Addressing Collective Trauma-in the Sri Lankan context

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INTRODUCTION

Disasters, both natural and manmade, are fairly common occurrences worldwide. Earthquakes, floods, cyclones, landslides, technological accidents, and urban fires occur daily. On the average, there are 700 natural and technological disasters which kill 100,000 people and affect 255,000,000 people each year (International Federation of Red Cross and Red Crescent Societies, 2010). They tend to occur suddenly, without much warning, and cause massive destruction, sometimes killing or injuring large numbers of people within a short time. The cost has been estimated at $ 100, 000 million each year (International Federation of Red Cross and Red Crescent Societies, 2010). In addition, the manmade disaster called war produces countless deaths and injuries of civilians as well as combatants, and displacement of massive populations. It can be estimated that there have been over 320 wars and armed conflicts in 162 countries since 1946 (Marshall & Cole, 2008), mainly internal, civil wars, producing over 378,000 deaths annually (Obermeyer, Murray, & Gakidou, 2008), many more injured, and 43.3 million displaced people, including 15 million refugees and 27 million Internally Displaced Persons (IDPs) (United Nations High Commissioner for Refugees (UNHCR), 2010). It has been found that disasters disproportionately strike the poor, socially deprived, minorities and marginalized, and that their consequences may be more serious and long lasting in these groups. Similarly, disasters affect developing nations more adversely than developed nations. However, these groups and nations may have the least resources or facilities to cope with the aftermath of disasters.
Unfortunately, Sri Lanka, has faced multiple devastating disasters, both manmade and natural, in the recent past. Predominantly in the South, there have been two Janatha Vimukthi Perumana (JVP) uprisings in the 70s and late 80s (Cooke 2011). Then there has been the long drawn out ethnic civil war in the north and east from the 1980's that hopefully ended in 2009 (Somasundaram In Press). Amidst all these manmade disasters, the massive Asian Tsunami devastated the Northeastern and Southern coastlines in 2004.

Disasters cause a variety of psychological and psychiatric sequelae (Green, Friedman et al. 2003). These could range from adaptive and resilient coping responses in the face of catastrophic events to understandable non-pathological distress as well as a number of maladaptive behavioural patterns to diagnosable psychiatric disorders. Conditions like Acute Stress Reaction (ASR, the old disaster syndrome), Posttraumatic Stress Disorder (PTSD), depression, anxiety, somatoform disorders, alcohol and drug abuse can occur in a significant number of survivors, although most people recover remarkably well (Green 1994; Green, Friedman et al. 2003). Chronic long-term trauma, particularly interpersonal where escape is not possible, can lead to complex PTSD (Herman 1992), enduring personality changes (World Health Organization (WHO) 1992) or Disorders of Extreme Stress Not Otherwise Specified (DESNOS)(de Jong, Komproe et al. 2005). Complex PTSD as a diagnostic category is being introduced for the first time in the new WHO ICD 11th revision (Maercker, Brewin et al. In Press). In addition, disaster-stricken communities often experience disruption of family and community life, work, normal networks, institutions, and structures. Loss of motivation, dependence on relief, hostility, and despair can sometimes develop in members of the community exposed to disasters.

Evidence based and effective, modern treatments like Cognitive Behaviour Therapy (CBT) and pharmacotherapy for PTSD to help individuals affected by the trauma of disasters to recover are now available in western countries (Nutt, Davidson et al. 2000; Australian Centre for Posttraumatic Mental Health 2007), but other experts have been critical(Institute of Medicine (IOM) 2008). On the other hand, once popular and routine methods like debriefing have been shown not to be helpful, even harmful (Hobfoll and Watson et al 2007). It is clear that disaster survivors will need food, shelter, other relief measures, and long term rehabilitation facilities. It is generally acknowledged that financial aid is needed for the survivors to recover. However, the need for mental health care is not as widely recognized. Short and long term mental health problems can hamper rehabilitation efforts by delaying recovery with poor motivation, difficulties in normal functioning, working capacity, relationships, and family life. Unfortunately, there are no clear evidenced based interventions applicable to post disaster situations. The Western tradition of seeking help from a counsellor or psychologist would be culturally inappropriate in a collectivistic community (Yeh, Arora et al. 2006). Equally, Cognitive Behaviour Therapy (CBT), the most validated psychotherapy for

