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Community-Based Approaches to Mental Health and Conflict Resolution in Post-Conflict Libya

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**COMMUNITY-BASED APPROACHES
TO MENTAL HEALTH AND CONFLICT RESOLUTION
IN POST-CONFLICT LIBYA**

Amanda Lubit
Applied Policy Paper

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ABSTRACT

Post-conflict Libya faces the challenges of establishing a national health system that is capable of addressing mental health needs for a population traumatized by decades of repression and a recent war. In order to recover, traumatized populations require feelings of safety, calm, empowerment, connectedness, and hope. To help achieve this outcome, programs must focus on medical and social aspects at both the individual and community level.

As part of an internship experience, I worked with Dr. Omar Reda, a Libyan psychiatrist at Oregon Health and Science University (OHSU) who helps communities, organizations and mental health professionals throughout Libya to address the effects of trauma on Libyan society. From November 2011 until December 2012, I developed plans to assist social and psychological reconstruction, healing and reconciliation processes currently taking place and made recommendations for creative, community-based, psychosocial programs that are cost-effective, culturally appropriate and adaptable to different regions and communities. I divided these recommendations into the categories of nature, arts, movement and memory-based programs. In this paper, I reflect upon the product of my internship project in light of contemporary anthropological and sociocultural theories.

My research into post-conflict trauma falls within the realm of applied medical anthropology and also deals with the interrelated anthropological subjects of post-conflict society, global health, human rights and public policy. Although anthropology can and should engage with these subjects, currently little published research exists that addresses this particular combination of topics. In this document I reflect upon my internship by considering issues of neoliberalism, identity, subjectivity, and governmentality. Through this lens, I consider how psychosocial programs can potentially impact a post-conflict nation such as Libya. I argue that carefully crafted psychosocial programs can use positive forms of governmentality to shift the subjectivity of participants, creating conditions conducive to improving mental health and reducing conflict.

INTRODUCTION

In 2011, popular protests known as the Arab Uprisings spread throughout the Middle East and North Africa. Although connected, the protests that arose in each affected country looked very different from one another. Each state had a different historical, political, economic and social background that contributed to the ways in which the uprisings played out (Anderson 2011). In Libya, protests quickly spread into a bloody revolution as freedom fighters sought to end Colonel Mu'ammarr al-Qadhafi's longstanding dictatorship. For more than four decades, Qadhafi ruled the country as absolute dictator, suppressing all opposition to his power. He created a culture of oppression and terror, instilling divisions in society that contributed to the violence seen during the 2011 revolution. Although the revolution removed Qadhafi from power and successfully came to an end by October 2011, Libyan society continues to experience deep divisions and other consequences of this traumatic period in its history (Brahimi 2011).

During my internship, I worked from November 2011 through December 2012 in association with Dr. Omar Reda, a Libyan psychiatrist at Oregon Health and Science University (OHSU), developing plans to address consequences of trauma affecting Libyan populations. In late 2011, Dr. Reda created the Libya Al-Shefa (Healing Libya) project to identify and address psychological trauma experienced during Libya's revolution. To achieve these goals, Dr. Reda formed connections with non-governmental organizations (NGOs) throughout Libya to implement trauma programs in association with mental health professionals, teachers, social workers and others. Additionally, Dr. Reda actively participates in the Mental Health Professionals' Association of Libya (MHPAL), a network of Libyan mental health professionals working to respond to the recent conflict through nation-wide initiatives. In association with this organization, Dr. Reda organized the first national conference for Libyan Mental Health

Professionals in 2012 where participants worked to develop immediate and long-term mental health plans for the whole of Libya. Through his community-based and state-level involvement in Libya, Dr. Reda continues to work to create self-sustaining psychosocial programs to benefit a wide variety of individuals and communities within Libya.

Due to my combined backgrounds in public health, trauma, conflict resolution, and anthropology, I was able to contribute complementary perspectives to Dr. Reda's ongoing work. Before attending Portland State University (PSU) I obtained a Master's degree in Public Health which provided me with an understanding of the policies and politics involved in health care. I am also in the process of completing Harvard's Global Mental Health certificate in Refugee Trauma and Recovery, which provides me with an understanding of the specific needs experienced by traumatized populations. Additionally, my work in conflict resolution while attending PSU allowed me to consider how concerns for mental health and peace-building are interconnected and can mutually benefit one another. Finally, my studies of sociocultural anthropology at PSU provided me with the theoretical and methodological framework for understanding the various social and cultural aspects of the problems currently facing Libyan communities in the post-war period.

Using an anthropological perspective, I engaged in an internship that allowed me to use my multidisciplinary background in an applied setting. The focus of this internship was on developing program and policy recommendations that will simultaneously address mental health and conflict resolution needs in post-conflict Libya. Dr. Reda and his colleagues specialize in mental health and therefore are better equipped than I am to develop plans for a national mental health system in Libya. For this reason, I focused my contributions on identifying non-medical ways of addressing mental health at the community level. Because Dr. Reda's work extends

beyond the local to the national level, my own research focused upon developing broad-scale recommendations. To accommodate the needs for both national-level policy and locally relevant post-conflict interventions, I developed a set of program recommendations that can easily be adapted to a community's unique culture, resources and environment. Unfortunately, I could not perform any ethnographic research to support these recommendations due to ongoing conflict in Libya. Despite these limitations, using literature-based research I developed an extensive resource packet intended to serve as a reference for future program building. This deliverable outlined potential ways to improve mental health and reduce conflict using cost-effective, culturally appropriate and creative methods. I argued that communities themselves have the capacity to utilize techniques of biopower as a way to heal from the traumas they experienced. By implementing different types of psychosocial programs, communities can work to reshape participants' subjectivities and foster identities associated with values of peace and wellbeing. As the final product of my internship, I delivered this resource packet to Dr. Reda who will distribute my findings to his varied network of contacts working throughout Libya.

CONTEXT:

RESEARCH PROBLEM

During my internship, I performed literature-based research on the problems that face post-conflict societies similar to Libya as they work to recover and heal from the trauma of violence. I was then tasked with developing a resource packet to provide communities with methods for both improving mental health and reducing ongoing conflicts. In order to develop a comprehensive and appropriate set of recommendations, I considered Libya's history and the current conditions the nation faces as it works to rebuild (see Appendix A for Timeline

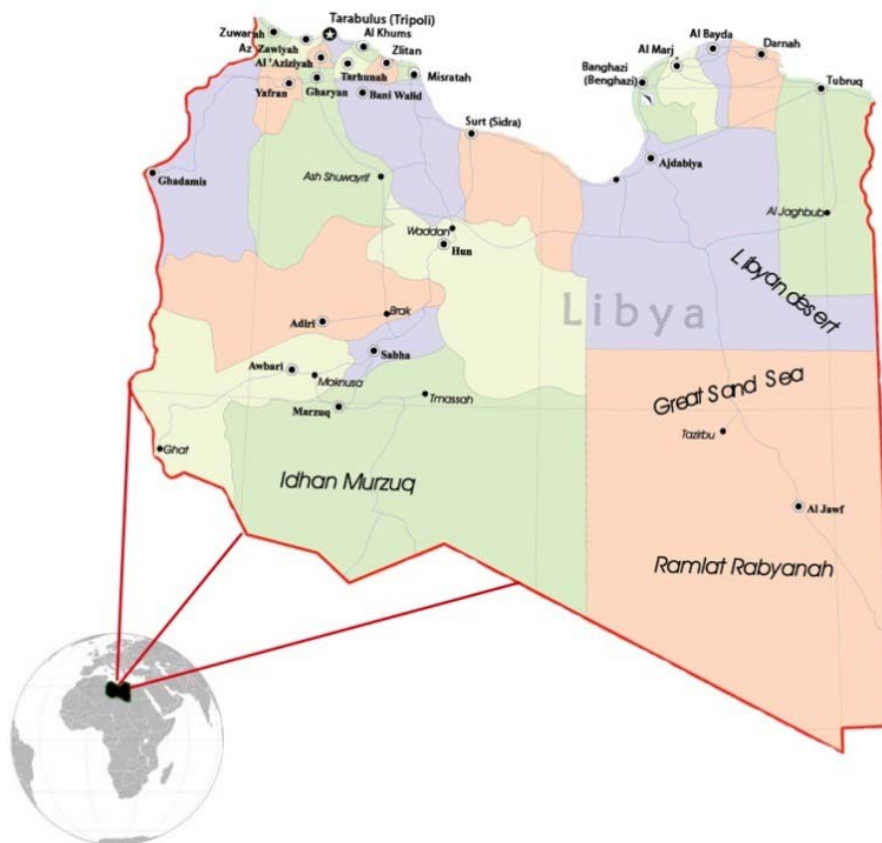


Figure 1: Political Map of Libya, a country located in Northern Africa on the Mediterranean Sea

Image compiled from: "Libya Map-Africa," *Geographic Guide: Africa*, <http://www.geographicguide.net/africa/libya.htm> (accessed 30 Nov 2012); *Wikipedia: Libya*, <http://en.wikipedia.org/wiki/Libya> (accessed 30 Nov 2012)

of Events). In this section I briefly describe some relevant historical events that created the conditions seen in Libya today. I also consider the events that took place during the 2011 revolution and of ongoing conflicts. This combination of historical and recent traumas contributed to both current barriers to mental health and to the enormous demand that exists for mental health interventions. It is within this context that I outline the plans for the future of mental health in Libya as envisioned by Dr. Reda and other Libyan mental health professionals during the First National Conference on Mental Health held in 2012.

HISTORICAL BACKGROUND

The political history of Libya contributed significantly to the Libyan Revolution which erupted in 2011 as part of the Arab Uprisings. While under Ottoman rule during the 16th to 20th centuries, the Sanussiyyah Muslim reformist movement arose in the Cyrenaica region to become a regional political power (Brahimi 2011; Deeb 2011; Paoletti 2011). After the Ottoman Empire fell, Italy imposed colonial rule which from 1912 until 1942 when French and British forces liberated the region. With liberation came French and British occupation, which lasted until 1951 when the United Kingdom of Libya gained independence as a Sanussis led monarchy. Although united within one nation, the regions of Cyrenaica in the east, Tripolitania in the west and Fezzan in the south remained largely autonomous with political structures dependent upon tribal affiliations (Deeb 2011; Paoletti 2011). This regional political structure contributed to ongoing divisions experienced in Libya today.

