissociative
24 amnesia.
25 We were satisfied with including it in the second report because he described more

1 vividly the times, at least two times, one of which was when he was involved in battle
2 with the enemy in South Sudan. He reported the loss of memory with quite
3 distressing experience and looks on his face. He reports, or he reported that he was
4 taken to hospital in Juba, but he did not know how he got there and for how long.
5 He was unable to tell when he recovered.
6 So that appeared to be to us a significant memory gap from time X in the battlefield to
7 time Y when he woke up in the hospital and he could not account for events
8 in-between the two. We were criticised for not providing differential diagnosis, but
9 let me answer it, let me answer the critics this way: When I was an undergraduate,
10 there was an old professor of paediatrics, in fact he wanted me to become professor of
11 paediatrics. I said no, I want to be psychiatrist. He said, "In that case, you can
12 come and be professor of paediatric psychiatry."
13 The point I want to raise about this professor was, every Thursday there was what we
14 call a grand round. At the grand rounds, difficult clinical problems were presented
15 to professors in a room like this, we call it -- we call it the Davis Lecture theatre. And
16 they would sit in front, the rest of us students we would sit behind, and the problems
17 were presented by postgraduate students and some of them wanted to prove to the
18 professors that they had read, they knew a lot. And then this professor would, with
19 tongue in cheek say, "But why do you give us a long list of diagnoses? At the end of
20 the day, you want to treat one condition. So tell us of this long list, what is it that
21 you, you are telling us about?"
22 So, yes, for example, with amnesia, it could have been traumatic brain injury, but with
23 traumatic brain injury one would also have additional physical features, which -- that
24 is, paralysis or sensory loss due to injury to the brain, which he did not have.
25 One could say faking, as it was alleged two days ago, and also by the critics. But

1 here is a man who does not want to free himself from the detention centre. Instead,
2 if it were his wish, he would, he would request these eminent judges to condemn him
3 to -- to death. A faker would not ask for the death penalty. There is nothing
4 the young man there, in relation to my age, gains from faking an illness, faking
5 amnesia.
6 We did talk about the possibility of memory loss or loss of consciousness from one of
7 his wives who was brought to us to talk to. She, as a layperson, as Dr Akena said,
8 she had no idea of what we were asking about. Did he have strange behaviour after
9 battle? She said, you know, she didn't see anything strange. He would sit with his
10 colleagues on their compound and they would talk, joke and laugh. So what we put
11 there was what we, in our view, based on our assessment, was the most likely
12 problem.
13 What was the other question?
14 Q. [11:45:58] You answered -- the same question --
15 PRESIDING JUDGE SCHMITT: [11:45:59] (Overlapping speakers) And also I would
16 say, just a remark, I don't overtake --
17 MS LYONS: [11:46:00] Sorry.
18 PRESIDING JUDGE SCHMITT: [11:46:00] -- the questioning, but the expert has
19 foreseen quite a number of your questions, I think already --
20 MS LYONS: [11:46:10] Yes.
21 PRESIDING JUDGE SCHMITT: [11:46:10] -- I would say.
22 MS LYONS: [11:46:12] Absolutely, that's why, you notice, I'm --
23 PRESIDING JUDGE SCHMITT: [11:46:15] Yes.
24 MS LYONS: [11:46:16] Yes, absolutely.
25 Q. [11:46:17] But the other area that -- that we wanted you to explain a little bit

1 about is whether this -- the symptoms of OCD --
2 A. [11:46:26] Yes.
3 Q. [11:46:27] -- which was not, that was the second area, which was -- which has
4 also been attributed, at least in the pleadings, if I may, of the Prosecution as a new
5 diagnosis?
6 A. [11:46:38] Yes.
7 PRESIDING JUDGE SCHMITT: [11:46:39] Yes.
8 MS LYONS: [11:46:40] And I want to also add and you don't need the reference,
9 but --
10 A. [11:46:45] Wait, let me answer that one first.
11 Q. [11:46:46] All right.
12 PRESIDING JUDGE SCHMITT: [11:46:47] The witness is absolutely right, one after
13 the other and we have dealt with the first one.
14 MS LYONS: [11:46:51] Thank you for (Overlapping speakers).
15 PRESIDING JUDGE SCHMITT: [11:46:52] and --
16 MS LYONS: [11:46:53] Okay, I'm slowed down.
17 PRESIDING JUDGE SCHMITT: [11:46:54] Yes.
18 MS LYONS: [11:46:54]
19 Q. [11:46:55] But OCD, which you deal with in this report.
20 A. [11:47:01] Yes, OCD, as I explained just before we went away, is a prominent
21 category in both ICD and DSM diagnostic systems. We referred to it as symptoms of,
22 not disorder of, because the number of symptoms that we elicited were not sufficient,
23 we were not satisfied with the number.
24 Also, the element of significant interference with psychosocial functioning was not
25 evident. But we entertained the symptoms because of this recurrent report of him

1 saying that he would smell gun powder, blood and then he would go blank or he
2 would dissociate and then go to battle. And after battle, he would then say, "What is
3 it that happened? Is the battle over?"
4 So here you have a mixture of dissociation and OCD features occurring together. So
5 we were not entirely satisfied with the criteria that should have been met for what we
6 called symptoms to have become a disorder.
7 Q. [11:48:44] Thank you.
8 May I have just a moment?
9 Now, I would like to ask you one question about the, the methodology on pages 24 to
10 26 of your second report. And it's ERN UGA-D26-0015-0971 and 72.
11 My question is, for now, could you just explain in terms that -- in layperson's terms,
12 what multi-axial diagnoses is, please?
13 A. [11:49:55] Multi-axial diagnosis refers to a psychiatric formulation of a clinical
14 problem that a client has presented with. And what then the clinician believes to be
15 the issues causing the problem and that require management attention, that is, clinical
16 management attention.
17 There are five areas that are components of the multi-axial diagnosis.
18 Axis I is the first primary psychiatric diagnosis. I said first psychiatric diagnosis.
19 There could of course be two or three. But there is usually a first psychiatric
20 diagnosis. And the others, depending on timing of onset of symptoms, one can then
21 say secondary diagnosis, third diagnosis, or say major depressive disorder with
22 features of schizophrenia, major depressive disorder with features of anxiety.
23 So those appear in the first axis.
24 Axis II in adults refers to personality issues, personality disorders. In children,
25 axis II talks about cognitive problems such as deficit, impairment and so on.

1 Axis III refers to physical health problem that could have led to the manifestations of
2 the psychiatric illness and disorder or disorders.
3 Axis IV refers to a long list of stressful events in the life of the individual. These are
4 stressors. These may be precipitators, they may be predisposers, they may be
5 maintaining factors, but they are all stressful. But under axis IV there is also the
6 issue of positive factors that the clinician needs to take care of in prescribing
7 management.
8 For example, if Mr Ongwen is highly suicidal but the positive social factors here
9 would be his friends at the detention centre, the occasional permission given to his
10 family members to visit him, those would be considered positive factors. They also
11 appear under axis IV.
12 And then axis V is concerned with how severe, how severely has the illness affected
13 Mr Ongwen's functioning, his performance in life at the detention centre -- sorry, let
14 me backtrack.
15 Under axis V there may be -- we, we define it in terms of -- we grade it in terms of
16 zero per cent to a hundred per cent. Zero means -- between zero and 10 means there
17 is no impairment, but 90 to 100 means there is significant impairment in his life
18 imposed on him by, by his illness. In most cases, individuals are rated somewhere
19 between 40 and 60 or 40 and 70, but in groups of 10. So the higher the impairment
20 score, that is, in terms of percentage, the more severely an individual is, is impaired in
21 functioning.
22 So put together all the five, then inform how best, for example, Mr Ongwen, should
23 be helped.
24 PRESIDING JUDGE SCHMITT: [11:56:00] May I shortly.
25 So if I would summarise it, would it be correct to say that this multi-axial diagnosis

1 enables you and experts to assess the psychiatric condition in a holistic manner?
2 THE WITNESS: [11:56:17] Yes.
3 PRESIDING JUDGE SCHMITT: [11:56:17] From a holistic perspective?
4 THE WITNESS: [11:56:20] Yes.
5 PRESIDING JUDGE SCHMITT: [11:56:22] Correct, okay.
6 MS LYONS: [11:56:23] Thank you, your Honour.
7 Q. [11:56:24] I just have one factual question, if you can answer it.
8 Under axis V on page 26 you say that Mr Ongwen was admitted to Juba referral
9 hospital for at least a two-month period due to an episode of severe mental illness. If
10 you recall, do you know the approximate timing of that, when that happened? If
11 you can --
12 A. [11:56:52] I don't remember it off head, but it is in the report. Unfortunately, to
13 preserve my attention and concentration, if you can --
14 PRESIDING JUDGE SCHMITT: [11:57:05] There is no problem at all.
15 MS LYONS: [11:57:08] (Microphone not activated)
16 PRESIDING JUDGE SCHMITT: [11:57:09] Let me just -- this is exactly to explain the
17 reason why at the beginning of today we established that the report -- your reports, so
18 to speak, are part of your evidence. So we need not, we need not establish that in
19 detail because it's already in the report.
20 THE WITNESS: [11:57:28] Thank you, your Honour.
21 MS LYONS: [11:57:33] Thank you, your Honour.
22 Q. [11:57:34] And thank you, Professor Ovuga.
23 Now, what I want to focus on now is, is the ending, the conclusions in this report.
24 And I'm now, as a bit of background, looking at pages 28, 29, 30, 31, 32. Many of
25 these pages were used yesterday, I believe, or referred to in the cross-examination by

1 the Prosecution with, with Dr Akena.
2 Let me phrase my question.
3 We've talked about, for example, today you've mentioned -- we've talked -- well,
4 we've talked about a number of diseases or disorders or symptoms that were found in
5 Mr Ongwen. And the question is, for example, with, with dissociative disorders and
6 particularly amnesia, the question is: Did having this disease, and we will go
7 through each of them, but did having, for example, a disease you diagnosed as
8 dissociative amnesia, did that influence or affect Mr Ongwen's ability during the
9 charged period to make a judgment about what was right or what was wrong? Is
10 there a link between the diagnosis and being able to say what is right and what is
11 wrong?
12 A. [11:59:36] Let me approach it from two ways, one following the other.
13 You remember me saying in relation to OCD that Mr Ongwen would feel or
14 experience the smell of blood, gun powder and then a premonition that they were
15 being attacked. And then of course he would organise his forces to ward off an
16 attack.
17 So already the planning to ward off an attack are as a result of a set of things, smell of
18 this, smell of that and premonition. So there, the strategy is the instinct of survival,
19 not necessarily that Mr Ongwen deliberately wanted to go to battle. It was as a
20 result of two events followed by a premonition, two experiences followed
21 a premonition. And this kept on happening.
22 The problem with these experiences is or was that, unless he took action, then he
23 would be overcome with severe levels of anxiety, distress, unease, insecurity. And
24 the only way, the only way that he would get relief was, so to speak, to ward off
25 danger from himself and from his soldiers.

