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 Pangalangan

Trial Hearing - Courtroom 3

Thursday, 24 May 2018

(The hearing starts in open session at 9.36 a.m.)

THE COURT USHER: [9:36:13] All rise.

The International Criminal Court is now in session.

PRESIDING JUDGE SCHMITT: [9:36:30] Good morning, everyone.

Could the court officer please call the case.

THE COURT OFFICER: [9:36:45] Good morning, Mr President, your Honours.

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're in open session.

PRESIDING JUDGE SCHMITT: [9:36:59] Thank you.

I ask for the appearances of the parties.

For the Prosecution, Mr Sachithanandan.

MR SACHITHANANDAN: [9:37:04] Good morning, your Honour. Appearing today with Mr Hai Do Duc, Mr Ben Gumpert, Sanyu Ndagire, Yulia Nuzban, Ramu Fatima Bittaye and Maya Talakhadze.

PRESIDING JUDGE SCHMITT: [9:37:19] Thank you very much.

And Ms Massidda.

MS MASSIDDA: [9:37:21] Good morning, Mr President, your Honours. For the Common Legal Representative teams appearing today myself, Paolina Massidda. With me Ms Jane Adong, Mr Patrick Tchidimbo and behind us, Mr Orchlon Narantsetseg and Ms Caroline Walter.

PRESIDING JUDGE SCHMITT: [9:37:39] Thank you.

Ms Hirst.

MS HIRST: [9:37:42] Good morning, Mr President, your Honours. My name is Megan Hirst. With me James Mawira, Maria Radziejowska.

PRESIDING JUDGE SCHMITT: [9:37:50] Thank you.

And for the Defence, Mr Ayena.

MR AYENA ODONGO: [9:37:52] Good morning, Mr President and your Honours. Today I'm accompanied by Chief Achaleke Taku, Mr Thomas Obhof, and our client Mr Dominic Ongwen is in court.

PRESIDING JUDGE SCHMITT: [9:38:08] Thank you very much. And you can remain standing, so to speak, and continue with your questioning.

MR AYENA ODONGO: [9:38:17] Yes. First of all, Mr President, I must apologise for late coming. It is about technology. We are trying to rephrase our questions and print them, and being the analogue person I am, I got defeated.

PRESIDING JUDGE SCHMITT: [9:38:39] You know we are very indulgent as long as it is useful for the proceedings.

MR AYENA ODONGO: [9:38:45] Yes.

PRESIDING JUDGE SCHMITT: [9:38:46] And it concentrates the proceedings.

MR AYENA ODONGO: [9:38:49] Much obliged.

WITNESS: UGA-PCV-0003 (On former oath)

(The witness speaks English)

QUESTIONED BY MR AYENA ODONGO: (Continuing)

Q. [9:38:59] Good morning, Professor Musisi.

A. [9:39:03] Good morning, Mr Ayena.

Q. [9:39:05] Yes. Professor Musisi, yesterday when we left we were on the verge of discussing specific issues in relation to Dominic Ongwen from the trauma related health issues when he was in the bush. Evidence points to the fact that around September 2003 Dominic Ongwen had a massive injury, which has actually kept him disabled up to now, in the knee, and that was the second one. He has 11 bullets still in his body to date. And around about 2003 because he was alleged to have been attempting to get in touch with General Salim Saleh, he was removed prematurely from the sickbay and put under Vincent Otti in virtual prison and forced to walk from Pader up to Soroti.

Now, Professor, in these circumstances, what would you describe as possible traumatic experiences that may have impacted on him?

PRESIDING JUDGE SCHMITT: [9:40:53] Ms Massidda.

MS MASSIDDA: [9:40:54] Objection, your Honour. I think that the expert is not an expert about generally the health conditions of Mr Dominic Ongwen here. The expert has been called as an expert on mental health and Acholi culture. I will not object to general questions dealing with hypothetical scenario, but I don't think that it's fair for this witness to be questioned on this specificity or these specific facts dealing with the conditions of Mr Ongwen because the expert is not able, will not be able to answer that question. He has no knowledge about the condition of Mr Ongwen and he has not been tasked or instructed to look into the proceedings about what happened to Mr Ongwen. Thank you, your Honour.

PRESIDING JUDGE SCHMITT: [9:41:45] Strictly speaking, you are right, because it's

an expert that you have named. But he is a psychiatric expert, and if he thinks he can answer the question meaningfully, he might do so; and if he thinks he cannot, he might tell us himself, I would say.

And also, Mr Musisi, you have to be informed that what Mr Ayena put to you are some propositions, so they are sometimes, I think some of them are contested, some are not contested or will be contested whatsoever, but if you hear that and take this as a hypothesis, can you from your professional expertise say something about it, about the question that Mr Ayena has put to you. And if you can, you might, and if you say you are not informed enough about the circumstances, you can also say so.

THE WITNESS: [9:42:49] Thank you, Mr President.

In answer -- may I answer?

MR AYENA ODONGO:

Q. [9:42:54] Yes, yes.

A. [9:42:56] To your question --

PRESIDING JUDGE SCHMITT: [9:42:57] Please answer. It's simply because he's simply standing up to receive your answer.

THE WITNESS: [9:43:09] Okay. I have never met Mr Ongwen. I have never been his doctor. I have never examined him. I don't know anything about his health. Thank you.

MR AYENA ODONGO: [9:43:19]

Q. [9:43:20] Thank you, Professor. Just like the proceeding Judge has said, some of these are fairly hypothetical, but also clear propositions. If the circumstances that I have described were true, of course, in your expertise and on the background that Ongwen himself is an Acholi from an Acholi cultural background, what will you describe as the possible impact on his mental perceptions?