In 1969, Colonel Mu' ammar al-Qadhafi overthrew the government through a military coup to establish an absolute dictatorship that lasted for four decades. During this time, he “artificially induced scarcity in everything from simple consumer goods to basic medical care”

(Anderson 2011:6). Formal state institutions did exist but they proved themselves to be corrupt, inefficient and unreliable; Qadhafi created a system of governance that relied on nepotism and involved heavy overlap between institutions, creating a chaotic situation where no true authority existed besides his own (Paoletti 2011:316-317). He further maintained his dictatorship by outlawing political parties, free media, and civil organizations (including non-governmental organizations, sports clubs, cafes and other places where people could gather). Under Qadhafi's rule, many Libyans were also denied access to basic necessities such as employment, healthcare or security (in the form of a trustworthy police force or military), forcing them to rely heavily upon traditional kin and tribe networks rather than on the government or civic organizations (Anderson 2011:6; Brahim 2011:608; Dunne 2011:370). Furthermore, Qadhafi's regime also

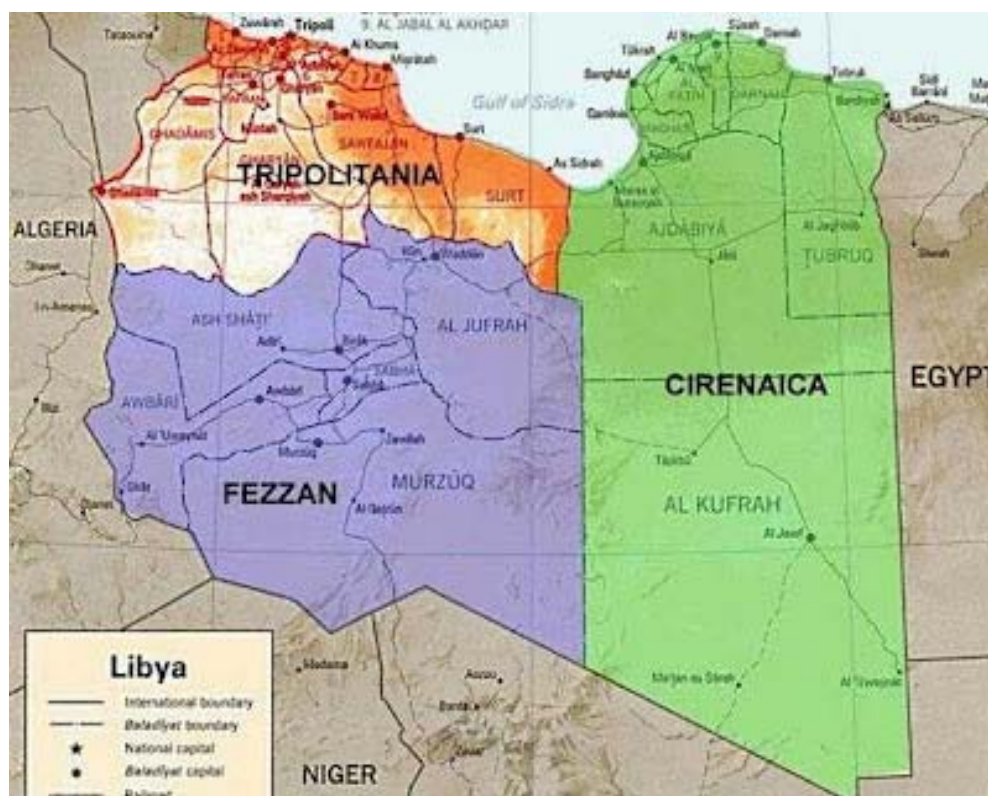


Figure 2: Political Regions of Libya – The Provinces of Cirenaica, Tripolitania, and Fezzan

Center for Research on Globalization, "Libya Regional Map," *Global Research*, <http://www.globalresearch.ca/the-war-on-libya-an-imperialist-project-to-create-three-libyas/25637>, 29 July 2011. (accessed 19 Oct 2012.)

“eliminated the private sector...confiscated and destroyed property, nationalized oil and land, and asserted the monopoly on imports and exports[,]...making itself the principal source of income for most households” (Brahimi 2011:608). These policies resulted in a nation that centered on Qadhafi and lacked a well-developed, centralized state apparatus, infrastructure or civil society. Unfortunately, the consequences of these policies continue to pose a challenge for Libya and its people today as they work to rebuild and recover.

CURRENT CONFLICT CONCERNS

As with any conflict situation, the reality of conflict in Libya is extremely complex. Although it goes beyond the scope of this paper to discuss all of these complexities, it is important to understand some general points about the current forms of conflict. Significant divisions continue between regions as well as between communities harboring feelings of jealousy and animosity.

Regional divisions, especially between east and west, remain an issue in Libya today. Qadhafi originated from Tripolitania and ruled with the support of tribes in this and the Fezzan region. Due to this association, many communities in Tripolitania received more resources and support from the Qadhafi regime than did those in Cyrenaica (Brahimi 2011; Paoletti 2011). The continuing importance of these tribal associations and regional divisions became clear in February 2011, when peaceful anti-Qadhafi protests began in Cyrenaica. Despite violent suppression by national security services, these protests spread throughout all of Libya. Leaders in the Cyrenaica region soon declared themselves the true government of Libya, igniting a violent clash between freedom fighters and Qadhafi supporters that exacerbated existing divisions. The resulting conflict was both prolonged and extremely violent. The intractability of

this conflict and the devastation it caused led the United Nations to issue a mandate for international military intervention, which took the form of NATO bombings. Although the bombings failed to end the fighting, by August 2011 the freedom fighters succeeded in displacing the Qadhafi regime (Brahimi 2011; UNSC 2011). Despite this success, conflict continued to plague many regions throughout Libya.

Qadhafi's political strategy of encouraging division and conflict caused numerous types of violent clashes to erupt during 2011. In addition to regional, tribal and political conflicts, fighting also emerged between rival communities that spent the duration of Qadhafi's rule competing over resources. Favored communities had access to resources and opportunities such as education, healthcare and employment, which made these populations both dependent upon Qadhafi's regime and resented by their less fortunate neighbors. Qadhafi actively encouraged these local rivalries to prevent communities from joining forces against him (ICG 2012). The result was a culture of jealousies and resentments that contributed to the country's fragmentation.

Since 2011, multiple forms of conflict erupted; regional and tribal tensions divided the nation, and communities oppressed under Qadhafi struck out at their neighbors to exact revenge for decades of inequalities. These realities raise the question of what can be done to combat these conflicts. Unfortunately, as I write in early 2013, no centralized government force exists to establish security for the nation. Instead, the government sanctioned the use of local militias and military councils that act autonomously in their own localities without national oversight. Although some of these militias do protect the communities under their jurisdiction, others use their powers to dominate neighboring rival communities, and a small minority actively sought revenge through violence (ICG 2012). As a result, these military forces contribute to the ongoing conflicts and confusion that plagues Libyan society.

At this time, historical conflicts and prejudices throughout Libya remain prevalent. As a result, communities continue to experience instability due to the threat of renewed violence in the name of revenge. In the current situation, initiatives must begin to focus on the joint tasks of working towards emotional healing and conflict transformation. The work I performed during my internship aimed at developing some viable options capable of contributing to this ongoing effort within Libya.

CURRENT MENTAL HEALTH CONCERNS

In late 2011, the International Medical Corps (IMC) performed an assessment of mental health resources and needs in Libya. The IMC identified several populations that they consider most affected by the conflict and most at risk of future violence. At risk populations include children, women (especially mothers), families with missing or killed relatives, freedom fighters (especially those wounded or with amputations), freed prisoners, medical first responders, and vulnerable populations targeted for retaliation due to previous association with the Qadhafi regime (Weissbecker 2011). These populations' experiences of trauma predispose them to greater mental health problems.

Despite the high rate of trauma-related mental health problems that the IMC predicted to exist throughout Libya, both health care and mental health resources remain in short supply. When violence spread throughout the country, many healthcare workers fled and the existing healthcare infrastructure was severely damaged. Shortages abounded not only of medicines, supplies and equipment but also of the psychiatrists, psychologists and trained nurses needed to handle mental health cases. These shortages add to the difficulties the lack of mental health facilities create; in the entire country only two psychiatric hospitals exist, one in Tripoli and

another in Benghazi (Weissbecker 2011). Even if people wanted to seek help, they have little opportunity to access the relevant health services.

Additional barriers to mental health services include lack of funding, adequate training and government support. Libyan culture socially stigmatizes mental illness; this stigma makes it extremely difficult for affected individuals to seek help from a mental health professional. Instead, most people rely upon traditional healers and Sheiks within their communities (Weissbecker 2011). This current shortage in mental health resources, infrastructure and popular acceptance will impact the future of mental health in Libya.

THE FUTURE OF MENTAL HEALTH IN LIBYA

In 2012, the Mental Health Professional Association of Libya (MHPAL) convened the “First National Conference on Mental Health” to discuss the future of mental health in Libya. Like the IMC, this meeting identified multiple barriers to delivering and accessing mental health services. During this conference, mental health professionals discussed what could be done to address these problems in order to better manage the psychological wounds of the 2011 revolution and its aftermath. The product of this discussion was a 25-point list of recommendations (Reda 2012) that called for a standardized national mental health profession, specific programs and policies to address ongoing mental health needs, and holistic approaches to mental health (see Appendix B).

Each of these recommendations point to significant issues that Libyan policymakers must navigate as the nation begins to rebuild and recover. In the resource packet I produced for Dr. Reda, I argued that carefully crafted community programs can provide culturally appropriate forms of assistance that address several of these recommendations identified by the MHPAL.

THEORETICAL APPROACH:

THEORIES IN ANTHROPOLOGY, MENTAL HEALTH, AND CONFLICT RESOLUTION

Rather than impose programs upon communities, I argue that communities themselves have the capacity to develop and implement techniques of biopower aimed at addressing the effects of trauma. Most post-conflict recovery efforts focus on using Western medicine to treat post-conflict mental health symptoms. Although medical interventions have their uses, a greater emphasis on non-medical approaches can benefit traumatized individuals, families and communities. In terms of mental health, cultures interpret the manifestations of trauma according to their own understandings of illness. In order to respect these interpretations, I developed recommendations that seek to improve mental health by working with rather than against these cultural beliefs.

