International Criminal Court
Trial Chamber IX
Situation: Republic of Uganda
In the case of The Prosecutor v. Dominic Ongwen - ICC-02/04-01/15
Presiding Judge Bertram Schmitt, Judge Péter Kovács and
Judge Raul Cano Pangalangan
Trial Hearing - Courtroom 3
Monday, 18 November 2019
(The hearing starts in open session at 9.35 a.m.)
THE COURT USHER: [9:35:07] All rise.
The International Criminal Court is now in session.
Please be seated.
PRESIDING JUDGE SCHMITT: [9:35:31] Good morning, everyone.
Could the court officer please call the case.
THE COURT OFFICER: [9:35:38] Good morning, Mr President, your Honours.
The situation in the Republic of Uganda, in the case of The Prosecutor versus Dominic Ongwen, case reference ICC-02/04-01/15.
And for the record, we are in open session.
PRESIDING JUDGE SCHMITT: [9:35:52] Thank you.
I ask for the appearances of the parties.
For the Prosecution, Mr Gumpert, first.
MR GUMPERT: [9:36:00] May it please, your Honour, Ben Gumpert for the Prosecution. With me today, Colleen Gilg, Colin Black, Adesola Adeboyejo, Beti Hohler, Pubudu Sachithanandan, Grace Goh, Jasmina Suljanovic, Kamran Choudhry, Nikila Kaushik and Yulia Nuzban.

PRESIDING JUDGE SCHMITT: [9:36:15] Thank you.

And for the representatives of the victims, first Ms Massidda.

MS MASSIDDA: [9:36:20] Good morning, Mr President, your Honours. For the Common Legal Representative team appearing today, Orchlon Narantsetseg, Caroline Walter and myself, Paolina Massidda.

PRESIDING JUDGE SCHMITT: [9:36:32] Thank you.

And Ms Sehmi.

MS SEHMI: [9:36:34] Good morning, Mr President, your Honours. On behalf of the Legal Representatives for Victims, Anushka Sehmi and with me is James Mawira.

PRESIDING JUDGE SCHMITT: [9:36:42] And for the Defence, Mr Obhof. Oh, I didn't see you, but that is really -- that happened for the first time, I have to say. Please, Mr Obhof.

MR OBHOF: [9:36:53] Thank you very much, your Honour.

Today we have Beth Lyons, Tibor Bajnovic, Eniko Sandor, Krispus Ayena Odongo, Michael Rowse, Chief Charles Achaleke Taku, Roy Titus Ayena, Gordon Kifudde, myself Thomas Obhof, and Mr Ongwen is in court today.

PRESIDING JUDGE SCHMITT: [9:37:10] Thank you, Mr Obhof.

Today's witness is Mr -- Dr Dickens Akena. Before we start with his testimony, we go shortly into private session because the Chamber has to make a short oral decision.

(Private session at 9.37 a.m.)

THE COURT OFFICER: [9:37:35] We are in private session.

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(Open session at 9.45 a.m.)

THE COURT OFFICER: [9:45:35] We are in open session, Mr President.

PRESIDING JUDGE SCHMITT: [9:45:37] Thank you. As I said, we can now bring the witness in.

(The witness enters the courtroom)

MR GUMPERT: [9:45:46] Do I understand the other potential witnesses will also be brought in at the same time?

PRESIDING JUDGE SCHMITT: [9:45:54] Yes, but --

MR GUMPERT: [9:45:55] The observers, if I can call it that.

PRESIDING JUDGE SCHMITT: [9:45:57] Yes, of course. If, for example, I think it's Mr Weierstall in your case, but I am informed that there is a medical issue here and -- but that is of course something, whenever the -- now, whenever the experts of any of the party, the additional experts or the potential experts wish to join now, they are free to do so.

But I was of course at the moment preoccupied with the witness and the expert that we have to examine now.

Good morning, first of all, Mr -- Dr Dickens Akena. I think I have to repeat that.

Now you hear me, Mr Akena?

WITNESS: UGA-D26-P-0041

(The witness speaks English)

THE WITNESS: [9:47:24] Yes.

PRESIDING JUDGE SCHMITT: [9:47:25] Good morning. On behalf of the Chamber I would like to welcome you in the courtroom.

And I think for the record, we have also now Mr Weierstall now and Mr Ovuga, yes? Yes.

Mr Akena, you are well aware that you are going to testify before the International Criminal Court. As I said, I welcome you and there should be a card in front of you with the solemn undertaking to tell the truth. I would kindly ask you to read out this undertaking aloud.

THE WITNESS: [9:47:56] Okay.

I, Dickens Akena, solemnly declare that I will speak the truth, the whole truth and nothing but the truth.

PRESIDING JUDGE SCHMITT: [9:48:08] Thank you very much.

THE WITNESS: [9:48:09] You're welcome.

PRESIDING JUDGE SCHMITT: [9:48:10] I have a few practical matters for you for your testimony. First of all, everything we say here in the courtroom is written down and interpreted and therefore we ask every witness to speak at a relatively slow pace and please start only speaking when you are asked a question after two or three seconds so that the interpreters simply can follow.

THE WITNESS: [9:48:37] Okay.

PRESIDING JUDGE SCHMITT: [9:48:37] Another information for you, the Chamber has decided that we are only going into private session when there is particular sensitive information discussed that might relate to the accused.

The decision on that is made by the Chamber, but if the expert, or also perhaps the examiner, thinks that such particular sensitive information might be touched, you can ask us to go to private session that we discuss the matter and the Chamber will have the final decision on that, so simply that you understand it.

So we do not go completely into private session, but when need be, and as I said the final decision on that is made by the Chamber.

Ms Lyons, I assume you are questioning the witness. All indicia point to this.

MS LYONS: [9:49:27] Yes, all indicia --

PRESIDING JUDGE SCHMITT: [9:49:28] Yes, yes, so --

MS LYONS: [9:49:29] The pile -- yes. Yes, is the answer.

PRESIDING JUDGE SCHMITT: [9:49:36] So I have three preliminary remarks that we perhaps -- and it's good that Mr Akena is in the room and he can also listen to

that.

First of all, but this is directly to you, we assume that you request the application of Rule 68(3) with regard to the 2016 and 2018 report. Are we right in that respect?

MS LYONS: [9:50:00] (Microphone not activated)

Yes, but there are four reports we want to enter into evidence, the brief report, first, second and supplemental.

PRESIDING JUDGE SCHMITT: [9:50:13] Okay. Fine. We are fine with that.

MS LYONS: [9:50:15] Yes.

PRESIDING JUDGE SCHMITT: [9:50:15] And since we have two authors, we would perhaps have to exercise this, to be on the safe side, twice. You are probably aware of that.

MS LYONS: [9:50:20] Yes.

PRESIDING JUDGE SCHMITT: [9:50:21] Prosecution I think is fine with that, no? It's a little bit formalistic because Mr Ovuga is also there. We could ask him now, but he's only on the stand on Thursday. So I think to be absolutely clear, procedurally we do this, we exercise this twice, it does not cost us too much time.

The second thing, Ms Lyons, and also Mr Akena:

We are here in the next probably two weeks to discuss the mental state of the accused during the charged period. We have to focus on that, yes? I would like to remind you.

And thirdly, experts are here to provide us with a factual basis against the backdrop of their professional expertise. They are not, and I think we understand each other here, to tell the Chamber what legal conclusions the Chamber has to take. With this short preliminary remarks, Ms Lyons I give you the floor.

MS LYONS: [9:51:28] Thank you, your Honour. And I would like to welcome

the witness and like to welcome the two persons observing, Professor Ovuga and Weierstall.

Now before we proceed, let me just go through what we have in front of us so everybody is clear about the paper.

PRESIDING JUDGE SCHMITT: [9:51:49] We appreciate that a lot. Because, as you have heard, I referred now to two reports, but we have to be absolutely clear what should be, so to speak, in, in via Rule 68(3).

MS LYONS: [9:52:02] Okay. With a little assistance, I hope we have risen to the challenge of the paper in the case.

PRESIDING JUDGE SCHMITT: [9:52:14] I think you have help here to your right.

MS LYONS: [9:52:16] I have excellent help. Okay. Now, one moment.

PRESIDING JUDGE SCHMITT: [9:52:22] Perhaps in the meantime, I can inform Mr Akena what we are now doing or what I assume what we are doing.

You have signed several reports together with Mr Ovuga and there is a provision in the Rules of Procedure and Evidence at the Court that these whole reports can be part of your evidence, what you have written down, with your consent under certain conditions. This is meant to shorten a little bit the examination of, for example, in your case, of the expert.

So you know that that -- the examiner would not have to go to everything what you have said in these four reports, but simply that they are in, and that then are asked additional questions on that, just to inform you that you understand what's going on.

And I think the other two witnesses have also heard it, so when you are -- when it's your turn, then you know this already.

Now, Ms Lyons.

MS LYONS: [9:53:20] Let me step one back. Let me, before we get to the Rule 68

issues. Everyone in the courtroom, especially the witnesses, but all of the parties and participants have two binders in front of them. I think today we'll probably be referring mostly to the first one and there is a list attached of items in the binder. Then we have a second binder. The second binder, so that everyone is clear about what it is, is essentially the bibliography that was provided by Dr Akena and Professor Ovuga in the second report.

Initially, I wanted it copied for everybody, really for the convenience of the witnesses, in case the witness wanted to refer back to an article. This is not a university examination. That's all we wanted.

I will be referring in my direct examination for both Dr Akena and Professor Ovuga to a few of the articles, but we're not using all of the articles; so I think that that's a perspective particularly on the second binder.

PRESIDING JUDGE SCHMITT: [9:54:33] But we appreciate that. That's a good idea, I think.

MS LYONS: [9:54:37] All right. Thank you.

And so I appreciate the work that was done to provide all of this.

All right. Now, the other point I just want to make to the Court, I will endeavour to present as much of my questioning in public session. I understand the restrictions. We will do the best we can. And, with your assistance and also the indulgence of the witnesses, we should be able to get through this successfully.

PRESIDING JUDGE SCHMITT: [9:55:13] I think in the past we have all done this together in a way that, in the end -- I will not say everybody, no, never everybody will be satisfied, but in a way that we can say it's -- we have done this in a fair manner.

MS LYONS: [9:55:26] Okay.

PRESIDING JUDGE SCHMITT: [9:55:27] Please proceed.

MS LYONS: [9:55:31] Thank you, your Honour.

QUESTIONED BY MS LYONS:

Q. [9:55:38] Now, let me deal with the issue of the reports in evidence first, and then I will move into questions, Dr Akena, about your background and your CV, which are in the binder.

And then there will be a probably lengthy session, most of which or all of which will be in public on the issue of methodology.

And then we'll proceed for the rest of the day in dealing with both clarifications and issues which have emerged from the first psychiatric report, the December 2016 report, and then we're going to jump to the supplemental report and we're jumping because of your involvement in that report, which was, I believe, made by both you and Dr Ovuga in January of 20 -- this year, 2019. Okay.

Now, then on Thursday I want to let everyone know that we will be focusing again on the CV of Professor Ovuga, again methodology because not each person has his or her own, own position and view and expression of this.

And, secondly, we will be focusing mainly on the second psychiatric report and some of the issues that have arisen out of that report.

PRESIDING JUDGE SCHMITT: [9:57:13] That all sounds reasonable, so to speak.

MS LYONS: [9:57:16] Okay. Now, let me get to what could be unreasonable, okay, which is, it's not going to be seamless. We are doing the best we can. There will be some references back and forth, but, you know, obviously we will -- this is the plan, but, as a trial attorney I know what is on paper doesn't always translate into here. So let's start and see how far we get.

PRESIDING JUDGE SCHMITT: [9:57:43] But that, doesn't that make a little bit the charm of the trial proceedings that there is at least a little bit of spontaneity in it that

you can't plan everything?

MS LYONS: [9:57:56] Thank you. For other discussion. Okay.

Now, let's go to -- all right, let's go to binder 1, we are looking at tabs, 6, 7, 8 and 9.

Q. [9:58:25] Now, Dr Akena, are you at binder 1, tab 6?

A. [9:58:30] Yes, ma'am.

Q. [9:58:31] Okay, great. Thanks, okay.

Now, this is entitled "Brief Medical Report for Dominic Ongwen" and the ERN number for the Court is UGA-D26-0015-0154.

Now, if you turn to page 57, 0157, it is said the report is prepared by two parties, Dr Dickens Akena and Professor Ovuga.

Did you prepare this report -- for your part of it, did you prepare this report, Dr Akena?

A. [9:59:20] Yes, I did.

Q. [9:59:21] Okay. Now let's move ahead to what's entitled the psychiatric report on page 7 -- sorry, tab 7 and --

PRESIDING JUDGE SCHMITT: [9:59:44] 0023 is the end I think.

MS LYONS: [9:59:49] Thank you.

Q. And it ends on 0023. Did you prepare this report with Professor Ovuga?

A. [9:59:58] Let me just get that clear.

Q. [10:00:00] Yes. It's tab 7.

A. [10:00:02] Tab 7. Yes, yes, I did.

Q. [10:00:10] Okay. Now, moving ahead to the next tab, number 8, we get into the second psychiatric report, which starts at ERN UGA-D26-0015-0948, and ends at 093.

PRESIDING JUDGE SCHMITT: [10:00:47] 0983.

MS LYONS: [10:00:49] 0983. Thank you.

Q. [10:00:51] And it's signed by Dr Akena and Dr Ovuga. That's you?

A. [10:00:57] Yes, that's me.

Q. [10:00:59] Okay. Now we are going on to the last report, which is entitled, "Supplemental Report of 25 January 2019". It is at tab 9. It's ERN UGA-D26-0015-1229, it starts, and the signature page is at 1223.

Is that -- you signed this report? Okay.

Now these reports obviously pre-date your testimony today. I need to ask you, is there anything you need to change, correct, amend?

A. [10:01:59] None that I know of.

Q. [10:02:01] Thank you. Now, do you as the co-author of each of the four reports have any objections to placing these four reports into evidence for this case?

A. [10:02:18] No, I don't.

MS LYONS: [10:02:22] Your Honour, pursuant to --

PRESIDING JUDGE SCHMITT: [10:02:24] I think that the requirements of Rule 68(3) with regard to these four reports and this expert witness would be fulfilled, I think there is no objection by anyone about that.

MS LYONS: [10:02:39] Thank you.

Q. [10:02:52] Now, Dr Akena, I would like to spend the next period of time talking about your résumé and your CV.

Now you will find at tab 2 a shortened résumé, which I requested, in terms of your background -- I'm sorry, tab 2.1. It's number 2.1 on the sheet, but it's under tab 2. It is a shortened résumé. And in addition at tab 2 there is a longer CV, which is at UGA-D26-0015-0849. They are both in the same section in tab 2. So this is what we are going to talk about. The Chamber and parties and participants have all this information, but what I would like you to do is to respond to my questions and

highlight the areas that you think are important.

Now, first, could you please state your full name for the Court.

A. [10:04:16] My name is Dickens Howard Akena.

Q. Okay. And could you tell the Court where you were born.

A. [10:04:27] I was born in Gulu in northern Uganda, 1979.

Q. [10:04:31] And where do you currently live, Dr Akena?

A. [10:04:35] I live in Kampala district in Uganda.

Q. [10:04:37] And could you also tell the Court, please, what languages you speak?

A. [10:04:42] I speak English, and I speak Acholi, Luo.

Q. [10:04:57] Now, could you also tell the Court if you identify as part of any grouping within Uganda?

A. [10:05:07] Grouping?

Q. [10:05:08] Grouping, by grouping I mean in terms of your, in terms of your origin --

A. Ethnicity?

Q. -- or your heritage --

THE INTERPRETER: [10:05:15] Your Honour, could there please be some space between the answers and the questions.

PRESIDING JUDGE SCHMITT: [10:05:21] Yes, I think we have heard it. We are a little bit too quick. And this is something that Ms Lyons shares with me, but I have to tell you, Ms Lyons, we have to wait a little bit and also Mr Akena, of course. It's simply because the languages have different structures. For example, English, at least in my understanding, is relatively a concise and short language, but when it has to be translated into other languages interpreters need a little bit of time.

So, Ms Lyons, please --

MS LYONS: [10:05:55] Thanks. And I appreciate that and hopefully please feel free to slow me down.

Q. [10:06:02] Okay. Ethnicity is probably the best word to use. Could you answer that question, please, sir.

A. [10:06:08] I am an Acholi by tribe.

Q. [10:06:12] Thank you. Now, could you tell us a little bit about your educational background, please.

A. [10:06:22] I graduated as a doctor, medical doctor in the year 2003. Then I specialised as a psychiatrist in the year 2008. Then I obtained a PhD in psychometrics from the University of Cape Town in 2011. And then I obtained a post-doctoral research fellowship in the same area in the year 2016.

Q. [10:06:55] Thank you. We will get into the details of some of those in a second. But could you first tell us what your current position now is.

A. [10:07:03] I am a senior lecturer in the department of psychiatry in the College of Health Sciences of Makerere University in Uganda.

Q. [10:07:14] And do you have any appointments at other colleges right now?

A. [10:07:19] Yes, I do. I am a visiting scientist at the TH Chan School of Public Health at Harvard. I am also honorary lecturer at Makerere -- I mean, sorry, Mbarara University of Science and Technology. And maybe that's not here, but I also provide lectures at the University of KwaZulu-Natal in South Africa.

Q. [10:07:53] Now, could you talk about just generally the kind of practice or clinical work that you do right now?

A. [10:08:01] So I practice psychiatry, general adult psychiatry at Butabika National Referral Hospital in Uganda and my roles include assessing patients and providing clinical care to them. That's my clinical -- those are my clinical duties. But during

the clinical duties I also provide teaching to undergraduates and postgraduate doctors.

Q. [10:08:46] Now, you mentioned a little bit about research. Are you conducting research at the present time?

A. [10:08:53] Yes, I do. My main areas of focus has been in the area of assessing for mental illnesses in persons with low literacy. We call that psychometrics. So I am particularly interested in the development of visual scales or visual instruments for people with low levels of -- people who cannot read or write. So that's my -- that's been my main focus of research over the last seven to eight years. But I also do research in systematic reviews and meta-analysis, which is the summarising of available scientific literature to inform clinical practice, policy and future research. So those are the two main research areas that I have been involved in, but I have also worked in areas of implementation science, which is basically to transfer available knowledge to individuals with little or no mental health training and we call that task shifting.

Q. [10:10:13] Thank you. Now let me -- before I ask some more questions about that, let me ask you about psychometrics. Can you just say again what is psychometrics?

A. [10:10:25] So psychometrics is the science that involves the use of rating scales or rating instruments or assessment of measures for people with mental illnesses. I don't know whether that answers the question.

Q. [10:10:44] It does. And what is your focus in terms of the target group?

A. [10:10:54] Persons will low literacy, persons who cannot read or write, and predominantly persons of African origin to whom some of the constructs of mental illnesses don't make sense in the way the -- the current way in which they are, yes.

Q. [10:11:11] Okay. When you say don't make sense in the current way in which they are presented, can you say that in different words for us so that we can understand?

A. [10:11:23] So the assessment of mental illnesses require that people understand what they are being asked and the meanings of those. Mental illnesses manifest in various forms and this can vary by culture, by religion, by people's ethnicity and origin and social and demographics parameters. So, we have to be aware of those subtle differences when we are assessing people for mental illnesses because if we apply one standard across, sometimes it is not entirely appropriate.