A. [9:44:13] Mr Ayena, I cannot really answer that question. You asked me to theorise on anybody anywhere in the world who is injured on what injuries might do to them mentally, that's very hypothetical. I cannot speak about the mental impact of an injury on someone when I don't know their background, especially when we talk about things mental, like post-traumatic stress disorder, which as we saw yesterday has many things that go to influence its development.

For example, we know that soldiers in combat, not all of them get PTSD, but some do, even for the same injuries. So it is very hypothetical. As a psychiatrist, you have to see the individual and the patient and examine them, a full psychiatric evaluation. I've never done that for Mr Ongwen. I can't answer that question meaningfully.

PRESIDING JUDGE SCHMITT: [9:45:26] Mr Ayena, we simply have to take this answer.

MR AYENA ODONGO: [9:45:29] Yes, yes.

PRESIDING JUDGE SCHMITT: [9:45:30] So you have to move on to another point.

MR AYENA ODONGO: [9:45:32] I will have to move on.

PRESIDING JUDGE SCHMITT: [9:45:33] Yes.

MR AYENA ODONGO: [9:45:34] Yes.

Q. [9:45:35] Thank you for your position taken.

Professor, at page 25 of your report, you said that Acholiland suffered mass trauma. Now, regarding the various mental health problems identified in your report, what is the possibility that these can be observed by friends and colleagues who may also be going through the same challenges, especially within the LRA?

A. [9:46:27] Mr Ayena, I would like you to please clarify that question. Who are the friends? I don't know what you mean by that. And colleagues, I don't know what you mean by that. My colleagues?

Q. [9:46:37] No.

A. [9:46:38] Whose colleagues?

Q. [9:46:38] I'm talking about --

A. [9:46:39] Which friends?

Q. [9:46:40] -- the colleagues, the colleagues of the former soldiers in the LRA. Is it possible for them to identify some of these problems by observation?

A. [9:46:56] To identify or to identify with?

Q. [9:46:59] I mean to identify it.

A. [9:47:01] To see?

Q. [9:47:02] Yes, to see.

A. [9:47:03] Of course.

Q. [9:47:04] I saw, I saw he is there.

A. [9:47:05] Any individual human being who sees a traumatic situation will see it.

Q. [9:47:13] And in that context, Professor, did you ever interview anyone who identified science of mental health challenges in a colleague or a commander?

A. [9:47:23] No, I did not interact with the commanders of the LRA. I still have difficulties understanding what you mean by colleague. You mean soldiers in uniform, soldiers of the LRA?

Q. [9:47:43] Soldiers of the LRA.

A. [9:47:45] I did not go, except for the child soldiers.

Q. [9:47:48] Yes.

A. [9:47:49] But I never went into the ranks of the LRA in the bush to talk to them. I've never met them.

Q. [9:47:58] Yes, can we take the possibility of you talking to one of the former LRA child soldiers and discovering that --

A. [9:48:11] When they came out --

Q. [9:48:11] Yes.

A. [9:48:12] -- to be treated.

Q. [9:48:13] Yes.

THE INTERPRETER: [9:48:14] Your Honours, could the speakers please wait.

PRESIDING JUDGE SCHMITT: [9:48:17] Indeed. So you are entertaining a dialogue again, I would say, so please observe what I said when we started with your testimony that only one person is speaking and wait until you answer. But the problem here is that you do not understand each other at the moment.

I understood that you have talked to former child soldiers.

THE WITNESS: [9:48:41] Yes, your Honour.

PRESIDING JUDGE SCHMITT: [9:48:42] So perhaps you can, taking this as a starting point, so to speak, Mr Ayena, if you want to refer to them, please formulate your question anew, if you take this. So he has expertise on former child soldiers.

MR AYENA ODONGO: [9:49:01] Yes, yes.

PRESIDING JUDGE SCHMITT: [9:49:02] And from then on we can perhaps elaborate more on what the trauma that they experienced in the bush made to them, how it persisted or not persisted, how they dealt with it. But I think this is also in the report.

THE WITNESS: [9:49:22] Thank you, Mr President.

MR AYENA ODONGO: [9:49:27]

Q. [9:49:27] So in this context, Professor, you have made it clear that some of your patients were child soldiers --

A. [9:49:42] True.

Q. [9:49:43] -- who returned from the bush. Were some of them able to tell you

about the mental health conditions of some of their commanders? For instance, say, "Oh, well, you know, that commander, I was under this and that commander, and he was a very terrible man. He believed -- behaved in such and such a manner. He was a madman" and that kind of thing, this is what I mean.

A. [9:50:11] Thank you, Mr Ayena. The question is now clear to me.

As a doctor I guess I would prefer to call them my patients. The patients who I treated who were child soldiers spoke in general terms about life, but they specifically spoke about Kony. That's the one they tended to talk about more, about his temperaments, his prophesies, his mannerisms, his almost God-like features that they saw in him and how they feared him.

They did not go to tell me specifically about all the various commanders. But one patient told me about one commander.

PRESIDING JUDGE SCHMITT: [9:51:01] Could you perhaps elaborate a little bit on that.

THE WITNESS: [9:51:04] Yes, I was giving it a pause to sink in.

He told me about Dominic Ongwen because she was married to him, quote, in the bush and had his children. That one was not a soldier. It was a wife, an abducted girl.

MR AYENA ODONGO:

Q. [9:51:31] Would you recognise her now? Would you remember her name?

MS MASSIDDA: [9:51:37] Your Honour, private session.