With ongoing conflict, people continue to experience negative emotions of fear and insecurity, making it difficult for true emotional healing to take place. Due to this interconnection between conflict and emotional wellbeing, I argue that mental health interventions must simultaneously work towards conflict transformation. The term *conflict transformation* refers to the process of identifying underlying causes of conflict and then working to change them as a way to create sustainable peace (Lederach 1997; 2003). To address this conflict and its effects, conflict resolution theorist Lederach (2003:22) advocates for the use of conflict transformation as a way “To envision and respond to the ebb and flow of social conflict as life-giving opportunities for creating constructive change processes that reduce violence, increase justice in direct interaction and social structures, and respond to real-life problems in human relationships.” This involves the cultural construction of new identities through a form of governmentality capable of changing the ways in which people relate to one

another. In this context, the term *governmentality* refers to disciplinary forms of power that seek to manage all aspects of life in order to achieve a sense of order and control. Using governmentality to construct new subjectivities, conflict transformation processes address both society's present conflict situation and underlying relationships and patterns of conflict (Lederach 2003:10-11). As a result, this comprehensive approach requires a long-term commitment to change in order to address the roots of conflict and produce subjects with an improved sense of mental wellbeing and community cohesion.

VIOLENCE AND TRAUMA

Before I can discuss methods for addressing trauma in post-conflict societies, I must first explain how trauma disrupts the different levels of society. The term "trauma" refers to:

An encounter with an event or series of events so shocking that our understanding of how the world works is severely disrupted.... Traumatic experiences rupture the linear narratives through which one experiences the everyday.... Those who survive traumatic experiences may well have preserved their physical lives, but the meaning ascribed to being becomes altered (Hutchison and Bleiker 2008:387-388).

Because trauma affects cultures, communities, and individuals, I consider it essential that initiatives take a holistic approach using diverse multi-level interventions. As a psychiatrist, Dr. Reda focused his work largely on medical treatment for traumatized individuals. I instead draw upon my knowledge of anthropology and conflict resolution to focus on social methods of addressing cultural and community needs. Although we took different approaches, I consider our work to be complementary.

Anthropological theories on violence demonstrate that several types of violence often exist concurrently, interacting with and contributing to one another. According to Schröder and Schmidt (2001:13), "Violence as a social fact can be viewed from three angles: as violence

understood more narrowly as a form of interpersonal relations in everyday cultural reality, as conflict, and as war.” Using this anthropological understanding of violence, I considered both how violence is experienced and how it affects relationships and interactions between conflicting parties.

Libyans experienced decades of terror in the form of Qadhafi’s totalitarian state. Totalitarian regimes use actual violence and the threat of violence to create a culture of fear that becomes part of the everyday experience. Pervasive repression and silencing of the population under these regimes lead to suppressed feelings of anger, hatred, and bitterness. Unfortunately, even after the regime fell, these experiences and emotions continue to affect society (Kleinman 2000:233-234). Beyond everyday forms of violence, Libyan society also recently experienced violent conflict and war, which further contribute to the trauma experienced. Even after physical violence ceases, psychological traumas and many underlying causes of conflict persist.

Once terror becomes part of everyday reality, as in Libya, it permeates peoples’ lives. Anthropologist Linda Green (1994:227-228) emphasizes the importance of considering how people experience and deal with the fear, alienation and distrust that result from this reality. Terror should be understood as a source of profound fear and insecurity due to the chronic threat of violence it brings. This threat leads people to develop feelings of suspicion and distrust that degrade relationships and communities. In essence, “Fear has become a way of life” (Green 1994:227) not only for the individual but for all of society.

The political terror scale provides a yearly report indexing terror and political violence experienced in countries around the world. Academics in political science created this index, developing a “standards-based human rights data set” (Wood and Gibney N.D.:2). They compile data from Amnesty International and the US State Department Country Reports on Human

Rights Practices to determine the degree of state terror a country experiences during any given year (Wood and Gibney N.D.). According to this scale, Libya received the highest score of a five in 2011. This means that “terror has expanded to the whole population. The leaders of these societies place no limits on the means or thoroughness with which they pursue personal or ideological goals” (PTS 2012). Prior to this, Libya spent decades with a terror score that ranked between three and four out of five. These rankings indicate that populations in Libya experienced a variety of civil and political rights violations that include political executions, disappearances, imprisonments, detentions, and brutality (PTS 2012; Wood and Gibney N.D.:6). These scores provide a contextual view of the environment in which Libyan populations lived both under Qadhafi and during the 2011 revolution.

NEOLIBERALISM, GOVERNMENTALITY, SUBJECTIVITY AND IDENTITY

Comparing my work with other research in an applied medical anthropology settings demonstrates that the field requires further work be done on the issues of post-conflict mental health and conflict resolution. Although anthropologists working within violence theory and post-disaster literature write about these issues, several anthropologists recently pointed to the lack of attention being paid to issues of war and conflict, human rights, global public health and public policy within medical anthropology (Campbell 2010; Checker 2009; Inhorn 2008; Janes and Corbett 2009). Although my research falls within these categories, I focus not on the medical approach to trauma but instead on proposing alternative non-medical, social options. In a review of the literature, I found that medical anthropologists take an approach different from mine by not only focusing on medical interventions but also by focusing on single ethnographic examples rather than considering broad-scale policy.

Medical anthropologist Marcia Inhorn (2008) wrote a recent commentary pointing to the lack of medical anthropological research on either conflict or post-conflict societies. Using the example of Iraqi society, she demonstrated the vast short and long-term effects of war on the mental health of entire populations. Based upon these observations, Inhorn (2008) calls for medical anthropologists to advocate for appropriate policies to promote peace and address mental health needs. In my research with Dr. Reda, I attempted to do begin this process of advocating for the needs of the Libyan people. While this author appealed to anthropologists for further involvement in this subfield, the anthropologists McKinney (2007) and Abramowitz (2010) dealt with issues of post-conflict mental health through ethnography. Both authors worked with community level mental health program to identify shortcomings and recommend ways to improve delivery of care to these survivors. Several anthropologists criticized this small-scale approach within medical anthropology and called for the application of local data to national and international health policies (Campbell 2010; Checker 2009; Inhorn 2007; Janes and Corbett 2009). Although I share McKinney and Abramowitz's focus on post-conflict, community-based mental health programs, I took a broader approach and applied my anthropological perspective to nation-wide policy issues rather than to one specific community. To do this, I draw upon theories of neoliberalism, governmentality, and subjectivity.

Many medical anthropologists evaluate the effects of global health policies on the delivery of healthcare or, more specifically, mental health services to less developed nations. One of their main criticisms points to the problems that arise when implementing programs based on Western conceptions of medicine. These issues relate to the application of neoliberal agendas to healthcare, the medicalization of society and problematization of illness, and the use

of technology to address illnesses (Ecks 2010; Garcia; Pfeiffer and Nichter 2008). According to McKinney (2007:483), critics of post-conflict mental health programs question the:

Appropriateness of a medical orientation to care, especially with regard to the widespread exportation of trauma programs to resource poor countries during humanitarian emergencies.... Referred to as the 'medical model,' critics pejoratively associate this type of intervention with biomedical reductionism and the reification of the psychiatric diagnosis of post-traumatic stress disorder (PTSD), and with psychological interventions targeted at individuals.

These policies can exacerbate existing inequalities, create new categories of disease, and neglect social aspects of trauma in favor of medical treatment for the psychological trauma. This approach to health poses a problem because it imposes programs on marginalized and traumatized populations without consideration of the broader effects these programs can have (Janes 2004:459; McKinney 2007:497; Pfeiffer and Nichter 2008:411). Global health policies have several consequences which international aid programs need to understand and consider so that they can maximize the benefits for target populations and minimize unintended consequences.

To understand how global health initiatives can result in negatives consequences, I must first explain the larger forces at work. In this modern era of intensified globalization, health problems moved beyond the borders of the state to become transnational. For this reason, in order to adequately address health concerns, approaches must move beyond national borders to also become transnational. This requires cooperation and interaction between states, non-governmental organizations, corporations, and individual actors (Janes and Corbett 2009:168); Pfeiffer and Nichter 2008:410). At present, neoliberal agendas largely influence these interactions and, consequently, the delivery of healthcare through international aid. In this context, I use the term "neoliberal" to refer to a technique of governance which involves new economic strategies that intensify the processes of globalization, and irrevocably alter the role of

nation-states and their relationships with their citizens (Ong 2006:1; Gledhill 1999:332). With regards to healthcare, these strategies often result in the privatization of both social and medical services. States increasingly disengage from providing services to their citizens, shifting these responsibilities to non-governmental organizations and private health providers (Ecks 2010:152; Garcia 2010:65, 185; Janes and Corbett 2009:175; Pfeiffer and Nichter 2008:410-411). In nations recovering from trauma, the privatization of health care often results in chaos due to a lack of sufficient infrastructure to support these programs and due to the overlap of private organizations that fail to coordinate (Pfeiffer and Nichter 2008:411). Therefore, these neoliberal approaches fail to meet their objectives of efficiently delivering healthcare to the target communities.

Not only do neoliberal agendas affect the efficiency of aid programs, but they also affect their efficacy. Economically driven approaches to health result in “a conception of health care...that focuses narrowly on demonstrable individual and biomedical (rather than social) outcomes...[and] advances a highly rational, universal, and efficiency-based model of health care...that takes little account of local conditions” (Janes 2004:459). This approach proves problematic because it ignores the fact that health is an integrated part of communities and cannot be considered separately from other important elements such as culture, economy, politics and security (Janes and Corbett 2009:177; Pfeiffer and Nichter 2008:412). Medical anthropologists understand this technological approach to healthcare in terms of biopower which is a form of governance used to control bodies and what bodies do.

Foucault (1977:140) defines the term *biopower* as the “Subjugation of bodies and the control of populations.” Power acts upon individual bodies, through institutions such as the family, the workplace, the military or schools. Each of these institutions functions to discipline

individuals with the goal of creating segregated and docile bodies which are maximally productive while being easy to govern (Foucault 1977:140). Although this application of power differs from that applied to the social body, the two remain intimately connected. Power acts upon the social body through the use of certain interventions and techniques that aim to manage the population. This management depends upon acts of monitoring and counting to achieve a certain knowledge and understanding of populations. Defining a population through these methods allows the population to be known and identified, giving instruments of power a way to control and regulate it (Foucault 1977:140-141). These management techniques combine with the disciplinary techniques applied to individual bodies to allow for both individuals and populations to be supervised and controlled with greater ease. Therefore, in producing docile bodies and managed populations, disciplinary power achieves its objective of overseeing and maintaining all life.