1 So the main thing that links his actions in the battlefield is the experience of intrusions,
2 smell, bad smell, repeated bad smell, and premonition.
3 The amnesia comes as a result of, and I would not say that the amnesia themselves
4 led to his battlefield activities, but they are significant in that he does not remember
5 his role in the, in the battlefield. And if he doesn't remember his role, what he did,
6 then that is the, the link.
7 Q. [12:03:40] Thank you. Let me ask a similar question on -- but we are focusing
8 more generally on dissociative disorders. In this section at page, it's page 28, it's
9 UGA ending 0975, you make an overall conclusion that the --
10 PRESIDING JUDGE SCHMITT: [12:04:06] Which we are not -- it's about criminal
11 responsibility and, as you know, the conclusion if there is criminal responsibility or
12 not is, in the end, made by the Judges. We have all our different areas of
13 responsibility and the experts are here, any expert is here to provide, of course,
14 a factual basis with a backdrop of their professional experience and expertise to the
15 Judges.
16 I just want to foreshadow any objections by the Prosecution which would come if you
17 would entertain that.
18 But any question with regard to the factual findings and, as I said, for the backdrop,
19 background of the expertise is okay. But don't ask, please don't ask an expert about
20 criminal responsibility.
21 MS LYONS: [12:05:03] Okay. I don't want to ask in those words, but if I have -- can
22 reach for my file on this issue, there were examples in the transcripts of the witnesses
23 from the OTP, the experts, as well as in the reports, where there were questions asked
24 about right and wrong, ability to control --
25 PRESIDING JUDGE SCHMITT: [12:05:21] We have --

1 MS LYONS: [12:05:22] -- and criminal responsibility.
2 PRESIDING JUDGE SCHMITT: [12:05:23] Okay.
3 MS LYONS: [12:05:23] So I'm simply saying, I can find those citations for
4 your Honour. It's in those reports and there are questions. I'm not asking for the
5 ultimate question because that's up to the Judges but --
6 PRESIDING JUDGE SCHMITT: [12:05:37] (Microphone not activated) how it goes,
7 how it works out. Please.
8 MS LYONS: [12:05:42] Okay, thank you.
9 Q. [12:05:45] All right, the question is do dissociative disorders, as the one
10 specifically that you concluded Mr Ongwen had or has and had during the charged
11 period, do they affect in any way his judgment about right or wrong?
12 A. [12:06:22] You see, we have a primary difficulty here. The primary difficulty is
13 that we do not have corroborative sources of information, but if we had those sources,
14 then, yes, one would say dissociative disorders or experiences would have
15 a significant impact on his moral ability to decide to tell right from wrong.
16 I will give you an example of one of his reports that he gave during our first visit.
17 He was -- he and his colleagues were called to the command room, and they were
18 being given a task to go and perform. He was not willing, but he knew expressing
19 unwillingness would attract capital punishment, and as he sat there, like we are all
20 seated, and the instructions were being issued, he straightaway went blank. What
21 I am saying is that he dissociated in the, in the command room where they were being
22 instructed. Whatever followed thereafter, he does not remember.
23 So that was the first episode of dissociation that he reported. Again, I don't
24 remember the exact year, but it is in the report.
25 So under a situation like that, what I might add is, yes, he was unwilling, he knew

1 what they were supposed to go and do, but he was unwilling because it was wrong
2 and so he dissociated. And when he dissociated, then he was absolved from this
3 burden of telling right from wrong.
4 So dissociation, you see, can have those protective, such protective values to, to us
5 during times of difficulty.
6 PRESIDING JUDGE SCHMITT: [12:10:04] Thank you.
7 MS LYONS: [12:10:05]
8 Q. [12:10:07] Along the same lines, I want to make a general -- I want to give
9 a general quote that comes from Dr Mezey. It's, for those who want to check it,
10 binder 1, transcript 163, a sentence in pages 44 to 45. I'm sorry, I don't have the line.
11 But what she says is: "... in severe mental illness you do not have control over your
12 thought processes and behaviours and feelings."
13 As a general proposition, this lack of control, can you apply this to Mr Ongwen and to
14 his mental health diseases?
15 A. [12:11:05] Absolutely. I would like to agree with her, although her intention
16 was to say that Mr Ongwen did not suffer from severe mental illness. She did not
17 have the opportunity to talk to him. She was assuming, based on reading our report,
18 which I acknowledge it was lacking in detail, especially referring to the first. But
19 still, if I were her, I would not have made a statement like that with intent to say
20 Mr Ongwen was not severely mentally ill and that he was faking an illness. I would
21 not have portrayed that assumption.
22 I want to -- as Mr Presiding Judge said, I want to forestall a possible question, the
23 issue of significant duress, for example, as related to the example I narrated about two
24 or three minutes ago. These child soldiers were boxed in a one-way -- sorry, not
25 one-way, a no-through room, no-exit room. The only exit is behind me here. Let us

1 assume. The child soldier is there, and there is no exit there. There is no exit on
2 either side, except here. The child soldier is told, "You either do this or you are not
3 getting out of here through here."
4 In a situation like that in this room, let me ask, with your permission, your Honour,
5 Mr President, in this room, including myself, we find ourselves in situations like that.
6 How many of us would want to be a martyr? How many of us - I'm looking from
7 my left to the right - how many of us would be willing to become a martyr? I would
8 probably be one. Any other?
9 PRESIDING JUDGE SCHMITT: [12:14:58] I think we -- of course you don't
10 expect -- I'm sure you do not expect an answer or even raising fingers or something
11 like that.
12 THE WITNESS: [12:15:10] Yes.
13 PRESIDING JUDGE SCHMITT: [12:15:10] But we might never, we might never
14 know, you know, we might never be sure of ourselves.
15 Please, Ms Lyons.
16 THE WITNESS: [12:15:18] So that is the situation in which Mr Ongwen lived. That
17 was the situation; the concept of duress. And here the concept of duress probably
18 was the factor that led to his first dissociative experience when he was in the
19 command room. You either go or you perish. If you want not to perish, you go
20 and do this. And a young man, as I said, in relation to my age, had to comply, under
21 many, many situations during that period of 2005 -- sorry, 2002 to 2005.
22 PRESIDING JUDGE SCHMITT: [12:16:21] Ms Lyons.
23 MS LYONS: [12:16:22] Thank you.
24 Q. [12:16:24] Now, we had some description yesterday from Dr Akena of two
25 personalities that Mr Ongwen was living with. And my question is this: Can you

1 talk about whether the existence of these two personalities, did they have any effect
2 on his ability to tell right and wrong, or did they have any effect on his ability to
3 control his conduct? With emphasis on the 2002 to 2005 period.
4 A. [12:17:25] The two personalities existed way before 2002 and they were active
5 during the period that -- of 2002 to 2005.
6 What he described to us was that one personality was the cheerful, happy, friendly,
7 sociable, helpful Mr Ongwen -- sorry, Mr Dominic. The other one was the hostile,
8 combative, aggressive Mr B, Dominic B.
9 And he asked us, of course we didn't have any answer: "Why do I have two people
10 living side by side, one is B, one is A? I don't like B because he is always walking on
11 my left and when he is on my left, he walks with me and he directs me. When time
12 for battle comes, he is at the back, he is on my back, always pushing me forward, no
13 retreating."
14 So whether he liked it or not, this Dominic B was the one who ruled his life in the
15 battlefield. "Always behind me, pushing me forward, no going back until I wake up
16 and I find myself weak, without energy."
17 So if we assume that Dominic A is the one being charged or is being tried, then we are
18 trying the wrong person.
19 The Dominic B is the one who we should be trying, but the reality is the two
20 Dominics are in that body seated there. That is our challenge. That is the challenge
21 of their Honours sitting in front of me there, the challenge. They don't know who
22 they are charging or trying because they are trying a physical, somebody there. But
23 there are two people inside there.
24 PRESIDING JUDGE SCHMITT: [12:20:54] Ms Lyons.
25 MS LYONS: [12:20:55] (Microphone not activated)

1 One moment, your Honour.
2 Q. [12:21:12] Now, at the same section of this report on page 29, you conclude there
3 were interferences with Mr Ongwen's ability to follow court proceedings.
4 Do you want to -- we talked a little bit about that yesterday. Do you want to say
5 anything more about this?
6 PRESIDING JUDGE SCHMITT: [12:21:32] But I think we are not talking about
7 the court proceedings now. We are talking about the --
8 MS LYONS: [12:21:40] No, not now, but I was moving in the section. But okay,
9 we'll wait.
10 PRESIDING JUDGE SCHMITT: [12:21:44] I think that's not necessary now.
11 Because any defence with regard to the mental health status goes back to a time in the
12 past and we know this time in the past.
13 MS LYONS: [12:21:58] Right. Okay. Well, then I will -- what I will do is let
14 me -- let me -- when I finish this section, there are, there are some instances for the
15 current that go back and I want to know if they go back and if they are indicative.
16 PRESIDING JUDGE SCHMITT: [12:22:12] You can assume that Professor Ovuga
17 knows these incidents and you can ask him if they reflect something that might have
18 already been present in the past.
19 MS LYONS: [12:22:24] Sure. Okay.
20 PRESIDING JUDGE SCHMITT: [12:22:25] Something like that. I think you can
21 simply answer if you have understood our encounter.
22 MS LYONS: [12:22:32] All right.
23 Q. [12:22:38] Then let me ask this: You can -- in your report you talk about
24 interferences with court proceedings. One we discussed yesterday. And I wanted
25 to know, are you familiar with the example with Prosecution Witness 3, P-3?

1 A. [12:22:57] Yes.

2 Q. [12:22:58] Okay.

3 MS LYONS: Now I would ask you if, if you want the question in public or private.

4 I want your guidance, your Honour. I mean, the question is what he makes of this,

5 his interpretation. I don't know the answer.

6 PRESIDING JUDGE SCHMITT: [12:23:16] Didn't I say that we want to talk about the

7 mental state of the accused way back in 2002 until 2005? Didn't I just say that?

8 MS LYONS: [12:23:26] Yes, but I thought if there was a link backwards. All right.

9 I'll --

10 PRESIDING JUDGE SCHMITT: [12:23:29] That is the question then, then simply

11 that -- it's much more easy.

12 Mr Ovuga, you are familiar of this incident. Does this, for you, enable you in any

13 way to draw conclusions back to the past? You see what I mean? Is there

14 a connection in your, in your expertise, in your opinion as an expert?