So my work basically is to try and refine those little, what we call underlying constructs or hidden constructs or latent constructs to try and use available explanations in the local context so that potential recipients of these instruments are able to understand those questions in a manner that they identify with, yes.

Q. [10:12:46] Now, along the same lines, I want to point out to the Court that there is -- and the participants and parties, in the second binder at number 29, there is an article entitled, "Sensitivity and specificity of the Akena Visual Depression Inventory (AViDI-18) in Kampala and Cape Town." And the number of this document, which is not on the list of evidence, is UGA-D26-0015-1474.

A. [10:13:30] Excuse me, where can I find that here?

Q. [10:13:33] Yes, binder 2.

A. [10:13:34] Number?

Q. [10:13:35] Number 29.

A. [10:13:36] Okay.

MR GUMPERT: [10:13:35] Your Honour, just before anything substantive happens, as Ms Lyons has observed, this document is not on the list of evidence. It's included

within the binder. My understanding of the purpose of the list of evidence is to make a definitive reference tool of those documents which may be used as part of a party's case.

My understanding equally is that you can't get around the obligation and indeed the deadline, the original deadline or the 30 September deadline, the second deadline, if you like, which the Court imposed by simply putting a document into a binder and asking a witness about it. That would be a circumvention of the rules which the Court imposed.

PRESIDING JUDGE SCHMITT: [10:14:25] Ms Lyons, do you want to say something to that?

MS LYONS: [10:14:29] Yes. First of all, the -- clearly, the -- the intent is not to circumvent anything. The fact of the matter is Ms Lyons found this after the deadline. I was not cognisant that an application should have been made to the Court for late addition. I am happy not to use it, but it seemed relevant. Now, the issue of submitting into evidence and all of the legalities and the rules that go with that we can deal with later. But for now I simply wanted it to provide additional information on the standards issue on which this person, this witness, is an expert.

PRESIDING JUDGE SCHMITT: [10:15:15] In principle, of course, it is clear that Mr Gumpert is right. We have a certain procedure here in place that should be followed.

I think we don't have to make a big issue out of it because it seems to be an article from the British Journal of Psychiatry, I also see now for the first time, from 2018. So this is something that can easily be read by everyone who wants to. Even, for example, by a judge who is sitting in, at some point in time perhaps, the deliberation room and wants to do it. So I am not sure, perhaps we should not ask the witness on

it, we should move forward. But that we have it here in an binder, I think there is no need to make a big issue out of it.

Can we agree on that, Ms Lyons?

MS LYONS: [10:16:01] If you don't want me to ask more questions about it, I would be happy not to.

PRESIDING JUDGE SCHMITT: [10:16:01] Yes.

MS LYONS: [10:16:06] If that's a problem. But you have access to it.

PRESIDING JUDGE SCHMITT: [10:16:09] Yes.

Mr Gumpert, I think you understand my point here. If it was, for example, a -- something --

MR GUMPERT: [10:16:17] Can I cut you short? I have no issue. We can move on.

PRESIDING JUDGE SCHMITT: [10:16:21] Good. Fine. Fine.

So, Ms Lyons, please move on.

MS LYONS:

Q. [10:16:32] May I ask, did you publish on this scale, this standard that you were describing?

May I ask that, your Honour?

PRESIDING JUDGE SCHMITT: [10:16:43] Let's make it short.

Mr Akena, obviously it is an article in a British journal on psychiatry and there are two coauthors and I think it is absolutely appropriate to ask you if you have written that together with these two coauthors.

THE WITNESS: [10:16:59] Yes, I did.

PRESIDING JUDGE SCHMITT: [10:17:01] And any further conclusions that might be drawn from that, I think you can really trust the Chamber that (Overlapping speakers)

MS LYONS: [10:17:07] I trust. Okay.

PRESIDING JUDGE SCHMITT: [10:17:09] Okay. Please move on.

MS LYONS: [10:17:11] All right.

Q. [10:17:12] Let's move on from the article and the issue of the scale.

In terms of your research, and I know that you have conducted based on your résumés a fair amount, can you just let the Court know generally who has funded various projects so we have some sense of the funders and the breadth of your research.

A. [10:17:46] Thank you. I have received some funding from the Medical Research Council of the United Kingdom, the UK. I have also received funding from the University of Cape Town. In the beginning I have received funding from Makerere University. I have received funding through colleagues from the National Institutes of Health of the United States.

Yeah. For now, that that's what I can remember. Yes.

Q. [10:18:22] Okay. Thank you.

Now, in line with that question as well, have you received particular awards based on your work and your research?

And I refer you to page ending in -0850 of the longer CV from Dr Akena.

A. [10:18:55] Yes. Yes, I have received a number of distinguished awards in the area of mental health and development of instruments for use in this population that I described earlier.

Q. [10:19:19] Now, you have a lengthy list of publications at the end of the longer CV and what I want to know is, are any of these, in your view, of particular importance in terms of your work in this case? This case being the Ongwen case.

A. [10:19:55] Yes, I think the two publications about scale development are

particularly of interest to this case because they, they -- I think they describe my, my ability to be able to assess for mental illnesses in vulnerable populations and people who can't read or write.

Q. [10:20:20] And for the purposes of clarity for others in the courtroom, you are referring to which numbers of your publications? I know one is 10, but what is the other?

A. [10:20:37] Just hold on a minute. There is publication number 2 --

Q. [10:20:42] Two. Okay.

A. [10:20:42] I think that was the very first one. And then, and then 10, which is what's in the binder.

Q. [10:20:48] Okay. Thank you.

Now, you mentioned that you have been a psychiatrist now for -- since 2008. That's 11 years. That you research and you teach. Can you tell us within this what is your experience with children or adolescents?

A. [10:21:32] In terms of -- in the terms of the work that I do, we, we see a number of children who present with all sorts of mental illnesses, from disorders which are mood disorders, traumatic disorders, disorders of neurodevelopmental problems. I mean, children are born with these kinds of things. And then also the fact that it's a bit more difficult to assess children with mental illnesses because they don't have to -- they don't express the signs and symptoms the way adults would do, they don't appreciate some of the questions. But that psychiatry in children is also a bit different from psychiatry of adults, the instruments are different, the questions are different. The circumstances under which you assess the children are not the same like the ones you assess adults.

So, yeah, it's a bit more challenging to deal with little -- I mean, children, adolescents,

compared to adults. Yes.

I don't know whether that answers the question.

Q. [10:22:58] It does. But maybe in terms of your thinking, when we are talking about children and adolescents, can you just give a rough age group, grouping for each, as you use the terms?

A. [10:23:12] Okay, so children is anything from birth, toddlers, up to about maybe 8, 9, 10 years, and then adolescents 12, 13 to about 18, 19. Yeah.

Q. [10:23:31] Now, I understand that there is a phenomena which has been described in this courtroom, actually by one of your colleagues, as transcultural psychiatry. Can you tell us what is this -- what is transcultural psychiatry?

A. [10:23:51] I would describe it, maybe not define it, but I think it's the ability to know that psychiatric illnesses manifest and present differently in different cultures, and that the identification and treatment of those illnesses require one to be aware of cultural differences across populations, and that the inability to do that is costly.

So let me just give an example of how -- this is just like schizophrenia, for example, present differently in different populations, and depending on where you see a psychiatrist from, whether it's the US or in the UK, you may, you may get two different diagnosis, even if they use similar methods.

And so there are things, there are expressions of mental illnesses that some are what we would call culturally-bound syndromes, so somebody could say I am possessed, for example, by some spirits, and some psychiatrist could consider that as a psychosis and make a diagnosis of a psychotic illness.

So that's what we mean by transcultural psychiatry. So when we are dealing with immigrant populations, when we are dealing with individuals who don't necessarily come from where we are and where we trained from, then we need to be aware of

that, yeah.

Q. [10:25:37] Thank you. We will get into this more a little bit later, but that gives us some groundwork.

Now, can you tell me what experience you have had, both within your academic career and as a practitioner, in terms of dealing with the issues of, particularly, former child soldiers or children in armed conflict, more broadly.

A. [10:26:04] So, usually, former child soldiers or children who come from conflict areas, generally speaking, are very disturbed compared to those who are not from conflict areas, because there is, there is just lots of disruptions in their early childhood. And when they come and they present to us with a mental illness, sometimes it's, it's quite -- it's difficult, it's really difficult to deal with, with such situations, because we -- I said earlier, for example, that it's not straightforward to make a diagnosis of mental illness in a child because of the expression of some of the things that we have been talking about.

More often than not, children from conflict areas, child soldiers, have undergone some kind of traumatic event, and that basically means that the assessment of such a person takes a much longer time, because you need trust. A big number of them unlikely to trust you because they are just not sure whether you are one of their tormentors or not. So that that requires time, that requires patience, that requires skill. More times than not, they are disadvantaged, so they present alone with very fractured social networks and systems. And because of that you have to rely on other sources of information to be able to make conclusive remarks or diagnosis in such, in such situations.

Generally speaking, it's difficult and challenging, yes.

Q. [10:28:10] Could you just briefly detail the countries in which you -- or, can you

briefly detail the work you have -- or, tell us from what countries have the child soldiers or children affected by armed conflict come in terms of your work and research?

A. [10:28:31] So we, we see lots of people who come from the northern parts of Uganda, which has had a long history of, of armed conflict.

I have also seen a number of people and children who have come from Somalia, and the people who come from Somalia, the people who come from the Democratic Republic of Congo, and sometimes Rwanda and South Sudan. But I must say that the people from those other countries, there is a much bigger problem because of language barriers and all sorts of things that come with it.

So we have seen children from, yes, from northern Uganda, South Sudan, eastern Democratic Republic of Congo, Somalia and Rwanda. Yes.

Q. [10:29:41] I have a few questions about your CV in the specifics of this case, but let me just raise one general point first because I will forget it and it's important.

You have obviously dealt with mental health issues in a variety of environments and countries?

A. [10:30:01] That's correct.

Q. [10:30:02] And you have dealt with persons whom you were treating, you have persons whom you have taught, persons with whom you are researching, and I assume funders.

Could you tell us, generally, what are your experiences in talking about mental health issues with people generally? Are there prejudices people have for or against mental health issues? Either way, could you talk a little bit about how the mental health issues are perceived, based on your experience?

A. [10:30:55] Yeah. So, there is a lot of what I would call -- what we call

mental -- sorry, mental illness stigma. So people have a lot of stigma towards mental illnesses, and this includes those who suffer from mental illnesses and those who suffer from -- sorry, and those who don't suffer from mental illnesses.

But I like to look at it from the perspective of something we call mental health literacy. So mental health literacy is basically the ability of somebody to know that they have a mental illness, they can get the treatment from it -- sorry, they have a mental illness, these are the signs and symptoms of the mental illness, and this is where they can get help from.

So one of the challenges we have in Africa, particularly where I come from, is that there are multiple explanatory models of mental illnesses. So some people think, for example, that they have been bewitched or this is witchcraft, so they don't consider that as a condition, a medical condition for which there is treatment.

But also they, because they don't consider that as a, as a condition for which there is medical -- I mean, medical treatment, they don't access medical care. That's one.

Two is that they are also not aware of available resources for mental health care, and that's compounded by a general limit of resources; few mental health-care workers in low-resourced setting. So you have a vicious cycle of individuals not knowing that they have a mental illness, but even if they access the hospital they can't access the services because there are few mental health-care workers. And so a number of people end up with severe forms of mental illnesses that are not very pleasant to the eyes of members of the public and then that drives the stigma. And once it drives the stigma, then those same individuals can't access help and their loved ones cannot take them to hospital because then they equate them with everybody else on the street.

So stigma is a big problem and so it, at the individual level, it's a barrier to accessing

care, but at the systemic level is that we also have a lot of mental illness stigma among individuals who are supposed to actually provide the resources. And because of that you end up in a situation where you have, you know, limited budgets and limited trainings and everything else. So this generally makes the practice of mental health quite challenging in settings from where we come.

Q. [10:34:02] I just want to follow up quickly on the stigma part: It's individuals feel -- the person who has a mental illness, he or he feels --

A. [10:34:16] Inadequate.

Q. [10:34:17] Inadequate. Feels a stigma. Okay.

But looking at it from the other side, let's suppose as a hypothetical the individual admits: I have schizophrenia, I'm bipolar, I'm whatever, okay, a mental health category. How do stigmas apply, or do they apply in that case, and from where do stigmas come if they apply?

A. [10:34:47] So --

Q. [10:34:47] The reaction to the knowledge.

A. [10:34:48] Yes, so a number of people would -- a number of people actually don't fully have a grasp of mental illnesses, so they think this is either character weakness or something a person did to attract such a punishment. So the moment somebody declares that they are mentally ill or they have this diagnosis, it doesn't end well for them. Sometimes they lose their and they are not allowed to enjoy some of the benefits that people enjoy at workplaces.

And that is what we call enacted stigma, so that's the stigma of the population or the people out there who supposedly don't have mental illnesses - some of them of course do - towards those who have overt forms of mental illnesses. And because of this, if that same person with enacted stigma is supposed to provide care or take their loved

one to a health facility or whatever it is, then they don't do that. And, once they don't do that, then it gets out of hand and then already the patient is feeling inadequate, they are feeling they can't, they can't achieve whatever it is that they are supposed to achieve, so the vicious cycle just goes on and on and on without end.

Q. [10:36:25] Now let me ask -- move to a little slightly different area, but in your experience now. Can you tell us, do you have -- what is your experience in forensic psychiatry? Do you have experience in forensic psychiatry, dealing with legal proceedings, for example?

A. [10:36:43] Yes, we've been involved in assessment of a number of people who may have been suspected or are suspected of having committed a crime and labouring under the burden of a mental illness. And so this experience dates back to the times when I was a student. And then also in regular clinical practice you come across individuals who, who have, who are suspects, suspected to have committed a crime, but sometimes they say they are mentally ill, sometimes the authorities are able to tell that this person is unwell, usually from the cell. So they refer them to the hospital and then they ask us for an assessment of this person to be able to provide information regarding the status of their mental health before, during and maybe after the act of -- the act for which they are suspected or they have been brought to you, the criminal act or whatever it is. Yes.

Q. [10:38:01] Let me ask you, what you are describing now, are you - what is your role?

And if I may ask a leading question to move forward on this, your Honour.

Are you appointed by the court, for example, in Uganda to assess suspects? I am just trying to clarify the position you are in when you make these assessments.

A. [10:38:27] Sometimes the courts can write that, actually, and ask you to provide

that information. Sometimes the hospital can actually ask you to make that assessment. As the head of the ward or the head of the firm or the head of the unit, the patients who are brought under my care, I am -- I have the duty to provide that. But we also have specialised units, forensic units within the hospitals and we, we have to consult with, with colleagues in order for them to be able to furnish the courts with these kinds of information, yes.

Q. [10:39:13] Now, could you very briefly and generally describe how you got involved in the Ongwen case, so everybody knows.

A. [10:39:35] Well, I was approached by a member of the Defence team, for two main reasons, one of them was that I was a psychiatrist, but the second was that I was able to speak the local language that the client was able to speak. So they thought I was qualified to be able to engage with him and understand him much better than through a translator. So one thing led to the other and then here I am.

Q. [10:40:11] And, if I may, could you -- how do you think you can assist this Court in getting to the truth of the matters that we'll be talking about in terms of mental health issues and the client? The assumption was that you could assist, but do you think you can assist?

A. [10:40:33] Well, I'll provide the information that we got when we were interacting with the client, and I'll provide it to the best of my knowledge. And then I hope that the Court can make informed judgment and decision based on, based on that. I will try as much as possible to provide everything else that we got from him, yes.

Q. [10:40:58] Thank you.

Now, how do you know -- you know Professor Ovuga, that's a fact. Just tell us how, how long you have worked with him, how you know him.

A. [10:41:14] So Professor Ovuga was my teacher when I was an undergraduate, and then he was also my teacher when I was a postgraduate, and I have -- I knew him as a member of the department. I joined the department of psychiatry shortly before he left, then I continued interacting with him when he was the dean faculty of medicine in Gulu University. And then we, we met again for this case and we have worked together as, as colleagues, but him as a mentor as well. So that's the interaction we have had with him.

And this dates back to 2002 when I was an undergraduate student, that's how long I have known him, yes.

Q. [10:42:12] Now, a witness, expert witness testified, one of your colleagues for the Prosecution, I know you have seen her material, Dr Catherine Abbo. Could you tell us how you know her and what relationship you have to her, if any.

A. [10:42:35] We are both psychiatrists in the department of psychiatry and we, we are colleagues at work, but that's, I think that's it. We don't have much in the way of, of doing work together with her, outside of the fact that we sit in departmental meetings and then teach students and supervise them, yeah.

Q. [10:43:05] Thank you.

A. [10:43:07] You are welcome.

Q. [10:43:08] Now I have come to the end of my queries on your CV and I just simply want to ask if there is anything you think I have missed that's important, that everyone should know about you right now, that they can't read themselves later in the bios?

A. [10:43:32] Nothing that comes to mind now.

Q. [10:43:35] Thank you.

A. [10:43:38] You are welcome.

Q. [10:43:39] Now I want to move on to the general area of methodology, but I want to start first with a question to transition from your CV to here, which is: How does who you are, where you come from, what you know, how does who you are influence, in general, your methodology and approach to your work? And if it doesn't, please say so, but if it does, tell us how.

A. [10:44:32] So mental health training is similar across the world, but it also has differences based on regions and universities.

So, for example, we are all trained to be able to interact with the patient, and interview them, be courteous, establish rapport, and that whole long process.

But sometimes the way you look at things can be influenced by the way you are taught and where you come from, and -- but we also have in our training whole course units and semesters where we are particularly trained against biases, prejudices, and also the ability to be able to separate your emotions from the emotions of the patient, because it can be disturbing to constantly listen to traumatising information from mentally ill patients on a regular basis. This is what some of us do for a living, so the training that you go through prepares you to be able to, if I can say it, to be able to empathise with the patient but not necessarily sympathise with them.

So empathy usually helps you to be able to figure out a way out for the patient.

I don't know whether that answers this question. I don't know -- (Overlapping speakers)

Q. [10:46:24] That answers it, but I want to --

A. [10:46:26] Partly.

Q. [10:46:28] Partly. Okay, partly. You can see me getting ready to ask something else.

Let me, let me raise a specific in terms of this, as particularly in terms of your own

background or your own - how do I say it? - cultural milieu.
Do you as a psychiatrist, for example, when treating your patients, Ugandan patients, particularly those from the northern and those that who believe in spirits, do you ever interact with the individuals in the Acholi culture, the ajwaka, the traditional healers, others who are looked at as also healers, maybe not psychiatrists, but as healers by the people?
Just talk a little bit about that, please?
A. [10:47:23] There are -- I think there are 53 tribes in Uganda and I belong to just one of them. It is definitely way easier when I am talking to an Acholi patient, because, one, I can speak in my local language, in my local dialect; I can decode and decipher differences between what is culturally appropriate and what is not. I can be able to tell whether this is a mental illness or whether this is part and parcel of what the community believes in. And this also goes back to transcultural psychiatry as well. And I am aware that a lot of people believe in, in all sorts of explanations for the signs and symptoms that they are undergoing at the moment.
But we have to put this into the context of available science and research findings to be able to make up the diagnosis of a mental illness because if you don't do that, then everybody else becomes mentally ill, which is not entirely correct.
So we are also aware that a lot of the traditional healers, faith-based healers from churches, from wherever it is, provide a certain form of respite for patients with severe forms of psychological distress. They do something that helps them to cope at least; they are able to explain to the patient. So the patient is busy hearing voices of unseen people in their head and they don't know who that is and what's going on. Or the patient is feeling sad, they have lost interest, they don't know why, patient wants to kill themselves. So traditional healers do offer some form of explanations

for these extremely disturbing experiences that the patients have to go through. When they do that, they lessen the form of psychological distress, but that is not entirely mental health treatment, that's just a bit, a part of it. So the engagement of traditional healers, faith-based healers in mental health is something that we tread on carefully. We always tell the clients that, please stick to the prescribed regiments that we are going to give you. It's good to pray, but stick to the current treatments that we have given.