The politics of health represent one way in which power governs bodies and populations. This powerful governance technique can have a spectrum of uses and results. Many medical anthropologists focus on examples that demonstrate the negative effects of the medicalization of society. Using science to produce a medical reality, neoliberal and globalizing forces shape how people understand and experience illness. Consequently, in these situations people learn to see illness as a problem that needs to be controlled and managed (Foucault 1980:167-168). In terms of global health, governmentality often appears in the ways that institutions turn people into patients seeking medical care and products to treat their illnesses. Both Ecks (2010:146) and Biehl (2007: 82-83) discuss these trends and examine the role played by private corporations in this process. They demonstrate that with privatization, the pharmaceutical industry increasingly contribute to shaping not only how people understand health and illness, but also how

institutions address health. They promote the labeling of certain conditions as diseases so that doctors will increasingly diagnose their patients and prescribe medications sold by the corporations. This form of governmentality creates global health agendas that focus very specifically upon certain conditions rather than upon overall public health. As a result, these types of health initiatives often ignore many significant and basic issues of health (Biehl 2007:86). I argue that this approach to post-conflict trauma problematizes mental health and, therefore, risks neglecting essential needs in favor of diagnosing and medicating patients.

In his discussion of social suffering, Kleinman (1997:319-332) describes how the biomedical approach to trauma results in the minimizing of survivors' actual experiences. These experiences disappear from the post-conflict dialogue in favor of discussions on diagnoses and treatments. By using science to understand these deeply personal experiences, people and institutions can maintain a safe distance where these painful emotions cannot be felt. Kleinman (1997:320) states that "By disavowing the broad contextual implications of deeply human experiences of suffering in favor of a narrow technical agenda of professionally defined principles...these principles frequently overshadow everything else that matters in the experience of families, patients, and health practitioners." This demonstrates that certain social institutions, policies and programs create a subjectivity that identifies some individuals as patients worthy of treatment and care while denying that care to others. Not only do these processes deny people their voice, but they can also contribute further to their suffering (Kleinman 320). Programs and organizations that seek to help traumatized populations need to consider these potential unintended consequences of their actions so that they can minimize them whenever possible.

Responding to this negative example of biopower, in my own research I propose the use of these techniques in a different and potentially positive process. Rather than impose forms of

governance on populations from above, I argue that communities themselves can exercise techniques of subjectivization and governmentality to develop new ways of understanding conflict and the trauma it caused. As Garcia (2010) argues, “forms of governance become forces for the creation of new forms of subjectivity.” This means that techniques to discipline individuals and populations will change the ways in which people understand their bodies. Biehl (2005:137) defines *subjectivity* as “neither reducible to a person’s sense of herself nor necessarily a confrontation with the power that be....Always social, subjectivity encompasses all the identifications that can be formed by, discovered in, or attributed to the person.” He also argues that anthropologists should identify and analyze this process of subjectivity creation in order to understand the complex dynamics involved in the delivery of healthcare.

Having considered the negative connotations of biopower and subjectivity as discussed by Biehl (2005; 2007), Ecks (2010), and Garcia (2010), I determined that these same processes can also affect positive changes in populations. I propose that carefully constructed programs can implement a form of governmentality that alters current identities associated with tension, anger, hatred and violence, replacing them with new identities associated with peace, cooperation and forgiveness. In the remainder of this paper, I discuss specific ways that various community-based forms of conflict transformation and healing can bring about these changes to subjectivities.

One potential way to effect positive change in subjectivities is through interventions that address the cultural construction of identity. Considering identity as an ongoing process rather than a static classification, Brubaker and Cooper (2000) argue that people identify themselves differently at different times and in different contexts, meaning that people can simultaneously hold several complementary and conflicting identities. For this reason, identities cannot be considered universal within a population because “How one identifies oneself – and how one is

identified by others – may vary greatly from context to context; self- and other-identification are fundamentally situational and contextual” (Brubaker and Cooper 2000:14). In everyday life, as people interact with the rest of society they identify both themselves and those around them either relationally or categorically. Relational forms of identity refer to the ways in which people see themselves in relations to others in terms of family, friendship, work or other relationships. Categorical forms of identity refer to social categories such as nationality, religion or language. In any given situation, people assign themselves an identity based upon these classifications; yet at the same time other people and institutions assign their own interpretations of that person’s identity which may differ drastically (Brubaker and Cooper 2000:15-16). Recognizing these complexities of identity, I suggest that post-conflict initiatives carefully choose what aspects to address.

When people associate strongly with certain identities they can be motivated to kill or be killed in their defense. As in any conflict, multiple forms of identity contributed to the violence experienced in Libya. Although I cannot address each and every form of identity that contributed to these conflicts, I must address nationalism which historically proved itself to be an extremely powerful and potentially explosive form of identity. Throughout history, nationalism showed itself to be capable of mobilizing people to extremes of violence in the name of the nation. In this context, the *nation* refers to a political community founded upon the shared characteristics of a “people” who share certain

Nationalism refers to a belief in the nation as a political community that functions to connect individuals on the basis of shared characteristics and identities. National populations view themselves as sharing many common qualities including history, tradition, territory, ethnicity, language and religion (Anastasiou 2008; Anderson 1991). However, as Brubaker and

Cooper (2000) demonstrate, identity is much more complex and much less unified than this concept suggests. Although emotionally powerful for those who embrace this identity, in reality the national community is a cultural construct. Anderson (1991:4-6) labels the nation an “imagined community,” because people envision a connection that does not exist in reality. Despite no tangible connection between members of a nation, people mentally construct an imagined connection on the basis of a perceived shared experience.

As a socially constructed form of identity, nationalism can be understood in terms of biopower. Nationalism acts as a worldview which promotes “a certain view of life, society and history, along with a code of expected behavior, and a particular understanding of identity and belonging” (Anastasiou 2008:17). Consequently, it exerts control over both individual and social bodies, managing how people perceive and act in relation to the nation. In terms of individuals, the nation works to train the minds of its people to think and speak about the nation in a particular way, thus ensuring that individuals support the nation and present little resistance to its authority (Anastasiou 2008; Staub 1989). Nationalism also acts upon the social body, enabling the nation to identify and manage its population. According to Anderson (1991:168, 174), the nation does this through the use of maps and censuses. While maps identify the nation’s population on the basis of space, censuses categorize and count populations on the basis of labels such as ethnicity, religion and language. These often arbitrary classifications make the population and its spatial distribution knowable, improving the ease with which these populations can then be managed.

The cultural construction of national identity proves highly significant when considering how to address issues relating to conflict because by its nature, nationalism inspires conflict. The nation considers itself and its people to be superior to all others, fostering an egotism which

creates conditions that lead the nation and its people into conflict with others. Based upon certain shared, defining characteristics, nationalism defines who belongs and who does not. This exclusionist approach to identity construction essentializes and magnifies the differences that exist between identities, creating tension between those defined as “self” and those defined as “other” (Staub 1989:250-251). When people experience times of crisis they become frustrated with the unjust conditions of their lives; threats to financial stability, health and security all bring with them an insecurity that infects society and leads to increased tensions. Under these stressful circumstances, societies experience feelings of anger over the circumstances of their lives and direct these feelings at a population that they identify as being to blame. Blame drags these societies into a downward spiral towards the desire for retribution (Kressel 1996:248-250; Staub 1989:249). Under these conditions violence becomes an increasingly attractive option as a way to not only gain revenge for previous wrongs but also as a way to protect oneself and one’s nation from the threat posed by the enemy. Once the nation labels a population as “other,” it becomes an enemy because its interests are seen as being in opposition to those of the nation. This justifies any actions, no matter how violent, as being necessary for the protection of the nation and its people (Anastasiou 2008; Kressel 1996; Staub 1989). The danger posed by nationalism demands that post-conflict interventions work to enable society to move beyond these highly polarized forms of identity. This involves the use of conflict transformation processes that are capable of managing the ways in which culture constructs the concept of the nation and of its subjects.

The methods by which nationalism defines the identity of its people plays a crucial role in understanding how intra-state violence like that seen in Libya develops. The conflicts witnessed since 2011 between political groups, tribes, ethnic groups, and rival communities all

represent conflicts that can be understood, at least partly, in terms of nationalism. When stressful conditions arose such as the recent financial crises and the subsequent political instability of the Arab Uprisings, competing identities increasingly came into conflict with one another and resulted in violence. In order for post-conflict initiatives to adequately address these continuing tensions, they must consider how identity contributed to and been shaped by conflict. While national identities likely play a significant role in most of these conflicts, interventions must also take other identities into consideration. This means considering the multiple, competing and complementary identities that people draw upon in different contexts, then identifying those identities that require reshaping in order to bring about conflict transformation. Once identified, psychosocial programs can employ positive governance strategies to alter subjectivities and create new forms of identity based upon inclusive forms of community that promote peace and wellbeing.

COMMUNITY-LEVEL PSYCHOSOCIAL INTERVENTIONS

According to Scheper-Hughes and Bourgois (2004:1), “Violence can never be understood solely in terms of physicality....[It] also includes assaults on the personhood, dignity and sense of worth or value of the victim. The social and cultural dimensions of violence are what gives violence its power and meaning.” As a result, terror, like that experienced in Libya, profoundly affects individuals and communities. These traumatic experiences lead to a range of powerful emotions which not only affect wellbeing, but also contribute to the ways in which people rebuild their communities. Common emotional responses to violence include fear, anger and resentment. As conflict escalates into violence, enemies also begin to dehumanize one another; by perceiving the opposing population as less than human, people can more easily justify acts of

violence against them (Halpern and Weinstein 2004:566; Hutchison and Bleiker 2008:385-386; Kirmayer 2010:7). Unfortunately, unless society addresses the emotional realities that linger after the conflict ends, they will not have the capacity to heal and forgive, meaning that sustainable peace will be unlikely. Over time, negative stereotypes of the enemy and deep feelings of anger and fear can become integrated into cultural identity. As a result, “Individual experiences of trauma can translate into collective experiences, and thus political formations. This [translation] process plays a crucial role in shaping processes of reconciliation and...influences whether conflict or peace will prevail in the long run” (Hutchison and Bleiker 2008:390). Therefore, emotions affect not only the ways in which people experience life, but also the ways in which communities interact with one another. Based upon this understanding of the emotional and mental consequences of trauma, many experts in the fields of psychology and conflict resolution argue for holistic approaches to trauma.