PRESIDING JUDGE SCHMITT: [9:51:41] We have to be careful here.

MS MASSIDDA: [9:51:43] Thank you.

PRESIDING JUDGE SCHMITT: [9:51:44] So if any names are going to be mentioned we would have to do this in private session. So if you know the name and if you can

tell us now, we go to private session.

THE WITNESS: [9:51:57] I will have to look into my records, but also I would like to thank you, Mr President, we, in my profession, have also a confidentiality thing that I have to respect irrespective of whatever is happening. And I would rather that I don't mention that name. But if it was in private session and under professional guidance and protection, if it's necessary, that would be possible to do at a later, much later time.

PRESIDING JUDGE SCHMITT: [9:52:29] I think it's not necessary.

But what I think perhaps would be interesting is you mentioned that some of your clients talked about Kony and his behaviour and what he observed, how he acted. It is of course very difficult to make a diagnosis from afar, and I would not of course expect a diagnosis, so to speak, but from your professional expertise, from your experience and background, can you say to us at least something what you would derive from these details that came from the clients that you talked to.

THE WITNESS: Thank you, Mr President. I actually implied this in my report when I talked about cult indoctrination and cult leaders. Kony fitted a lot of that and I even put in a statement saying that psychiatrists have always warned that certain personality types tend to get leadership. These people are usually very, if you want me to say that in general terms, are very self-centred or narcissistic, grandiose, paranoid, thinking they can do it all, very powerful, no one can stop them, but at the same time very suspicious of others and a tendency to want to protect themselves by first to attack. We see them in many cult leaders and also dictatorial leaders of the world. And in history, they're full of them. Also in present world they're full of them. And if you ever go to news medias you hear people describe about them in different ways. He had those characteristics.

As to whether he actually had a psychotic illness as such, I don't think he had a psychotic illness. I think he had a personality problem. But I never met him, I never examined him, I never took history from him, I can't tell you what that personality, exact personality is, but there is a personality problem there.

PRESIDING JUDGE SCHMITT: [9:54:56] Thank you that you at least tried to give us some information because we have very often heard in this courtroom about this personality and of course we don't take it as psychiatric diagnosis. That is perfectly clear.

Mr Ayena, please continue.

MR AYENA ODONGO: [9:55:15]

Q. Thank you for that answer. At page 74, Professor, you say that Acholiland suffered mass trauma. Regarding the various mental health problems identified in your report, what is the possibility that these can be observed -- well, I have already put this question.

PRESIDING JUDGE SCHMITT: [9:55:41] Yes.

MR AYENA ODONGO: [9:55:42]

Q. [9:55:42] In your experience, does the fact that one is able to share his painful experiences in the bush preclude them from having mental health issues? For instance, does talking about the time in the bush contradict avoidance of PTSD?

A. [9:56:12] If I understood the question correctly, Mr Ayena, you want specific mental illnesses and you want to say what about other things happening in one's life.

Q. [9:56:26] My question is I am from the bush, and I now talk openly, I tend to recite what happened in the bush, say, after the passage of some time. Does this preclude or contradict the fact that I may have had PS -- what is it, PTSD --

A. [9:57:00] Well, you can have --

Q. [9:57:01] -- while I was in the bush?

A. [9:57:02] You can have PTSD and still come out and talk about it. You can have PTSD and also other illnesses prior, during or even after. So, yes, they could have had other illnesses.

In medicine we also talk about complications of illnesses. PTSD becomes complicated with other illnesses, like depression, for example, panic attacks, substance abuse, sometimes seizures, I've even seen psychosis being a complication of PTSD. So it is not that you only have one disease, period. You can have many.

If you want me to use psychiatric jargon, in the old DSM-IV, say you can have more than one diagnosis on axis 1, in other words, you can have more than one psychiatric diagnosis, and some of them had, you know, for example, many were depressed at the same time having PTSD, you know. Many had substance abuse at the same time having PTSD. Some were psychotic. I saw psychotic patients, but also with PTSD or epilepsy, not to mention also physical diseases, which can come along, like HIV, for example. So you can have more than one disease, yes. And you can come out, talk about them, but also have signs and symptoms of PTSD, all needing treatment.

Q. [9:58:53] Thank you for that answer, Professor.

Now, yesterday you talked about the nodding disease in northern Uganda. And you seemed to have attributed this to people -- I mean the LRA conflict and particularly the concentration camps; is that correct?

A. [9:59:23] In medicine epidemiologically we have things that we say are factors that may be associated with. Nodding disease is controversial by people studying it. It became political. Different disciplines approached it. We went there as psychiatrists to see what was happening. Neurologists came. Epidemiologists came. I gave you the psychiatric perspective. I could summarise it, that in war

situations in the IDP camps there were many problems that happened there, most significant of which were that there were continuing traumatisations, there was little food, there were many epidemics. There was no medicines. Diseases were neglected. Children suffered physical and mental health problems.

A child in an IDP camp who is starving, whose parent has been killed, who has seen massive trauma, whose brother was abducted or sister was taken, who has no food, who gets measles which is not treated and gets convulsions and gets brain damage has all the symptoms of PTSD in addition to the physical disease and malnutrition and that spells nodding syndrome and could have epilepsy, consequently brain damage. That was the most rational way of understanding it, which we published about. But other people are looking for viruses and parasites and toxins as explaining nodding syndrome. Up to now they're still looking for them, even though there are no new cases.