I don't know whether that answers the question.

Q. [10:50:25] Yes, I think for now it does. We may revisit some of the issues that are raised because it's an important issue, the issue of -- this is an important issue in our case and we may go back to it.

A. [10:50:40] Yes.

Q. [10:50:41] All right. Now let me start off or continue on this methodology. Let me start off upfront. You and Professor Ovuga have been criticised by the OTP experts, Dr Mezey and Professor Weierstall, who will have an opportunity to contradict me later, but anyway, for basically not adhering to a methodological approach. I can see what is going to happen here, but anyway, not adhering to methodological approach. And what I want to do in the next section, you know, you have read everybody's reports and perhaps you have read the transcripts. I want you to explain under methodology, I am going to ask you some questions, to explain to the Court --

A. [10:51:36] Mm-hmm.

Q. [10:51:37] -- do you have a methodological approach? I mean, you know, do you -- what it is and share any comments you may have, you know, about, about this or criticisms you have of approach of other experts.

PRESIDING JUDGE SCHMITT: [10:51:52] I think it would be okay simply to, as you are suggesting it, as I interpret it at the moment, to induce, so to speak, a narrative, a narrative explanation by the witness. If this takes longer, we could perhaps start with it after the break.

MS LYONS: [10:52:13] Sure. I will do a narrative. Let me, let me just give you also an alternative, your Honour --

PRESIDING JUDGE SCHMITT: [10:52:19] Yes.

MS LYONS: [10:52:19] -- which is, sorry, I wanted him to explain kind of who was at all the -- now the meetings that have each -- and we can do that first or I can wait to start later. It's up to you.

PRESIDING JUDGE SCHMITT: [10:52:28] No, no, that is okay as a preliminary question. Why not.

MS LYONS: Yes, okay.

PRESIDING JUDGE SCHMITT: And then we can go into (Overlapping speakers).

MS LYONS: [10:52:35] And then go into --

PRESIDING JUDGE SCHMITT: Okay, fine.

MS LYONS: Because I want to do a narrative and then I will pick up from there.

PRESIDING JUDGE SCHMITT: [10:52:38] Fine.

MS LYONS: Okay. That's fine. Thank you for your suggestion.

Q. [10:52:42] But before we get into that introduction -- those remarks, could you just -- we have four reports, and so we get it out of the way, could you just give us a rough timeline, the number of times you met with the client, who was present, what language the interview was conducted, whether there was an interpreter, you know, kind of the -- this is terrible, but the nitty-gritty.

PRESIDING JUDGE SCHMITT: [10:53:13] The setting.

MS LYONS: [10:53:14] Setting is better than nitty-gritty. Okay. Thank you.

Q. The setting of, of your reports. And we can go through each one. The first was in February 2016. It was a very brief report that you wrote.

A. [10:53:31] Okay. So we -- the interviews took place at the detention centre. We sat in with the client and had face-to-face discussions, and the language of communication was Acholi, I think for the first two interviews. But when we came back with proof, I think the third and the fourth interview the client was quite confident in describing some of the things in English. But most of the information was got using the Acholi language. I mean areas where the client needed clarity and couldn't speak in English, he was able to, to narrate to me what it was in Acholi. The interactions were face to face. They usually took about two to three hours, about four times a week for every time that we were here, sometimes five. So I could say for the four times that we were here, maybe, I don't know the number off head, but could have been anything between 15 to 18 interview, interview sessions between us and the client. Yes.

Q. [10:54:58] That's, that's fine, thank you. That gives a little perspective.

PRESIDING JUDGE SCHMITT: [10:55:01] I think then we will have the coffee break until 11.30, and then we continue with the methodology and I think the expert, Mr Akena, can simply explain. But you can of course induce with another question the narrative then, if you may.

MS LYONS: [10:55:20] Thank you, your Honour.

THE COURT USHER: [10:55:21] All rise.

(Recess taken at 10.55 a.m.)

(Upon resuming in open session at 11.33 a.m.)

THE COURT USHER: [11:33:04] All rise.

Please be seated.

PRESIDING JUDGE SCHMITT: [11:33:21] Ms Lyons, you still have the floor.

MS LYONS: [11:33:25] Thank you, your Honour.

All right. I'm sure that -- I haven't spoken to him, I'm sure that Professor Ovuga will join us --

PRESIDING JUDGE SCHMITT: [11:33:59] We have heard that there might be an issue, but it's not, it's not --

MS LYONS: [11:34:04] I have no information (Overlapping speakers)

PRESIDING JUDGE SCHMITT: [11:34:04] It's not a problem at all.

MS LYONS: [11:34:06] Okay, fine. I just wanted to be clear, because I'm not having any communication, I'm just talking to you.

PRESIDING JUDGE SCHMITT: [11:34:12] No, no, I'm -- we would not assume that.

MS LYONS: [11:34:15] All right.

Q. [11:34:16] All right. Welcome back, Dr Akena.

We are talking now more about some of what you touched on earlier, methodology, and hopefully we will get through some of this now and move into the issues of the diagnosis a little bit more.

But what I think -- I think the suggestion that Judge Schmitt made is an excellent one, which is, look, you have been criticised for not being methological enough or for your methodology. Talk to us about what your methodology was in the Ongwen case.

And then, after you have spoken, I will ask some follow-up questions, if you have not touched on them already.

A. [11:35:09] Okay. So we -- we used what we call a clinical interview or a clinical exam, and usually that's what we do in clinical settings. You need to have some baseline knowledge about mental health and the way you'll ask the questions, then

you form a hypothesis in your, in your head, and then you interact with the client. And this interaction is informed by existing literature about diagnostics criteria -- or, yeah, something like that.

So you, you sit, and we interacted with the client, meaning we asked him questions, he provided answers. We also observed the client. So observation, physical observation of clients in mental health is actually extremely important. You must see the client in totality, head to toe, preferably. The setting in which you sit, how you sit, which direction you face the door, who comes into the office first and not the other, also depends on how you would get that outcome.

Then we -- so, after that interaction, we would record that information on a piece -- on paper, would let him now that we would be writing down these things and that it's a hundred per cent confidential, and the information that we get from there is strictly for his own good or the good of the Court, but not for public consumption, for example.

And then we got what we call collateral history, because we wanted to be sure that whatever it is that we were receiving from him was, was appropriate. So we made attempts to interview a number of clients -- sorry, a number of, a number of people who had been with him. We made requests to that effect and we managed to get hold of four, four individuals, two males and two females, if I can remember, but they were all interviewed at different points in time. And the reason we did that was that we wanted to collaborate some, some of the information that he was giving us.

Then after we have gotten that information, then we go back and refer to text, written text in textbooks and manuals, and we then come up with a, with a diagnosis, and that diagnosis then helps us to make recommendations based on that.

You may have seen that I think one of our reports we, we wrote a report for clinical

purposes only, so a lot of it was medical jargon. And the reason we did that was we, in one of the interactions, we actually figured out the client was labouring under severe forms of illness, for which there was a need for treatment. So we made those recommendations and then we passed them over to the relevant authorities with the hope that he would get treated. I think he received some care based on that.

But I also think that at the detention centre there were other mental health professionals who were interacting with him regularly, so we made attempts to engage with them - we were successful on one attempt - to basically alert them to the fact that there were some, some things that we saw for which they needed to attend to medically, urgently.

We also, as a follow-up, we wanted to know what medications he was taking and why, for example, because later on during the assessment he started describing to us some things that looked or sounded like side effects to some of the medications that we give in our clinical practice, so we just wanted to know that. I think somewhere along the way we were able to establish those.

So I, I appreciate the critiques that we received from our, from our colleagues. I think they were helpful in helping us to shape our report better, but also helping us to understand the situation better. But we did what we could do to the best of our ability to be able to get this information in a clinical setting, which is very different from research setting. In a research setting you have many other ways of assessing clients who you deal with. So we, we did this for purposes of just not providing information to the Court but also, as medical practitioners, we are also ethically obliged to be able to identify illness and make recommendations that would help to alleviate the suffering of individuals in whatever circumstances they are in.

So the reports may have looked like they were unstructured or didn't follow a certain

procedure, but when we also saw some of the notes from the clinical centre, we didn't interact with the psychiatrist from the detention centre, for example, but I think it was -- it was clear that some of the symptoms that we elicited were similar or if not the same to some of the things that we -- that they had elicited.

So, basically, this brings to the conclusion that -- the methods that the different parties took may have been different, but the conclusions to those interactions were quite similar. We don't expect them to be the same, but they were quite similar and they were pointing in a certain direction, and that was helpful to inform our, our decisions going forward. Yeah.

PRESIDING JUDGE SCHMITT: [11:43:09] I think perhaps it's also clear, if you look at all these reports, that they served, so to speak, different purposes, also as you have described it. And as I said initially, we are now looking -- and I think this is the centre of the second big report from 2018, we are now focusing on the charged period 2002-3 until 2005. Others served other purposes, so we have to look at them also against the background of what the reason for the expertise was.

So we have, I think we have understood this.

Ms Lyons, please continue.

MS LYONS: [11:43:55] Thank you. Yes.

Q. [11:43:56] I just thank you for your presentation. I just have a few questions I wanted a little bit more information about.

You have talked about initial interaction with the client. Now, can you, can you say something more specifically about what this means, and I'll give you an example: Is there a role of trust in this relationship? How does it develop in specific with you and the client? That's what I'm interested in. What makes an interaction with the client go well or go badly?

A. [11:44:43] So, mental health professionals ask very personal questions to clients, some of these questions are distressing and not everybody is going to provide for you that information. Unfortunately, most times clients do not know what they are going to be asked, unless they are mental health professionals themselves, so we need, we need time, a long time to be precise, to be able to get to that point where the client can trust us.

In this particular situation, the client is in a detention centre. The client may be suspicious of the kinds of people they interact with. They may not be so sure whether you are a friend or foe in whatever form you come. So they establishment of what we call rapport, it's very, very important. Maybe on two or three or four occasions we, we had difficulty, because I think on two or three occasions the client was quite distressed, he was disturbed and couldn't provide a lot of information. On one occasion the client was unable to see us because there was, I think, some little skirmishes within the detention centre.

So we -- that that is, that's a very important part of our looking for information. I think we were lucky that maybe 80 per cent of the times we were able to establish proper rapport and proper contact and we were able to get information from the client. And also -- I mean, remember some of these interviews take two hours, some of them take three hours. That's a long time, that's, that's a very long time. So in between there you need to do everything within your means to keep the concentration up, because it drops. You also need to be aware that some of the things you ask cause significant psychological distress, they elicit bad memories, and all this needs to be taken into, into context. So whereas a one-page report may look one page, but the process of getting that information could easily be one week, or may be many hours, I don't know, may be 20 hours or something like that.

So establishing rapport is actually quite important, but also observation of the client. And these are things that are not written in a lot of books. You must look at the client, you must tell the mood, you must, you must, you must look at whether they are sweating, whether they are wriggling their fingers, whether their toes are moving, whether they are restless, whether their intonation is going up or it's down. Some of the assessments took place during winter so, you know, people would, you know, somebody would be feeling cold inside the room and, you know, they are complaining about that.

So, so all this had to be taken into consideration and, because of that, we use all that information to be able to come up with the signs and symptoms that we came up with. We are confident that whatever it is that we found was what was there and that the methods that we -- the procedures that we took were sufficient and adequate to provide the kind of information that we got. Yes.

Q. [11:48:55] Along the lines of your last --

PRESIDING JUDGE SCHMITT: [11:48:59] Microphone, please.

MS LYONS: [11:49:04] Sorry. Okay, microphone.

PRESIDING JUDGE SCHMITT: [11:49:05] Mr Bajnovic.

MS LYONS: [11:49:08] I know, he is busy doing something. All right, we know the rules here. Okay, microphone is on.

Q. [11:49:12] Now, following up on what you said -- I lost my question. Could you --

PRESIDING JUDGE SCHMITT: [11:49:29] But I think it was, your question and what you wanted to know is the reason why this personal rapport is of significance. I think the witness, the expert has answered that.

MS LYONS: [11:49:45] Okay. Thank you, your Honour. Okay, now the

microphone is on.

Q. [11:49:48] The question I wanted to ask you is this: In the process of building up a relationship of trust with the client, and specifically with Mr Ongwen in this case, did you personally -- what issues did -- did you have any personal issues you had to deal with on your end, as a psychiatrist, as an Acholi from the north, you know, family in the north? Those kind -- that's my question: if you are willing to share some of that with us here.

A. [11:50:26] Well, it's a bit difficult, but you know as a mental health practitioner we listen to all sorts of things from, from people. But this particular situation had some graphic and gruesome events and I knew some of the areas that the client kept on talking about. I knew them, I passed there. I have lived in some of those places, he did know that.

But I also looked at the client and his age, and I looked back at that time and I, like, oh my goodness, this could have actually been me.

So these are very difficult situations and you need to detach yourself from them, to be able to provide your -- to be able to help the client and the Court and everybody else and everybody else who is involved in this situation, from everywhere in the world.

So, yes, there were -- there were moments like that, but I also go through moments like that on a daily basis at my workplace. But -- but like I have said, some of the things that -- that were described by the client were slightly overboard. They were -- some of them were extremely disturbing, some of them we couldn't write them down because they -- they are difficult, they are actually difficult to conceptualise that somebody can go through that or expose themselves or be exposed to that, yes. But we try to do whatever it is we could do within our means because again in mental health if you allow your personal opinions and prejudices and

everything else to go into your way -- you just do harm to yourself and to the client and this is basically counterproductive in normal settings, yes.

Q. [11:53:35] Thank you. Now, the fact on the record is that the OTP experts, Professor Weierstall, right, did I say that -- Professor Weierstall, Dr Abbo and Dr Mezey did not examine the client, the client did not agree to be examined by them. Nevertheless, they were provided with a bundle of materials concerning the client and the case and the reports.

Now I want to call your attention to the position that Dr Mezey expressed to this -- this Court. It is at binder 1, tab 18, page 17, lines 19 to 22. And actually, I'm sorry, it starts on page -- it's all of page 17, lines 11 to 22. Where she talks about how -- and I will paraphrase it and my colleagues across the aisle can correct me if they have a problem with it. But my paraphrase is basically she said, look, I couldn't see the client. I received a lot of material, and yet she says -- this is a quote, she had an accurate picture and a very good picture of Mr Ongwen's mental state, his level of functioning over a period of time, including the time she was asked to comment on. And she describes this as an advantage. That's essentially what is on page 17.

Now, my question is this: You've described a methodology to us. Do you have any comments on the methological comment that Dr Mezey made?

A. [11:56:09] I -- I feel sorry that -- I feel sorry for my colleagues, because the practice of mental health is that you need to interact with the patient, or if you haven't interacted with the patient, you need to take a look at that interaction. So, for example, if you haven't talked to the client, then you could maybe get the opportunity to look at the video and the audio of that interaction and then make your inferences from that. I think it's difficult to work backwards, I think it's difficult to work backwards from text that you have, to go back to a diagnosis and find out whether

that was correct or not. Because there's just too many things that happen before that text is written. There's a lot of things. There's a lot of observations, there's a lot of questioning, there's a lot of probing, there's a lot of -- there's just too many things that happen before one actually gets to elicit a symptom and ultimately make a diagnosis. So I don't know how this could have -- this conclusion could have been made. I didn't make the conclusion, but I would find it extremely difficult to make a conclusion if I were provided text from a colleague or texts from colleagues, plus other forms of -- I don't know everything else that my colleagues got, but the provision of text, the provision of audio of the client in different settings may work, but maybe not all the time.

The ideal thing would have been for them to just simply observe our interactions with the client, and then if they had done that, it would have been easier for them, way easier to actually look back and say, well, this question was asked like this, the client responded like this, I don't believe that this is the response -- I mean, I don't believe in the conclusion. So the client was asked a question, there was no probing, the client gave an answer, the person who is asking the question made a conclusion, I think you can -- based on that kind of information, that you can make better judgment of -- of the outcome. But I think it was a difficult spot for them. I think it was difficult. I wouldn't have liked to have been in that situation as a person. Because I -- I think it would have been a bit unfair for everybody, myself, the people who have sent me, and the client to make that decision.

Q. [11:59:16] Hypothetically speaking, if you were presented with such a situation where you were asked to be an expert in a case, you had access perhaps to transcripts, open source Internet material, but you didn't have access to videos of a professional psychiatrist interacting with the client, you just didn't have that, what -- are there any

caveats you would have -- are there any caveats or are there any disclaimers you would have made, I mean if you were in that situation, in general, how would you handle it?

A. [12:00:04] I would be cautious in making conclusions.

Q. [12:00:21] Now, I want to keep going on some of the methodological issues of -- we talked about this a little bit this morning, the issue of -- of culture, but I specifically wanted to talk to you -- or ask you, I'm not testifying, ask you to talk about how this affects, in general, the -- a diagnosis of PTSD. And to start off and focus the discussion, I want you to look at again the binder at tab 18, transcript 162, pages 24 and 25, where Dr Mezey concludes and I will quote, there are "... considerable similarities and consistencies in the clinical manifestations of psychopathology across diverse affected groups globally tend to outweigh cultural ethnic differences." So she puts out the thesis --

MR GUMPERT: [12:01:45] No. With respect, that's a completely misleading proposition. She is quoting from the report of another doctor, Dr Schauer.

MS LYONS: Ah, yes.

MR GUMPERT: Really --

PRESIDING JUDGE SCHMITT: Yes, yes, yes. I would have --

MR GUMPERT: -- greater caution needs to be exercised.

PRESIDING JUDGE SCHMITT: [12:01:56] I was about to speak too. First of all, I think to make it easier for Mr Akena, this is now -- perhaps you have followed already, but this is on page 25 and it is lines 3 to 5 and this is indeed a quote. But of course Mr Akena may comment on the quote, but it's not -- yes, of course, but it's not -- it has to be clear and it is clear to everyone here in the courtroom that the expert at the time was quoting.

MS LYONS: [12:02:28] Right, but then -- yes, your Honour, and she -- let me try to rephrase. I have listened to -- let me try to rephrase. The question is whether -- looking at page 24 and 25 here, whether he agrees or not that core symptoms of PTSD manifest themselves more or less similarly across culture.

PRESIDING JUDGE SCHMITT: [12:02:54] Fine with the question, absolutely. That is clear.

MS LYONS: [12:02:56] Okay.

PRESIDING JUDGE SCHMITT: [12:02:58] You may answer, Mr Akena.