15 THE WITNESS: [12:23:56] My opinion is that, yes, that incident is linked to his

16 experiences of dissociation during 2002 to 2005. You see, the remarks of that witness

17 informed him or seemed to have informed Dominic that here is somebody who does

18 not understand the experiences I went through from when I was a child to now.

19 He described seeing the appearance of Mr Kony approach this witness, the witness

20 grew smaller and smaller in size and was replaced by Mr Kony in this chair, I

21 suppose.

22 PRESIDING JUDGE SCHMITT: [12:25:23] This is your interpretation.

23 THE WITNESS: [12:25:24] Yes, that --

24 PRESIDING JUDGE SCHMITT: [12:25:25] That is what -- okay, I understand. I

25 think we proceed from there. I think that's enough on that.

1 Please proceed.
2 MS LYONS: [12:25:33]
3 Q. [12:25:33] Now, in the conclusions on page 28 of your report, you, you conclude
4 that Mr Ongwen's development of moral values was disrupted by the LRA, also, his
5 ability to make moral choices and appreciate the significance of moral values or
6 judgment. Could you explain this a little bit more what you meant?
7 A. [12:26:09] Dominic A was fathered by a catechist who was also a volunteer
8 village health care provider. He was close to his father and he was close also to his
9 grandfather, paternal grandfather. These two men taught him the Acholi versions of
10 what is normal -- sorry, right, morally right, what is not morally right to do.
11 Particularly, the grandfather saw an individual, an adult individual coming out of
12 this young boy, he had high hopes, and so he took all the pains to teach his grandson
13 the moral values of the Acholi people.
14 Then, just like that, he was abducted. And the first experience was his cousin's sister,
15 who was younger than him and who could not keep pace, was brutally killed as he
16 watched helplessly. Then came the four boys and then himself being ordered to kill
17 his victim using a very inhumane, very cruel, brutal way he didn't like. With tears in
18 his eyes he asked for a better way. He was ordered either do it or. The "or" of
19 course is death.
20 These horrifying experiences that young children went through left them helpless, left
21 them fearful, left them feeling numb, having no emotions for human suffering.
22 So, all the teachings that his father and his grandfather gave him were thrown out
23 there, overboard. We don't have a sea here, we are not seated on the sea, but we can
24 say the moral teachings he received were thrown out the door and he was left with
25 things that he summarised as the LRA were killers.

1 Let me qualify this. Another former victim of the LRA was a client to me at our
2 mental health unit in Gulu. He too described the killing of his brother as he watched,
3 helpless. The brother, just before he died, was told to dig a hole. Probably knew
4 what that hole was meant for. Nevertheless, he dug it. And then he was told to
5 climb in and the hole was filled up to the neck. And then they took his life. And
6 this old man watched. And he said after that, nothing else mattered, nothing else
7 mattered to him.
8 Dominic A or Dominic B didn't tell us whether things mattered to him after the killing
9 of his sister, or after he was forced to kill his friend. He didn't tell us. But if we can
10 extrapolate, that is also what Dominic A felt like or Dominic B felt like.
11 So you are here, again a challenge to their Honours, the challenge is you are trying
12 somebody who is or who was forced to be emotionally dead. A person who is
13 emotionally dead cannot tell right from wrong. Nothing else matters after the
14 experience.
15 PRESIDING JUDGE SCHMITT: [12:32:44] Ms Lyons.
16 MS LYONS: [12:32:45]
17 Q. [12:32:46] Can somebody who is emotionally dead control his or her conduct?
18 MR GUMPERT: [12:32:55] Your Honours.
19 PRESIDING JUDGE SCHMITT: [12:32:56] Mr Gumpert.
20 THE WITNESS: [12:32:57] That is asking the same question differently.
21 MR GUMPERT: [12:32:59] Your Honours, it may be that all of us would have a view
22 on that, but I would seek to point out that this witness is here as a psychiatric expert.
23 I don't find emotional death in DSM-5 and indeed I don't believe it has anything to do
24 with psychiatry. These are not appropriate questions.
25 PRESIDING JUDGE SCHMITT: [12:33:28] No, it was simply -- yes, of course I

1 would not reproach Ms Lyons because she simply drew these words out of what
2 the witness has answered.
3 But he has already said this is simply asking in a different manner. So you can
4 proceed. The witness himself assumes that he has answered sufficiently already.
5 So you can proceed to the next witness.
6 MS LYONS: [12:33:46]
7 Q. [12:33:46] Now -- one moment.
8 Before we move into more on the moral values and development of moral values, I
9 have more questions there. I want to ask the witness: Is there anything else you
10 want to add, add on the issue is there a link between any of your other
11 diagnoses - there was major depressive disorder, other forms of dissociative disorders,
12 PTSD - is there anything you want to add that would explain -- or, is there anything
13 you want to add as to whether any of these conclusions that these diagnoses had an
14 effect on whether Mr Ongwen could control his conduct or not, or whether he could
15 tell right from wrong.
16 PRESIDING JUDGE SCHMITT: [12:34:57] A very long question, Ms Lyons.
17 Complex and long.
18 MS LYONS: [12:35:01] All right, let's try again.
19 PRESIDING JUDGE SCHMITT: [12:35:02] No, no, but -- no, no. We have an expert
20 here who grasps it, but --
21 MS LYONS: [12:35:06] You are right (Overlapping speakers).
22 PRESIDING JUDGE SCHMITT: [12:35:08] You know, sometimes I tend to make
23 remarks.
24 THE WITNESS: [12:35:14] Let me try, your Honour.
25 A feature of depression is a feeling of hopelessness, helplessness followed by suicidal

1 feelings. A depressed individual sees no hope in the future. They are pessimistic.
2 They have lost everything. They feel guilty for the sufferings of the world. And
3 Dominic A himself says what the LRA did has caused a lot of disruption in northern
4 Uganda. And for all this he blamed or he continues to blame himself and he says
5 there is no better reward for him than being killed.
6 In fact, he dramatically said, "Sometimes I go to battle hoping that I will not come
7 back alive."
8 So some of his examples of participation in the field were suicidal in nature. He told
9 us -- and here, your Honour, I request that critics should accept our explanations of
10 relying on what the clients tell us. So, he said sometimes or quite often when he
11 goes knowing he will not come back, he runs towards the enemy fully exposed. And
12 he could not understand -- in his words, he could not understand why his enemies
13 didn't shoot to kill him. So his participation in battle sometimes were suicidal in
14 nature.
15 Now my request about our claims that we should respect what the client says is that,
16 if a client comes to a doctor, the client knows why he or she has come to see this
17 particular doctor and the doctor must take his story, in a roundabout way conduct
18 examination and so on, using the information given by the client. The client knows
19 best what they are going through.
20 So I don't accept the criticism that I rely on X, on Y or on A for information. That
21 person knows best what they are going through, provided of course I take precaution
22 to exclude faking, feigning, or I exclude the possibility that this individual has caused
23 the illness in themselves.
24 There is another psychiatric disorder in the DSM system, or ICD system which talks
25 about some individuals causing illnesses in themselves to attract medical attention, to

1 attract the attention of caretakers. I have personally attended to at least three in my
2 experience.
3 So, yes, depression was a suicidal -- with a suicidal element was the one which drove
4 him to go to battle.
5 PTSD often is co-morbid with depression. But PTSD in itself also leads to suicidal
6 feelings, guilty feelings for surviving while comrades have gone. Why did I survive?
7 So-and-so went, how come I survived? I better follow that person.
8 So, again, the PTSD would be a factor prompting him to have participated in field
9 activities.
10 OCD, as I said, we didn't have sufficient number of symptoms. Dissociation, it was
11 common experience for him. So it was linked to his participation in the, in the field.
12 He dissociated because he didn't morally want to participate in atrocious activities
13 against the communities in northern region.
14 He told us in a very stern voice one time, and this will be the last one to that question.
15 He told us in a stern voice, when he started openly questioning his boss, he said one
16 time he told him off: "You have been telling us, oh, oh, oh, this would happen.
17 Now where has this oh, oh, oh of yours, where has it taken us?" And the boss
18 laughed it off. He says, "You're a young man, you don't know what you are talking
19 about. You know the consequences of this kind of talk?" And he told his people,
20 "This young man is mad, take him away. Not to kill, but take him away." Take him
21 away, possibly to be punished. He didn't conclude that one at that point.
22 Q. [12:43:37] From the purposes of the information you have and looking back in
23 your diagnoses, is this example that you just recounted of the boss, Joseph Kony
24 saying he's mad, Joseph Kony's assessment, how does this factor in to, to your -- does
25 it factor in to your assessment of how what you see in 2016 and 2018 goes back to the

1 charged period?

2 PRESIDING JUDGE SCHMITT: [12:44:12] Mr Gumpert.

3 MR GUMPERT: [12:44:13] I'm sorry, I have to object.

4 MS LYONS: [12:44:16] Well --

5 MR GUMPERT: [12:44:17] The diagnosis of mental illness by Mr Kony can't

6 seriously be a matter for consideration or comment by this witness.

7 PRESIDING JUDGE SCHMITT: [12:44:26] I think it was not meant like that.

8 MS LYONS: [12:44:28] No.

9 PRESIDING JUDGE SCHMITT: [12:44:29] And also of course it might not have been

10 at the time - I'm speculating here, I am not saying yes or no - that Mr Kony did not

11 attempt to make a psychiatric diagnosis at the time.

12 MS LYONS: [12:44:43] No, no, this is not about Mr Kony and his ability or not

13 (Overlapping speakers).

14 PRESIDING JUDGE SCHMITT: [12:44:46] No, the question was also a little bit

15 (Overlapping speakers)

16 MS LYONS: [12:44:47] Is mad. I heard the word "mad".

17 PRESIDING JUDGE SCHMITT: [12:44:50] (Overlapping speakers) a little bit unclear.

18 MS LYONS: [12:44:52] Okay.

19 PRESIDING JUDGE SCHMITT: [12:44:53] A little bit unclear. I would ask you to

20 reword it so that (Overlapping speakers).