So we as psychiatric epidemiologists take solace, take satisfaction in that our explanation seems to fit the picture more than other theorisations of what nodding syndrome may be about. But there are people there in CDC and at Makerere, the medical school, I could tell you their names, Dr Richard Idro, who were still under Angela Kakooza, who were still looking for toxins and viruses and prions and virus particles to explain nodding syndrome. I would like to find a day one day when they tell me we have found it.

Q. [10:02:16] Professor, you know we are canvassing this in view of the fact that it is only in East Africa that this kind of disease has manifested; whereas we are aware that there are many places like, for instance, in Afghanistan, Syria, Turkey, Jordan where there are also IDP camps. Why is it that it has manifested itself only in Acholiland?

A. [10:02:50] Thank you very much, Mr Ayena. By the way, the history of nodding syndrome per se is old. Somebody called Winkler who first talked about in Tanzania whereby in Mabira Forest there are people called Nakalanga and people said they had nodding syndrome. But epidemic nodding syndrome which we saw in northern Uganda and South Sudan only happened in that Acholi group, not just in northern Uganda but also in South Sudan. And research say by James Tumwine showed that in only a particular group, for example, in South Sudan it never happened in the Dinka cattle keepers who had access to milk and protein, whose children, but in the other neighbouring tribes that were cultivators and had no access to high-protein foods. So there are many things about nodding syndrome.

Our explanation, I'll refer you, if you would like, to my paper which I wrote in the East African journal -- in the African Journal of Health Sciences about the neuropsychiatric aspects of nodding syndrome, will argue that the cultural manifestations of nodding syndrome could have explained why it was more rampant in the Acholi group in northern Uganda. And we talked about what the people thought was causing it in addition to the many other associated factors, which tries to answer that interesting question, because as psychiatrists we asked ourselves that question. And that's why I said culture-bound post-traumatic stress syndromes, it fitted the picture. That's why I put it in the atypical forms of PTSD that we have seen in various parts of Africa.

I have actually written about this and I've said what, by that term, culture-bound post-traumatic syndrome, is my term. If you find it in the literature, you read source. That it goes on to show how a disease becomes -- how a PTSD becomes culture bound, specific criteria for it to become, usually located in a certain specific group explained by that culture and sent -- tending to be confined and not necessarily being shared,

you know, by others. So it kind of fitted that picture.
But like I said, if you went in academic audience and you had an international conference on nodding syndrome, you should have been there to see the arguments. They were coming from all sides, neurologists, epidemiologists, microbiologists and of course psychiatrists.
For your interest, if you really want to know, I actually put my student to go and write a thesis on nodding syndrome, one of my students.
Q. [10:06:06] On nodding syndrome?
A. [10:06:08] Yes.
Q. [10:06:08] Okay. Yesterday you alluded to the Stockholm syndrome. Now, relating this to the experiences of the young abductees in the LRA, how would you explain that syndrome in that context, in the context of how it impacted on the behavioural patterns and the restraints and the limitations and things and the behaviours of the abductees?
A. [10:07:02] To be more exact, Stockholm syndrome would be an example of a cult indoctrination syndrome. That's a better term. The first time it was recognised, so-called Stockholm syndrome because of, you know, Palme in Sweden and how he was, you know, arrested by -- is it the Red Brigade and stuff like that. But cult indoctrination syndromes have been described or syndrome has been described and that's what those LRA child soldiers were subjected to.
You get a charismatic leader, who usually is very dominant, gets people, cuts them off from communication with anybody else, gets them to watch him or her and they have to follow orders. And usually there is a code of silence also, secrecy, you know, about it, and then begins his or her manipulation of the population which is under captivity, and they will follow orders automatically.

So the Stockholm syndrome is a cult indoctrination syndrome. And certainly the child soldiers and some of the abducted girls showed signs and symptoms of being indoctrinated in a cult-like manner.

Q. [10:08:45] Now in your experience does the fact that -- I think I've dealt with it. Do you think, Professor, that a child who grew up in an environment where brooding, for instance, was interpreted as a sign of sadness and desire to escape or, as narrated on your page 26 of your report, "If anyone cried, they would be shot", is such an individual able to mask their emotions?

A. [10:09:25] Mr Ayena, could you please explain to me what you mean by "brooding".

Q. [10:09:31] Brooding, you know, somebody who is expressing disgust, dissociation I think in your --

A. [10:09:40] These are very technical terms for us.

Q. [10:09:42] In your world, in your world I think it would amount to dissociation, you know, somebody who is aloof, and he's showing signs of disinterest in everything that is going on around him, that is signs of annoyance, displeasure as it were.

A. [10:10:05] I think I have understood you, Mr Ayena. We'd call that depression, not dissociation. They are sad, they are crying, they are isolative, they are withdrawn, they are uncommunicative. They feel disgusted, sometimes irritable. They wish they would die. They usually would also have other things like poor sleep or appetite, loss of weight, energy and all of these things. So it's really depression.

Like I said, the two most common mental disorders in those child soldiers and abducted girls were PTSD and depression, and sometimes the two go together.

Interestingly, the treatments are usually nearly the same.

In my description I said complications of PTSD, and the first was depression. But you can argue that they have two different disorders in the same individual. So it is depression, which can go on to very extreme states, you know, to the point that one can actually become immobilised and just be there, like those children of the nodding syndrome, and waste away, refuse to eat -- not refuse to eat, but have a total loss of appetite to the point of emaciation and walking like a skeleton.

We have seen that not just in northern Uganda. For example, in the IDP camps in north Kenya at the border with Somalia, or Waduwadu (phon), you know, camps. Those things were also there. We've seen in it many other places of conflict, this very massive loss of weight, sometimes not just attributed to lack of food, but also extreme depression.