No accurate measurements exist to quantify emotions, but experts in the fields of mental health and conflict resolution argue that they play a crucial role in both reconciliation and healing processes. Transcultural psychiatrist Kirmayer (2010:11) notes that, “A focus on mental health problems per se is insufficient to grasp the wide impact of communal violence....Mental health systems and services must expand their perspective to encompass broader psychosocial programs to assist with post-conflict reconstruction and health promotion.” For this reason, in my own work with Dr. Reda I argued that multidisciplinary psychosocial programs are needed to address mental health and conflict resolution simultaneously. These approaches should work with traumatized populations to move away from negative emotions and towards feelings of empathy. With empathy, people attempt to understand their enemy’s experiences and perspectives even if they do not agree with them (Halpern and Weinstein 2004:568; Kirmayer

2010:8). Through the process of developing empathy, both the victim and the perpetrator regain their humanity, paving the way for forgiveness to develop. Forgiveness proves to be essential both for emotional healing and for conflict resolution. It involves releasing feelings of anger and hatred in favor of respect, understanding and acceptance. Not only does the experience of forgiveness provide feelings of wellbeing and calm, but it also opens opportunities for new forms of social engagement between former enemies (Kirmayer 2010:14). Forgiveness is the first step in healing social schisms. For this reason, in order to address the complex social and psychological consequences of mass violence adequately, interventions must move beyond medical approaches to mental health and work to reshape hostile community identities forged in trauma and conflict.

This means expanding the focus of post-conflict interventions to increasingly emphasize community-level forms of healing. Within the mental health literature, Hobfoll et al. (2007) and Silove (2007) wrote persuasively on this topic. These authors recommend models for mental health interventions seeking to address traumatized populations. Interestingly, both psychiatric studies independently come to the conclusion that post-conflict societies must meet five psychosocial needs in order to heal fully from and overcome their traumas. These needs include: feelings of safety, reduced anxiety, self- and community empowerment, connectedness to one another and to the environment, and hope (Hobfoll et al. 2007:284; Silove 2007:245). Silove (2007:244) refers to this as the “Adaptation and Development after Persecution and Trauma” (ADAPT) model; this model seeks to go beyond mental health to consider the “social, cultural, historical, and political influences [that] undoubtedly shape individual psychological interpretations of these complex events.” Based upon these considerations, both sets of authors argue that experiences of insecurity, anxiety, powerlessness, disconnection from others, and

hopelessness will all exacerbate symptoms experienced by traumatized individuals and communities. If a threat of violence persists, people continue to live in fear, waiting for the next trauma to occur. They often feel powerless to change their circumstances and lose hope for a better future. Additionally, these feelings of insecurity and hopelessness erode social support networks and deprive people and communities of interpersonal connections essential for recovery (Hobfoll et. al 2007; Silove 2007). Due to the significant degree of interrelation between these needs, initiatives should seek to address them all simultaneously rather than addressing them individually.

While Hobfall et al. (2007) developed their recommendations using a review of the relevant literature, Silove (2007) developed his model based upon his own clinical experiences of working in trauma situations. Having worked with several Asian refugee populations, Silove (2007:250-252) recognized that the greater the exposure to trauma (in terms of time or intensity), the greater the impact of mental health symptoms on individual subjectivities. He also found that despite the high levels of symptoms initially experienced, most people will recover on their own over time. Based upon this finding, Silove (2007:242-244) concluded that cultural, community strategies for dealing with trauma offer the support needed for the majority of the population to form healthy subjectivities. For this reason, he argued that “A multilevel response to traumatic stress according to the ADAPT model is warranted for populations exposed to mass violence” (Silove 2007:255). These responses can reinforce already existing and accepted methods of healing and social support, building a community’s capacity to cope with traumatic situations.

Although strongly connected to mental health, none of the needs identified in the ADAPT model can be addressed adequately using mental health approaches alone. This again demonstrates the need to combine conflict resolution and mental health approaches when

developing post-trauma initiatives. Conflict affects people and communities on personal, relational structural and cultural levels; for this reason, conflict transformation efforts must take each of these four levels into consideration. On a personal level, conflict transformation seeks to deliberately invoke new cultural constructions of identity that change how people understand and emotionally experience conflict. Relationally, it works to improve the ways in which people communicate and interact with one another. Conflict transformation also attempts to provide insight into the underlying social structures that form the root causes of conflict; to do this, programs promote structures that allow people to participate in decision-making and that ensure all basic needs are met. Finally, transformation as a form of governmentality also modifies existing cultural patterns that contribute to conflict and violence, as well as those that promote healing and peace (Lederach 1997:81-83; Lederach 2003:27). Through these processes, conflict transformation seeks to fundamentally alter relationships and social contexts that contribute to ongoing conflict.

According to several conflict resolution experts, conflict transformation should be implemented in post-conflict situations because of its potential to resolve problems and to create a foundation for future relationship development between conflicting parties (Broome et. al. 2011: 97). This concept translates into long-term projects that implement techniques of governance focused upon altering identities through reestablishing communication, rebuilding relationships and developing mutual feelings of respect and trust on both sides of the conflict. Many different types of projects acting at various levels of society can help accomplish these goals. Specifically, conflict transformation takes place at three different levels of society; high-level negotiations take place between the political and military leads, mid-level dialogue takes place between respected social leaders (such as religious leaders, academics, NGOs, etc.) and

low-level efforts occur amongst grassroots leaders at the community level. Regardless of the level at which conflict transformation begins, once established it can place pressure on the other levels to take similar actions towards peace (Broome et al. 2011:90-91; Lederach 1997:38-42, 52-53). Whichever path transformative projects take, they all have as their fundamental goal the desire to stimulate peaceful interactions that will allow for new, respectful relationships to develop across conflict lines. Such transformative projects manipulate subjectivities to reduce the effects of trauma and build more cooperative identities for individuals who survived decades of intercommunity violence and national conflict.

The process of conflict transformation affects not only the conflict in which people are engaged, but also the five psychosocial needs of post-conflict societies. As conflict transforms, there will be less risk of violence which will increase feelings of safety and decrease anxiety. Conflict transformation also provides a sense of empowerment because of the active role individuals and communities play in improving their own situation. Finally, as this process increases contact and communication between conflicting groups, it helps to alter identities by challenging the ways in which nationalism defines who belongs and who does not. Hope develops as subjectivities begin to shift, leading enemies to realize that they are both in fact human and share certain characteristics (Broome et al. 2011:89-90; Hutchison and Bleiker 2008:394). With these potential benefits, conflict transformation should be integrated into post-conflict trauma interventions. Healing will occur much more readily and thoroughly when individuals, families and communities no longer experience the ongoing trauma or threat of conflict.

Community-level social interventions have an enormous capacity to address trauma-related mental health problems. According to Silove (2007:255), “Most persons can be expected

to recover spontaneously if the social and cultural environment is supportive.” This means that through positive forms of governmentality, community-based interventions can have a powerful impact upon the majority of individual level concerns. By using community focused programs to address the majority of post-traumatic mental health symptoms, reconstruction efforts can significantly reduce the demand for individualized care, breaking the neoliberal healthcare paradigm. Thereafter, individual treatment programs can provide care to those remaining individuals whose needs were not adequately addressed through social programs, or who experienced untreated mental illness prior to the conflict. In post-conflict countries like Libya, where there are very few mental health professionals and limited funds to address mental health concerns, this multilevel approach can significantly reduce the burden placed upon individual-level services.

When implementing any aid program, recommendations such as these should only be utilized as guidelines. This raises several ethical questions regarding the use of governmentality in post-conflict interventions. Whenever people deliberately intervene to change identities and subjectivities, power relations play a role. To minimize the negative impacts of these relations, communities themselves should be placed in charge of the process. By enabling communities to develop their own techniques of governance, aid organizations can ensure that affected populations decide what is most meaningful for them. This involves an empowered form of community involvement which strives to allow all sections of the community to participate in deciding what they need, the types of programs they want to see, and how to implement them (Morgan 2001:221; Janes 2004:465). Within applied anthropology, this approach falls under the theory of collaboration; this theory of practice prioritizes the inclusion of community members into all stages of program planning, development and implementation. According to Lassiter

(2005:13) “Such practice transforms the role of the so-called informant: instead of collaborators appearing to only inform the production of knowledge, they take on the role of ‘consultant,’ of co-intellectual.” By encouraging the inclusion of local voices and experiences, this approach ensures that local perspectives and needs are incorporated and addressed throughout the process (Lassiter 2005:10-13, 97; Mertus 2004:345). The end product is not only culturally appropriate, but also ethically responsible.

Examples (such as those included in the resource packet I developed) provide options that should be used only for inspiration. In any aid work it is especially important to remain aware of the types of changes that are desired within the community, and to ensure those changes are implemented in a way that respects local cultures and beliefs. This involves working within existing social, cultural and belief systems, as well as remaining aware of the ways in which any program and outside presence can affect those systems. Because every community will hold multiple, competing beliefs, not all programs will be appropriate or relevant for all locations or communities.

INTERNSHIP PROJECT METHODOLOGY

INTERNSHIP

From November 2011 until December 2012, I was engaged in an internship with Dr. Reda on multiple projects related to his work in Libya. Using a multidisciplinary approach, I produced several deliverables that document the need for a holistic approach to trauma recovery in Libya. I first developed an academic paper on the importance of integrating peace-building and reconciliation efforts into post-conflict and mental health initiatives. I then adapted this paper into both a funding proposal for Dr. Reda's work in Libya and an article published both in *Peace Talk Magazine* and in Dr Reda's book manuscript *Journey of Hope*. Initially I planned to spend ten days in Libya presenting this research at the Conference for Libyan Mental Health Professionals; however, due to a resurgence of violence in the city of Misrata and my inability to acquire a visa, I was not able to travel to Libya and collect first-hand data. Although I could not attend, I did develop a presentation on ways to rebuild social connections and forms of communication in post-conflict nations like Libya. Unfortunately, due to resurgent feelings of animosity in the region, Dr. Reda felt it best not to present my research at this conference. Instead, he submitted this paper to the 2012 Pan Arab Psychiatric Conference.

For the final stage of my internship, I built upon my initial research to develop policy and program recommendations for jointly addressing mental health and conflict resolution needs of communities throughout Libya. Although I was asked to present research with a broad focus, I did take community differences into account by developing program recommendations suitable for adaptation at the community level based on differing local conditions, beliefs, and needs.