21 MS LYONS: [12:44:54] Yes, let me try to reword it. Okay.

22 Q. [12:45:00] Did the recounting by Mr Ongwen to you of this incident where Kony

23 is described as saying "He is mad, take him away", did the use of the word "mad"

24 trigger anything in your psychiatric --

25 A. [12:45:24] No. No.

1 PRESIDING JUDGE SCHMITT: [12:45:26] No is enough, Mr --
2 MS LYONS: [12:45:28] Okay. Okay, that's all I want to know.
3 PRESIDING JUDGE SCHMITT: [12:45:33] Mr Ovuga. I would -- again, Mr Ovuga,
4 I would have been surprised if you had answered differently.
5 Please, Ms Lyons.
6 MS LYONS: [12:45:40] Your Honours, with permission, I would like to ask
7 Mr Ovuga the question of whether the concept, although I was criticised for how I
8 used it in an ill-worded question, whether the concept of emotional -- being
9 emotionally dead, emotionally unable to feel, is that a, is that a construct in
10 psychiatric terms, and if so, does it apply, yes or no?
11 PRESIDING JUDGE SCHMITT: [12:46:09] I think if we label it this way that we say
12 this emotional deadness, is this, would this be part of -- for example, if we look at
13 these multi-axial diagnoses, these five sections, would it be -- would it fit under one of
14 them?
15 THE WITNESS: [12:46:26] It would be a symptom.
16 PRESIDING JUDGE SCHMITT: [12:46:28] Okay, good.
17 Next question.
18 MS LYONS: [12:46:34] Now -- one moment.
19 (Counsel confer)
20 PRESIDING JUDGE SCHMITT: [12:47:19] Ms Lyons, perhaps I can, in the meantime
21 I can ask you, for the planning purposes, if you have already an idea how long your
22 examination is going to last. I speak of an idea. I wouldn't --
23 MS LYONS: [12:47:33] Okay. Definitely today and maybe a little bit more, as we
24 did, tomorrow. I don't know.
25 PRESIDING JUDGE SCHMITT: [12:47:37] I think we should strive to finish today.

1 MS LYONS: [12:47:39] I will make best efforts. I --
2 PRESIDING JUDGE SCHMITT: [12:47:41] Because I have the impression that
3 you are making progress with the expert, also in light of the fact that Mr Ovuga
4 sometimes reads your mind and answers questions that you have not asked already.
5 MS LYONS: [12:47:53] Yes. Yes, and I appreciate it. And I'm saying, but I said
6 today, but I would also ask if we could have an abbreviated lunch just to give a little
7 cushion --
8 PRESIDING JUDGE SCHMITT: [12:48:03] Fine. I think nobody would complain
9 so --
10 MS LYONS: [12:48:04] For my psychological well-being.
11 PRESIDING JUDGE SCHMITT: [12:48:06] Do we want to have it now then until
12 2 o'clock or do you want to finish with something before the break?
13 MS LYONS: [12:48:13] It's -- really, it doesn't matter. I'm happy to continue after
14 and move to --
15 PRESIDING JUDGE SCHMITT: [12:48:19] Then we make a slightly abbreviated
16 break until 2 o'clock and then we expect, let me word it, we expect that you can finish
17 until 4 o'clock.
18 MS LYONS: [12:48:32] I will make best efforts.
19 PRESIDING JUDGE SCHMITT: [12:48:35] Please do your best.
20 A break until 2 o'clock.
21 THE COURT USHER: [12:48:39] All rise.
22 (Recess taken at 12.48 p.m.)
23 (Upon resuming in open session at 2.00 p.m.)
24 THE COURT USHER: [14:00:52] All rise.
25 Please be seated.

1 PRESIDING JUDGE SCHMITT: [14:01:01] Good afternoon.
2 Ms Lyons, you have still the floor.
3 MS LYONS: [14:01:13] Okay.
4 Q. [14:01:27] Good afternoon, Professor Ovuga.
5 When we were finishing up before lunch you mentioned that duress was one of the
6 factors which led to the first dissociative episode that Mr Ongwen had, and that was
7 at the real-time transcript page 49, lines 22 and 23. And I just have two short
8 questions about that, I'll raise them one at a time.
9 First, is a person suffering from a mental disease or defect, for example, such as
10 Mr Ongwen during the charged period, more vulnerable to duress or to the control of
11 somebody else, to the threats from somebody else which come with duress?
12 A. [14:02:30] I would put the answer in the reverse. Duress would occur
13 independently of any mental disorder or defect. Mental disorder or defect in itself, in
14 my opinion, does not make an individual vulnerable to duress, but let me qualify the
15 answer this way: Individuals, particularly those with mental retardation or learning
16 disability, are more likely to be influenced to commit crime. But that is not to say
17 their mental status makes them vulnerable, there is a difference.
18 Q. [14:03:55] Thank you for your clarification of that.
19 Now, in your report, I think it was the first report at pages 9 and 10, you talk about
20 abducted child soldiers, including Mr Ongwen, as being held in captivity in the LRA.
21 Now, could you explain what you mean by captivity?
22 A. [14:04:36] What I mean or what we meant was that the children and adults
23 alongside with them were removed from their natural habitat and taken and kept in
24 incommunicado in the bush against their will. So they were kind of like hostages
25 being kept in an environment that was not natural to them, in an environment where

1 they felt helpless and they lived in constant fear of death or dying from other causes.
2 Q. [14:05:53] Now -- hold on one second.
3 Now, can you tell me, does this concept of captivity, does it have any relationship to
4 what is known as Stockholm syndrome, which I would also like you to explain?
5 MR GUMPERT: [14:06:17] I'm afraid --
6 PRESIDING JUDGE SCHMITT: [14:06:19] Mr Gumpert, what --
7 MR GUMPERT: [14:06:20] Well, a massive piece of leading. And I'm not quite
8 aware where in the reports. Perhaps it would be helpful if there is a reference to
9 Stockholm syndrome in the reports.
10 PRESIDING JUDGE SCHMITT: [14:06:33] No, there is none. But, you know, when
11 we have an expert here, we don't have to be too severe with so-called leading
12 questions. He is a neutral expert and he may tell us if it has anything to do with it.
13 Yet, I have to admit, that indeed this -- that does not appear in the report, but it might
14 well be that Mr Ovuga simply says no, it ...
15 MR GUMPERT: [14:06:59] And if he does I shall sit down and at least silently
16 apologise for interrupting. But, with respect, there's another aspect. I quite
17 understand as a neutral expert who can perhaps help the Court with matters which
18 may eventually have some affect upon the Court's determination, then it is harsh
19 perhaps to ask that a witness does not speak about a matter.
20 But where a matter is never referred to in the material which the other parties have as
21 the necessary advance notice of what is to be said, so that they can ask their experts
22 what do you think about Stockholm syndrome, then it leads to unfairness in the
23 proceedings.
24 PRESIDING JUDGE SCHMITT: [14:07:45] Yes, but there is, though, if I recall it
25 correctly - of course, you allow me not to have the exact reference - this was, at least

1 in questioning the Prosecution witnesses, it was put to the Prosecution witnesses as
2 a question. Because of that, I did not intervene here now, and I think we let it pass
3 and wait on the answer. And if the answer is in a certain way, you might have your
4 expert also and you can ask him then. See what I mean? If the situation were that
5 we would not have on hold, for example, Professor Weierstall, I would agree with
6 you. But in that instance, and since it has been brought up with the Prosecution
7 witnesses, I think it's fine to let it go. Yes.
8 Mr Ovuga, a long discussion, but you have heard it. I think you can answer.
9 THE WITNESS: [14:08:44] Yes, I do agree, your Honour, with the Prosecution
10 lawyer. But as you said, it is my understanding that the same subject matter was
11 discussed by one of their experts. The Stockholm syndrome refers to the taking
12 hostage initially -- or taking hostage workers in a bank in Stockholm. I think it was,
13 if I remember, in the seventies.
14 PRESIDING JUDGE SCHMITT: [14:09:41] Indeed, so there are some in the room
15 who are old enough to --
16 THE WITNESS: [14:09:47] To remember.
17 PRESIDING JUDGE SCHMITT: [14:09:48] -- have a concrete recollection of the
18 event.
19 THE WITNESS: Yes.
20 PRESIDING JUDGE SCHMITT: [14:09:52] I belong to them. It was in the 1970s,
21 indeed.
22 THE WITNESS: Yeah, so the poor bank workers were held hostage by two
23 would-be bank robbers, but their attempt to get away with the money was foiled and
24 they, instead of surrendering to the police which surrounded the bank, they then
25 turned their weapons on to the hostages, ordered them to either lie down or sit -- or,

1 in other words, do nothing in the form of escape. And the negotiations were tough
2 and protracted and eventually also involved some of the hostages in the negotiating
3 process. And they were released only when the police agreed that the hostages
4 could come out together with the would-be robbers, and then the robbers took their
5 hostages to some location where they felt safe and then released the hostages and
6 they went their way.
7 Now, the features of the Stockholm syndrome are someone having been taken captive
8 or hostage, someone cooperating with their captors in doing what the captors want
9 them to do, and then being unwilling to cooperate with anybody else who was seen to
10 be anti-hostage takers.
11 It was reported extensively I think in the -- on the Web, and also it became a training
12 topic for the police, especially in the US. I am not sure if it is how to handle
13 situations like that is also being -- is also being taught here in Europe, but what I
14 know is it is a training topic in the US for the police.
15 PRESIDING JUDGE SCHMITT: [14:12:54] May I shortly. And my understanding
16 was and still is that this so-called Stockholm syndrome is about that the captor and
17 those in captivity form a certain psychological bond.
18 THE WITNESS: [14:13:13] Yes. They form an alliance, yes --
19 PRESIDING JUDGE SCHMITT: [14:13:15] Yes, that ties, that ties them together.
20 THE WITNESS: [14:13:17] Yes.
21 PRESIDING JUDGE SCHMITT: [14:13:18] The question would be then if you see
22 any similarities with the situation here. That that would be -- we could talk about
23 the Stockholm syndrome in abstract of course, but the question would be if you see
24 here anything that you can draw from these discussions.
25 And I also understand that it's not a defined psychiatric diagnosis, I think.

1 (Overlapping speakers)
2 THE WITNESS: [14:13:46] Your Honour, you are right, it is not a definitive
3 diagnosis in the practice of psychiatry. At least it has not entered the diagnostic
4 systems, that is, the DSM and ICD systems. But nevertheless, it has received
5 considerable attention.
6 Now, to answer your question directly, one could say yes, there is a similarity
7 between the Stockholm syndrome and in the case of Prosecutor versus
8 Dominic Ongwen. The only difference of course is that Dominic Ongwen was not an
9 ally of the, of the boss, that is Joseph Kony. He has never -- at least from what he
10 says, he has never been an ally. He worked for the boss as a tactical strategy to
11 survive, but there was no alliance as defined in the Stockholm syndrome, because if
12 there was an alliance, he would not have started to question the wisdom and
13 authority of Joseph Kony when he attained a senior rank in the system. So the
14 answer would be yes and no.
15 PRESIDING JUDGE SCHMITT: [14:15:38] Okay.
16 Ms Lyons, please continue.
17 MS LYONS: [14:15:40] Thank you. And for the record, one of my colleagues found
18 the reference, T-177. It was actually during the questioning of Professor Musisi,
19 apologies, it wasn't the Prosecution. It was one of the Victims parties' witnesses,
20 page 83, line 11.
21 PRESIDING JUDGE SCHMITT: [14:15:59] I have -- okay, I would not want to insist,
22 but I think it has popped up also time.
23 MS LYONS: (Overlapping speakers)
24 PRESIDING JUDGE SCHMITT: But it's not, it's not important now. Please
25 continue.