THE WITNESS: [12:03:02] Yes, so the manifestation of mental illnesses, the core similarities -- sorry, the core symptoms, yes, would be similar across cultures, but the diagnosis of mental illness doesn't rely squarely on -- on the core symptoms. They rely on other perhaps -- well, let me not call them non-core symptoms, but they rely on a number of things. They rely on a number of things. And that's why when we are reporting, when you read text, when you read literature everywhere you come across things like the prevalence of PTSD or depression, varies or is -- they usually give a range, so they will give a range of maybe 5 to 7 per cent, and then even the world mental health surveys, they will tell you, maybe in Africa this is the prevalence, in East Asia it's this, in Western Europe, it's that, in the US -- so how do we come up with those variations? We come up with those variations because of these kinds of differences. We come up with those variations because even when you administer the same instrument in English, the US, and then you administer the same instrument in Uganda to somebody who speaks English, for example, chances are that you may not get the same responses, you may not get the same way they understand this. And these are the things that affect the prevalences to the burden of mental illness across.

So whereas patients who would all complain or present with in the case of post-traumatic stress disorder, they have been exposed, they are avoiding situations, they are hypervigilant, etc, etc. The way in which each of those symptoms manifest may vary based on where somebody comes from, and two, how they understand the question that they have been asked, whether it makes sense to them or not. Some questions don't -- are difficult to assess.

I'll give an example. There's a famous screening instrument for depression called a CESD which is used for screening depression in general populations. I think question number 3 of the CESD asks something like have you been feeling blue, talks about blues. Many African languages cannot translate the word "blues", so if you ask somebody that question in Africa and everywhere -- I mean, and some other places, they don't understand what that means. So how do you ask that question in our setting?

That's just one of the examples of how context matters. If you talk about feeling blue in Western Europe, in the US, everybody understands what you mean. If you talk about feeling blue in Africa, people don't understand what you're saying. They don't know what blues means. Yes. So it is those little differences that makes these variations that we see happen. Yeah.

So I don't know whether they entirely outweigh the cultural and ethnic differences. I don't know what that means. I don't know what it means to outweigh by what per cent, by what effect size, I don't know. It's difficult for me to appreciate that statement. Yes.

Q. [12:07:02] Thank you.

Now let me ask you another issue related to methodology. You described so far observing the client and interacting with him and, secondly, collateral sources. In

other language, this has been described here as - in experts' reports - as self-reporting, relying on what the client tells you. Could you explain to us what the role or use of self-reporting is in the case of Mr Ongwen and your work?

A. [12:07:56] In comparison to something else? Self-rating versus -- I don't know.

Q. [12:08:13] Let me try to rephrase it. Did Mr Ongwen's self-reporting -- what role did Mr Ongwen's self-reporting play in your, in your reports, in your observations, in your conclusions?

A. [12:08:32] Ah, okay.

Q. [12:08:33] Yes, sorry, that was -- is that better? Okay.

A. Yes, that makes --

Q. Okay. Sorry. Thanks.

A. [12:08:34] Yes, that's, that's much better.

So you prompt the patient -- sorry, the client. You ask the questions and you get a response. You don't always get a yes and no response every time you ask the client a question about something. For example, if you ask somebody whether they have been feeling sad persistently for the last two weeks, most of the time during the day for most of the days during the two weeks, what's in the text is that the client can say yes or no. But the client may not actually say yes or no. Most times they don't. But in the process of trying to explain to you what that is, they could end up talking about a disturbance in their sleep or a disturbance in their concentration, or they could talk about dreams, for example, or they could talk about something directly opposite to that. So you have asked about sadness, they could just tell you about happiness, they could say, "I don't feel happy" but you have asked them about sadness.

So the information that the client gives us, we look for it. It is, it is rare that in

a mental health assessment situation the client volunteers some of these things to you, unless they are distressing, and usually the signs and symptoms that they volunteer to you are what we call somatic symptoms. So they will say something like: I don't sleep. I don't eat well. I've lost weight. But in mental health, again, those are pretty much nonspecific or they are not pathognomonic, they don't make -- they don't lead to a single diagnosis.

Earlier I had talked about the lack of mental health literacy, which is a very common thing in African populations. Most people in Africa, for example, cannot describe the signs and symptoms of depression by themselves. They cannot volunteer that. They don't go to the healthcare practitioner and start to tell the healthcare practitioner that: I'm feeling blue. I'm, you know, I'm in the gutters. I'm feeling sad. You know, I've lost it. I need Prozac.

They don't say that. Which is extremely different from what we see in the western hemisphere, that in Europe, in the US and many other places, individuals actually go to seek mental health care from their -- from their healthcare practitioners, especially for things like anxiety disorders and depressive disorders and post-traumatic stress disorders.

So we don't -- we don't -- we rarely get into a situation where the client volunteers that information all by themselves. We must probe for this information, we must probe for this and we need to get the answers, yes.

I don't know whether that answers the question about self-reporting.

Q. Yes.

A. [12:12:08] And I don't know whether the question was in relation to self-reporting of symptoms by the client or self-reporting of symptoms using the rating scale, or a screening instrument or something. I don't know. Whether it was

just the information that the client gives us, where does it come from? We ask questions, the client provides answers. That's how it -- (Overlapping speakers)

PRESIDING JUDGE SCHMITT: [12:12:34] I have understood it this way.

MS LYONS: [12:12:36] Yes. That's right. That's how it was asked.

Q. [12:12:38] You used a word - I have one follow-up - you used a word, pathomon -- pathomon -- what is that word?

A. [12:12:42] Sorry.

Q. [12:12:43] That's okay. Translate for us, please.

A. [12:12:47] Pathognomonic, meaning --

Q. [12:12:48] How do you, how do you spell it? Because I can't read the screen from here.

A. [12:12:50] It's P-A-

Q. [12:12:52] T-H-

A. [12:12:53] -T-H-A-G-N-O-M-I-C.

Q. [12:12:57] Okay. That's what -- okay.

A. [12:13:01] Pathognomonic. So pathognomonic basically means that -- there are situations in mental health where when a client tells you one or two signs of symptoms it actually points toward a certain diagnosis straightaway, like somebody, for example, believes that they are being controlled by external forces or a satellite. Or, you know, somebody is taking away their thoughts or that, you know, they are spying on them and they have planted a chip in their head. Usually that points in a certain direction.

But what we call somatic symptoms, somatic symptoms are things that sleep, appetite, weight changes, concentration, they, they cut across fear, anxiety, you get that whether the person has a mood disorder, whether they have a psychotic disorder,

whether they have an anxiety disorder or other disturbances, or substance abuse, or something like that, yeah.

So that that is what I was saying, so the client may report signs and symptoms that are not necessarily indicative of somebody having a mental illness. Or, if they are, they don't point towards any particular mental illness and you need to go ahead and look for what this means for you to be able to make any inconclusive remarks, yeah.

Q. [12:14:19] Now there is one last question on this self-reporting by the client, which is: Explain to us as laypersons how you can rely on self-reporting from a source, a person, who is in fact mentally ill?

A. [12:14:47] Yeah, it's -- usually it's a bit of a difficult construct to explain to laypeople, but there are many ways to do it. One is that you must ask questions, what we call open-ended questions. You try not to ask close-ended questions. Two, there are techniques that we use, like probing. But three, there are also observations that we do. So if I ask somebody whether they have been feeling persistently sad and the person says no, but they are tearing. So those are some of the -- those are some of the techniques that we use. So use probing, you observe, very important to observe. So we ask somebody "Do you feel sad?" Says, "No, I'm okay. No, I'm all fine," but they are asking for a tissue from you, they are feeling sad. Have they been feeling restless or fidgety, and they say no, but when you look at the feet, it's like they almost want to take off, you know. Something like that.

So we rely on that, but also we try as much as possible to ask the same question multiple times, and going round and round it, so you ask the same question, you go ask other questions, and then you come back.

There is something which we call social desirability in mental health. So social desirability, basically, is most of us instinctively want to feel, look good and happy

and normal. So when you are assessing for things like depression, you must ask for something that is exactly opposite, which is happiness. If you are asking for loss of appetite, you must ask for something extremely -- like the other side, which is increase in appetite, but when you get the responses you attach different scores. For example, if you are using an instrument to assess for those, you attach different scores to that.

But also, in a clinical setting when you are interviewing somebody and you are asking socially desirable questions, then you look at those responses and then you get back to your previous question.

So in mental health maybe it's a bit difficult to use, but in public health the things are usually a bit more clearer, things like: How often do you exercise? Everybody will say they exercise three days a week, even if they don't. How often do you use dental floss, for example, and people will say, "I use it all the time, I admit," but you know that's not entirely correct, it can happen in other people but doesn't happen all the time. So those are what we call the social desirability questions. We try as much as possible to ask it multiple times when we are interacting with a client, and that's what gives us the opportunity to rely on the client's perspective. That's one.

The next one is what we call collateral history, and usually preferably from the people who live and stay with the client. And that can also help to corroborate the evidence that we have. Yes.

But maybe 9 out of 10 or 10 out 10 times individuals with mental illnesses actually tell you the truth. And this is what we usually tell, tell our students, that psychiatric diagnosis don't change overnight.

Q. [12:18:44] Thank you.

A. [12:18:47] You're welcome.

Q. [12:18:47] Now I want to move on related to the general issue of self-reporting by a client. This Court has heard testimony in regard to malingering --

A. [12:19:03] Uh-huh.

Q. [12:19:03] And I -- could you tell us what malingering is in a context of as a psychiatrist and in the context of getting information from a patient.

A. [12:19:22] So malingering basically -- I'll describe it, maybe not define it. You have a situation where somebody has a material gain by providing certain information, so in the context of mental illnesses, in the context of forensic psychiatry particularly, somebody has committed a crime and then the person says they committed the crime under -- when they were labouring under the influence -- sorry, under the burden of a mental illness, and they know very well that in such a situation the M'Naghten rules would apply, meaning that they would, they would be let off the hook.

So there should be a gain, and the gain here is that I will not go to prison by providing this kind of information. So is it can, it can work both ways. Somebody can feign an illness or somebody can provide information that is contrary to what you, you provided. But usually they just, they just say they are ill and -- when there is a clear outcome which is positive to them. So they feign, they feign, they feign an illness for that purpose, yes.

Q. [12:20:52] Now, when Dr Mezey was here she raised the issue and presented the position - it's at tab 18, binder 1, around page 18, at the top, lines 2 to 3 - she presented the position that the client was malingering or faking it. That was the position.

Now --

PRESIDING JUDGE SCHMITT: [12:21:32] I think it is easier also in the near future, so to speak, if you cite simply what you, what you want to know. The paraphrasing

has always a little bit of a problem to --

MS LYONS: [12:21:44] Okay, sorry.

PRESIDING JUDGE SCHMITT: [12:21:45] -- that there might be an objection or there might be a misunderstanding. I think we would prefer it if you simply cite.

MS LYONS: Okay.

PRESIDING JUDGE SCHMITT: [12:21:51] And then also Mr Akena can follow better. If you tell him the lines he can read it and he has also a better understanding of what you're talking about.

MS LYONS: [12:22:03] Thank you, your Honour. I apologise to the Court. Okay, it's tab 18, transcript 162, lines 2 to 4, it's page 23.

PRESIDING JUDGE SCHMITT: [12:22:21] Because we have it here exactly, that she speaks obviously --

MS LYONS: [12:22:26] On page 18 --

PRESIDING JUDGE SCHMITT: [12:22:27] Yes.

MS LYONS: [12:22:28] -- yes, two places. On page 18 is Dr Mezey and on page - of the same transcript - 23 is a question asked by Judge Pangalangan about game -- gaming the system. Okay. So I won't say anything. So now --

PRESIDING JUDGE SCHMITT: [12:22:48] No, no, simply -- why not, page 18 now. The expert at the time has said in a more generic manner:

"The reason is because many of the individuals that I assess in a forensic context have something to gain from what we would call 'faking bad' or malingering is another word."

And perhaps you can continue from there.

MS LYONS: [12:23:12] Yes.

Q. [12:23:13] My question is, looking at these two sections, dealing with these concepts of faking it and gaming the system, do you have any response? Particularly, in terms of Mr Ongwen, we are talking about right now. Not generally.

A. [12:23:38] I find it a bit difficult to appreciate the role of malingering in this particular case simply because there -- there did not seem to be a direct gain, at least when we assessed him, that would accrue from that. But also usually in other forensic situations, by the time the person is taken into custody, they're aware that this is an outlet valve that they can always use to get out of -- it's like a jail, you know, a get out of jail card of some sort.

It's -- it's difficult. Somewhere in this, somewhere in our interactions with the client I remember, I think towards the end of something, the client was so disturbed and told us something like, "You know, I also want to be normal, like you people. I don't understand these things that are disturbing me. I want to be normal. I don't understand why I need to go through this. I don't understand why these things are disturbing me all the time. I don't understand why I'm ill."

Most people who are malingering would not say that. They would instead just insist that they are about to die or something like that, yeah. So I find the role of malingering, maybe I didn't understand the context properly, but I think it's -- it's difficult to explain it in this particular context because the client was clear about what he was going through and the disturbances that he was going through and how it was affecting him.

And we don't see why he would have wished to go through that at that particular point because he really wanted to get out of it, which is a direct opposite of what you get when people are malingering.

They want to have the symptom -- they want to have the signs and symptom. This

client doesn't want to have the signs and symptoms. This client wanted to be able to concentrate in the court. He wasn't doing that when we saw him at that time, yeah.

Q. [12:26:07] Thank you. Maybe it is assumed, but let me -- I have to ask, did you consider the possibility of malingering or faking symptoms as you worked with Professor Ovuga and prepared the reports?

A. [12:26:23] Absolutely, absolutely. And usually we, I mean, we must ask this question to -- to everybody we see in our -- in our clinical settings:

"What do you think this -- this interaction is going to help you with? Why do you think what's going to happen to you? What is this illness doing to you? What do you want out of this interaction?"

People who are malingering don't want to get better. People who are not malingering want to get better. They are looking for help. They're saying, "I wish I could end this suffering", which is contrary to that.

So we may not have included it in our text, but I think it was -- it was something that we -- we explored. And again, malingering is dangerous. It's actually extremely dangerous to malinger both for you as the professional, who is looking for this information, because should somebody find out that the client has been malingering, then your credibility really goes down the drain. And we were not willing to -- to go through that.

But also when the client is malingering, the more reason -- actually, the onus is on the mental health expert to ensure that the client is not malingering. Because apportioning a mental illness to a client - a mental illness that they don't have - is something that you shouldn't do in normal circumstances.

So we try, it's instinctive, to ensure that the patient actually has a mental illness so that they can get the best treatment available. If you don't do that, then, you know,

that -- that borders on lack of ethics. It's actually unethical, yeah.

Q. [12:28:30] And last question on the Mezey criticism, I want to call your attention and read to you from tab number 12, ERN, UGA-OTP-0280 at page -- page 806, it's paragraph 81. It's at, as I said, tab 12 on page ending -0806, where the report from Dr Mezey says ...

A. [12:29:20] Which page is that again? I am having a bit of --

Q. [12:29:22] It's okay, sure, no. Binder 1, it is either normal -- normal number is 21, but the number for the ERN at the bottom for the court system is UGA-OTP-0280-0806.

A. [12:29:45] Yes.

Q. [12:29:45] Page 21. Okay. This is a section from her criticism of reports from Professor Ovuga and Akena.

Paragraph 81 reads:

"The authors" -- meaning you and Professor Ovuga --

"have not considered the possibility of exaggeration or malingering, or the reliability of Mr Ongwen's self-report."

Is there anything you want to add in response to this?

A. [12:30:16] To assess reliability, we looked for collateral history to make sure that whatever it is we're getting was -- was reliable. That's one. To assess reliability, we asked the client the same kinds of questions but using different methods. That is one of the ways you assess for reliability. Malingering was inherently assessed during the whole process of the interaction to ensure that the client was getting the best that there was at that point, but also to ensure that our own credibility was not something that would be questioned in these kinds of situation because we see this all the time. Yeah, so I think the information that we got from the client was reliable based on the

self-report that he gave us, the collateral history that we got from the other people and also the -- the notes that we read from the detention centre. Some of the things pointed towards the diagnosis that we came out with.

So the long and short of it is that these methods were different, but they tended to point towards one direction, yeah.

Q. [12:31:49] And how -- how did you assess the issue raised also in this criticism of you? You didn't deal with exaggeration. I mean, how did you think about this methodologically?

A. [12:32:07] The issue of exaggeration comes as a secondary gain usually, and this secondary gain is either to get out of a situation. In clinical settings usually, somebody would exaggerate symptoms of what may be their -- a transfer to a much better ward or they have better food or whatever it was. But there was -- there was -- we didn't seem to see an exaggeration of this.

Again, the client was able to give us this information over a long period of time. We used multiple techniques to ensure that he provided this information. For example, of a two-hour period, we could take breaks. We could have breaks in between this. If the client was exaggerating stuff, it would have been very difficult to complete these interactions, extremely difficult, because the signs and symptoms would escalate out of this. Let's remember that in between these interviews, there were moments when the client was extremely distressed psychologically, extremely distressed. But we needed to get information and we needed to de-escalate those situations before we proceed.

If the client indeed was exaggerating these things, it would have been very difficult for us to control those episodes where he was distressed. We would have ended up calling for help from the guards who are always seated outside or calling for the

psychologist or something like that. Yeah.

Q. [12:34:05] Is there a difference -- the issue of masking feelings has also been raised in this courtroom in some of -- in -- when the experts gave evidence, the masking issue.

Now, is there a difference between malingering and someone masking his or her feelings?

A. [12:34:26] A big one at that. People who malinger for purposes of getting benefits by being mentally ill don't mask symptoms. It's actually the opposite. Masking symptoms means, I'm feeling sad. I've lost interest. I'm totally unhappy but I show up smiling. I say everything's okay. You ask me questions and I say I'm fine. I don't have any challenges whatsoever. I can concentrate.

But then you see that the person can't even read. So let me just give an example of a place where somebody maybe needs to read a consent form in a research setting. And you ask the person whether their concentration is good and the person says their concentration is perfect, but they can't read the consent form. That's masking. You try to hide signs and symptoms of a mental illness to make sure that you -- everything is fine. How do we deal with masking? We ask - what I earlier said - social desirability questions. If somebody's masking symptoms, we ask the exact opposite of what we want to know.

So instead of asking about sadness, we ask about happiness. Instead of asking about loss of appetite, we ask about increased appetite. Instead of asking about low energy, we ask them how often they've been playing football -- in the case of the client, the client liked to play football. So some of the questions we would have asked is, "Over the last one month, how often have you played football?"

Now, if the client for some reason says that they have been extremely energetic,

they've had a lot of drive and enthusiasm and everything else and you ask them how often they have been playing football, remember that most times the client doesn't know why the question is being asked the way it's being asked. So the natural thing they will tell you is that, "I really haven't been playing football for a long time." And then you ask them why. And then at that point, that's when they tell you that, "Actually, I don't have energy to play football" or "I feel that I need to isolate myself. I don't -- I don't want to be with people all the time."

Then you go back to the question that you asked earlier about loss of interest and lack of sleep, and you say, "But earlier you had said that your, your sleep was fine, but now you're telling us that you can't play football because at that point you're feeling sleepy. Is that because you didn't sleep at night?" More times than not it becomes apparent to the client that they have been caught in this little game of theirs, and they are able to tell you that, "Yeah, it's true, I've been struggling."