In the resource packet I developed (see Appendix C), I began by presenting the rationale for combining mental health and conflict resolution approaches to healing. Then, I demonstrated

how these approaches can contribute to the goals set out by MHPAL. Next, I considered practical considerations for implementing these types of programs and provided a list of potential sources of funding and partnership. In the final section of this report I described creative, community-based programs successfully used in other post-conflict countries to aid communities and individuals in the process of trauma recovery. I divided these initiatives into four groupings: nature, arts, movement and memory-based programs. In addition to information on ways that these categories can be interpreted and applied, I also listed print, video and online resources that provide more detailed information on how to develop and implement these types of programs. The intention of this resource packet was to introduce a range of alternative methods for addressing mental health and conflict resolution needs. I collected data on programs that succeeded in a variety of other post-conflict cultures around the world so that Dr. Reda and his colleagues have a variety of programs to choose from. These recommendations were meant only as a starting point to guide organizations and communities as they work locally to develop their own, culturally appropriate methods for recovering from the experiences of trauma. For this reason, I expect that to implement programs within Libya, some translation of these initiatives will be necessary.

WHO THIS INITIATIVE WILL BENEFIT

The research I performed during my internship with Dr. Reda can potentially benefit a variety of communities, organizations, and governments working to improve mental health and reduce conflict in Libya. My research provided Dr. Reda and his colleagues with an alternative and complementary way of addressing these issues outside of medical interventions. I consider this to be significant because the combination of both medical and social approaches to mental

health and conflict resolution can maximize effectiveness more than either method could if implemented alone.

In addition to sharing my research with Dr. Reda and his colleagues, I also brought it to the attention of my colleagues currently completing Harvard's Certificate Program in Refugee Trauma. Having presented my research as part of a case study, I was able to discuss my research with psychologist, psychiatrists, programmers and journalists actively engaged in trauma and post-conflict recovery work around the world. Through our discussions, I gained a better understanding of the realities involved in developing and implementing programs, and I was also able to expose my fellow participants to an alternative way of thinking about these issues which might benefit them in their ongoing work.

CROSS-CULTURAL DATA:

THE LOGIC BEHIND SPECIFIC PROGRAM RECOMMENDATIONS

Interventions prove more successful when they consider the context of trauma in the area, address local needs, incorporate cultural elements and collaborate with existing groups and structures within communities (Campbell 2010; Janes 2004; Mertus 2004). Taking these factors into account, I developed guidelines for four categories of social programs: nature, arts, movement and memory-based. When applied in post-conflict settings, both mental health and conflict resolutions theories demonstrate the usefulness of each of the four types of programs I recommended. Each of these programs can consciously reshape governance structures and participants' subjectivities, resulting in conflict transformation and reduced mental health symptoms related to trauma. Cultures and communities hold their own relationships with nature, practices of art, performances of movement, and methods of addressing memory. Programs aimed at trauma recovery can use these resources as a starting point to create interventions with a strong foundation in local culture and practices, rather than imposing neoliberal healthcare paradigms for treating trauma. These approaches proved themselves to be highly effective, low-cost and well received within numerous post-conflict communities and cultures around the world.

NATURE-BASED PROGRAMS

First, I focused upon nature-based programs, with the logic that all peoples and cultures connect to nature in some form. Although these relationships assume different appearances, they are all based upon the fundamental and historical link between human beings and the natural environment. We all depend upon nature for water, food, shelter and more. For this reason,

nature provides a valuable and accessible resource that can contribute to post-conflict recovery efforts (Berger and McLeod 2006:81; Sampson and Gifford 2010:116). Often, conflict damages and can even destroy the connections people and communities have with nature. It forces people off of their land, destroys crops, buildings and public spaces, and can separate people from their animals (whether pets or livestock) (Sampson and Gifford 2010:117). To combat the negative effects of this displacement, and to return this precious relationship to communities and individuals, I recommended that post-conflict recovery programs consider integrating nature into their strategies. Working to reconnect people with nature can take many forms, and can benefit both mental health and conflict transformation processes.

I identified three potential sub-categories of nature-based programming to consider: horticulture, public spaces and human-animal relationships. The first of these, horticulture, involves engaging with nature through gardening activities. Growing flowers, vegetables, herbs and other forms of vegetation allows people to tend their plants over time and to witness a tangible outcome to their efforts, providing a sense of ongoing stability and ownership over what they produce (Söderback et al. 2004:245-246; Haller 2004:5-6). Next, programs aimed at public spaces work to establish healthy, accessible spaces which can take many forms including public parks, bicycle paths, walkways, squares, marketplaces, waterfronts, and neighborhoods. Even simple additions to public spaces, such as park benches, lighting or artwork, can make a difference by increasing aesthetic appeal and accessibility, both which contribute to a population's wellbeing (Berney 2010:542-543; Cattell et al. 2008:545; Sampson and Gifford 2010:128). The third and final category, animal-assisted activities, includes programs that focus on encouraging people to engage with animals (including but not limited to dogs, cats, rabbits, birds, horses, farm animals and primates) as a way to improve mental, physical and social

wellbeing. These activities may involve simple interactions with animals, basic care and husbandry or even full-time companionship relationships (Kruger and Serpent 2006:22-23; Granger 2006:264-268). Each of these nature-based activities can significantly contribute to both mental wellbeing and conflict transformation processes.

Although all human beings engage in relationships of some form with nature, not all relationships will be the same. As Cronon (1996) demonstrates, cultures understood nature differently at different periods of time, proving that cultures construct the ways they interpret nature under the influence of time and place. Therefore, no universal definition of nature exists. For this reason, I caution that cultures create their own conceptions of nature, and therefore programs should be careful not to impose foreign concepts on the populations with which they work.

Cultures may interpret and interact with nature differently, but often they can still derive great benefits from nature-based programs. Therapeutically, nature-based interventions can improve wellbeing for both individuals and communities. According to mental health experts, research shows that nature can be an effective tool for addressing trauma in both diverse environments and with diverse target populations. In each of the studies that Söderback et al. (2004) review, as well as in their own research with horticultural therapy, nature-based programs decrease mental health symptoms of stress, insecurity, fear, anger and anxiety. Additionally, with active participation in a community-based project, participants practice and build skills that give them an increased sense of self-confidence that helps them feel good about themselves. Finally, these programs strengthen community cohesion by providing people with a safe, non-confrontational space where they can meet and connect with one another. This social consequence affects mental health by restoring relationships and support systems that were

damaged or destroyed during the trauma experienced (Cattell et al. 2008:546; Söderback et al. 2004:248, 255). These academic studies on the psychosocial benefits of nature-based programs illustrate that through these efforts traumatized populations have the opportunity to begin the process of healing.

At the same time as these community projects benefit mental health, they also provide opportunities for conflict transformation. Although I was unable to locate conflict resolution literature that examines the use of nature, mental health experts illustrate that nature programs can increase contact and communication within a community, which can lead to relationship building and conflict transformation. Any program can lay the foundation for future relationships by creating a comfortable environment where people can begin to interact with one another. The programs all provide opportunities for people to come together to garden, to experience public spaces, or to care for animals (Cattell et al. 2008:546-547; Sampson and Gifford 2010:126; Söderback et al. 2004:246). Whatever the focus of the program, nature can provide a non-confrontational subject of conversation that can act as the first step to rebuilding relationships. According to Sampson and Gifford (2010:126), “One of the key tasks of recovery...is restoring social relationships and places of sociality[,]...[which] contributes to a sense of belonging.” As these programs stimulate social interaction, people can begin to work on their communication skills and build new interpersonal relationships (Cattell 2008; Sampson and Gifford 2010). Once new social bonds begin to form, communities experience opportunities for new pathways of dialogue and discussion to open, leading further down the path of conflict transformation. Consequently, nature-based interventions possess the potential to contribute to post-traumatic recovery through improved emotional wellbeing and social relationships.

Although I cannot predict how any of these program categories can function in Libya, I argue that each of these types of programs can contribute to post-conflict recovery. Although information on existing Libyan recovery programs remains sparse, I did locate a brief description of one nature-based program begun in 2011 by the Libyan Red Crescent. As part of a psychosocial program, this organization provided sheep to displaced populations living in refugee camps. Having been forced to abandon their homes and community, these people lost their human-animal connections as well; for this specific community, sheep contribute to identity and play a central role in rituals. For this reason, the reintroduction of sheep aimed at returning a sense of normalcy to these people while enabling them to reconnect with an important element of their identity (Bell 2012). At this time, no data publically exist on how this program impacted the target populations. Additionally, no information exists on the broader applicability of this program to other communities in Libya; however, this program does demonstrate that animal-based programs can be adapted to the specific needs and cultures of Libyan communities. Despite the lack of data, academic literature in the mental health field strongly suggests that reestablishing a culture's normal interactions with nature will have profound healing effects.

Several gardening programs working with different cultural groups demonstrate these positive effects. In the United Kingdom, Muslim refugees seeking asylum were given opportunities to seek psychological counseling and participate in a gardening project. A large proportion of the refugees refused counseling because they considered it to be a foreign concept that did not align with their own cultural values; at the same time, however, many of these refugees enthusiastically participated in the gardening project, feeling that these activities reconnected them with their old lives before displacement (BBC 2008). Similarly, in Taipei victims of a typhoon also engaged in gardening projects aimed at addressing the mental health

effects of trauma. These participants not only learned new agricultural skills with practical benefits, but they also experienced dramatic improvements in emotional wellbeing and hope for the future (Taipei Times 2011). These examples demonstrate that although the academic literature largely focuses on Western implementation of nature-based programs, these types of programs can also significantly contribute to trauma recovery in other cultures when used appropriately.

These examples illustrate how nature-based programs can utilize governance structures to develop new subjectivities. These initiatives govern the bodies of participants by engaging them in activities that promote mental health and community building. Rather than imposing common forms of governmentality that medicalize society, I instead proposed that communities develop their own methods for addressing subjectivities associated with trauma and conflict. In order to alter these detrimental identities, community-driven initiatives can teach people new ways to interact not only with forms of nature but also with one another, placing value on emotional wellbeing, interpersonal communication and social interaction.