1 MS LYONS: Okay. So we have it. Okay.
2 Q. [14:16:21] Now I want to ask is a question about people in captivity. I'm now
3 going to read something from an article that's in the binder, it is "Complex PTSD:
4 A Syndrome in Survivors of Prolonged and Repeated Trauma" by Dr Herman, who
5 you have mentioned.
6 PRESIDING JUDGE SCHMITT: [14:16:40] Which tab?
7 MS LYONS: [14:16:42] It is at tab 27 in binder 2. It's just one sentence, I'll read it
8 out. And the UGA number is UGA-D26-0019-1395 and it's at page 1401.
9 I'm sorry, I have been corrected, I misspoke. Our case is D-26-0015 not 0019. Okay.
10 Q. [14:17:24] At page 381 of that, which is at 1399, there's a section labelled
11 "Disassociation". And what Dr Herman says is, quote: "People in captivity become
12 adept practitioners of the arts of altered consciousness."
13 Does this conclusion apply to Mr Ongwen or does it not?
14 A. [14:17:58] Can you read it again, your Honour?
15 Q. [14:18:01] Sure. Okay, sure.
16 "People in captivity become adept practitioners of the arts of altered consciousness."
17 And I'm not actually sure what altered consciousness means.
18 PRESIDING JUDGE SCHMITT: [14:18:19] Would exactly have been the first what I
19 would have want -- how Mr Ovuga understands altered consciousness.
20 MS LYONS: Right. That's right.
21 PRESIDING JUDGE SCHMITT: [14:18:24] But let him --
22 MS LYONS: He'll explain it.
23 PRESIDING JUDGE SCHMITT: Let the expert answer and --
24 MS LYONS: [14:18:27] Thank you.
25 PRESIDING JUDGE SCHMITT: [14:18:28] -- he will cope with the situation.

1 THE WITNESS: [14:18:32] What we mean by altered consciousness in psychiatry is
2 an individual experiencing their level of wakefulness to the environment and the
3 events in the environment being lowered to a subthreshold level so that we would not
4 typically talk of them being conscious but we would not also typically say they are
5 unconscious.
6 I am not sure what Herman means by "adept practitioners of altered consciousness".
7 Maybe what she meant in that sentence was to say, but failing short of saying it, that
8 people held in captivity tend to dissociate so that they can cope with their situation
9 and experiences from second to second in order to survive.
10 PRESIDING JUDGE SCHMITT: [14:20:07] I think you can move on.
11 MS LYONS: [14:20:09] Yes. Let me move on to one more point in this article.
12 Q. [14:20:16] She identifies three clinical observations on page 379 that transcend
13 simple PTSD. She says that the symptoms are prolonged trauma are more complex,
14 diffuse and tenacious than in simple PTSD. She also says that survivors of
15 prolonged abuse develop personality changes. And lastly, survivor's vulnerability
16 to repeated harm, both self-inflicted and at the hands of others, is the third
17 characteristics of this PTSD, the repeated exposure to trauma. Do you have any
18 thoughts on this?
19 PRESIDING JUDGE SCHMITT: [14:21:18] Mr Gumpert is rising again.
20 MR GUMPERT: [14:21:18] Very briefly. Essentially I make the same objection. It
21 appears that the Doctor is being asked for the first time in the witness box to make
22 a diagnosis of complex PTSD. That has never appeared before in any of the expert
23 reports from the Defence and I object.
24 PRESIDING JUDGE SCHMITT: [14:21:40] But about PTSD we have talked
25 extensively.

1 MR GUMPERT: [14:21:43] But this is a separate condition.
2 PRESIDING JUDGE SCHMITT: [14:21:46] Then let me rephrase, if you allow me, Ms
3 Lyons, yeah?
4 MS LYONS: [14:21:51] May I say one thing in response?
5 PRESIDING JUDGE SCHMITT: Of course.
6 MS LYONS: Let me point out that there is a report in evidence, which is
7 Professor De Jong's report. It's -- now, it's the first, tab 1, it the first box on our
8 extracts where he talks about complex -- severe PTSD complex trauma and then
9 complex PTSD he goes on to define, so it's not a new concept within the reports of an
10 expert in this case is all I'm saying.
11 PRESIDING JUDGE SCHMITT: [14:22:35] So if I have understood the quotations
12 correctly, then it's about -- then we could word it, perhaps, the question as follows:
13 Does the possibility, the fact that a trauma is prolonged over a certain period, over
14 a long period, if you will, does -- and, if any, what effect has it on the diagnosis of
15 PTSD? I'm not saying complex now to avoid this, yes? We word it this way and
16 you may answer.
17 THE WITNESS: [14:23:13] With the permission of Mr Gumpert, can I have that read
18 again?
19 MS LYONS: [14:23:20] Yes.
20 PRESIDING JUDGE SCHMITT: [14:23:22] And, frankly speaking, she writes a little
21 bit complicated, but -- I understand that that we want to hear it a second time.
22 Please do.
23 MS LYONS: Sure. And I'll indicate the page so you can look for yourself. But let
24 me say also that there was a (Overlapping speakers)
25 PRESIDING JUDGE SCHMITT: [14:23:39] Simply, simply read. Simply read it out.

1 MS LYONS: [14:23:40] (Overlapping speakers) we found a reference, a question by
2 Mr Black to Dr Mezey in T-162 where the response is, on page 27, lines 8 to 9, includes
3 the words complex PTSD. So I'm not -- let's -- I'm not clear what's happening.
4 PRESIDING JUDGE SCHMITT: [14:23:56] No, I would be, I would be glad if you
5 simply would read it out again for the --
6 MS LYONS: [14:24:00] Absolutely.
7 PRESIDING JUDGE SCHMITT: -- for the service of everyone here in the courtroom,
8 especially for the expert and then (Overlapping speakers)
9 MS LYONS: [14:24:06] Actually, may I ask --
10 PRESIDING JUDGE SCHMITT: [14:24:08] He answers my question then.
11 MS LYONS: [14:24:12] All right.
12 Q. [14:24:15] Actually maybe let me just -- I will read it out. It's on page 379, for
13 others, tab 27, binder 2, the complex PTSD. And let me read it out for you and for
14 others.
15 "Clinical observations identify three broad areas of disturbance which transcend
16 simple PTSD. The first is symptomatic: the symptom picture in survivors of
17 prolonged trauma often appears to be more complex, diffuse, and tenacious than in
18 simple PTSD. The second is characterological: survivors of prolonged abuse
19 develop characteristic personality changes, including deformations of relatedness and
20 identity. [And] the third ... involves the survivor's vulnerability to repeated harm,
21 both self-inflicted and at the hands of others."
22 PRESIDING JUDGE SCHMITT: [14:25:22] So I think it was not so wrong when I said
23 that it's about, if it makes any difference, how long the trauma lasted and how intense
24 it perhaps was. Perhaps you may answer to that.
25 MS LYONS: [14:25:36] Okay.

1 THE WITNESS: [14:25:38] Let me give the answer in a winding way. This morning,
2 I talked about simple PTSD and then complex. And linking what I said in the
3 morning to that makes it easier I think for the room to appreciate that prolonged
4 exposure to traumatic events on repeated occasions can lead to severe manifestations
5 of malfunction as well as mental health in general.
6 She talks about also domestic violence, if I heard it right, particularly domestic
7 violence meted out on the sexuality of young children, particularly the girl child.
8 The character changes that she talks about are real, and I agree with her. And the
9 character changes may lead to the development of identity disorder or episodes of
10 other forms of dissociation, including dissociative amnesia. So I fully agree with her,
11 and if the, if the clarification is not clear, kindly ask that particular aspect which is not
12 clear. But I, I agree with her.
13 PRESIDING JUDGE SCHMITT: [14:28:01] I think you have answered the question.
14 And to Mr Gumpert, of course, like in the other instance, you have the possibility to
15 question the rebuttal expert, if need be.
16 Ms Lyons, please continue.
17 MS LYONS: [14:28:16] Yes.
18 Q. [14:28:17] When we were -- also before lunch we began to talk -- you began to
19 talk a little bit about moral development of Mr Ongwen, based on your report and
20 other -- based on your report.
21 Now the question is, can you describe to us what were the effects of being abducted at
22 8 or 9 on moral development or other types of development, mental development,
23 cognitive development, how did this affect a person --
24 PRESIDING JUDGE SCHMITT: [14:29:01] But part of it, I think, Mr Ovuga has
25 already answered before the break, if I recall it correctly. Because he described the

1 moral values that Mr Ongwen established before and what it meant.
2 MS LYONS: Correct.
3 PRESIDING JUDGE SCHMITT: [14:29:17] Please correct me, Mr Ovuga, if I'm
4 wrong, but you then elaborated on the question what happened after the abduction.
5 I think this was already done. So it's a little bit repetitive, I would say.
6 MS LYONS: [14:29:30] Yes, I -- okay, I'm sorry. My apologies to the witness and to
7 your Honour on this. All right.
8 Q. [14:29:36] Now, can you -- there's been some -- there were a couple of questions
9 in this court, discussion about the concept of blank slate or *tabula rasa*. They were
10 raised in a slightly different -- in a different context, but can you tell us, is it -- what is
11 your view, when Mr Ongwen was abducted, was he a blank slate or not?
12 A. [14:30:14] When I read -- what is it -- the transcript, that was not the, the
13 understanding I had. What I understood the Prosecution expert saying was that, as
14 Mr President put it, after abduction, whatever had been written on his mind, which
15 we can refer to as a "slate", was wiped out by the series of experiences that he went
16 through within the first week or two. And then, new learning material was forcibly
17 and like a stone ingrained onto this new slate which was created by the older one
18 having been wiped out by the experience of abduction and traumatic events that he
19 went through.
20 So if I understood the transcript that way, then we are seeing in, in Mr Ongwen
21 a textbook of human functioning adapted to situations in the bush which did not
22 correspond or align well with the textbook which was created and written before his
23 abduction, if I can put it that way.
24 Q. [14:32:51] Thank you, that answers the question.
25 Now let me ask you, related to that, what effect, if you can assess it, what effect, if any,

1 did the forcible abduction on Mr Ongwen at 8 or 9 have on his development as an
2 Acholi member of -- as an Acholi young man, child and then young man?
3 A. [14:33:21] In his --
4 PRESIDING JUDGE SCHMITT: [14:33:22] Isn't this nearly the same again? It's
5 okay, but --
6 MS LYONS: [14:33:27] There's a culture --
7 PRESIDING JUDGE SCHMITT: [14:33:28] Okay, the cultural aspect.
8 MS LYONS: [14:33:30] The cultural aspect is what I want to get at. I don't want to
9 say more about that, but that's --
10 PRESIDING JUDGE SCHMITT: [14:33:36] Yes, you're right, you're right.
11 Mr Ovuga.
12 THE WITNESS: [14:33:42] So the question is what effect did the forcible abduction
13 have on his moral development, is that what the question is?
14 MS LYONS: [14:33:55]
15 Q. [14:33:55] His development as an Acholi. Not -- okay --
16 PRESIDING JUDGE SCHMITT: [14:33:59] But it might be difficult to distinguish this
17 from moral --
18 MS LYONS: Okay, I see --
19 PRESIDING JUDGE SCHMITT: But if Mr Ovuga is able to distinguish something --
20 MS LYONS: [14:34:06] If he can't, we'll move on.
21 PRESIDING JUDGE SCHMITT: -- then he may, please.
22 THE WITNESS: [14:34:12] His abduction, as I said, destroyed the initial
23 development -- developmental textbook which was written on his brain, memory and
24 intellect and emotions, and it was replaced by a textbook, the contents of which were
25 not those of an Acholi.