So this is what we see, this is what we see in mental health. The first few interactions -- the first few minutes of your interaction with a client yields responses that are socially desirable to the client, to their environment, and to their sociocultural context. But as the interview proceedings, it becomes much more apparent that this person actually needs, needs help. Yeah.

Q. [12:38:01] Thank you. Now I just want to ask two other -- a couple of other areas in this methodology. I'm going to make it briefer though.

You raised the issues of standards and scales earlier --

A. [12:38:19] Uh-huh.

Q. [12:38:19] -- and, for the moment, could you just talk about the PH -- what is this PHQ-9 scale and also this HSCL scale? What are these scales and how are they used, just briefly?

A. [12:38:40] So the PHQ-9 is a Patient Health Questionnaire-9. It's a screening instrument for depression in primary health care settings, but it can also be used to diagnosis depression.

The Hopkins Symptoms Checklist, the HSCL, either 10 or 25, is also used to assess for depression in, in setting. Sometimes the Hopkins Checklist can be used to rate depression symptoms.

So these are skills that are used both in clinical settings and in research settings to know how severe somebody is -- I mean, severe a condition or an illness is. Yes. I don't know whether that answers the question.

Q. [12:39:36] No, that answers it. Let me ask you in terms of the Hopkins Symptoms Checklist, has this been used across cultures with both populations that speak English as well as nonspeak -- those who do not speak English? Talk about some of the caveats in using the Hopkins scale. Just briefly.

A. [12:40:07] So the Hopkins scale, like many other scales that were developed in, in Europe and in the United States, have been used before in Africa. I think the Hopkins Checklist was used somewhere in Tanzania in some work. A couple of colleagues I think have also used it in Uganda.

But the process of ensuring that the responses that you get from this checklist is valid is a bit long, but nonetheless we use them often, we translate them. We may use them in a clinical interview setting to come up with outcomes that we are interested in.

So yeah, sometimes the scale may not be developed -- I mean, may not be validated in a certain population but it will still be used. And at the end of the publication usually we say that there is a limitation, that this scale was not validated here, but we still trust whatever it is that we have gotten.

Maybe not for the purposes of the Court, is that there are a number of statistical tests that you can do that will help you to know whether -- how good this scale was in the population that you used it, whether it changed significantly or not. But maybe that's not -- that's not for the consumption of this Court here.

Q. [12:41:35] Okay, I'm going to actually not go -- further go on with this question, I think we have enough for right now, and the Court, certainly, or the Prosecution, can ask more on this.

Just briefly, because it's going to come up here: What is the DSM-5 and what do you -- what is it? What do you teach about it -- what do you teach about it to your students? And how do you use it? Just tell us, please.

A. [12:42:03] So the DSM is the -- is a diagnostic and statistical manual for mental illnesses, so it has versions 1 to, now, 5. It's -- it's a manual that we use to communicate as mental health practitioners. It helps us to standardise our language, so if we say somebody is depressed, according to the DSM we know that they are nine or so symptoms that the person should have had, and there's a criteria that you use for that.

There's also the International Classification of Diseases, which is the ICD, which is more commonly used in Europe compared to the DSM. The DSM is more, more American. But our training, we use the DSM and not the ICD. Although now the DSM-5 and the ICD-11 are meant to be similar and meant to communicate with each other, because I think colleagues in the field realise that the differences between the two texts -- sorry, the differences between the two manuals was unhelpful for clinical practice.

So we use the DSM as a base for people to be able to understand the signs and symptoms in a certain manner and classify these disorders in a certain manner. It's

not textbook, we don't use it as a textbook. The DSM is not a textbook, it's a manual. So it does help us to communication with people and to communicate amongst us as specialists.

So that's what we teach, so during the training you have to get DSM training to make sure that you, you know what people are saying. But you also need the clinical aspects of it, because the DSM doesn't talk about so many other things that you need in order to make a diagnosis or to inform practice or treatment. Yes.

Q. [12:44:22] Now, one of the issues that came up in diagnoses and conclusions, one of the criticisms that has been raised is that you did not -- you and Professor Ovuga did not eliminate the alternatives. So, could you explain to the Court how do you reach a diagnosis and what is the role, if any, in your processes of eliminating the alternative diagnosis. What is your approach to this?

A. [12:45:01] So, there are -- when you are making a diagnosis of a mental illness there are multiple alternatives, maybe limitless, but you cannot go into all that. You cannot state all of them. So I give an example of a mood disorder like depression. If you look for depression, then you must tell people about bipolar affective disorders. If you look for depression, then you must tell people about maybe substance use. If you look for depression, maybe you tell people about psychosis. But, if you look for depression, you can't -- you know, you can't tell people about Tourettes, for example, disorder, or tic disorders or something like that.

So the alternatives that we provided in the report were appropriate for that setting, so the hypothesis was that this is a young man who has been exposed to all forms of problems, what is it that he could suffer from? He could suffer from depression, he could suffer from epilepsy, he could suffer from post-traumatic stress disorder, he could suffer from anxiety disorders, he could suffer from dissociative disorders. It is

very unlikely that he suffers from Alzheimer's, dementia, for example, or that he's delirious at that point in time.

So the alternatives that we provide, we provide it in that kind of setting. Otherwise, it becomes impossible to assess somebody for a mental illness if you are going to provide alternatives for all the disorders in the textbook. It's practically impossible to do that.

Q. [12:47:15] When you teach your students about this aspect of methodology, how do you use a diagnosis that you have reached and how do -- and how do you use other possible diagnosis? What do you say to them?

A. [12:47:31] I tell them that you -- it's difficult to make a diagnosis in one setting for any mental illness to be precise. I tell them that they need to interact with the patient multiple times. I tell them they need collateral history, and I tell them that they could be wrong at the end of it all. I tell them that the signs and symptoms that you see are important to make that diagnosis. I also tell them that, at the end of the day, when you prescribe treatment and the person gets better, if you make a diagnosis of depression, you give the person anti-depressants, they get better, then you are happy, you say, "I made the diagnosis of a depression." But there are times that you think you have made a diagnosis of a depression, but it's not, you are giving somebody anti-depressants and they are not getting better. But I just tell them to continue interacting with, with clients all the time, and that's the only way they can get this, because sometimes the information that you get that helps you to make a diagnosis is got at the end, at 12.55 p.m. when it's just five minutes to lunch, that's when the patient actually tells you what the problem is. So that's, that's what happens in our practice. Yes.

Q. [12:49:04] Okay. As we get to 10 minutes to lunch, let me get to one of the

heart -- the heart of the issues of methodology. There are a number we haven't yet covered, I will raise them, but let me just focus on this. The big question around diagnosis in this case is how can you - in 2016 you saw the client, 2018, 2019 - how can you make a diagnosis in 2016 to 2019 and relate it back to the charged period, 2002 to 2005?

That's the underlying issue with all of this for this Court right now. So can you begin to respond to that, methodologically, you know, how you can do this.

A. [12:50:11] So the client was aware that they had been charged with crimes between a certain period of time. The ideal thing would have been to just stick to that period of time during our assessment. The reality though is that that process is flawed, it's highly flawed. So we had to go back, we had to go back to way -- many years backwards, and then many years after that. And then we point out that whatever it is that we are seeing now, some of it started way back and they continued, including through the period for which the charges are laid on, on to the client. So why did we do that? We did that again for two reasons, maybe three:

One is the issue of social desirability. Two is that sometimes you really don't want to cue the client, you don't want to -- you don't want to put the client in a situation where they are boxed into a little corner and they must provide information. Remember that period is, is extremely significant to him. You don't get much information if you stick to that period when you are assessing for a mental illness. You don't get much information.

But remember that up until 2016, the client had not really received an assessment for a mental illness or treatment for it, as far as we were aware, so these things had gone on unabated, untreated for as long as they could. So the diagnosis that we get in 2016 is not so far away from the one we get in 2017, it's not so different from the one

we get in 2018.

In between there the client was receiving care in the Detention Centre. I think there is information to that effect of there are improvements that we see. There are reports that we get from the detention centre that maybe things are getting better. Although sometime in 2018 things were getting worse because of one of the therapies that he was getting (Redacted) They were actually making

him worse than before.

So I don't know whether that -- so I think the whole idea was to put as much information as possible into context, to say: These things began at this point. It wouldn't help the Court, the client or anybody else to just limit our information to that. Although I think in our report at the end of the day, we still point out times in between that period where we have information from the client that he had disturbances, and these disturbances we wrote them in our report and I think they are available here.

Q. [12:54:00] But still, if I may press you a little bit further on this, you said that, you know -- how did you know when something started? You diagnosed PTSD, for example. You diagnosed dissociative disorders. You diagnosed, you know, you made other diagnoses in your reports. How did you as a -- were you thinking about -- how did you as a psychiatrist know that -- or think, why do you think did these go back to 2001, 2002, 2003? That's what I'm trying to understand, that there's a step in between that I'm asking about.

A. [12:54:47] So you -- in the assessment of mental illnesses, there's current and past. So you have current mental illness, like today, for example, or two weeks ago. Then you go into what we call the past signs and symptoms. Usually in clinical settings we call that the past psychiatric history. Now, in the past psychiatric history

you document the number of episodes this has happened. So this is how you do it, you say: "Have you ever felt sad in your life? Lost interest, lack of appetite?" Blah, blah, blah. Then the person says: "Yes."

"Did this take so much time? Was it there almost every day?" They say "Yes". You say, "Okay, are you feeling like that now?" They say "Yes". Then you go back, you say, "In the course of your life or over your lifetime, how many times have you distinctly felt like this?" And then the person starts to tell you, "Oh, in 1990, I had this. In 2001, I had this." Sometimes the memory is quite fuzzy and some of the information that you get is difficult to allocate to a particular point in time. But it is of -- it is regular practice to document the episodes of a mental illness.

And, again, maybe it's second nature, it's not difficult for a mental healthcare worker to do that and they can document that somebody has had maybe 10 episodes of depression in the past between this period and the other period. So it's, it's possible. You must go back. But that -- again, that's difficult. I mean, that's easier said than done because the memory keeps on shifting.

PRESIDING JUDGE SCHMITT: [12:56:53] May I say on this, I think in the forensic context - you can contradict me or agree - you always have to go back in time. You always sit -- at some point in time you sit a courtroom, and be it 10 years or be it two or three years, you always have to go back in time and try to figure out how the state of the client, as you say, was at the time. I think that that is inherent in forensic psychiatry. That is at least my understanding, a little bit.

THE WITNESS: [12:57:25] Yes, sir, that's correct.

PRESIDING JUDGE SCHMITT: [12:57:33] I think we have nearly reached 1 o'clock, Ms Lyons. And of course for planning purposes, do you have already an idea how long it would last, examination?

MS LYONS: [12:57:45] Well, I think the full amount of time that we have, I will -- it will last. There's a little bit more on this section and then we move into the two reports. It's --

PRESIDING JUDGE SCHMITT: [12:57:58] More concretely, because we can -- we already indicated that we would contemplate to extend hours today, for some reasons that I need not explain. We would then perhaps shorten the lunch break so that we have two hours in the afternoon. Perhaps we are --

MS LYONS: [12:58:16] Your Honour, this is -- I think that we need more than two hours in the afternoon. I think we need maybe three hours.

PRESIDING JUDGE SCHMITT: [12:58:26] So let's --

MS LYONS: [12:58:28] I think we should shorten the lunch break.

PRESIDING JUDGE SCHMITT: [12:58:30] Yes, yes, yes.

And of course the next question - Mr Gumpert is already nearly on the rise - although for you it's even more difficult to assess it, but something that you -- something that you can tell us.

MR GUMPERT: [12:58:43] I will get my cross-examination done - short of something extraordinary - in the four and a half hours which a full day represents.

PRESIDING JUDGE SCHMITT: [12:58:53] So then we -- first of all, we shorten the lunch break today. And then we -- you try, at least, to be over with two hours. If not, we continue tomorrow, you are not curtailed in any way. And if you would need three hours, meaning tomorrow perhaps two-thirds of a session at the maximum, then we will again shorten the lunch break tomorrow and we will extend hours tomorrow so we will be done with the witness, with the expert. Which is of course also very intensive for the expert, by the way, but it's for everyone. And you're a professional, I think you won't mind.

So we have now then only a lunch break until 2 o'clock.

THE COURT USHER: [12:59:43] All rise.

(Recess taken at 1.00 p.m.)

(Upon resuming in open session at 2.03 p.m.)

THE COURT USHER: [14:03:36] All rise.

Please be seated.

PRESIDING JUDGE SCHMITT: [14:03:57] Good afternoon, everyone.

Good afternoon, Mr Akena.

THE WITNESS: [14:03:59] Good afternoon.

PRESIDING JUDGE SCHMITT: [14:03:59] You have still the floor, of course, Ms Lyons.

MS LYONS: [14:04:09] May I proceed, your Honour? I'm sorry I put it on two minutes late. Okay.

First of all, we have one of our interns, Veronica Stachurski has joined us in the seat where Mr Obhof was. Is not Mr Obhof -- she is not Mr Obhof.

PRESIDING JUDGE SCHMITT: [14:04:27] Okay.

MS LYONS: [14:04:28] Okay, so to know who's here. Okay.

PRESIDING JUDGE SCHMITT: [14:04:35] Acknowledged.

MS LYONS: [14:04:37] Acknowledged. All right.

Now, let's go.

Q. [14:04:43] Okay. Dr Akena, let me ask you a quick, quick question before we continue. I forgot to ask this this morning. When you and Professor Ovuga prepared your various reports, did you consider the report done in I think probably January or February of 2017, by the independent expert appointed by the Chamber, Dr de Jong, did you read it or did you consider it?

A. [14:05:24] No.

Q. [14:05:24] Okay. Now, the second question is, have you ever met Dr de Jong, or if you have, have you ever consulted with him?

A. [14:05:33] No, I don't know -- I don't know Dr de Jong.

Q. [14:05:40] I want to finish up a little -- just a few concepts on methodology and then we'll get into the reports.

If you can briefly explain to us what makes a trauma into a disease? How does a trauma become something else, a disease?

A. [14:06:08] I think there are complex mechanisms that happen: So somebody gets exposed to an event that either threatens their life or their existence and this has been shown to lead to biochemical -- biological changes in the brain, and then that then leads to physical manifestation of the disease in some people.

Whether that person develops the disease or the disorder is dependent on a number of things, including how that person was functioning before, whether the person used substances or not. Substances, I mean alcohol or anything like that.

Then the meaning that the person attaches to the kind of event that has happened.

And then the support systems that the person has at the time through which the trauma has happened. If somebody has better social and psychological support available, that could be a mitigating factor.

So that's what happens. And then if it doesn't get treated, usually it simply gets worse. Yeah.

Q. [14:07:36] Thank you. Now you talked about disorder and disease. Can you tell us briefly what the -- how they are different or the same? How -- or describe them. How are you using the terms?

A. [14:07:57] Something becomes a disorder if it is interfering with somebody's

social and occupational functioning levels. So, we all have signs and symptoms of an illness, but it doesn't reach the point that the symptoms are many enough or severe enough to cause a dysfunction in the way you -- you -- sorry, a dysfunction in your either social interactions with people or in your work. It doesn't do that. And this varies quite substantially. The disruption in somebody's social occupational functioning varies -- varies quite widely across, depending on what the person does and in what context they operate. So then, if you have that, then we call that a disorder. So, yeah.

Q. [14:09:04] Now, can you tell us, let's take, for example, generally, PTSD, post-traumatic stress disorder. If -- how do you -- can you tell us what criteria you use or how you make a determination? When does it stop being a disorder and become a disease?

PRESIDING JUDGE SCHMITT: [14:09:39] If --

THE WITNESS: [14:09:41] The two are used interchangeably sometimes.

PRESIDING JUDGE SCHMITT: [14:09:45] Exactly. That I wanted to (Overlapping speakers)

THE WITNESS: [14:09:46] So sometimes you -- yeah.

PRESIDING JUDGE SCHMITT: [14:09:47] You answered what -- what I wanted --

MS LYONS: [14:09:48] Okay.

PRESIDING JUDGE SCHMITT: [14:09:48] I did not want to contradict you, but simply I had the impression - until now in this courtroom and also from cases I had in my former professional life - that they might be sometimes used in a similar fashion, to put it --

THE WITNESS: [14:10:10] Yes.

PRESIDING JUDGE SCHMITT: [14:10:10] -- mildly.

MS LYONS: [14:10:11] Okay.

PRESIDING JUDGE SCHMITT: [14:10:12] So you would confirm that, so to speak.

MS LYONS: [14:10:14] Now I have testimony from two. Thank you. Fine, thank you, that makes it easier for me. Okay, just -- I just -- no need to clarify. All right.

Q. [14:10:22] Now, is -- let's talk about traumas. You know, for example, in child soldiers, in general, just rough, generally. Does trauma come and go? I mean what, how -- what is its -- does it have a life? A linear -- that's a bad word. Does it come and go? That's the question. Enough.

A. [14:10:58] The exposure or the outcome? I think the outcome?

Q. [14:11:04] Yes, the outcome.

A. [14:11:06] Okay. So the trauma itself can happen to somebody multiple times. But the science indicates that when somebody is exposed to this, they could develop changes in their brain and these are the changes that lead somebody to express the signs and symptoms that they get.

A number of mental illnesses may abate on their own, but that's rare. The longer a mental illness takes without treatment, the higher the chances that it will become chronic, but the higher the chances that it would also evolve into other illnesses.

And I think that's the kind of reasoning that we have now for the DSM-5 is that the disorders are arranged in a manner that they start from the disorders of childhood until the disorders of adulthood. So the chapters are arranged in that manner. And the reason for doing that is that the assumption is that these things happen on a spectrum, so maybe you can have an anxiety disorder, then later on have a depressive illness, and maybe later on have like a bipolar affective disorder and then, with time, we may not know whether you still have bipolar affective disorder or, like, schizophrenia or some other psychosis that's not known.

Without treatment, that's what I usually tell my clients, mental illnesses don't go away by themselves. Without an intervention it is very unlikely that something would leave you by itself.

The severity of those disorders may fluctuate. Why do they do that? Because in the course of people's lives they encounter things that can help them to cope, things that can make things like mental illnesses less severe. But, at the end of the day, if efficacious treatments are not administered that particularly target the reversal or the stopping of that process, then usually the outcomes are not good, the outcomes are poor. Yes.

Q. [14:13:38] Now, in the -- in the lifespan of an illness - as an example PTSD, dissociative disorders, if I may, just may give some examples here - is there something called symptom fluctuation or, in other words, in layperson's terms, I mean are there good days and bad days? You know, do the symptoms --

A. [14:14:08] Uh-huh.

Q. [14:14:08] What is -- does it happen every day? Is it 24/7?

A. [14:14:15] Yeah, that's -- maybe, maybe I didn't explain it well in my last sentence, but the textbook makes it look like somebody would have sadness, loss of interest, lack of appetite, poor sleep and everything else happening almost every time during the day -- for most of the days during that period of time. Realistically, is that there are days when things get better. There are days maybe when somebody sleeps better so they can concentrate a little bit better. There are days when somebody gets good news and when they get good news they feel better. There are days when they get bad news and the symptoms get worse. So, yes, symptoms can fluctuate based on circumstances through -- under which the person is going, but that doesn't mean they're not there. Actually, if you make an assessment, even when the

symptoms are fluctuating, you're still able to tell.