Even in not in other times of war, depressed people can become emaciated completely and immobilised and even develop bed sores until pneumonia gets them and they die.

Such extremes of depression these days are not so common because of the massive amounts of antidepressants everywhere, but they have been described, you know, in the literature. It's not a psychiatric lesson, but I'll say something like quartered syndrome is an example of such. But these are not so common these days because, at least in many countries there are psychiatrists, not so many in Uganda, but, you know, and there are treatments available.

Q. [10:12:46] Now, yesterday you talked about compartmentalisation of right and wrong of LRA child soldiers in the bush. When they came out of the bush, they nevertheless showed signs of mental illness. Can you explain, Professor, the relationship of compartmentalisation?

A. [10:13:16] Okay. First, I did not use that word yesterday.

Q. [10:13:17] You used --

A. [10:13:18] But I know what you are talking about.

Q. [10:13:19] You didn't use --

A. [10:13:21] I did not use it. Someone else used it.

PRESIDING JUDGE SCHMITT: [10:13:27] Again, please, for the interpreters, do not entertain a dialogue, please.

MR AYENA ODONGO: [10:13:32] Sorry, sorry.

PRESIDING JUDGE SCHMITT: [10:13:34] Okay. I also do not have it in my mind that the specific expression was used, but nevertheless the expert seems to understand what you want to know.

So, Mr Musisi, please answer.

THE WITNESS: [10:13:49] Thank you. Mr President and Mr Ayena, it is very, very important for me that words attributed to me are mine, and those that are coming from elsewhere should be put as coming from elsewhere.

The phenomenon of compartmentalisation is that ability of individuals to have aspects or to wear one hat in one instance and then wear another hat in another instance.

So a child soldier may know what is wrong in one instance, and then at another one may do something else for survival in another instance, and they don't feel contradicted. So feelings of guilt and remorse at one part, but having to do a duty and feeling the fulfilment that they have done that duty because maybe they were commanded to, it's like a dissociation, it is like they have two different emotions. You compartmentalise. That's the phenomenon. It is seen in situations where people have to make choices which may be contradictory.

Q. [10:15:14] Thank you very much, Professor.

PRESIDING JUDGE SCHMITT: [10:15:16] Microphone, please.

MR AYENA ODONGO: [10:15:18]

Q. [10:15:18] Thank you very much, professor. Well, maybe you explained and I understood them in the terms I used. I'm glad that we nevertheless are reading from the same script on the matter.

Now, Professor, can you briefly explain the importance of dreams in the Acholi culture and how nightmares could be an indication of mental health problems in an individual?

A. [10:15:56] Thank you, Mr Ayena.

We're talking about two different phenomenon. All people dream. Not all people get nightmares. Nightmares are frightening dreams that you recall, and usually they tend to happen in situations where people have gone through psychologically very distressful times. That's why they call them nightmares, differentiation from night terrors, which we don't recall, although may act out in very loud, loud ways.

Now, dreams in the usual sense are actually usually pleasant. You dream of becoming a doctor if you are young or becoming a pilot or becoming a lawyer or becoming a judge, these are nice dreams, or being married to Prince Harry; we can go on.

A nightmare, you dream of something harrowing coming to you, a lion attacking you and eating you alive. You shout and your voice cannot be heard. You look for help, and everybody has run away from you. You try to run and your legs cannot run and you wake up very frightened.

The kind of nightmares that were being experienced by the abducted girls, by the child soldiers, were because of the horrendous situations they had experienced which

came back to them in their dreams and of course which they attributed to cen.

Q. [10:17:41] At page 79, Professor, you discuss appetitive aggression.

A. [10:17:48] Aggression.

Q. [10:17:49] You talk about how traumatic experiences lead to emotional deregulation, which in turn leads to easy irritability and ultimately aggression. Can you explain this phenomenon in greater detail in terms of --

A. [10:18:15] Appetitive aggression is something that we are beginning to understand a little bit more today in psychiatry as happening especially in people who have been traumatised and having a heightened response of vigilance, hyper-vigilance to ward off future attempts which would be traumatising to them. So their emotions are always on edge, they're always on the look-out, and they're always reading and often misinterpreting signs that they see as being directed to them, especially when they live in situations where they're stigmatized.

Somebody who is stigmatised -- and there are two types of stigma. There is what is internalised and what we call external. External is actually what somebody said to you. Internal is what you think they are saying to you because of what you are or what you have been, what you have gone through.

Many of these abducted children, when they came out, they felt that the whole world was looking at them. Sometimes they did, calling them names, bush people or olums or whatever it is or tong-tongs, you know, it went on, and abusing them, outcasting them, isolating them. They felt very uncomfortable.

Even when they wanted to leave away about that life in the bush and forget about it, somebody would bring it up. So they would tend to want to defend themselves before the offensive stigmatisation would be brought to them, so they become aggressive.

Sometimes when they come within family or in a classroom -- teachers in Uganda can be very authoritative. They didn't like that. If you tell them it is not unusual for a teacher to shout at a pupil and say, "Hey, shut up, sit down", they would find that very threatening and they would attack them. And many of them would just drop out, they couldn't take orders anymore.

So this appetitive aggression became like a militarisation of their personality and wanting to attack before they attacked, and it caused great difficulties for them to adapt in communities and live and respect orders and authority, especially the social order as we know them in African families, respecting the elders, even the frail.