1 To put it differently, and using his, his narrative, Mr Ongwen said that his
2 development in life was cut short by his abduction. His education was cut short.
3 He was, I think, in primary 3 or 4 at that time, doing very well, but that was destroyed.
4 And his life, his transition from -- in his life, his transition from being a child to an
5 adult was also severely curtailed. And in fact, he went on to say that as far as he was
6 concerned, he was a child and he looked forward to the time and the day when he
7 would go and start life afresh.
8 My colleague Dr Akena also referred to the incident that occurred on our first visit
9 whereby he reacted by declining to see us. And throughout that period of one week,
10 we never got to see him and we had to travel back empty-handed, only to be called
11 back one month later.
12 So in a -- in my mentorship relationship with Dr Akena I jokingly said, you see, the
13 client is an adult, but he's also a child of 10 years because that is how a child of 10
14 years or 8 years, whose gratification needs have been frustrated, that is how that child
15 would also react under normal circumstances.
16 So his response to the events of that morning seemed normal to him, but to us, as
17 professionals in mental health, it showed that his development was arrested at the
18 age of 8 or 9 or 10.
19 PRESIDING JUDGE SCHMITT: [14:38:21] Okay, yes. Thank you.
20 Ms Lyons, please.
21 MS LYONS: [14:38:23] Thank you. Yes.
22 Q. [14:38:25] Now let me ask you, there has been testimony in this court from
23 experts and also in one of the reports at least that compare the socialisation of
24 Mr Ongwen in the LRA to the socialisation of a gang member. I believe that
25 Dr Abbo in her report, which for those who want to find it, tab 11, binder 1,

1 UGA-OTP-028 -- -0280-0732 at 0744, page 13. Her report states that, just like gang
2 socialisation, there was bush socialisation that could have helped him, Mr Ongwen to
3 cope. So there's -- there's a comparison being made.
4 And, as well, there's a conclusion which Professor Weierstall raised in the transcript
5 T-169, pages 12 to 15, and I will quote the conclusion. After he had some discussion
6 about this issue, the conclusion says: But in the end we assess the PTSD symptoms,
7 and when we focus on mental health issues and how the development of PTSD
8 happened over the year, we don't see much difference
9 And the difference he is talking about is between LRA and township gang. Really
10 what I want to ask you is: is there a difference between the LRA and township gang,
11 particularly in terms of this issue of socialisation which has been identified by two of
12 the experts who have given evidence here?
13 A. [14:40:28] I don't know much about the psychology of gangs, because we do not
14 see them that often in Uganda, but one can conceptualise the psychology and
15 behaviour of gang groups in similar terms, only that gangs have their primary
16 objective of fighting against one another so that one group becomes supreme over the
17 others and they control territory within the city or urban areas. Other than that, I
18 don't see the similarity between the gang with its objectives to those of the LRA.
19 The LRA was established for the sole purpose - and you might say that is where the
20 similarity is - for the sole purpose of replacing a government, a sitting government,
21 and only that they were disorganised and they didn't have the ability to organise
22 themselves tactfully in order to achieve what they wanted to achieve. Their goal was
23 national, but the goal of a gang is local. And as I said, I don't know their psychology
24 and dynamics, but I would seem to assume that gang membership is not recruited the
25 way the LRA membership was done. And I may be wrong, as I said.

1 PRESIDING JUDGE SCHMITT: [14:43:27] No, no, but it's fine. I think we can, we
2 can move on here. I think that that's okay.
3 MS LYONS: [14:43:35]
4 Q. [14:43:35] Now I would like to move on to an area that deals with PTSD and *cen*.
5 And you authored with Professor Abbo an article which is tab 26, binder 2, it's called
6 "'*Orongo*' and '*Cen*' Spirit Possessions: Post-Traumatic Stress Disorder in a Cultural
7 Context: Local Problem, Universal Disorder with Local Solutions in Northern
8 Ugandan".
9 And for the record, it starts at UGA-D26-0015-0197 and ends at 0 -- oops, one second,
10 I will tell you.
11 PRESIDING JUDGE SCHMITT: [14:44:27] 205.
12 MS LYONS: [14:44:28] 205. Thank you. Thank you, your Honour. At 205.
13 All right.
14 PRESIDING JUDGE SCHMITT: [14:44:35] And perhaps ask a specific question with
15 regard --
16 MS LYONS: [14:44:39] No, I have a (Overlapping speakers)
17 PRESIDING JUDGE SCHMITT: [14:44:40] Okay, good. Fine.
18 MS LYONS: [14:44:48]
19 Q. [14:44:49] Two specific questions:
20 First, is there any similarity or is there a difference between symptoms of *cen* and
21 PTSD, from your perspective? And feel free to, if you want to, to explain what you
22 mean by *cen*?
23 PRESIDING JUDGE SCHMITT: [14:45:10] I think we have heard, heard about that.
24 MS LYONS: [14:45:12] All right.
25 PRESIDING JUDGE SCHMITT: [14:45:13] But you can assume that we --

1 MS LYONS: [14:45:13] All right.
2 THE WITNESS: (Overlapping speakers) you have --
3 PRESIDING JUDGE SCHMITT: -- are familiar.
4 No, no, it's absolutely important that we get familiar with those cultural concepts.
5 MS LYONS: Absolutely.
6 PRESIDING JUDGE SCHMITT: And we have done this in the past. Insofar it is
7 necessary for your answer, of course, you may elaborate on it.
8 THE WITNESS: [14:45:32] *Cen* is an Acholi word that refers to the vengeful spirits of
9 the dead. The dead meaning individuals who were either murdered by fellow
10 human beings and then -- or -- that is murdered or killed deliberately -- or killed or
11 murdered accidentally, maybe in self-defence. And these spirits then become, as I
12 said, hostile and vengeful and they take their revenge on the living, members of the
13 living. And members of the living that get affected develop various forms of
14 psychological distress symptoms, especially anxiety states and depressive disorder.
15 Occasionally they might also present with psychotic symptoms that fall short of, say,
16 bipolar illness and/or schizophrenia and psychotic depression.
17 And then the related term is *orongo*, which is the equivalent of *cen*, which is human,
18 but it refers to the spirit of an animal that is considered dangerous to human beings in
19 the same environment. And it gets killed by a hunter or hunters and it takes its
20 revenge on the hunter particularly who, who the animal recognises as being the
21 primary killer.
22 In the case of both, the similarity between the manifestations of *cen* and *orongo* to that
23 of PTSD are fright, anxiety, flashbacks, fear of being attacked, and a lot of agitation
24 and sweating and lack of sleep and so on.
25 The individuals who are affected, as I said, may develop psychotic –

1 pseudo-psychotic symptoms or symptoms of anxiety and depression. In order to
2 treat this, the Acholi and Madi people go through a ritual of creating friendship with,
3 say, the wild animal which is dead before it is prepared for consumption.
4 In the case of human beings, the rituals might involve going through a cleansing
5 ceremony, which might include also paying damages to the home of -- sorry, the
6 people of the dead person. In the case of the LRA, what I have heard in my practice
7 is that -- and also general population, is that when they come across a decomposing
8 corpse they pluck a branch of a tree and then, with their back towards the dead body,
9 they throw this twig of a tree onto the dead body or at the dead body while saying, "I
10 am not the one who killed you," that they hope will enable the spirit of the
11 decomposing body not to follow them. So --
12 PRESIDING JUDGE SCHMITT: [14:51:00] May I perhaps ask a question, if would it
13 be -- but excuse my layman's wording, would be it be correct or incorrect to say that
14 this concept of *cen* or *orongo* is a cultural --
15 THE WITNESS: Yes.
16 PRESIDING JUDGE SCHMITT: -- Peculiarity of PTSD? Or emanation even? Or
17 is this wrong?
18 THE WITNESS: [14:51:22] From the source that, from the source that I got it from,
19 who happened to have been one of the paramount chiefs, it seems to be a reality.
20 And as this chief was narrating the concepts of *cen* and *orongo* to me and my team, I
21 suddenly remember a ceremony in which my father was -- went through. He was
22 a hunter and in one of his, in one of his traps a leopard got caught, and he brought the
23 dead leopard home. And people were gathered and he was, he was made to lie flat
24 on the ground in the compound together with the leopard, facing the leopard. And
25 then, as I said, as if to make friends with this leopard, that they are not enemies, they

1 are friends; what happened was accident.
2 So -- but otherwise, this ceremony is to prevent the terrifying experience of the hunter
3 in coming face to face with a wild animal, so that this terrifying experience does not
4 come to disturb the hunter.
5 If it is not done, as the chief explained, this individual can go on to develop frank
6 mental illness with psychotic features. And he also said, if the ceremony is not done,
7 some people can become serial killers. So it is, it is probably he didn't read about the
8 concept of appetitive aggression, but there you are a chief, a local chief, talking about
9 appetitive aggression but differently.
10 PRESIDING JUDGE SCHMITT: [14:54:14] Thank you.
11 Ms Lyons.
12 MS LYONS: [14:54:16]
13 Q. [14:54:17] One or two more questions on this and we can move into - you read
14 my mind - a few questions on appetitive aggression. We'll segue into it. Okay.
15 Now, the -- you just -- okay, let me start again. If someone were to diagnose PTSD in
16 a person of Acholi origins in northern Uganda during the war, let's say, and did not
17 take into account the concepts of *cen* that you are talking about, would this have any
18 effect on the PTSD diagnosis or the accuracy of the diagnosis, or would it mean
19 nothing at all?
20 A. [14:55:14] That is a question similar to what was asked before. I don't think
21 there will be any effect on the diagnosis.
22 Q. [14:55:23] Okay.
23 A. [14:55:24] As I said, Dr Akena and I share some of these beliefs, but we practice
24 and make diagnoses without necessarily referring to our cultural concepts and
25 constructs.