So I'll give you an example of, well, PTSD in this case. So if you're assessing somebody for PTSD over the last one month and you tell them that, "Okay, so over the last one month, starting today, how often have you experienced these things?" And then the person can say, maybe haven't slept well for two weeks. And then you say, "What do you mean?" They say, "Well, over the two weeks, I haven't slept well for 14 days out of the two weeks." So then you say, "Okay, so what do you mean?" "That maybe for eight days I had insomnia, maybe for the other days I was sleeping too much. Maybe the other days I was having nightmares." But the description is like "I didn't sleep well."

But then, maybe over that one month the person got good news, maybe they won a million dollars and -- from a lottery and they got happy. And once they get happy, they may forget their troubles a little bit, but if you ask them, if you ask them objectively whether these things have gone away, they will say "A little bit, but really no." Yes, something like that.

Q. [14:16:34] Now, if a person is suffering from PTSD or dissociative disorders or severe depression, would it follow that another person could look or observe that individual and see this, or does that not make any sense, that proposition, to you?

A. [14:17:05] Apart from psychotic disorders like maybe schizophrenia, bipolar affective disorder manifests where people are all over the place running. It's generally difficult to just look at somebody and say they have a mental illness without talking to them. So simply looking at somebody and coming up with a diagnosis is, is ill-advised.

Q. [14:17:33] Now that --

A. [14:17:33] You could get some pointers, but you will not -- you will not -- you

will not get something concrete, yes.

Q. [14:17:42] Now, I understood that would be the perspective of you as a professional. Let's say I looked at the person - I'm a lawyer, I'm not a doctor, okay - would I be able, except for psychotic illnesses, would I be able to tell?

A. [14:18:04] Unlikely, because the signs and symptoms that we use to make a diagnosis are usually objective, they are not subjective. So if you're going to make a diagnosis with mood disorder, you really need to ask the person whether they have been feeling extremely happy or extremely sad, for example. You can't get that answer from just simply looking.

If you're going to make a diagnosis of post-traumatic stress disorder, whatever it is, you need to ask whether they were exposed, you need to ask whether they are hypervigilant, you need to ask whether they, they avoid things, you need to ask whether they make cognitive alterations. So it's a bit -- I think it would be very difficult for somebody to, for a layperson to make a diagnosis with mental illness, without any form of disrespect, but I think most laypeople would see that something is wrong, but they wouldn't particularly tell that this is what the problem is. So they could say that: Well, you know, there are some -- something is amiss here. But that's most likely where they would stop. But in the context of -- in this context, that information is not sufficient.

Q. [14:19:31] Now, the last point on this, on this issue here, I would like you to look at the chart -- you have a chart that says "Materials Drawn from the Ongwen Case Proceedings for Consideration and Possible Commentary by Defence Witnesses".

A. [14:19:52] Yes.

Q. [14:19:53] And take a look at number 2, which is on page 2.

A. [14:20:09] Yes, ma'am.

Q. [14:20:09] And what I'm interested in is the first part of the first sentence. This is from Dr Mezey's report at paragraph 98, and the ERN number is UGA-OTP-0280-0786 at 810. It's paragraph 98 or, or page 25, and I will read the first part and then I will ask you to comment:

"If Mr Ongwen had been suffering from serious mental illness and mental instability, one would have expected this to have been readily apparent to other fighters and members of the LRA."

Do you have a response to this or do you agree or disagree with this statement?

A. [14:21:12] You would need to have interviewed those individuals, and you need to have interviewed them in a manner that you can elicit that kind of information that is helpful towards making a diagnosis. People simply describing somebody's character is not -- it's unlikely, it's unlikely that you can get something out of that regards -- I mean, with regards to just the first sentence alone.

Again, we've talked about the fact that definition, description of a mental illness various widely in the populations across the world. In the African setting it's perhaps not extremely clear what a mental illness is, so describing a mental illness in the context of the African setting and, for example, these kinds of setting, is something for which you need to dig slightly deeper and you need more information. I would say you'd need more information, yes.

Q. [14:22:32] If I were a member of the LRA and a fighter with Mr Ongwen, could I tell if he were suffering from mental illness?

A. [14:22:51] You see, what we describe as mental illness among the laypeople in Africa is somebody who stripped naked and running around and eating from, from the bin. If you don't have that, it's very unlikely that people will say you are mentally ill. So you could have lots, loads and loads of signs and symptoms of a

mental illness but the general population may not know. They may think something is amiss, but that's where it would end, and they could, they could dismiss it basing on the circumstances under which they're operating.

Q. [14:23:32] Thank you. Earlier you talked about children and adults may manifest signs of mental illness in different ways. Do you think this would present difficulties to me as, for example, if I were a child soldier with Mr Ongwen when he's still a child soldier, would this present difficulties to me in seeing any mental illness, in addition to the point you raised about what is mental illness, but would this present any difficulties to me?

A. [14:24:25] Let's look at depression, for example. If a child is depressed they are going to be irritable, extremely irritable. They may not feel sad -- sorry, they may not express the symptoms of sadness. So if somebody has had a chronic depression, let me say from 20 years, and they started having that depression when they were still young, maybe 10 years or five, and they can't even express the symptoms, it starts over as anger. And the way those kinds of clients present to us is they present as disturbed children, bullies in school, they like fighting, they're aggressive, they're irritable, they don't listen to their parents, they are "spoiled", in quotes. But when you sit down and take the history, you realise that this is more than simply just anger. A number of children cannot express or describe suicide and suicidal ideations, for example. It's difficult for them. If you ask them the way you would ask an adult, you are unlikely to get, to get answers.

So depending on when he was seen, whether he was seen -- because he spent a long time in there, so depending on when he was seen, people who saw him as a child will definitely describe him differently from people who saw him as an adult. But again, the descriptions may point towards an illness or may not point towards an illness,

depending on how the question was asked and to whom the question was asked, but, most importantly, in what context the question was asked.

Q. [14:26:18] Thank you. We're going to now move on to the reports, but I will ask you first to define a few terms very, very briefly so that everybody can understand better what you're talking about.

We're going to talk about -- I'm going to ask you about your conclusions about severe depressive illness, PTSD, dissociative disorder. I'm going to ask you also about severe suicidal ideation and high risks of committing suicide, which is not -- which is something else, but I'm going to ask you about that. Those were five points that came out of your conclusion in your first report.

So could you tell us how you -- what you mean by severe depressive illness for starters?

A. [14:27:19] So generally speaking, depression is a -- or a depressive illness is a situation where somebody has a very low and sad mood and usually it is either persistent sadness or loss of interest in the pleasure of activities that the person used to have, as what we'd call the cardinal symptoms. Plus a couple of other symptoms, which include disturbances in sleep, guilt about past wrongs, poor concentration, lack of appetite, changes in weight, and then suicide.

It becomes severe if most of those symptoms are there most of the time, during at least a two-week period, it could be way longer than that, and if those symptoms, for example, cause a dysfunction in the -- social and occupational dysfunctioning.

Now in the case of the client, occupational dysfunctioning is difficult to assess because he doesn't or did not hold the kind of formal jobs that most of us would hold. So it's way easier to assess occupational dysfunctioning, for example, in a lawyer. You say, "You're no longer able to go to the court. You're no longer able to do this.

You're no longer able to do that."

But social dysfunctioning is easier to assess in this situation and that really has to do with the way the person interacts. So depressed people are likely to isolate themselves because sometimes they feel inadequate, sometimes they want to die, and sometimes they just don't see they're pessimistic. They don't see why they should live.

So if you have all these symptoms there and if you have a situation where the client is clearly extremely disturbed, then you make that diagnosis of a severe depressive illness.

Now the reason we said illness - if I remember in our first report - and not a disorder is at that point we really still did not have adequate information to confirm whether this was a disorder or not.

So in that situation, we call it an episode. We say, you know, somebody has had this episode. It becomes a disorder if, you know, they've had it multiple times and then you can corroborate that history and confirm that indeed, in the past the person had that. Or going forward, you assess the person again and you still find the symptoms are there. They haven't gone away.

So we made that diagnosis of a severe depressive disorder.

(Redacted)

(Redacted)

(Redacted)

And I think there are maybe two or three other times that happened at the detention centre.

PRESIDING JUDGE SCHMITT: [14:31:03] And I think we have this in the reports. Otherwise, I think we would -- I would suggest that we discuss these matters not in

public.

THE WITNESS: [14:31:05] Yes.

PRESIDING JUDGE SCHMITT: [14:31:06] Yes, but we have it in the reports and I think I understood you that you refer also to incidents reported from the past, I understood you.

THE WITNESS: [14:31:25] Yes.

PRESIDING JUDGE SCHMITT: [14:31:26] Okay. Good. Thank you.

MS LYONS: [14:31:28]

Q. [14:31:30] Do you -- do you want to just explain -- explain briefly what -- just on the description, just so we know before we move forward through this --

PRESIDING JUDGE SCHMITT: [14:31:38] May I shortly?

MS LYONS: [14:31:39] Yeah, sure.

PRESIDING JUDGE SCHMITT: [14:31:40] I think it's really a good idea to ask one after the other like you intended, the expert, how he understands these disorders. So we have had the first --

MS LYONS: [14:31:48] Right.

PRESIDING JUDGE SCHMITT: [14:31:50] -- and I would simply suggest that you go one after the other and perhaps then --

MS LYONS: [14:31:53] Okay.

PRESIDING JUDGE SCHMITT: [14:31:53] -- go more into details, if you want.

MS LYONS: [14:32:00] Okay. Thank you. Thank you.

Q. [14:32:02] Okay. So now, let's talk about dissociative disorder. Okay. How do you understand that? And I would like you also to please differentiate between a person kind of spacing out, again being in a situation and spacing out or losing a sense of consciousness about a situation with someone who has a dissociative

disorder.

A. [14:32:38] So dissociative disorders are situations where an individual has a loss of awareness of their surroundings and usually it follows a severe form of psychological distress. And it's a mechanism that the brain puts in place to take away a traumatic event or a traumatic happening or a traumatic memory.

So when somebody has disassociated, they are really not fully aware about what it is that is happening to them at that point. They may communicate with people, they may be seen to be communicating, they may be dazed, sometimes this can take hours, sometimes maybe days, sometimes just a few minutes, and recovery sometimes is spontaneous and then after that, the person basically has to be reminded.

So some people may -- may say, you know, "I had died" or "I had gone into a different world during that period." And the definition has changed a bit. In the past, there used to be like a fugue state or dissociative amnesia where the person, they had -- they had situations where they just don't remember what's happening. There are persons who take on a different identity and move to a different state and stay there.

So it's -- usually, it's something that we see when individuals are struggling with illnesses of psychological trauma and it's a mechanism in-built in us that helps us not to either remember or be part of -- of that, yeah.

PRESIDING JUDGE SCHMITT: [14:34:58] May I shortly --

MS LYONS: [14:34:57] Thank you.

PRESIDING JUDGE SCHMITT: [14:34:58] -- Ms Lyons?

MS LYONS: [14:34:59] Certainly.

PRESIDING JUDGE SCHMITT: [14:34:59] Mr Akena -- again, a question that you also asked with regard to the depression. When does it become a disorder or a

disease, if you will, in your understanding?

THE WITNESS: [14:35:13] When it's repeated, when you have more than one of those episodes, so just one of them is an episode. So if you -- so a number of people would undergo a disturbance that would describe as an episode.

Let me give an example. An easier one is something like delirium, for example, where somebody is unconscious or has a bit of loss of consciousness. They're not orientated in place and time and that can take a short period of time when you -- when you, like in hospital and you've gotten some medicines or from a surgery. That's just an episode.

Now this becomes a disorder if you have multiple times. Sometimes it's triggered by something else. Sometimes it is spontaneous and it's not triggered by anything. And then it also leads to the social and occupational dysfunctioning, so that a combination of recurrent episodes, plus a disturbance in your functioning makes something a disorder.

PRESIDING JUDGE SCHMITT: [14:36:20] Thank you.

Excuse me for intervening, but you might have asked it anyway.

MS LYONS: [14:36:25] No, but thank you for the clarity. No, it helps. Okay.

Q. [14:36:28] And in terms of the conclusions, can you -- is there anything more you want to briefly say about how you describe PTSD for the purposes of our next discussions?

A. [14:36:38] So it is a post-traumatic stress disorder, so somebody was perhaps okay and then this person gets exposed to a traumatic event. A traumatic event is something that threatens that person's life or identity or, yeah, enough -- something severe enough to -- to cause that disruption.

And then what we observe in that person after those events is that -- and I talked this

a bit earlier, why people develop it and others don't, is that the person then starts to get signs and symptoms that are very disturbing.

For example, they become hypervigilant or alert. A pin drops and they are startled, and then they avoid the situation in which the trauma is remembered or encountered. And then they can also undergo what we call negative cognitive alterations. So they're sad, they're angry, they're irritable, they have poor concentration and that could look like depression. But they -- there's also the intrusion and that's one of the things that makes the disorder a very difficult one because -- and painful, to be precise, because most of us are in control of our own thoughts. But somebody who suffers from post-traumatic stress disorder has repeated intrusive thoughts, negative thoughts, painful memories and this causes them to become extremely disturbed psychologically and distressed, so the repeated intrusions of the thoughts from a medical perspective is the disturbing one.

And usually the clients or the patients describe it as like they are watching that movie. It's like there's a -- the time stalls and they go back exactly to that point and then they re-experience that -- that process. These intrusions are the ones that -- that clinically are very disturbing to clients and so somebody has to go -- somebody goes through that. So there are criterias based on -- on whether you use the DSM or ICD or just your clinical judgement. So somebody has to have at least one of those, and this has to take place for at least one month, and then causes all sorts of problems. And then people can get this multiple times. So they can get re-traumatised. They can continue to go through these things.

So in brief, I think that's what PTSD is, yeah.

Q. [14:39:50] Thank you. Now, the -- how would you define suicide -- another term, suicidal ideation, in general?

A. [14:40:05] So where we come from, suicide is a highly stigmatised condition. In some places in the world, it is not. But in Africa it is. So there are three or four steps that happen. The first one usually is suicidal thought. So somebody thinks they would be better off dead than alive. And then the next step would be the -- so that's the, like the suicidal thoughts, the suicidal ideation. So they're -- they're thinking of death, thinking they are better off dead than alive.

Then after that, the person usually makes a plan, and after the plan, they could execute the suicide.

So it fluctuates in between there. So some people may go until the point of attempting. Some people may just have recurrent suicidal ideations and thoughts. Most people don't share those thoughts because they feel that it's very culturally inappropriate. And then -- and because of the stigma and everything else, some people who are religious consider suicide as murder, for example. So they struggle with these kinds of thinking.

But a number of mental illnesses, PTSD, depression, alcohol and substance abuse, schizophrenia, even bipolar affective disorder have suicide as one of their signs and symptoms. So the fact that somebody is suffering from a mental illness makes them have that reoccurring thought about suicide all the time. So even if the person wants to get the thoughts out of their head, the suicidal thoughts just continue to come back. So suicidal ideation, yes, is the intention to kill oneself.

Q. [14:42:19] Thank you.

A. [14:42:20] You're welcome.

MS LYONS: [14:42:22] Now, your Honour, I would like to move into the first brief report at tab 6 --

PRESIDING JUDGE SCHMITT: [14:42:28] I think there was another -- (Overlapping

speakers)

MS LYONS: I'm sorry.

PRESIDING JUDGE SCHMITT: -- disorder.

MS LYONS: [14:42:31] Your right. Thank you.

PRESIDING JUDGE SCHMITT: [14:42:33] So since we are now in the process --

MS LYONS: What did I miss? Help me.

PRESIDING JUDGE SCHMITT: [14:42:33] No, the fourth one is, let me have a look, I think I find it quickly.

MS LYONS: [14:42:41] I raised high risk of suicide.

PRESIDING JUDGE SCHMITT: [14:42:45] No, no, no, no. We have it soon. This obsessive compulsive disorder.

MS LYONS: [14:42:56] Oh, okay. Let me -- may I say something? I am not going to answer the question, but there are two dis -- no, I do not testify. There are two, there are two other disorders that are raised in the second report, and what I was going to do was to raise those with Professor Ovuga because he's going to talk about that, if that's okay.

PRESIDING JUDGE SCHMITT: [14:43:14] Of course -- (Overlapping speakers)

MS LYONS: [14:43:15] If not, I'm sure that Dr --

PRESIDING JUDGE SCHMITT: [14:43:16] No, no, no --

MS LYONS: -- professor -- Dr Akena can certainly talk about it, but I, I was going to --

PRESIDING JUDGE SCHMITT: [14:43:17] No, I'm fine with it. It's your examination and when you thought -- of course I couldn't know this.

MS LYONS: [14:43:24] Okay, no, no, no, no, no. There's no way you could know, I'm telling you.

PRESIDING JUDGE SCHMITT: [14:43:27] But it has to be addressed later on --

MS LYONS: [14:43:30] Absolutely.

PRESIDING JUDGE SCHMITT: [14:43:32] -- and we are fine with having it addressed with Professor Ovuga.

MS LYONS: [14:43:34] Okay, that's fine. There's that and the symptoms of, symptoms of OP -- of Obsessive Compulsive Disorder, and there was a fifth one --

PRESIDING JUDGE SCHMITT: [14:43:43] OCD.

MS LYONS: [14:43:45] Right. And there was a dissociative amnesia. I'm aware, but I'm holding off on those. Let's see how it works.

PRESIDING JUDGE SCHMITT: [14:43:54] Yes. No, no it's --

MS LYONS: You may be right, but anyway.

PRESIDING JUDGE SCHMITT: No, it's your examination. Please continue.

MS LYONS: [14:43:58] No, we'll get there. I hope. Okay. But thank you for reminding me.

Q. [14:44:03] So let me ask you a few questions about tab 6, it's a brief medical report, and I would like to ask some very brief questions about this in pub -- okay, tab 6, tab 6, the brief medical report.

I want to ask a few questions in private session. I'll hold those to the end --

PRESIDING JUDGE SCHMITT: Yes.

MS LYONS: And let me just ask a few in public session.

PRESIDING JUDGE SCHMITT: [14:44:33] Yes, I would, I would have suggested that I would leave it to you, but I think there would be some issues where it would be better to discuss them in private session, yes. But I leave it up to you. Obviously, you have an idea that you want to split it a little bit.

MS LYONS: [14:44:47] Yes.

PRESIDING JUDGE SCHMITT: [14:44:48] Okay, good.

MS LYONS: [14:44:49] But I welcome your guidance, because I am -- this is not a -- this is -- I don't have a lot of experience in public/private, so.

PRESIDING JUDGE SCHMITT: [14:44:57] No, this public/private is no natural science. It is simply --

MS LYONS: Yes, I know.

PRESIDING JUDGE SCHMITT: -- as we said initially, when we come to especially sensitive issues, especially which refer to the present - I think we understand each other - then I would subject we go to private session.

MS LYONS: [14:45:19] Okay. Thanks. I welcome your suggestions, is what I'm saying. I take the help of the Bench seriously.

Q. [14:45:26] Okay, Dr Akena, we're looking tab 6, the brief medical report, which I understand was disclosed by the Registry to all of the parties in this case, and it was prepared 9 February. Do you have it?

PRESIDING JUDGE SCHMITT: [14:45:46] 2016.

MS LYONS: [14:45:47] 2016.

Q. [14:45:48] The general question I want to ask is -- first, is: Did this report serve as a kind of baseline for your future reports?