Some cultures, I'm sure it's also true in Acholiland, you may be supposed to respect somebody who is well younger than you because they say "That one is your aunt", you know, and they could be, but they are 2 years old, and you're supposed to respect them. Those things would become very difficult for them. So they would tend to lash out and be aggressive in the community.

Now I give you an example of an accountant, a very accomplished man, who had great marital difficulty to a very pleasant and nice wife, but whose every move he misinterpreted. And he became very violent and almost the marriage was breaking up. That's when they came in for therapy, you know.

So this appetitive aggression is something that we see. We are studying more. And we think it characterises political situations in Africa, I'll put it like that. We are a big continent. You can look for it wherever you want.

Q. [10:21:57] Very well put.

Now, is this in any way related to what we have just talked about, compartmentalisation?

A. [10:22:14] The two are two different phenomenon. Appetitive aggression is a

reaction, you know. It's almost automatic. Many of them actually regret, say, "Why did I do that? Why did I hit my wife? Why do I hit my child? Why do I shout back at a teacher? Why do I walk out of situations?" Compartmentalisation is different. It is saying, "Today, I'm supposed to do this" and you do it. And then another day you feel, you may feel guilty at having done it, but full knowing you had to do it and you live with yourself. And you let the two not disturb you. Compartments (indicating).

Q. [10:23:01] Now, Professor, what is learned helplessness? And how can it explain some of the mental health issues you have dealt with?

A. [10:23:14] Learned helplessness is a very old term I think by Spiegel. To talk about psychological phenomenon, whereby, well, I'll give you maybe the experiments that were done in monkeys. If you, for example, train a monkey. We have two brains, left side and right side. If you section something called the corpus callosum and you cut off one hemisphere from the other, you could train one eye to say green light means food, and you train the other eye to say green light means danger. You put their food, and you open both eyes and the monkey would be there, "What do I do? Shall I be electrocuted or shall I be rewarded?" It becomes helpless. So this learned helplessness is when you have contradictory stimuli coming to you and you find it difficult to respond.

Maybe you want to bring it in the context of compartmentalisation. It is the same individual in which both of these are. The difference is that in a compartmentalisation, the two may not be necessarily coming at the same time; that it is a psychological thing, you feel it and you know it, as opposed to an automatic stimuli that you must, you know, do this.

So there is a time element there, you know. I would not put compartmentalisation

and learned helplessness together. One produces a neurosis, learned helplessness in the old term, compartmentalisation does not.

Q. [10:25:07] Do you put it together with suicidal tendencies?

A. [10:25:23] Can I use the word "ideations" instead of "tendencies"? The two mean different things in psychiatry or in psychology.

Q. [10:25:35] Can you --

A. [10:25:39] I'll explain.

Q. [10:25:40] Okay.

A. [10:25:41] A suicidal ideation means that you think about suicide and you plan it and you want to do it. Suicidal tendencies may be that you tend to act suicidally, not necessarily having thought about it. You may just be angry and want to kill yourself; a suicidal tendency. But ideation takes time to think about it.

Now, those are not related to compartmentalisation or to learned helplessness because strictly speaking, suicidal acts are not helpless. They're volitional. You get up and you go to do it. You make a decision to solve your problem. Learned helplessness, you sit there docile and don't do anything about it.

Now, when we go back to compartmentalisation, that compartment where there is a lot of guilt and shame can lead to suicidal acts because it tends to come or to be associated with depression. Does that part answer your question, sir?

Q. [10:27:01] Very much, very much. That excites me into probing into another topic you have brought up, the monkey story. Professor, I am sure you may have heard about this monkey boy in the Luweero Triangle?

A. [10:27:23] Robert.

Q. [10:27:24] Robert. That monkey boy, according to the ordinary layman's language, appeared to have taken on the behaviour of monkeys; although he was a

human being because of continuous, you know, association with them and maybe learning from them.

How do you liken that situation of Robert to the situation of child soldiers of the LRA in the bush and the instructions they were, you know, guided, the way -- the survival mechanisms they were taught and instructions they were given to do certain things?

A. [10:28:19] Thank you, Mr Ayena. We are illustrating things, feral children, the so-called monkey boys, they are all over the whole world. They were written about in Europe a long time ago. They've been found in Latin America. They've been found here. We have found them in war situations in Africa. These are children, before the formative years, get taken over or get abandoned and they cling to whatever is animal like and moving to survive and move along, maybe at age of two years.

Child soldiers were abducted at a much older time, beyond two years, at which time they have already learned what is right and wrong, but not in the abstract sense, because we've said that's progressive over time.

They would know that this is right, this is wrong. Many of them were in school by the way; so already they had been introduced to scriptures, to all kinds of things. They would not behave like feral children.

PRESIDING JUDGE SCHMITT: [10:29:43] May I say that perhaps on a certain level, of course, you said it's not the same, it would be better described, the effects that you want to indulge in as this cult indoctrination; would that be correct if I word it like that?

THE WITNESS: [10:29:59] Thank you, Mr President. That would be the second logical statement, my conclusion of that part, that they would be behaving like indoctrinated children or adults, and for that matter -- except, of course,

indoctrination is coming in at different stages of their intellectual development. The cult indoctrination syndrome best describes what happened to the child soldiers.

MR AYENA ODONGO: [10:30:34]

Q. [10:30:35] And at page 31, Professor, you discuss cult indoctrination systems.

A. [10:30:47] Thank you.

Q. [10:30:48] In particular, you mention how personal feelings were suppressed and members had to appear content and enthusiastic. Now, is it necessarily so that people who exhibited these behaviours did not struggle under mental illness or bear the brunt of the coercive environment in which they lived?