1 Q. [14:55:49] Now, if someone, for example, a child soldier has gone through all of
2 the killings that we are talking about and that we've heard evidence about here, and
3 the person has not had -- gone through a cleansing ritual, can you talk about what the
4 effects of that may be?
5 A. [14:56:19] There was one time, I think I mentioned it early this morning, about
6 a rehabilitation -- a government rehabilitation school. One morning I come to office
7 and then my junior colleague rushes into my office, that is, the office of the dean,
8 excitedly saying we had a case of mass hysteria. I said, mass hysteria, I don't think
9 that is correct. Can you go to the school and make appointment for us to assess what
10 the situation is. Because in management of hysteria, mass hysteria, that is what we
11 would normally do, go and assess the environment in which the alleged episode of
12 mass hysteria has taken place. But before I released him to go, I said that is most
13 likely to be mass psychotic reaction.
14 So we conducted the study. As I said, I had modified the Harvard Trauma
15 Questionnaire, leaving out some one or two items and rephrasing others so that the
16 children could understand us better, and my colleague administered it. And what
17 we found out was that -- what I decided to do was split the group of children that
18 were randomly selected into two groups. One group were those who came to the
19 school direct from reception centres for children. The other group came from home
20 after they had been rehabilitated and they went through their cleansing rituals at
21 home. And what we found was that their scores on the modified Harvard Trauma
22 Questionnaire were lower for the children who came from home than the children
23 who came straight from the reception centres.
24 So meaning that the rehabilitation at home, including going through ritual cleaning,
25 had more beneficial effect on the mental state of the children, although some of them

1 also took part in the mass psychotic episode, maybe that is not the right way of saying
2 it, they were affected by the mass psychotic episode.
3 This brings me to how did it develop. And it takes us back to the bush. The
4 children were used to praying in the bush, praying out loud to God for help, for
5 protection and so on. So that evening they prayed and their prayers went on for
6 much too long and then - you used the word "vulnerable" earlier - some who were
7 vulnerable to a psychotic episode developed psychotic episode.
8 So that is the long answer to the question.
9 Q. [15:01:15] Yes, thank you.
10 Now a few minutes ago you used the term, as you were recounting the story of a
11 hunter, of "appetitive aggression". Can you explain to us -- you have also used this
12 term, it's used in the first report and it's used in the second report and a number of
13 your bibliographical resource -- bibliographical references deal with appetitive
14 aggression. Can you explain to us what it -- again, what it means, appetitive
15 aggression, as a psychiatrist. How do you define it?
16 A. [15:01:56] With due respect to, to my professor friend there, as I have thought
17 a lot about appetitive aggression and in fact, I don't know if me minds, but the
18 research -- the concept and research on appetitive aggression took place when I was
19 visiting his -- his university, the University of Konstanz as a visiting professor. That
20 was when his head of department brought the concept to us and we discussed it
21 briefly. And then the professor and him took it on from there. But as I said, having
22 thought about it a lot more, I think appetitive aggression, I will define it, I think it is
23 a form of or a manifestation of obsessive-compulsive disorder.
24 In the characteristic form, he will correct me when he, he stands up to give his
25 rebuttal, but the characteristic definition would be a phenomenon in which people

1 develop unusual appetite in killing others.
2 You see, why I say it may be a form of OCD is, I have read an account, I think it is one
3 of the references there, but I have also listened to laypeople recounting their
4 experiences of soldiers to the effect that an individual who likes to kill people goes
5 through the phase of an obsession with killing, they need to kill. Why do they want
6 to kill? No reason. But they feel they want to kill. They may try their level best to
7 refrain, but the more they refrain, the more the urge to go and kill. And so there is
8 mounting anxiety that they go through.
9 And once they have done the killing, the anxiety dissipates and they become normal
10 again.
11 The literature I refer to gives accounts of former child soldiers or abducted children
12 who -- who were involved in battle and they then went back home, either on being
13 rescued or after escaping, and then they recounted their experiences of getting this
14 overwhelming desire to kill. And then usually people with whom they stay would
15 recognise that something wrong is happening in this person and they will tell the
16 person tactfully to go and rest. So they sent this individual whom they noticed is
17 behaving funny to go and take a nap, to go and rest. And indeed, they usually
18 complied. And then after waking up, they would then feel -- the urge to go and kill
19 has gone.
20 In the case of the soldiers, there was one particular example in which the narrator said
21 the soldier was his friend and on occasions the soldier would become fidgety, restless
22 and agitated. And the soldier would say, "I feel like killing. I feel like killing."
23 And this layperson, not knowing how to handle the situation, would just listen and
24 watch, and then of course the soldier would go and get his pistol or gun and then say,
25 "Come, let's go." And the soldier would of course lead the way and then the first

1 person the soldier would meet, that is the victim, the victim he would kill. And after
2 that, the urge dissipates, the persons becomes normal, says, "Let us go back." And
3 here is a killing which is senseless.
4 But in the case of hunters upon which the concept was formed, you see hunters kill
5 because they want to eat meat. Sometimes people kill because they want to defend
6 their groups. Sometimes people kill just for the sake of killing and it is repetitive.
7 Q. [15:09:25] May I ask you based on that explanation, which was complete for us,
8 what -- if you can focus in a little bit briefly on what is the application of the concept
9 to Mr Ongwen or does it not apply? Because you've discussed appetitive aggression
10 in both of your reports, it's been raised. They're not -- it's not the same. The first
11 report is -- the second report is different than the first report, a little bit. But can you
12 just -- I just want to see how you think, based on the work you've done and your
13 expertise, how it does apply or doesn't apply to Mr Ongwen's case.
14 A. [15:10:19] I don't think it applies. If you say it applies, what I would say is that
15 the concept is not that of appetitive aggression but, rather, a manifestation of a poorly
16 formed obsessive-compulsive disorder. Poorly developed, not well developed.
17 Maybe more research is needed here. Since my friend is in the room, he might want
18 to take it up.
19 PRESIDING JUDGE SCHMITT: [15:11:05] Please continue.
20 MS LYONS: [15:11:06] Okay. Fair enough, all right.
21 Q. [15:11:08] Now, one -- may I have a moment?
22 PRESIDING JUDGE SCHMITT: [15:11:11] Of course.
23 MS LYONS: [15:11:13] Seventy-five seconds. Okay. Thank you.
24 PRESIDING JUDGE SCHMITT: [15:11:14] That is more than a moment, but I would
25 not count the seconds, yes.

1 MS LYONS: [15:11:26]
2 Q. [15:11:28] Now we're getting towards the end of my topics, but let me keep
3 moving here. Let me ask you one question that is probably -- and it's not in any
4 particular order that it's been raised. Just out of curiosity, do you have any
5 information about medications that Mr Ongwen may have taken or been given - same
6 thing, sorry - been given while he was in the bush? Do you have any information
7 about that and what their effects could be if he were given medications on his mental
8 illnesses?
9 A. [15:12:12] The information he gave us was that he was given antibiotics, but
10 sometimes the antibiotics were not there. So his injuries for which the antibiotics
11 were being given were treated with steaming hot water, steaming hot water, which
12 caused very severe pain, and that also led to more episodes of dissociation.
13 We asked him specifically about taking herbs or taking cannabis, particularly when
14 going out to fight, he denied. We asked him about alcohol, he denied. And, as you
15 know, he is the son of a catechist, so he likes reading the Bible. Reading the Bible
16 and taking drugs of abuse don't go together.
17 Q. [15:13:32] Thank you.
18 When Dr Mezey testified - it is T-162, page 20, binder 1, tab 18 - she talked about
19 re-experiencing -- a person re-experiencing, re-experiencing - I'm having a hard
20 time - re-experiencing symptoms of PTSD. All right. So she talked about this, this
21 and I want -- the question to you is: What is the effect of re-experiencing symptoms
22 for child soldiers with PTSD? And, in specific, do you have any comments as to
23 what re-experiencing means for Mr Ongwen?
24 A. [15:14:28] Re-experiencing in lay terms here would mean going through the
25 events of a traumatic event.

1 Let us say as an example, remembering in clear detail, vivid detail, the manner in
2 which his cousin's sister was killed, or remembering vivid moments of one or two or
3 other of his colleagues getting shot and killed or punished to death. So the effect on
4 an abducted child in the bush is to cause feelings of insecurity, unreality, fear, horror
5 and helplessness, but the LRA establishment was quick to get children not to focus on
6 the re-experiencing of the traumatic experiences. If you were seen to be moody, to
7 self-isolate and to be fearful, and so on, you would be severely punished.
8 So, child soldiers developed the ability to be joyful, even though internally they are
9 not joyful; to associate with others, although they would want to be alone by
10 themselves. And this is what Mr Ongwen also went through when he was a child.
11 Now, I remember one moment he remarked to us that our questions - which was of
12 course good for us - our questions reminded him of the events in the bush. It was
13 good for us because we knew that encouraging him to talk about his experiences
14 would inoculate him against memories, painful memories of his -- his experiences in
15 the bush.
16 So getting somebody to talk over and over is good, that is why I said when he
17 remarked about it we, we felt it was good for him. And in fact, with time, it became
18 easier for him to recount some of his most distressing experiences and trauma events.
19 Q. [15:18:34] (Microphone not activated)
20 PRESIDING JUDGE SCHMITT: [15:18:36] Microphone.
21 MS LYONS: [15:18:37] Sorry.
22 Q. [15:18:37] I would like to ask you, if you can tell us --
23 PRESIDING JUDGE SCHMITT: [15:18:47] Perhaps you can -- I think we can have
24 a short break --
25 MS LYONS: Sure.