ARTS-BASED PROGRAMS

Arts-based activities represent the second category of programs with the potential to facilitate conflict transformation and trauma recovery. Arts provide a creative method for expressing thoughts and emotions, giving them the power to deeply touch artists as well as audiences. As a non-verbal form of communication, artistry allows people to work through traumatic memories and emotions without words (Gray 2011:40; LeBaron 2011:29; Zelizer 2003:63). In his research on the social impacts of arts, Matarasso (1997:7-9) concludes that the arts affect individuals and communities through the construction of identity, improved social

cohesion, a sense of empowerment, and increased wellbeing. With participation in arts programs, people self-report increased feelings of confidence and significantly decreased mental health symptoms. Additionally, the arts bring people together in a non-confrontational environment where they can begin to reconnect and rebuild social support networks (Heidenreich 2005:130-131; Matarasso 1997:39, 75). Each of these benefits points to the potential for art-based programs to be useful in a post-conflict setting not only for mental health but also for conflict resolution. The arts enable people to express their emotions, share their stories, preserve their memories and heal their communities.

As an alternative form of communication, arts also give conflicting populations another way to connect and communicate with one another. Within the field of conflict resolution, many argue that programs underutilize the arts in this capacity (LeBaron 2011 Ramsbotham et al. 2011; Zelizer 2003; Zelizer 2011). According to Ramsbotham et al. (2011:358), “Communication theorists calculate that anything up to 93 percent of all communicated meaning is non-verbal, yet the dominant mode of action adopted by conflict resolution is to encourage people to talk.” The arts should not replace verbal forms of communication about conflict, but they can provide a valuable complementary resource. When communicating through a common language of art, conflicting parties can connect to and interact with each another on a sensory level. Ultimately, through these shared experiences participants can gain understanding, acceptance, empathy and respect for one another (LeBaron 2011; Zelizer 2003; Zelizer 2007). Therefore, art forms can potentially combine creativity with therapeutic and transformative processes to alter culturally constructed forms of subjectivity.

Arts-based programs draw upon music, visual arts, theater or any combination of these and other approaches. First, music can refer to both singing and the use of instruments as a form

of expression that promotes emotional and social wellbeing. Successful post-conflict music programs include a music-bus (a travelling platform for musicians to hold musical workshops), concert series to promote awareness and peace, music therapy for trauma healing, and the use of music for tolerance training and building leadership skills (Heidenreich 2005:132-134; Urbain 2008:2-3). Next, visual arts refer to the use of visual images through drawing, painting, carving, sculpture, photography and videography. Through these media people can tell their own stories, communicate their feelings and share experiences (Gray 2011; Kanyako 2005; Lederach 2005). Lastly, theater represents a performance art where participants act out their experiences and feelings for an audience. Not only do these performances allow the actors to work through emotions and memories, but they also incorporate the audiences allowing for conversations and transformations to take place (Cohen 2011:34-35; Kalisa 2006:517). To illustrate the power of arts-based interventions I will discuss one of countless examples where a community used Theater of the Oppressed to address conflict.

A popular theater method, Theater of the Oppressed encourages participants to discuss issues they want to portray, write scripts and then act out scenarios for a community audience. During the presentation, the audience interacts with the actors to rescript these scenarios and find better solutions to common tensions within the community (Cohen 2011:37-38; Kalisa 2006:518). This process allows for conflict transformation and healing to take place among the actors, the audience and the broader community. In Bengal, India the theater group Jana Sanskriti works with marginalized agricultural laborers teaching ways to discuss their differences and develop solutions. In the village of Digambarpur, conflict over access to the lands of a local temple resulted in the complete separation and disconnection of two neighborhoods. Under these circumstances Jana Sanskriti arrived seventeen years ago. Using the medium of theater, this

program was able to bring both neighborhoods together where they began the process of communication and cooperation, eventually succeeding in reestablishing a shared sense of community. Here theater became more than entertainment; the people values this art form as a celebration of community and of the village's empowerment (Mohan N.D.). Rather than impose solutions to conflict from the outside, the community developed its own methods which provided these villagers with a new sense of confidence and power.

The transformations witnessed in this community demonstrate that participation in the arts also involves the negotiation and reconstruction of identity. According to the anthropologist Abu El-Haj (2009:1), who worked with Arab Americans using videography, arts-based programs work to provide participants with the opportunities for “self-expression and exploration of their identities, and with opportunities for social analysis and critique.” She discovered that the arts provide a space where communities can not only share their stories, but also enter into dialogue about identity and political issues that can provide alternatives to dominant narratives. In their work with refugee populations, Guerrero and Tinkler (2010) similarly explored the narratives created through photography. They concluded that arts-based activities provide communities with a tool that allows people “to negotiate their identities and contest the stereotypes and negative messages they receive...in society (Guerrero and Tinkler 2010:55). Within the safe space of an arts program, participants create a narrative of their own experience which allows them to continually explore, construct and renegotiate their identity.

These examples show how victims of trauma can use the arts not only to share their experiences and memories, but also to make sense of them for themselves as individuals and as members of a community. This occurs not through biomedical forms of governance, but instead through locally determined processes that alters subjectivities and identities. Through artistic

expression, communities can develop and facilitate new forms of governance on the population that shape how people understand their experiences of conflict and trauma. In opposition to conflict-driven discourses which highlight difference, hatred and suffering, these programs offer participants an alternative way of understanding the world in terms of healing and security.

MOVEMENT-BASED PROGRAMS

The third category of programs that I recommended focuses on different forms of movement. Movement benefits people through the effects of physical activity on psychological and physical wellbeing. Additionally movement allows people to regain awareness and connection between their minds and their bodies, something that is often lost following traumatic events. According to licensed creative arts therapist David Harris (director of Global WellBeing- an international organization for dance/movement therapy) (2007), “Body movement [is] accepted across many...cultures as a ‘basic mode of communication,’” meaning that movement-based activities may help people express emotions too difficult to verbalize. As a communal activity, movement can also provide traumatized populations with a sense of community and group cohesion that provides a sense of security and support (Harris 2007; Ley and Barrio 2010). Essentially, movement-based activities work on multiple levels addressing physical, psychological and social needs.

One psychosocial approach to movement involves team sports and games. Despite multiple examples of sports acting as a source of conflict, they can inspire cooperation and tolerance rather than competition among participants. As with any type of movement, sports and games will benefit participants by providing a form of recreation and physical activity. More importantly, though, these activities provide opportunities to work on processes of conflict

transformation by teaching teamwork skills and encouraging people to work together as a group. If carefully crafted to avoid conflict and competition, sports programs can create socially inclusive environments where people can learn to interact and communicate respectfully. In the group environment, participants from conflicting social groups learn to cooperate with and depend upon one another, building a sense of community that can lead to the development of a social support system (Ley and Barrio 2010:109-111; Ramsbotham et al. 2011:354-355). These social benefits contribute not only to conflict transformation but also to mental wellbeing by improving access to social resources.

Other programs in the field of movement involve what is called dance/movement therapy. This involves creatively using bodily movement to work through memories and experiences, and to heal the connection between mind and body. Whether through general forms of movement or through dance, these types of activities allow survivors of trauma to express themselves creatively through the body (Gray 2011:42; Harris 2007:134-135). Violence gets acted out upon bodies, leaving victims with physical memories of their suffering and often creating a disconnection between the mind and body. By using movement to work through these experiences, people can address the embodied effects of violence so that the mind-body connection can begin to heal (Gray 2011:43; Harris 2007:136).

By using traditional forms of cultural expression and healing, dance and movement therapies help participants realize the cultural resources that are available to help them work through their trauma in ways that are familiar, comfortable, and empowering. Many cultures express feelings and communicate through ritual performances and traditional healing dances that allow people to release unpleasant emotions, negotiate uncomfortable situations, and strengthen community bonds (Gray 2011:43; Harris 2007:139). The anthropological literature

contains numerous examples of these types of rituals analyzed using a variety of theoretical approaches. Performance theory, however, proves to be the most useful theoretical approach for understanding how dance can benefit post-conflict communities as part of psychosocial interventions.

In his analysis of curing séances among the Kaluli people of Papua New Guinea, Schieffelin (1985:722) demonstrates that the significance of rituals goes beyond the symbolism they embody. He argues that an analysis of ritual must go beyond meaning to consider how rituals are created through the process of performance and through interaction with others. Understood in this manner, performances enable people to “reach fundamental symbolic understandings and arrive at solutions to their problems, not in a cognitive or intellectual way so much as in a participant one” (Schieffelin 1985:721). In her research among the Yolngu Aborigines of Australia, Tamisari (2000) similarly uses performance theory to understand dance. She defines dance as a form of movement that “transforms one’s consciousness through absorbing knowledge and fashioning relationships of care and competition, desire and compassion....Dancing celebrates being-in-the-world and being-with-others” (Tamisari 2000:284). This perspective places a greater emphasis on the interactive aspects of performance, whether they are between dancers or between the dancer and his or her audience. Through the act of dancing, people experience a form of empathy that involves a willingness to experience and be transformed by not only their own emotions but also the emotions of others (Tamisari 2000:276). Therefore, the emotional and transformative benefits of dance come not only from self-expression but also from the connections forged with others through that expression.

An example from Sierra Leone demonstrates the power of movement techniques. Using traditional music and movements, a dance program worked with orphaned, former child soldiers

who experienced anxiety, aggression, depression and PTSD. Despite initial trouble expressing their emotions, over time the program helped these men to regain a sense of self-awareness and to express feelings of remorse. As part of the program, the participants chose to perform for the community using music, dance and a dramatization. The young men demonstrated their experiences through a performance that illustrated a young boy being forced by rebel soldiers to shoot the bodies of his dead father and sister. They then shared their hopes for their own futures by showing the child returning to his village, asking for forgiveness and ultimately being welcomed back. Community leaders in the audience responded to this performance immediately by speaking to the young men and welcoming them back to their community. These leaders and other audience members were able to forgive these young men because the performance allowed them to better understand the children's experiences (Harris 2007). This demonstrates the potential power of movement programs to transform conflict and to bring healing, forgiveness and understanding not only to the participants but also to the audiences and broader communities.

As with the other programs I described, movement-based programs provide communities with the opportunity to develop their own forms of governance to address ongoing trauma and conflict. Sports and dance programs utilize biopower to discipline the individual bodies of participants. Using alternative forms of movement, this type of governmentality shapes both how people express their emotions and interact with one another. Consequently, movement can act as a technique for modifying identities in a way that rebuilds relationships and brings emotional wellbeing.