A. [10:31:14] I thank you, Mr Ayena. In the broad sense, a cult indoctrination syndrome is PTSD. To survive, you have to show that compartmentalisation. You have to show that you believe in what is happening, be enthusiastic about it, you're going to do it. But like I mentioned yesterday, about some of how they sometimes escape, is that somewhere in the back of your mind, you know it is wrong to do this and you're longing for that day and that chance to escape. You compartmentalise to be able to survive.

Q. [10:32:02] You mentioned how these children experienced narrowing, blunting and distortion of affect with psychological regression. Can you explain this?

A. [10:32:21] We have to remember that a lot is going on in these children at this moment in time. They have PTSD. They also have depression. They're sad about what is happening. Many of them have lost their families. It is in their mind. Some of them, and I've seen, I've talked to them who say they even came across their relatives being killed, but they dared not show any emotion.

One came and saw his father dead on the road, but if he showed any emotion, he would have been shot. So he pretended that these were enemies shot, "Let's go on",

to survive. That's compartmentalisation.

So many things are happening in these child soldiers. They're dealing with very unnatural circumstances in which they have to survive and, hopefully, one day escape.

What would be interesting, what we haven't -- what I did not see is find those who were completely indoctrinated and agreed with Kony and everything and believed in him. Such happens in some political -- oppressive political regimes whereby people, quote, "go with the leader. Die with the leader".

These children are different, and I think the explanation is because they had seen atrocities done to their own people, their own families; so you could not a hundred per cent convince them. And that's when the question goes back to leadership: Who knew, who may have been convinced in what they were doing as opposed to these children?

And that's what brings in the old question, I mentioned it in my report of the guiltless guilty. The children would know --

Q. [10:34:41] Can you --

A. [10:34:42] The guiltless guilty, described by Klasen, that what they're doing is wrong, but they know they have done it, and one would say, could children who have been taken and indoctrinated and ordered to do something be guilty when they're children? That's a debate which is still ongoing and it is there and we are talking about it and people have advanced those arguments. But like I said, abstraction, judgment grows with you as you develop more.

At a certain stage, usually after adolescence, you concretise, you know exactly what is right and what is wrong and how to go about doing that which is right. That may be different from children who are 5, 7, 9 years old, but as you become older, the

age-related abstraction, you know, comes in a judgment to decide so that individual will takes over or choice.

Q. [10:36:20] That discussion which is going on, Professor, did you have occasion to listen from the cultural leaders of Acholi on the debate as to whether children that were subject of our discussion here, especially in the context of the concept of mat oput, have you heard from the cultural leaders what they think about what you call the guiltless guilty in respect to Prosecutions?

A. [10:37:05] Not just hearing about, but I know, because I have engaged in those debates with my colleagues, if I'm also called an elder, talking about these things. That debate is big. It's worldwide. It's not just, you know, in Acholiland. There have been child soldiers in Latin America for decades before. People talked about those. In, for instance, Khmer Rouge, you know, things there. So this has been talked about. The academic debate still goes on. I am sure in the judges it still goes on, and in the lawyers and philosophers, you know, things like that.

But the elders in Acholiland felt that what should be done to their children is to cleanse them, to go through rituals, to go through traditional reconciliatory mechanisms to clean them of their past deeds and to say that now they should be children, innocent, and let their lives go on, not laugh at them, not point out atrocities that they may have done, and let them begin to grow up.

That's an idealistic wish of the elders as keepers of the custom, of the culture, of the society in which they live. It's idealistic. Unfortunately many other things come in. That's why the debate is on. Otherwise it would be a foregone conclusion.

Q. [10:38:59] Professor, that now brings to my mind what, you know, that story of the young lady who was forcefully "married", in quotes, to somebody in the bush is found on your page, is it 58 and 59, the ERN 58 and 59, this lady came back. Her

father had passed on. She had two brothers -- I mean four brothers and her mother, but they chased away her children. And the words you used were, they were chased to go and live with their rebel husband's -- with the --

A. [10:39:58] The family of the rebel, I'm sorry.

Q. [10:40:00] Yes, the relative of the rebel husband. But from the way, having interacted with you since yesterday, you cut a figure of, you know, of sympathy against stigmatisation. That choice of phrase, rebel husband, doesn't that stigmatise from the cultural background of the Acholi?

A. [10:40:38] Two things to be understood. One is that my writings don't reflect my opinions necessarily of where I fall. I put the facts as were told to me by my clients. She said they rejected her children because they rejected her husband, who had done atrocities in the community. And they said those children don't belong to us, they belong to another abile, to another family, take them, but you can't visit them, because those there are the ones that killed our people. A dilemma came for this lady. She had a parental motherly bonding to her children, whom she was not allowed to see. She hated the husband who had forced -- forcibly had intercourse with her to get those children, which she only did to survive, otherwise she would have been killed.

In a scenario like that of learned helplessness, to use that term, depression will come in, and she became, she became very profoundly depressed, isolative, would not eat even when food was there, didn't sleep, wondered about her life in this cruel world, if you want to put it like that.

The job of a psychiatrist is to wear the shoes of your patient and understand them to be able to help them. Sympathy is subjective. We say empathy.

Q. [10:42:42] Yes, empathy. Now, Professor, when we talk about psychological

regression, what does it do to a young mind and could it cause a mental defect?

A. [10:43:04] Thank you, Mr Ayena. Again, I have to be very careful. Mental defect is like brain damage. Mental deficit, psychological deficit, means that you lose psychological function at a point which can be recovered later. So it's not a defective brain. It's a distressed brain.