1 PRESIDING JUDGE SCHMITT: -- I would suggest. And then we continue. How
2 long will it take?
3 MS LYONS: [15:18:57] I'll be done by four, much before -- not much before.
4 PRESIDING JUDGE SCHMITT: [15:19:01] But nevertheless, it's --
5 MS LYONS: [15:19:03] No, no, I'm moving right ahead.
6 PRESIDING JUDGE SCHMITT: [15:19:05] -- it's good, it's good to have a break now.
7 MS LYONS: Thank you so much.
8 PRESIDING JUDGE SCHMITT: Four or five minutes --
9 MS LYONS: [15:19:12] That's perfect. Thank you.
10 THE COURT USHER: [15:19:14] All rise.
11 (Recess taken at 3.19 p.m.)
12 (Upon resuming in open session at 3.25 p.m.)
13 THE COURT USHER: [15:25:05] All rise.
14 Please be seated.
15 PRESIDING JUDGE SCHMITT: [15:25:15] Ms Lyons, please.
16 MS LYONS: [15:25:17]
17 Q. [15:25:19] Thank you. We are towards -- only the last -- we are towards the
18 end.
19 One -- there has been some discussion about the role of Joseph Kony, the spiritualism
20 in the LRA, how it was used by Joseph Kony in the LRA, and we have heard a lot of
21 testimony about this. My question to you is: Can you briefly recount what
22 Mr Ongwen said about Mr Kony and the spirits and what effect did this have, if any,
23 on his mental state during the charged period of 2002 to 2005?
24 A. [15:26:11] We heard a lot about the character of Joseph Kony, the people that I
25 would call our historians - here the historians excludes Mr Ongwen, but other

1 people - that there were times when Joseph Kony would gather his troops while
2 wearing a white robe and carrying a Bible and he would speak nonstop for many
3 hours while an assistant would be writing whatever he was saying. But that after
4 some period, the same Joseph Kony would be the opposite of what he would appear
5 in a white robe and giving instructions, instructions or teaching his troops about how
6 to conduct themselves while in the bush.
7 One of his main concerns was leading -- his troops leading a pure spiritual life
8 without any taint of wrongdoing and he would tell especially the young children that
9 whoever goes to battle and gets killed has broken one or other of the commandments
10 that the spirit has given.
11 So sometimes he would interchangeably refer to himself as the spirit or other times
12 a medium for the spirit.
13 One of our witnesses that we saw in Kampala also referred to this and he particularly
14 said Joseph Kony was a person who had supernatural powers and he had many
15 spirits in him, some of the spirits being Ugandan, others Russian, others Chinese, and
16 others Sudanese origin and so on. So there is a mixed picture of who Joseph Kony
17 was.
18 A journalist one time in passing told me that she thought Joseph Kony suffered from
19 schizophrenia. I simply listened and I didn't respond because you can't make
20 a diagnosis of someone whom you have not seen, whom you have not talked to. It is
21 okay to say somebody says he is a spirit or he is a medium of spirits, but it is another
22 thing to say so-and-so suffers from this disorder or that without assessing.
23 So the problem for the child soldiers was that they were indoctrinated and sometimes
24 with use of force, they were indoctrinated so that they came to believe who
25 Joseph Kony was and that is that he is a spirit and he had supernatural powers.

1 Dr Akena talked of stone bomb project and your client himself told us repeatedly that
2 one time he was told to hold a pebble in his hand and the pebble flew from his hand
3 and went and hit its target many miles away. So he, too, suffered from the
4 indoctrinating effects that he went through.
5 I'm not sure if --
6 PRESIDING JUDGE SCHMITT: [15:32:25] Please proceed, Ms Lyons.
7 MS LYONS: [15:32:31] Yes, thank you.
8 One moment, if I may?
9 (Counsel confers)
10 MS LYONS:
11 Q. [15:32:33] To maybe complete your narrative and your answer, could you say
12 what would be the ultimate, if you can talk about an ultimate effect of this system of
13 belief, the omnipotence of Kony, the indoctrination, the use of force, the brainwashing,
14 what is the ultimate effect on someone with Dominic's -- on Dominic Ongwen,
15 particularly with someone given his mental health illnesses that you have diagnosed?
16 A. [15:33:38] There is one concept that your clarifying question has brought to
17 mind, but let me start off with the ultimate effect. The ultimate effect is compliance,
18 one of compliance. At least when he was still vulnerable, he had to comply, he had
19 to believe. And this takes me to the concept that I said your clarifying question
20 brought up.
21 There is what we call delusional belief, which may be sometimes referred to as shared
22 belief. I don't know if it has been mentioned before, but let me start with delusional
23 belief.
24 A delusional belief is a belief system that a person holds on to, despite available
25 evidence to the contrary. It is delusional because usually the individual may be

1 educated and convinced out of the belief. If the individual cannot be argued out of
2 the belief, then it becomes a delusion.
3 A shared belief is a form of delusional belief in that a belief system surrounding
4 a particular topic or a particular object is held by a group of people living together in
5 the same environment under the influence of a charismatic leader with a strong
6 personality. Examples are cult movements. Cult movements, members of cult
7 movements hold on to a shared belief.
8 We had a very nasty dark Monday morning in 2000 in Uganda where -- sorry, when
9 we woke up to the deaths of more than 500 believers of a group of people, three of
10 them to be precise, a priest, a nun and a layperson, the layperson being the leader.
11 This group believed, under the influence of the three, that the world was going to end
12 I think it was January 17th, 2000. But January 17 passed and nothing happened, so
13 the group members did the ultimate they could do to take their members to heaven.
14 They locked them up into a small building which they were also using, apparently,
15 for their prayers and so on, bolted them inside with jerrycans of paraffin and petrol
16 and set these people ablaze. Unfortunately, amongst the 500 were children and
17 babies and their mothers as well.
18 So that is what a delusional belief system or a shared belief system can do to people.
19 In the case of Mr Ongwen, a belief system which was also a shared belief system
20 made him to believe in his boss and made him to follow the orders and rules and
21 regulations of his boss quite involuntarily, I would say. I say involuntarily
22 because - I have already said it more than three times - that when he became a senior
23 officer, he then came out openly to challenge the boss, at the risk of losing his life.
24 But at that point staying alive meant nothing to him and he was looking for, for him
25 being executed.

1 PRESIDING JUDGE SCHMITT: [15:40:07] Ms Lyons.
2 MS LYONS: [15:40:09] Thank you.
3 Q. [15:40:11] Now I'm on my last question -- questions, very short.
4 In this courtroom, there was an expert report presented by one of the victims' teams,
5 by Professor Musisi, whom I assume you know as a colleague at Makerere.
6 And in this report, which we have for those who are checking the binders, it's in
7 binder 1 at tab - I keep forgetting it - tab 14. On page 7 of the report he states that
8 many returned abductees and child soldiers had mental health problems, PTSD,
9 depression, and anxiety. And the quote I want to focus on is he said, quote:
10 ".. mass trauma ... in Acholiland ... caused violent disruptions of the peaceful
11 co-existence of the Acholi peoples with consequent deleterious effects on
12 individuals ... and families to one another, to their community and one community to
13 another."
14 He goes on to say that the Acholi cohesive, culture rural traditions were lost due to
15 two factors. The first factor he points to is the kidnapping of the children and the
16 abduction of the children by the LRA and the subjection of them to life in the bush
17 under LRA discipline and rules. And the second factor is the forcing of Acholi
18 peoples into IDP camps, displacing them.
19 Throughout the report he gives other indicators of mass trauma. My question to you
20 is: Was there mass trauma, from your professional perspective, in Acholiland
21 during 2002 and 2005? That's my first question.
22 A. [15:42:45] Yes, there was mass trauma involving areas and parts of Acholiland.
23 Not the entire population, but there were groups in areas that suffered collective
24 trauma, if I may put it that way, differently.
25 The trauma that they suffered initially was from, from what Joseph Kony would call

1 the enemy, and the Acholi cultural leaders were reported to have voluntarily
2 surrendered their children to go and join and fight for the cause of the Acholi people
3 who were facing potential annihilation.
4 But the enemy then devised a strategy of enabling particularly more severely affected
5 communities to group themselves into fighting back the LRA. And when this
6 happened, then the LRA responded viciously, because at that point, with their enemy
7 now at that point having secured the support of the population, also cut off their
8 supply of fighters, children who were supposed to be their fighters, and supplies in
9 the form of food and other necessities of life, so they reacted viciously and started
10 abducting children and adults alike. And that was when now at that point the
11 whole population of the Acholi people got affected by the insurgency in the northern
12 region and that is what Dr Musisi is referring to as mass trauma. It developed in
13 stages, up to the point where he says the Acholi people were then headed into safe
14 camps - safe, in quotes - because those camps became now easier legitimate targets for
15 the LRA. They didn't have to travel long, long distances between villages,
16 everybody was concentrated in one area or another. So if they wanted human
17 supplies as fighters, they would straight go to, to the camps. And so everybody was,
18 yes, affected.
19 And, you know, the problem with mass trauma according to another author, Volkan,
20 Blind Trust is the book, he talks of the effects of mass trauma being mass psychosis
21 and mass suicide. He was involved in the practice of peaceful resolution of conflict
22 between communities but, unfortunately, I think he went on to that career too late
23 and he had to retire, so I don't know who has taken on the mantle of developing his
24 initiative further.
25 PRESIDING JUDGE SCHMITT: [15:48:24] Thank you.

1 Ms Lyons.
2 MS LYONS: [15:48:26] Yes.
3 Q. [15:48:26] And the very last question. You and Dr Akena made conclusions
4 about the mental health illnesses, including the trauma and its mental health effect for
5 Mr Ongwen, and my question, my last question to you is: Conceptually or generally,
6 can you place the situation of Mr Ongwen with his mental health illnesses, including
7 those that were triggered by repeated traumas? Can you place that in the broader
8 context that Professor Musisi is talking about, of the mass trauma experienced by the
9 people at the hands of both the LRA and the UPDF between 2002 and 2005?
10 A. [15:49:28] If I say absolutely I don't know if you would want me to expound on
11 that.
12 PRESIDING JUDGE SCHMITT: [15:49:36] But it's already an answer, of course.
13 MS LYONS: [15:49:42] (Microphone not activated)
14 THE WITNESS: [15:49:45] Well, if is an accepted answer I rest my case.
15 But just for the sake of clarifying, you see, Mr Ongwen is a member of the Acholi
16 community. Although he is here he is still a member of the Acholi community. So
17 the repeated encounters, life-threatening encounters with danger, exposure to bullets,
18 exposure to punishment, severe punishment at that all occurred to him as an
19 individual and it also occurred to members of his community who are still back in
20 Uganda in the northern region. So what Musisi said applies to him.
21 Not to mention me from a neighbouring community, but it applies to him.
22 PRESIDING JUDGE SCHMITT: [15:51:12] Thank you.
23 MS LYONS: [15:51:13] Thank you.
24 PRESIDING JUDGE SCHMITT: [15:51:15] Thank you very much.
25 This concludes the hearing, only for today of course. We continue tomorrow at 9.30

1 with the examination by the Prosecution.

2 (The hearing ends in open session at 3.51 p.m.)