A. [14:46:08] Yes, I would think so. That report helped us -- okay, that period, we used it mainly to establish therapeutic alliance with the client and to be able to gather much more information thereafter. But again, it was the first interaction, so we needed, we needed more time, we needed more information to corroborate the evidence that had been provided.

But I think that interaction we were able to tell that something needed urgent medical attention, and that's the reason we addressed it that way.

Q. [14:47:02] Now, and the second general question is, if you can answer in a generally -- and if you can't generally we'll go into private session. Is it your -- do you -- was there consistency, in your view, between the narratives that you heard for the first, you know, during the first report, generally, in February 2016 and the later reports? If you can --

A. [14:47:32] Yes, that's true, there was consistency. The only variations was that we were able to get more detail with time. And I think that was expected because we had formed a therapeutic alliance with the client and we are able to get more information and we are able to do much more reading after that, yes.

MS LYONS: [14:47:58] Now, your Honour, I would like to go into private session so that he can freely summarise the observations and conclusions, and add information if there are questions from the Court or from me.

PRESIDING JUDGE SCHMITT: [14:48:09] Yes. I'm fine with that. Go to -- Mr Gumpert.

MR GUMPERT: [14:48:13] Well, your Honour, I really make the same observations I did in my email and earlier this morning. This is the heart of the case. Mr Ongwen, through his lawyers, is asking or will be asking this Chamber to find that he does not bear criminal responsibility for any acts which might otherwise be proved. I would respectfully submit that the victims of those crimes, if they are otherwise made out, have a distinct and legitimate interest in knowing how it is said that he should be excused from that responsibility.

PRESIDING JUDGE SCHMITT: [14:48:51] Nobody doubts that. And I think the Chamber has made a really, a balanced decision here and we -- and, squarely, it is about the current state of health of the accused, which we think as a Chamber should not be perhaps discussed in full public. And everything what is related specifically

to his potential criminal responsibility during the charged period, and we have decided that this is to be discussed in open session. And I think that is a fairly balanced approach.

So I understood, Ms Lyons, in a way that you wanted to address -- I hope briefly, because I said we focus on the time 2003 to 2005, on a state of affairs that is relatively recently. Have I understood this correctly?

MS LYONS: [14:49:53] Let me see if I understand you. We want to focus -- we are using the reports which were done during this time period to focus back on an analysis of whether a mental disease existed during 2002 to 2005. I mean --

PRESIDING JUDGE SCHMITT: [14:50:17] So I think then it might be possible for you to simply move on in a more abstract manner insofar as it is concerned the current state of affairs or the recent state of affairs, and then reword and concentrate on the charged period time. I think that that should be possible.

MS LYONS: [14:50:37] Let me ask your guidance, your Honour, because what I wanted to do here - and you have the report in front of you at tab 6 - I just wanted to ask if he wanted to add any comments to the complaints 1 to 5, basically --

PRESIDING JUDGE SCHMITT: [14:50:53] No, no, 1 to 5, this should be addressed in private session. So we go to private session.

(Private session at 2.51 p.m.)

THE COURT OFFICER: [14:51:06] We are in private session, Mr President.

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(Open session at 3.00 p.m.)

THE COURT OFFICER: [15:00:29] We are back in open session, Mr President.

PRESIDING JUDGE SCHMITT: [15:00:46] Thank you.

MS LYONS: [15:01:01]

Q. [15:01:01] The one -- in this first report you diagnosed both PTSD and

depressive illness. Can you describe whether they can coexist in somebody and, if so, what does that look like? And do they trigger each other? Do they aggravate each other? Do they mitigate each other? What happens? How do they, how do they work?

A. [15:01:30] Certainly they are unlikely to mitigate each other. They make each other worse. But it's possible that the two disorders can coexist. We call that comorbidity, meaning one is there primarily then there is another one which is a secondary disorder or diagnosis. It is easier said than done in regards to knowing which one came before the other, but we think the PTSD was the primary diagnosis, then, the depression was a comorbid disorder. And depression is quite comorbid in a number of illnesses as well.

PRESIDING JUDGE SCHMITT: [15:02:21] And how do they coexist, these two, with the dissociative disorders?

THE WITNESS: [15:02:30] So dissociation -- dissociative disorders can be a disorder of its own per se, but a number of people who have post-traumatic stress disorder can also have dissociative disorders -- sorry, dissociative symptoms.

PRESIDING JUDGE SCHMITT: [15:02:43] I understand.

THE WITNESS: [15:02:46] Yes. So you can -- why you make one as a distinct disorder and not as a symptom is how many symptoms there are, how severe it is, how long it has been, how recurrent it is, and how much dysfunction it causes. And I think we, in our last report, we made two distinct diagnoses based on that.

PRESIDING JUDGE SCHMITT: [15:03:17] Thank you.

THE WITNESS: [15:03:19] You're welcome, sir.

MS LYONS: [15:03:21] Your Honour, at this moment I have no further questions on the brief report and I would like to move on to the first psychiatric report.

PRESIDING JUDGE SCHMITT: [15:03:32] Yes, please proceed.

MS LYONS: [15:03:33] Okay. Which is at tab 7.

Now I had a number of questions about clarifications going through various sections that I wanted to present through the evidence.

PRESIDING JUDGE SCHMITT: [15:03:59] But that's absolutely okay, as long as you keep in mind that the report as such is already part of the evidence of this witness.

MS LYONS: [15:04:08] Okay. But the next problem though is, yes, I understand, is that I had anticipated the discussion of this -- I'm happy to make my question in -- try to summarise it in public, but the responses really veer into some matters that are more detailed perhaps than are written here, more details that are specific and that's why I am requesting a private session to have this discussion in.

PRESIDING JUDGE SCHMITT: [15:04:43] I think we have decided this now and I have tried to explain what the pattern here would be. So as long as we are referring to things, to behaviour, to feelings, to whatever Mr Ongwen has reported to the experts and that form the basis of their assessment of the time that we call the charged period, we would want to discuss this in open session. And since this is the focus of what we are sitting here or the reason why, the purpose why we are sitting here, it would be possible I think to word the questions in a way that they can be answered by the witness in open session.

Let's, for example, just one example hypothetically --

MS LYONS: Okay.

PRESIDING JUDGE SCHMITT: [15:05:46] In this first report is, for example, mentioned dissociative disorder. Of course Mr Akena knows this. When it comes to these episodes that might have been -- might have happened or have happened in the time from 19 -- as is mentioned here between 1989 and you want to go into details,

this would be discussed in open session. You understand the principle?

MS LYONS: [15:06:20] I do understand the principle and I will try to implement it, but I may need some guidance from the Chamber as I go along on this.

PRESIDING JUDGE SCHMITT: [15:06:31] Try it, please. Please try.

MS LYONS: [15:06:33] Okay. Yes, I'll try. Let's see.

Q. [15:06:38] The first question I wanted to ask is - this is in open session - can you calculate approximately Mr Ongwen's age when he was abducted?

PRESIDING JUDGE SCHMITT: [15:06:53] I think this is not --

MS LYONS: [15:06:55] That's open.

PRESIDING JUDGE SCHMITT: [15:06:57] Yes, but this -- Mr Gumpert.

MR GUMPERT: [15:06:58] Sorry. Not a matter on which this witness's expertise will help the Court. There is evidence from which the Court, if it's remotely relevant, will be able to make its own calculation.

PRESIDING JUDGE SCHMITT: [15:07:10] Yes, I would agree here with Mr Gumpert. But what of course you can ask the witness is what he came to know from Mr Ongwen about the age when he was abducted. I think nobody --

MS LYONS: [15:07:20] That's fine.

PRESIDING JUDGE SCHMITT: [15:07:21] Nobody would -- so this is a little bit different but it --

MS LYONS: [15:07:25] Accepted. No problem.

PRESIDING JUDGE SCHMITT: [15:07:27] Eventually it should be the same, perhaps.

MS LYONS: [15:07:30] Yes, absolutely.

Q. [15:07:30] What did you, what did you learn from Mr Ongwen about the age at which he was abducted?

A. [15:07:36] He says he was less than 10. Maybe 8, maybe 9.

Q. [15:07:42] Okay.

A. [15:07:42] Right about there, yeah.

Q. [15:07:45] You also describe information about his first experiences in the bush where he witnessed the brutal killing of four boys who attempted to escape soon after they had been abducted. Can you tell us as a psychiatrist what are the effects, if any, of these events on a person who is eight or nine?

A. [15:08:28] The events that the client described were disturbing for adults. So I really can't even envisage what a child would go through if they were exposed to such. They were frightening events. They were life-changing events, I think, in my opinion, the way they were described.

PRESIDING JUDGE SCHMITT: [15:08:57] You see, Ms Lyons, there is no problem to discuss this in open session. By the way, we have discussed a large part of the Prosecution expert witnesses in open session so also we have to strive a little bit for consistency here.

MS LYONS: [15:09:17] No problem.

Q. [15:09:19] Let me ask you about two other events as well that are -- one was there is information that he watched the killing of his younger cousin's sister by child soldiers. And he was also forced to participate in a reprisal attack on a village where the community had killed an LRA soldier. What is your response? Is it the same or different? What is your response to the effect of these instances on a child abducted eight or nine?

A. [15:10:03] I don't know. I think it's -- you see, these experiences are extremely disturbing for adults, the way in which he described it to us. It would be excruciating for a child to go through that. I'm not so sure it's a pleasant experience

whatsoever in whatever form it will be.

PRESIDING JUDGE SCHMITT: [15:10:32] I think we understand this.

MS LYONS: [15:10:35] Okay.

Q. [15:10:36] Now, there's been a lot of evidence in this case from witnesses both from the Prosecution and the Defence that children were favoured as recruitees by the LRA because of their malleability and the fact they were easier to indoctrinate. Briefly can you tell me what your view on this is based on your experience?

A. [15:11:06] I don't know whether this detail is appropriate for here or closed, I'm not an expert in knowing which one it is, but the initial rituals that were performed have a long-lasting impact. And up to the last time we saw the client, there were things that were done that time that he still believed in at his age, contrary to what most of us would think. And there are other descriptions that I could give if given the opportunity. But also we interacted with four other people who provided us information. One of them we couldn't get much because she was very unwell. The older gentleman who had been with the client for much longer, I think he's a man in his fifties, but he was also taken in when he was, when he was already an ex-combatant. But whatever he went through changed his mind forever. And the belief systems that he had, and the belief systems that another female collateral witness had, were quite similar to the belief system that the client had. And you could clearly see that the things had happened in the past had a long and lasting impression. I think some of these things these guys are going to live with them for the rest of their lives.

Q. [15:13:11] When you described the person changed his mind, can you talk about what you mean by that?

A. [15:13:18] Pardon?

Q. [15:13:18] You used the term "changed his mind", the experiences changed his mind forever.

A. [15:13:31] Yeah, so --

Q. [15:13:32] What do you mean generally?

A. [15:13:34] So the client, for example, that gentleman believed that their boss Joseph Kony was fully aware of what was going on, including the interaction we were having with him at that point. That all the rituals that they were performing worked, they still work. He believed in dreams. He believed in a number of things like something they called stone bomb project. They believed in the days of the spirits and there were many days of the spirits with different names. And these are things that an adult had acquired and even when this adult had been out of, out of the ranks for a couple of years, the things had stuck with him. So he believed that the boss was a spirit, the boss could read people's minds, the boss could figure out that a discussion was taking place. Occasionally you would see fear in his face because I think he still thought the boss was able to tell that he was talking to us at that point. And these are not so different from what our client go through. And these are, these are things that we as mental health experts challenge and we challenge it repeatedly to ensure that we -- that indeed this is a belief system and it's not just a fleeting thought or an idea. And this is something that people still harbour even when they are not under any more duress. So that's why I was saying that some of these things were life-changing experiences for both the adults and the children.

Q. [15:15:32] Okay. Thank you. Now, I want you to look at the chart, please, the Defence chart, materials drawn from the Ongwen case proceedings, look at number 3, paragraph 82.

A. [15:15:59] Number 3.

Q. [15:16:00] Paragraph 82.

MS LYONS: [15:16:05] This is a confidential document, but I assume it's not being shown any place.

THE WITNESS: [15:16:10] You mean this?

PRESIDING JUDGE SCHMITT: [15:16:13] Why is it confidential?

MR GUMPERT: [15:16:15] Public document, isn't it, the arrest warrant?

PRESIDING JUDGE SCHMITT: [15:16:19] I would be surprised if it was confidential.

MS LYONS: [15:16:22] Okay. It's not -- well, this is our information. I just, I'm simply saying that the amended application --

PRESIDING JUDGE SCHMITT: [15:16:30] No, no, no. This cannot be confidential

(Overlapping speakers)

MS LYONS: [15:16:35] The amended application? Okay.

PRESIDING JUDGE SCHMITT: [15:16:36] I see it for the first time, but with a quick glance --

MS LYONS: [15:16:38] It isn't, fine.

PRESIDING JUDGE SCHMITT: [15:16:39] I think we simply proceed now.

MS LYONS: [15:16:41] All right. Fine.

Q. [15:16:46] We're looking at paragraph 82 and especially the last couple of lines "... Kony compelled young people to do things against their ... desires because the young people were 'at a stage where we couldn't really differentiate' ... good and bad."

Do you have any response to this point?

A. [15:17:23] I think it was -- I think whatever it is they were told was all that there was and all that they had to learn and this stuck in their brains for a long time. Whether -- and at that point the definition between good and bad was skewed to one

side really and there was no, there was no control. There was just an intervention, there was no control. So it was this way and that was it, so to be able to tell whether this was good or bad on whose scale? I'm not so sure. But I think whatever it is that the little ones were exposed to at that point had a lasting impact. There was no other counter-information to that and some people grew up knowing just that and that's it.

PRESIDING JUDGE SCHMITT: [15:18:30] We appreciate this answer because the question if someone is able to tell good from bad of course borders at least a legal conclusion also. But we appreciate the answer. We can work with it, so to speak. You have not went into the realm of the legal conclusions that have to be, in the end to be drawn by the Judges.

It was just a comment. It was nothing -- no question.

Ms Lyons.

MS LYONS: [15:19:05]

Q. [15:19:10] In the report on page 8 under -- I'm looking at the -- which is UGA-D26-0015-0011, I'm looking at the top paragraph "Circumstances of arrest and escape". What I'm interested in is the conclusion in the first few sentences that "... Mr Ongwen began to openly question the moral basis of the LRA war and activities in the bush." And what I want to know from you is what -- there is this conclusion, you have a conclusion here. What time period does it reflect in terms of Mr Ongwen being in the LRA? If you can tell us.

A. [15:20:14] The time he starts to question?

Q. [15:20:18] Yes.

PRESIDING JUDGE SCHMITT: [15:20:30] There is some hint in the wording of this phrase, I would say: "Following his attainment of the highest possible rank in the

LRA ..." would give us some indication, perhaps.

You, for example, also.

MS LYONS: [15:20:47] Thank you.

THE WITNESS: [15:20:51] Yeah, but I'm also trying to remember an incident when, when he lost a relative in 1996 or 1998, something like that, and he really had second thoughts about everything else, he started to wonder what was, what was going on. But I think we wrote that somewhere. I just can't (Overlapping speakers).

PRESIDING JUDGE SCHMITT: [15:21:18] No, that is helpful because this is -- yes, that might be interesting too.

MS LYONS: [15:21:22] But this -- I think that your Honour is absolutely correct that this --

Q. [15:21:28] The question is do you have any idea of when he attained the highest rank in the LRA, his highest rank, roughly? I mean, for example, was it before the peace talks or after the peace talks start in 2006? If you don't know, it's fine. I just was trying to do a timeline.

A. [15:21:52] I can't recall the ranks. I can't.

Q. [15:21:55] Okay. Not a problem. Okay. Now, I want to move on to the section in the same page which is UGA-D26-005-0011 (sic), the section "Why it took long for Mr Ongwen to leave the LRA". Could you summarise your reports -- summarise your observations here, what you were thinking, what you concluded with Professor Ovuga?

A. [15:22:35] What I remember vividly was the client actually told us from day one that it was a very risky procedure to think about escaping because the spirit would know. That's the information he would give us. And he cites multiple examples where unfortunate colleagues would escape and then, you know, somehow find

themselves back in the camp. And when that happened, they would face the inevitable, death in this situation.

Then he said the older you grew, the more you got surrounded by people who he called intelligence. So the intelligence was another layer I think of forces within, within the establishment that reported directly to the boss and nobody else. And this intelligence had a lot of power and any intention whatsoever of making an attempt to escape, even if you had been framed, was costly to your life.

But throughout our discussion with the client we just couldn't count how many times he would say death or die or dead. And then he said all the orders in the LRA had the word "death" in it. So it would be something like if you don't do this, you will die. If you don't kill -- something like that. So it was always imminent. But one of the things you would get punished for severely was escaping. And there are many ways in which it would be known whether you are going to escape or not. One of them were through your friends, one of them were through the attempt, the physical attempt, but most importantly through the spirit. So the spirit would know that somebody wants to escape and it would -- it just never ended well for those who were unfortunate, yeah.

Q. [15:24:59] If you recall, did you have discussion about what happened -- did the client discuss what happened to him when he tried to escape on many -- on multiple occasions?

A. [15:25:15] There was a very gruesome experience, I think, within a few weeks or days of his, of his capture.

Q. [15:25:25] May I ask -- can this be discussed -- would you like to discuss this in private session?

A. [15:25:33] I don't know.

PRESIDING JUDGE SCHMITT: [15:25:34] No, no. Why should it? We had also witnesses here --

MS LYONS: [15:25:39] Okay.

PRESIDING JUDGE SCHMITT: [15:25:40] -- who have spoken about really, as you would word it, gruesome --

MS LYONS: [15:25:44] Right, okay.

PRESIDING JUDGE SCHMITT: [15:25:48] -- incidents and there is no reason to not discuss this in open session.

You might proceed, please, Mr Witness.

THE WITNESS: [15:25:56] So the client, the client describes a situation where some young people escaped. And the spirit told them that people had escaped. So they put up machetes in fire and started heating them until they were red hot. So these unfortunate souls, including himself, walked from morning until evening, about 4 p.m. Then they came back. When they came back the people said, "You see, we've been waiting for you. We knew you would come back." So they couldn't believe what was going on. And he was actually forced to skin one of those guys alive, the person was tied up and they skinned this person, removed his gut and put it up on, on trees. And they use that as -- and they said those were electricity wires. And he said that he wouldn't eat meat for about two or three months; he couldn't, he couldn't eat, he couldn't sleep, he couldn't think. But also that on its own was a risky venture, because isolation from your colleagues, showing sign of weakness or not being able to talk with people was considered as somebody -- you would be considered as somebody who wants to escape. Because they would say, but so why are you not talking to people? So these are gruesome things. That's just one of them. There are perhaps three, four or five more other things. Maybe that's

enough for now.

PRESIDING JUDGE SCHMITT: [15:28:31] Yes. I think that that is, for the moment that will suffice. Do you -- I think I have understood you correctly, this was -- happened shortly after the abduction?

THE WITNESS: [15:28:42] I think it was within a month or so.

PRESIDING JUDGE SCHMITT: [15:28:45] Okay, thank you. Just that we have a perspective, you know, from the time frame.

Please proceed, Ms Lyons.

MS LYONS: [15:28:50] Thank you.

Q. [15:28:52] Thank you. I would like you to again look at the chart, number 4, Prosecution Witness P-264, there's a question from Judge Schmitt and a response, and I had a question about that now?