Having corrected that or clarified that, to go back to your question, could you please repeat it?

Q. [10:43:44] I'm saying psychological regression?

A. [10:43:51] Yes.

Q. [10:43:51] Yes, psychological regression.

A. [10:43:53] Yes. It means --

Q. [10:43:56] What does it do to a young person's mind and does it progressively or eventually lead into long-term defect?

A. [10:44:07] What it usually means is that you begin to function at a lower level than what would be expected of you. For example, I got up this morning, washed up, brushed my teeth, went and had breakfast, got on the move, ready to come. If I could not get out of bed, could not even bring myself to washing up, I would have psychologically regressed. It's not permanent. It could be reversed.

But certain illnesses, like psychosis, can cause a very difficult regression to which one cannot come out of, unless if of course corrective treatment takes place; sometimes successfully, sometimes not so successfully. So here we've found that a regression, because of the depression, because of the PTSD, that they were not functioning at their best level. It's not an intellectual deficit which would make it wrong for them -- make it difficult for them to understand. Because when you said deficits, it means like mental retardation, it means like brain damage.

Kids of nodding syndrome who had brain damage would show deficits. People who are depressed with PTSD just show regression. But when circumstances change, when treatments are effected, they're reversible.

Q. [10:45:46] Now, Professor, do people who are caught in a cult-like situation and indoctrinated as such know what they are doing as wrong, or are they struggling with a mental illness or defect that affects their ability to conform to normal social ways of life?

A. [10:46:16] Again, I know that in legal terms the term defect is very popular. I'm going to use psychological terms and say deficit.

PRESIDING JUDGE SCHMITT: [10:46:28] I may shortly intervene. And of course the Judges prefer that neither counsel nor experts decide on the legal terms of anything. I just wanted to remark that.

THE WITNESS: [10:46:40] Thank you.

PRESIDING JUDGE SCHMITT: [10:46:41] So I would also really prefer that you use this other wording. And yes, it might be that it depends, of course, but this is your answer.

THE WITNESS: [10:46:54] Thank you, Mr President.

Could you please repeat your question?

MR AYENA ODONGO: [10:46:59]

Q. [10:46:59] The question is, do people who are caught in a cult-like situation and indoctrinated as such know what they are doing as wrong, or are they struggling with a mental illness or defect that affects their ability to conform to the normal social norm?

And, Professor, I want to clarify this. And for the benefit of the Bench as well, we have already talked about defects, which he reluctantly or, I mean, professionally

refused to accept as defect, but deficiency. But because he had already discussed it and differentiated it, I want him to answer in the best terms he may, not necessarily from my perspective.

A. [10:47:59] There have been cases, and I'm sure you're aware of them, even in Uganda, where people who were under the influence of a cult were acquitted of their crimes. I think there was one professor of psychology who was under Alice Lakwena, and I'm sure you know that case, who was acquitted of --

Q. [10:48:24] Professor Jong?

A. [10:48:29] Thank you. So I'm not a legal expert, but I'm going to say that -- and also I think in the States Patricia Hearst was also acquitted. But I'm going to leave it, I think, as a legal opinion to be argued, not from a psychiatric point of view. Psychiatrists want to defer and say this person has a delusion or has a preoccupation or has an over-valued idea, you know, and then we stop there. We bring these psychiatric findings and we leave it to the Judge or the jury to make the verdicts or rule. So I'm going to leave it at that.

PRESIDING JUDGE SCHMITT: [10:49:16] Yes. And that's a very nice compartmentalisation of work and of duties, so to speak.

Mr Ayena, may I remind you nicely of the time.

MR AYENA ODONGO: [10:49:28] Yes, yes. I am very acutely alert. In fact, I'm coming to the final question mercifully.

Q. [10:49:35] Professor Seggane, at page 18 of your report, while discussing punishment and the role of the Rwot Parwodi, you stated Kony and his LRA did not understand this system of elders. Kony was the law and we did not conform -- I am not stating exactly what you said.

A. [10:50:10] Thank you.

Q. [10:50:11] "Kony was the law and the system."

Is this prevailing state of affairs the reason for the divided opinion as to how to handle the fate of abducted children who were forced to perform or render atrocities?

A. [10:50:31] I think there are two things there; that in the bush there was no system of elders, which in the Acholi tradition was the arbitrator of conflicts. In its absence the law was as laid down by Kony. That's what I meant.

Q. [10:50:53] I think that's about the end of my questions.

But you said you wanted to give a parting shot. You warned me yesterday that you'd give something in summary. At your leisure, please.

PRESIDING JUDGE SCHMITT: [10:51:11] I think we don't need a statement by Mr Musisi. If you have concluded your questions, I think that should be it.

MR AYENA ODONGO: [10:51:20] Yes, I have concluded my question.

PRESIDING JUDGE SCHMITT: [10:51:23] Thank you very much. And this brings us to the conclusion of your testimony.

THE WITNESS: [10:51:27] Thank you.

PRESIDING JUDGE SCHMITT: [10:51:28] On behalf of the Chamber I would like to thank you very much for your very instructive and interesting information that you provided us with. And on behalf of the Chamber we wish you a safe trip back home.

This also brings us to the conclusion of the presentation of evidence by the Legal Representatives of Victims. The next part of this trial is reserved for the Defence opening statements and the presentation of its evidence. This will commence after the summer recess on a date to be announced in due course. Thank you.

THE COURT USHER: [10:52:05] All rise.

(The hearing ends in open session at 10.52 a.m.)