2.5.2. *Measures needed to protect children against all forms of participation in armed conflict*

Studying children's understanding of political violence: *Testimony of Lynne Jones, Senior Research Associate, Centre for Family Research, University of Cambridge*

Lynne Jones gave the Tribunal an account of the context in over a decade of work in the Balkans beginning before the period of armed conflict and ethnic violence, during which she had worked in Croatia, Bosnia and Slovenia. Her testimony focused on a psychiatric research project with Medécins Sans Frontières, which had caused her to question the way mental health is approached in situations of armed conflict. Her over-riding concern was the general absence of 'children's voices' in research in this field, the assumptions made by adults about children's needs and perceptions and the influence of this lacuna on funding and project design. In the research she reported to the Tribunal, she had studied children from both sides of the conflict, concentrating on detailed files from a total of 40 families in the town of Gorazde over a twelve-month period. After this, she had returned to Kosovo for a further year to establish paediatric and mental health services.

The illustrative example that Dr. Jones interwove with her evidence concerned 15-year-old 'Alban', a Kosovar Albanian boy from an extended family in a poor, rural area. In 1998 during an attack on his community by Serb forces, Alban hid in a forest with his father, brother and cousins, but they were caught, stripped, beaten and tortured. Dr. Jones expressed that for no particular reason that she knew of based on Alban's communication with her, the police allowed Alban to escape leaving him to wander, lost and alone in the woods for three to four days. When he was found, his mother described him as being 'like a baby', needing everything done for him.

Although Alban's behaviour might be taken as a symptom on mental illness, Dr. Jones pointed out that in this case regression could also be described as a 'healthy choice' because it resulted in the care that he needed. She stated that, in her experience, sophisticated tests that rely on Western cultural concepts are not always necessary for identifying severely traumatised children, whose symptoms are obvious. The fears expressed by war-affected children are rational responses to reality. It is thus not rational to use the practices of conventional psychotherapy as a substitute for basic security. Yet governments and powerful international bodies seem to use humanitarian aid and psychotherapeutic interventions for victims as 'a stop to public opinion', rather than addressing the root causes of conflict.

In this context, Dr. Jones also questioned the conventional use of terms such as 'innocence' and 'neutrality' by the international aid community with respect to children in armed conflict. In the first place, children are not necessarily perceived as innocent by other combatants. In Kosovo, for example, Albanian babies were viewed as 'demographic terrorists' who had to be eliminated. At the same time, children themselves may not wish to be seen as necessarily neutral. They may take an active role in armed struggles, and this should be addressed by those involved in protection programmes.

In the next stage of his story, Alban escaped from the massacre of the remainder of his family and lived for three months 'on his wits', learning and using the skills of survival. At the end of this period, he could be described as mentally healthy because the experience had restored to him the sense of his own strength. Dr. Jones emphasised that this was not an isolated incidence, claiming that between 60 and 80 percent of children are not traumatised (in the sense of being made 'psychologically unwell') by war.

Dr. Jones then passed to the meaning of 'trauma', which she asserted, is a term borrowed by mental health from the physical sciences. She suggested that it is now being used to found a rationale for service provision by establishing medical and pathological reasons for intervention on behalf of victims, rather than intervening in political situations in order to prevent or stop conflict itself. After returning to his family, Alban became ill and unhappy once again. Dr. Jones suggested that this was related to family anxiety about losing their temporary home with no alternative shelter available. Following the deaths of his father and older brother, Alban was the man of the family, yet he was unable to solve this problem.

In this case, Alban's apparent symptoms of traumatic reaction can be interpreted not as the irrational response of a child victim but rather as rational and healthy responses to impossible situations. Dr. Jones emphasised that to say this is not to denigrate mental health but to suggest that it is important to address it correctly. Mental health problems are best addressed through non-mental health interventions, which are based not on the assumption of pathology but rather on the provision of human rights to basic needs, justice, the rule of law, security and attention to the problems of lost official identity documents.

Questions to Lynne Jones

The Tribunal questioned Dr Jones about the 20 percent of children who are traumatised by their involvement in conflict asking if they were perhaps in a different environment, or if there were gender differences. Dr. Jones answered that the children were all from the same town of 40,000 inhabitants, whose experiences of conflict were broadly the same. The children who presented clinical symptoms of trauma tended to be those who were already vulnerable to mental health problem before the conflict, or to be those who had 'lost everything'. There were differences between boys and girls in that the latter might be more open about their symptoms. There was no evidence in her research data to indicate that girls are weaker in this respect.

Samual Doe commented that he had heard these arguments about traumatisation before, yet the symptoms he has seen do indicate that the Western medical condition does