A. [15:29:13] Excuse me, number -- okay, yes, yes.

Q. [15:29:14] Sorry, number 4.

A. [15:29:16] Yes, ma'am.

Q. [15:29:17] Yes. Pros -- says, Prosecution Witness P-0264, and my question is: What is your interpretation of the testimony?

A. [15:29:43] Well, over and above the things that are here, these guys were told that if you had sexual intercourse, for example, with a woman, your genitalia would be blown up in battle. If you coveted somebody's wife you would lose an eye in battle. If you stole something you would, you would be shot in the arm, or something like that. So there was almost an explanation for all kinds of unfortunate situations that happened. If you died, you had planned to escape or you had, you had not followed the instructions of the spirit, for example. So the spirit would give out instructions before people went out for battle, and if you went against them, you

would, you would end up on the wrong side of the establishment.

So yeah, so he says there would be, there would be people screaming and yelling, injured, in pain, all sorts of things, but they would be told those people deserve what they are going through because they, they did something against, against the boss.

Q. [15:31:17] Thank you. Based on your experience with the client or other child soldiers, were the child soldiers free to show signs of remorse or signs of despair within the regime of the LRA, if you know?

A. [15:31:51] I think you would get killed, from what he said. If you, if you showed remorse, if you showed weakness, you would get killed. Why? Because you would be suspected of planning to escape. And once, once that allegation was brought up against you, your peers wouldn't spare you, they would be given the order to kill you.

Q. [15:32:24] Thank you. Now take a look, we're still at your report, take a look please, turn to page 10.

Which for the ERN part is UGA-D26-0015-0013, and I'm in the section of depressed mood, (a).

PRESIDING JUDGE SCHMITT: [15:32:55] But we are here at the present mental state.

MS LYONS: [15:33:00] Yes, in that section, yes.

PRESIDING JUDGE SCHMITT: [15:33:02] Yes.

MS LYONS: [15:33:03] I know, but I want -- I'm sorry. Yes.

PRESIDING JUDGE SCHMITT: [15:33:07] Yes, but then we have, I think we have talked about that before. If what you want to ask is related to the charged period, then it's no problem, then you can ask it. If it is only related to the present mental state, I would perhaps doubt if we should discuss it now. In the first instance we

would go to, have to go shortly to private session.

MS LYONS: [15:33:37] All right, let me -- I listened to you. Okay, let me try to regroup here. I wanted to -- I want to ask about a contradiction that's observed in the present mental state but it's applicable (Overlapping speakers)

PRESIDING JUDGE SCHMITT: [15:33:52] Then we discuss this in private session.

MS LYONS: [15:33:55] Sure. I was going to do it in open session.

PRESIDING JUDGE SCHMITT: No.

MS LYONS: [15:33:57] Private session is fine.

PRESIDING JUDGE SCHMITT: [15:33:59] No, we go -- we just discuss it shortly, please, in private session.

MS LYONS: [15:34:03] Sure, no problem.

PRESIDING JUDGE SCHMITT: [15:34:05] And for the audience, that "shortly" means couple of minutes, perhaps (Overlapping speakers)

MS LYONS: [15:34:09] okay. Thank you. All right. Thanks, your Honour. Thank you. All right, on page 10 of the report, ERN ending in 0 --

PRESIDING JUDGE SCHMITT: [15:34:25] You are too quick, Ms Lyons.

MS LYONS: I'm sorry. Okay.

(Private session at 3.34 p.m.)

THE COURT OFFICER: [15:34:27] We are in private session, Mr President.

(Redacted)

(Redacted)

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(Redacted)

(Redacted)

Page redacted – Private session.

Page redacted – Private session.

(Redacted)

(Open session at 3.38 p.m.)

THE COURT OFFICER: [15:38:30] We are in open session, Mr President.

MS LYONS: [15:38:33]

Q. [15:38:39] What I'm interested in is two observations that you made about Mr Ongwen. One, that -- in your report, that it was difficult to perceive him as a person in distress. And, similarly, you made an observation that he was both cheerful and humorous, and tough and resilient. Is this a contradiction or is it consistent? Or am I making, you know, maybe I'm describing it wrong. How would you describe these two observations?

A. [15:39:21] So there are times when -- I think, I think the context here is that in the beginning we -- his demeanour, the way he carried himself, the way he said things, it would seem as if everything was okay, but later on it was apparent that it wasn't. So what do I mean? To establish the relationship to the point where somebody can, can actually tell you what's disturbing them takes a bit of time. So I think that's how we ended up in this, in this paradoxical situation, if I may call it that way, that on the one side everything else looks okay, on the other side doesn't.

Sometimes when people have what you'd call a typical depression, you could actually have individuals who are looking -- smiling and everything looks okay. I think in the morning hours you called it masking. So it's possible to mask symptoms of psychological distress, although not for long, not for long. With detailed questioning repeatedly, over time it becomes apparent that something is amiss.

But at times we also don't want to rock the boat when, when that is a coping mechanism of somebody. So you, you allow that to go on because, for you to be able to treat that person, you really need to put the person in the state in which the severe

distress and everything else that is negative.

So I don't know whether this answers the contradiction of maybe --

PRESIDING JUDGE SCHMITT: [15:41:35] I think this answers the question at least. Yes, I think so, yes.

MS LYONS: [15:41:39] (Overlapping speakers) Thank you. One moment.

Q. [15:41:58] Following up on your question, well, actually -- actually I think you may have answered it, but I want to just be sure.

Is it, is it possible that he had -- you described it as intense internal emotional turmoil that somehow wasn't, wasn't exhibited or wasn't outwardly exhibited while he had a face of being happy or tough or resilient or any of those words?

A. [15:42:39] Absolutely.

Q. [15:42:41] Okay.

A. [15:42:42] Yeah.

Q. [15:42:43] Thank you. I want to move on to the section, the general section about wrongfulness and remorse. It's in the report. And the questions I think that I can ask right now, they're all -- these are all questions in public basically.

PRESIDING JUDGE SCHMITT: [15:43:22] I would be surprised if they were not.

MS LYONS: [15:43:25] Yeah, all right. I'm really -- okay, all right.

PRESIDING JUDGE SCHMITT: [15:43:29] It is not easy, but I think --

MS LYONS: [15:43:32] I'm trying.

PRESIDING JUDGE SCHMITT: [15:43:34] -- it is -- I have explained this several times --

MS LYONS: [15:43:36] Yeah, I know.

PRESIDING JUDGE SCHMITT: [15:43:38] -- now. We have to balance here the interests of the public --

MS LYONS: [15:43:40] No problem.

PRESIDING JUDGE SCHMITT: [15:43:42] -- with the interests also, of course, of the accused and I think we found now a *modus operandi* that we can work with. Please proceed.

MS LYONS: [15:43:51]

Q. [15:43:52] You have noted in the report, I'm referring now to page 12, you have concluded or if -- you've said in the report:

"[...] that everyone in the LRA was trained and conditioned not to mourn or show any sign of remorse at what he or she saw, experienced or did. Any sign of despair, apathy and self-isolation [...] was 'severely punished'."

And you also say here -- one moment.

PRESIDING JUDGE SCHMITT: [15:44:41] It starts on page 11 of this report.

MS LYONS: [15:44:45] Yes. One moment, your Honour. One moment, your Honour.

PRESIDING JUDGE SCHMITT: [15:45:04] I have this UGA with the last four digits 0014. That's at least my version that I have. But it doesn't matter. Simply ask your question. Doesn't matter what we read here because we have this already on the record.

MS LYONS: [15:45:28] (Overlapping speakers) (Microphone not activated). We have it on the record. Okay. Fine.

Q. [15:45:29] (Microphone not activated) "It was therefore hard for anyone in the LRA" --

PRESIDING JUDGE SCHMITT: [15:45:29] Microphone, please.

MS LYONS: [15:45:32] "It was therefore" -- yes, thank you. Yes, it is on. *De rien, pas de problème. J'essaie ça.*

Q. [15:45:36] Okay. "It was therefore hard for anyone in the LRA to openly have second ..."

MS LYONS: [15:45:53] They're having -- they're still have problems.

PRESIDING JUDGE SCHMITT: [15:45:58] I'm now not aware what the problems are. Okay, you have probably the wrong channel.

MS LYONS: [15:46:09] I apologise for the -- for the crisis here. The computer, whatever it is something crisis. Computer crisis.

PRESIDING JUDGE SCHMITT: [15:46:15] No. There is no crisis. There is no problem.

MS LYONS: [15:46:17] All right.

PRESIDING JUDGE SCHMITT: [15:46:18] We have - frankly speaking - we have a lot of technology here in the courtroom. I'm always surprised how well things work; so if not everything works one hundred per cent, it does not pose a problem at all.

MS LYONS: [15:46:34] Good. All right.

PRESIDING JUDGE SCHMITT: [15:46:35] So don't worry.

MS LYONS: [15:46:36] Thank you. All right.

Q. [15:46:38] So here we are back on 0012, yes, I have it now. 0012, it's page 9 of the report:

"Mr Ongwen reported that everyone in the LRA was trained and conditioned not to mourn or show any signs of remorse at what he or she saw, experienced or did. Any sign of despair, apathy and self-isolation in sadness was 'severely punished'. It was therefore hard for anyone in the LRA to openly have second thoughts in relation to the wrongfulness of one's acts."

And there's a quote here from Mr Ongwen, which I'm not going to read. But he talks -- I'm not going to go into that. I'll just stop at the paragraph that you wrote.

My question to you is this:

From a psychological point of view, how does this description of the LRA affect someone for a short period of time, a longer period of time, for decades? What is the long-term effect of this situation that you describe?

A. [15:48:12] I think the short-term is really survival. So if you followed the rules, you didn't get killed. That was the short-term. But these individuals lived in this kind of situation all the days of their life and this - in one or the other - became deeply ingrained and became second nature. But it is a very -- I mean, they were flirting with death all the time, literally speaking. So you don't follow the orders, you die, or something like that.

But there was also another aspect to it and that's the aspect of confirming this hypothesis and -- and a lot of Acholi people we interacted with confirmed this hypothesis, the hypothesis that, if you followed the rules as stated by the spirit within the ranks, you survived. You didn't get killed.

And when we asked the client and the other people from which we got collateral history, and we say, "You know what, you people were faced with imminent death on a daily basis almost, how come you survived?" And they would say, "You know, we just followed the rules the way they were. Those who didn't follow the rules didn't come back." I think that was the general narrative, apart from, from one person who provided us a collateral history who had a totally different opinion about why he survived and why he did not.

So in the short-term it is extreme psychological distress, it saves you from death, but in the long-term I think the consequences of this kind of exposure to repeated trauma is -- it's difficult to comprehend that somebody grows up in such, such a situation.

Yeah.

Q. [15:50:18] Now I'd like you to take a look at this section on wrongfulness and remorse. It's also on page -- ERN, ending 0014, page 11 of the report.

Now, you report that:

"[...] Mr ... Ongwen said that when he was in the bush, he did not appreciate the wrongfulness of his acts. [...] He further" [stated] --

PRESIDING JUDGE SCHMITT: [15:51:12] I think perhaps it might make sense if you read the two following phrases too.

MS LYONS: [15:51:16] Sure.

PRESIDING JUDGE SCHMITT: [15:51:17] Or if you don't want, simply ask the expert to comment on this part.

MS LYONS: [15:51:23] All right.

Q. [15:51:24] Can you comment on that, what I've just read, the first part?

A. [15:51:28] So the wrong there is in -- in quotes as you can see. And why were we asking these questions? We really wanted to know what used to go on in the minds of these people. We also made it clear to him that we needed to know what was going on between the period through which he was charged, the 2002-2005, and whether he knew that whatever it is that was going on at that time was right or wrong. And those are the answers that he provided for us.

So the yardstick of measuring right or wrong was difficult in this situation and that's why we put it in inverted commas.

PRESIDING JUDGE SCHMITT: [15:52:32] Thank you.

MS LYONS: [15:52:33]

Q. [15:52:33] Now the next sentence says:

"However after coming out of the bush he realised that what he saw or did were wrong. He further said that the actions of the [LRA] ... resulted in human misery,

the loss of lives and property ... destruction of social infrastructure. Though Mr ... Ongwen ... says he does not understand any of the charges brought against him at the ... (ICC), he feels deeply remorseful and he regrets his participation in the activities of the LRA in the bush on orders from Joseph Kony and other LRA leaders (before he himself became [...] a leader)."

PRESIDING JUDGE SCHMITT: [15:53:25] And now the question.

MS LYONS: [15:53:27]

Q. [15:53:28] And now the question is, how do you interpret this statement from Mr Ongwen, where does it come from? How do you understand it?

A. [15:53:42] Again, we had brought it to the client's attention during that time that we needed to establish the *mens rea*. What -- what was happening in his mind at that time. Was this right, was this wrong? Whatever it was.

PRESIDING JUDGE SCHMITT: [15:54:02] *Mens rea* is something that --

THE WITNESS: [15:54:07] Different.

PRESIDING JUDGE SCHMITT: [15:54:08] No, not something different. It is important. Yet it is something that in the end, the judges have to decide if it was there. But I -- we understand each other. I don't see a huge problem here. I simply intervened before Mr Gumpert intervenes and it takes even more time. So please, please continue with your answer.

THE WITNESS: [15:54:27] Okay. So we wanted to know. You know, we really wanted to know whether he believed that these things were right or wrong at least by established criteria, whether they were inside or outside. And those are the kinds of answers that we kept on getting. Those are the kinds of answers that he kept on giving us. But we really tried as much as possible to try and establish whatever it is that was going on at that time, responsibility for these kinds of things, yeah.

MS LYONS: [15:55:00]

Q. [15:55:00] Let me deal with the time issue here. The distinction made is between when he was in the bush, there was one perception and when he leaves the bush, there's another perception.

A. [15:55:16] Yes.

Q. [15:55:18] So when he is talking about remorse, when is he -- when is he saying this? When is he feeling this? Is he feeling it in 2002 or is he feeling it when you wrote the report and interviewed him in 2016?

A. [15:55:48] I need to think. I -- I don't recall that. Something I need to think about.

Q. [15:55:55] No problem.

PRESIDING JUDGE SCHMITT: [15:55:56] But I think we have an indication also from the wording, what you read to him.

MS LYONS: [15:56:01] Yes, there was --

PRESIDING JUDGE SCHMITT: [15:56:02] "However after coming out of bush ..."

MS LYONS: [15:56:05] Yes, out of the bush.

PRESIDING JUDGE SCHMITT: [15:56:08] So perhaps that might, so to speak, trigger your memory. So this seems to indicate that it was after coming out of bush.

MS LYONS: [15:56:16] Right.

THE WITNESS: [15:56:17] Yeah. So, yeah, so I'm just trying to get back to the point where that information was elicited. And I think it was around the point that he started to see some of the things on the TV, started to interact with his colleagues, started to have different perspectives about life, something that he had not had in the past, and this started to have a different change in the way he approached matters regarding the establishment that he had been part of.

MS LYONS: [15:56:56]

Q. [15:56:56] But it was after he came out of the bush?

A. [15:56:59] Yeah.

Q. [15:57:00] Correct?

A. [15:57:01] Yes.

Q. [15:57:01] Okay. That's all.

Now I want to ask you, take a look at the binder, number 16. Binder 1. It's transcript T-26 and I'm looking at page 17, lines 2 to 6.

A. [15:57:38] That's page 26?

Q. [15:57:40] It's tab 26 -- I'm sorry. Excuse me, withdrawn. Tab 16 of the binder, there's a transcript there, one page, both sides, and it's on page 17, the second page, lines 2 to 6.

PRESIDING JUDGE SCHMITT: [15:58:19] So we are not litigating here again --

MS LYONS: [15:58:21] No, no.

PRESIDING JUDGE SCHMITT: -- the charges question.

MS LYONS: [15:58:24] Not yet.

PRESIDING JUDGE SCHMITT: [15:58:25] No, no, no, no.

MS LYONS: [15:58:26] No, I'm not, no.

PRESIDING JUDGE SCHMITT: [15:58:28] We understand each other.

MS LYONS: [15:58:30] Absolutely not, no.

PRESIDING JUDGE SCHMITT: [15:58:30] But I assume you are referring to the part of Joseph Kony and leadership in LRA, perhaps.

MS LYONS: [15:58:36] "And I'm not the LR" -- yes, yes.

PRESIDING JUDGE SCHMITT: Okay -- (Overlapping speakers)

MS LYONS: I'm not --

PRESIDING JUDGE SCHMITT: [15:58:39] Yes. No, no, I'm (Overlapping speakers)

MS LYONS: [15:58:41] I would tell you if I were.

PRESIDING JUDGE SCHMITT: [15:58:44] Yes, okay. Otherwise I would have to intervene.

MS LYONS: [15:58:48] I understand. I would be upfront about it. But no, I'm not at this moment.

PRESIDING JUDGE SCHMITT: [15:58:52] No, indeed you are. Please proceed. Okay. So please put your, put your question to the witness.

MS LYONS: [15:58:54] Now, okay, okay.

Q. [15:58:56] The question is -- question is this: Looking at lines particularly 5 and 6:

" -- the charges I ... understand as being brought against LRA but not me, because I'm not the LRA. The LRA is a Joseph Kony who is the leader of the LRA."

And my question is this: We've just had some discussion about the orders of Joseph Kony and what the client said about that. Do you see any link -- how do you interpret this statement, especially in light of his position that he acted on orders from Joseph Kony?

A. [15:59:53] I must say I have, have heard that statement before from him. And he said it was, it was -- it wasn't him, it was the LRA. The LRA was Joseph Kony. Joseph Kony is a spirit who could tell many things, had magical powers. And he's the one who used to tell them what to do and what not to do. So I have heard these kinds of statements before from the client on multiple occasions, yes.

Q. [16:00:40] (Microphone not activated)

PRESIDING JUDGE SCHMITT: [16:00:41] Microphone, please.

MS LYONS: [16:00:43]

Q. [16:00:43] Do you see any similarities between the statements, or differences, or inconsistencies?

A. [16:00:49] No, he's, he's told us something like that in the exact phrase, he said "I am not the LRA." So I'm seeing it here, but I have heard it before from him.

Q. [16:01:00] Okay.

A. [16:01:00] Yeah.

Q. [16:01:01] Okay. All right. Thank you.

Now --

PRESIDING JUDGE SCHMITT: [16:01:07] If you look at the watch.

MS LYONS: [16:01:11] Yes.

PRESIDING JUDGE SCHMITT: [16:01:13] I think it would be time. And can you now give us a more current estimation of how long your examination will last tomorrow?

MS LYONS: [16:01:26] One moment.

Probably, probably no more than an hour, I hope.

PRESIDING JUDGE SCHMITT: [16:01:39] Okay. No, that's fine.

Then we have discussed this before, before the break, and we will of course give you the time. But I think after a long day it would be now time to postpone it until tomorrow, I would suggest, because we have now two hours in a row very intense. I think that that's enough for today. Yes.

So this concludes the hearing for today. Thank you especially, Mr Akena, for providing us with this testimony until now.

THE WITNESS: [16:02:11] You're welcome.

PRESIDING JUDGE SCHMITT: [16:02:13] But you are not, not finished, of course. You have to come back tomorrow, like all the other ones here in the courtroom,

at 9.30.

THE WITNESS: [16:02:21] Okay, sir.

THE COURT USHER: [16:02:23] All rise.

(The hearing ends in open session at 4.02 p.m.)