MEMORY-BASED PROGRAMS

Lastly, I recommended programs that focus on memory as a way to aid the healing process. Although memories can be painful, recovery requires that trauma be remembered and mourned in order to avoid these memories becoming a haunting presence in society. The past cannot be changed, and programs can work to preserve evidence of this past, serving as a meaningful reminder and memorial of the losses society suffered (Duffy 2001:13; Dwyer and Santikarma 2007:190; Ramsbotham et al. 2011:348). When carefully used as part of a healing and recovery plan, memory can give people hope for a better future by opening discussions on how to use the past to develop a better way of moving forward. It can also empower people, allowing them to voice their experiences and to have those experiences respectfully acknowledged (Duffy 2001; Dwyer and Santikarma 2007). This engagement with memory can build a sense of community based upon shared experiences and trauma

While memory can potentially assist in recovery efforts, it can also reinforce society's divisions and inequalities. For this reason, Dwyer and Santikarma (2007:210) use their own experiences working with memory and violence in Bali to emphasize that "Projects to promote peace should not assume that the creation of social or political spaces or mechanisms for the articulation of local memory would necessarily undermine oppression or recuperate the voices of victims." No society holds one unified narrative; on the contrary, communities and individuals experience conflict differently based upon their positionality. As a consequence, some narratives may be more acceptable than others, meaning that some memories may be suppressed or rejected altogether (Dwyer and Santikarma 2007:209-210). For this reason, programs that engage with issues of memory must work to understand local contexts and different memories that may be held so as to avoid potential repercussions. Especially when dealing with nationalism, interventions must consider how populations construct their identity as a nation. Nationalism

connects people through a shared sense of historical memory, but this memory does not reflect an accurate portrayal of events; on the contrary, nationalism invents its own mythological version of history. These myths help to craft an idealized image of the nation by glorifying memories that add to its prestige, and denying memories that contradict it (Anderson 1991:204-205). The challenge for any post-conflict memory program will be to challenge these nationalistic interpretations of memory by emphasizing new memories that focus on inclusion and enhancing intergroup connections.

If programs engage issues of memory in a careful and inclusive manner, they can help traumatized populations to transform conflict and to heal emotionally. There are many ways to honor experiences and memories including museums, monuments, memorial parks, rituals and ceremonies (Duffy 2001; Ramsbotham et al. 2011; Walker 2011). Again I caution that the use of these institutions and practices can be controversial. As Anderson (1991:178) argued, museums, monuments and other representations of memory can be “profoundly political.” These representations preserve a particular version of history that does not represent all people, identities, or values within society.

In her work in South Africa, anthropologist Marschall (2010; 2012) discusses the ways in which the state used heritage sites to transform post-apartheid representations of history and society. The state officially sanctioned public art to commemorate historical events and places as a way to recognize and celebrate the memories of the African majority which were repressed under apartheid. While the dominant narrative in South Africa stresses a policy of racial inclusiveness, public representations of memory demonstrate that this is not a reality. While policies actively worked to include African memories into the dominant narrative, they also worked to suppress the memories of minority communities (Marschall 2010:81-83). An

additional source of tension exists in South Africa surrounding the lack of consultation with the people whose memories are being represented in monuments and memorial sites. Marschall (2012:198) argues that these experiences demonstrate the need for survivors to be “Acknowledged as important stakeholders. The fact that they are often deeply affected – physically, emotionally, and economically – by the traumatic events of the past, and moreover that the memorial is meant to assist them with their healing process, makes consultation all the more important and the lack thereof all the more offensive.” These examples demonstrate the potential problems that can arise when engaging with issues of memory following traumatic experiences of violence. Although risks do exist, programs can and should work with memories in a careful, inclusive and respectful manner.

The Kigali Memorial Centre in Rwanda attempted to deal respectfully with community memories. Ten years after the nation’s genocide, this center opened with permanent exhibitions containing artwork, photographs of victims, survivor testimonies and other objects that tell the story of Rwanda’s genocide. It also contains areas where victims of the genocide can be buried, photographs can be displayed, and names can be listed by families honoring their lost relatives. The importance of this center to affected communities was demonstrated when the center opened to an unexpectedly large number of visitors (over 1,500 survivors visited daily during the first week and more than 60,000 visitors attended by the end of the first three months) (Kigali Memorial Center 2012). This example demonstrates how drastically subjectivities can shift following extremes of violent conflict. Using memory to help communities grieve their losses, remember their past and look to the future, this center implemented techniques aimed at reconstructing cultural identities within Rwanda.

In addition to tangible forms of memory preservation, intangible forms can also prove useful in post-conflict healing processes. Marschall (2012:191) defines *intangible heritage* as “a variety of oral and performative genres such as language, storytelling, memories, beliefs, song, dance, traditional rituals and customary practices; as well as traditional skills and knowledge systems such as healing, arts and crafts, vernacular building technology, etc” that hold a symbolic significance. Within conflict resolution, communities successfully use ceremony and ritual to transform conflict and facilitate healing. Walker (2011:47) discusses several *transforming rituals* which she defines as processes that “aim to disrupt the status quo: the alienation and structural violence that mark relationships between many people.” To demonstrate the potential benefits of these rituals, she provides examples of memorial ceremonies practiced by indigenous and settler populations in both the United States and Australia. During these rituals, the participants come together to remember past violent events and to move beyond their historical relationships of conflict. Participants tell stories, share food, play music and enter into a dialogue (either symbolically or verbally). Through these experiences, both the descendants of indigenous and settler populations engage with one another and begin to respect and even understand one another’s perspectives (Walker 2011:50-51). In some situations, ceremonies profoundly changed historic relationships between these two groups; some results include the development of inclusive histories and of restorative and social justice initiatives aimed at broader policy changes (Walker 2011:57, 60). These examples demonstrate that through rituals, individuals and communities can change the ways that they interact with one another to build respectful and equitable relationships.

These examples illustrate how communities can construct their own forms of governance in order to alter subjectivities. Through memorials, rituals and ceremonies, communities can

engage with memory as a way of renegotiating how they understand their world. This allows people to reconstruct their identities, moving away from conflict and trauma towards forgiveness and healing. By engaging with difficult issues of memory, these programs provide communities with the potential to positively transform their subjectivities.

SUMMARY OF PROGRAM RECOMMENDATIONS

Nature, arts, movement and memory-based programs can contribute to mental health recovery and conflict transformation efforts in a variety of ways. Each of these initiatives can significantly assist efforts to secure the five essential elements for healing following trauma: feelings of safety, reduced anxiety, self- and community empowerment, connectedness to one another and to the environment, and hope (Hobfoll et. al 2007: 284; Silove 2007: 245). Locally driven, community-based initiatives like these can increase social connections, reduce anxiety and stress, and empower individuals and communities. In addition to benefitting mental wellbeing, these initiatives also aid recovery by reducing conflict and tension, which increases the population's sense of safety and can provide feelings of hope for the future. Due to these potential benefits, I recommended to Dr. Reda and his colleagues that programs such as these be considered as part of the post-conflict recovery process.

Conclusion

In conclusion, through my internship and research I demonstrated the potential usefulness of combining anthropological, conflict resolution, public health and trauma focuses to address the complex realities that exist in post-conflict states like Libya. The applied anthropological perspective I took allowed me to use my theoretical knowledge to develop comprehensive and creative approaches to issues of trauma and recovery. It is my hope that this multidisciplinary approach will contribute to ongoing efforts to discover sustainable ways of assisting mental health recovery and conflict transformation. To achieve this, post-conflict programs must focus on multiple dimensions: the individual and the community, the psychological and the social, the local and the national.

Although international aid and global health programs may have the best intentions, they face complex realities of neoliberalism, governmentality and subjectivity. Each of these forces acts upon individuals, populations, and institutions, affecting the ways that they understand and approach health and illness. Consequently, any attempt to address post-conflict mental health must take these realities into consideration, working carefully to negotiate the relationships between institutions, diseases, treatments, social structures, and the people they seek to assist. With careful planning, programs can potentially develop appropriate forms of governmentality capable of reshaping subjectivities in a way that creates new identities based on ideas of cooperation, forgiveness, peace and healing. If successful, these techniques can lead to greater mental health and the transformation of conflict.

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APPENDIX A:

TIMELINE OF EVENTS IN LIBYA

16TH-20TH CENTURIES	Ottoman Empire unites three provinces
1912	Libya colonized by Italy
1942	End of Italian colonization Beginning of British and French occupation
1951	United Kingdom of Libya gained independence
1969	Coup under Colonel Qadhafi overthrows monarchy
1969 – 2011	Dictatorship under Colonel Qadhafi
2011	
February	Anti-Qadhafi protests spread throughout Libya Libyan Revolution begins
March	NATO air raids
July	National Transitional Council recognized as government
October	Colonel Qadhafi captured and killed

APPENDIX B:

25-POINT RECOMMENDATIONS FROM

THE FIRST NATIONAL CONFERENCE FOR LIBYAN MENTAL HEALTH PROFESSIONALS

1. Large scale psychosocial educational campaign is needed to combat stigma
2. Work with religious and local healers is important to promote and improve the practice of Islamic mental health
3. Start interdisciplinary team approach to mental health is needed
4. Raise the ethical standards of practice of mental health professionals
5. Start high quality certification and licensure programs in Libya
6. Cooperate with world-class universities and treatment centers to improve mental health standards
7. Unite the many mental health teams working independently in Libya
8. Include psychosocial units in all government sectors
9. Raise awareness of the important rule of psychosocial professionals
10. Prepare and start applying realistic programs that deal with immediate crisis with focus on long-term improvement of mental health standards of the country
11. National reconciliation is a topic that needs to be always re-visited
12. Psychosocial professionals cannot engage in interrogation or torture procedures
13. Increase the number of inpatient units and in other cities than Tripoli and Benghazi
14. Focus on issues of PTSD, addiction and rape, also increase programs for children
15. Involve children with special needs in public schools and centers
16. Apply play and art therapy programs to school children
17. Provide parks, playgrounds and other avenues for relaxation
18. Work with international NGOs but encourage healing Libya through Libyan hands

19. Increase salaries for mental health professionals especially those willing to work in rural areas
20. Start anonymous hotline for psychosocial support and consultation
21. Exchange ideas and expertise between teams to prevent replicating efforts and reinventing the wheel
22. Revise academic curricula and focus on practical and hands-on aspects
23. Encourage the use of technology, psychological testing and mental health research
24. Provide opportunities for staff improvement through attending courses, CME activities and conferences inside and outside Libya
25. Start a national database to track admissions, discharges and medication dispense, also work towards inpatient units in general medical hospitals and open day treatment programs to reduce stigma and improve access to services.