PTSD in the western world, may not be applicable in non-western communities (Wilson 2007). Particularly in a low income and poor resource settings with lack of trained mental health workers and with massive populations that have experience trauma, western individual therapies would not be feasible, while public mental health, community based and culturally sensitive methods would be more appropriate (De Jong 2011).
In addition, there is less recognition or understanding of the effects disasters have at the supra-individual family and community levels which maybe more salient in collectivistic societies (Somasundaram 2002; Somasundaram 2007; Somasundaram 2010). Less is known about appropriate interventions at collective levels (Psychosocial Working Group 2003). There are many reasons for this relative deficiency. First, the field of disaster studies is itself rather young. For example, the diagnosis of PTSD was accepted only in 1980 with the American DSM III (American Psychiatric Association 1980, 1994) following extensive experiences with Vietnam war veterans.

Secondly, modern psychology and psychiatry as it has developed has had a western medical illness model perspective that is primarily individualistic in orientation (de Jong 2004). Geertz describes the Western concept of the individual self as "...a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against its social and cultural background....is a peculiar idea within the context of world cultures" (Geertz 1983). The 'Kantian concept of an autonomous self'(Flood, 2006) and 'Enlightenment values of individualism'(Kostelny, 2006) has come to mould western ways of experiencing the self, set against the world and events. Here, the 'self' actually refers to the Freudian ego (ahangkaram), the reality or mundane principle which is the coordinating, experiential centre of the individual identity, personality, cognitive, emotional and behavioural components. According to Losi (2000) , " The term 'egocentric self' refers to an understanding of the individual being as a self-contained, autonomous entity. Psychological normality and abnormality are therefore seen as internal processes also limited to the self. This idea disregards the social origins of mental illness. Most of the world's populations, however, hold a more sociocentric conception of the self, where individuals exist within networks of social relationships from which they derive self-worth, self-fulfilment, self-control and other attributes. In this model, reciprocal and interpersonal privileges or obligations are more important than the rights of individuals". Significantly, the central teaching of Buddhism is of annatta, that there is no real self, no essential, underlying substance, while Hindu metaphysics points to a different perspective of the self as a reflection of the universal Self (Haritayana, 2008).

Dimensions of Psychosocial well-being

A better understanding of the supraindividual effects can be sought through the ecological model of Bronfenbrenner (1979) with the micro, meso, exo and macro systems or the individual nested in the family nested in the community (Hobfoll 1998; Dalton, Elias et al. 2007). The Bronfenbrenner model fits the WHO definition of health which also emphasizes the need to look beyond the micro or individual level (see Table 1):

"Health is a state of complete physical, mental, (familial) , social, (cultural), (spiritual) and (ecological) well-being, and not merely an absence of disease or infirmity".

- World Health Organization (WHO) (1948)

The family unit (in parenthesis for author additions) has been included as it is paramount in traditional societies while the spiritual dimension is an essential part of most cultures. The spiritual dimension has been put forward at various WHO fora but has not been formally accepted yet. Culture is increasingly recognized as an important dimension of mental health (Bhugra and Bhui 2007). The ecological dimension arises from Bronfenbrenner's and environmental models and systems theory that emphasis an overall holistic approach, looking at how the different levels, dimensions and systems with different temporal trajectories of their own; influence each other to produce an interactive, dynamic (dys)functional whole. The disaster itself has an impact on these systems and their interaction, and moreover has a temporal trajectory of its own (Kinston & Rosser (1974); Sims (1983). More recently a growing consensus has been emerging on the need to look at these wider dimensions to understand the dynamics of the effects of disasters and to design interventions (de Jong 2002 ; Psychosocial Working Group 2003; Landau and Saul 2004).

Though the WHO definition of wellbeing artificially divides the physical, mental and social dimensions for the sake of elucidation, they are in reality interdependent and interconnected systems. When one dimension is adversely affected it causes disturbances at all the other levels also. A health problem can be considered under these dimensions under causes; symptoms and treatment.

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948.

The words within parenthesis are my additions the reasons for which are explained in the text

Table 1 Dimensions of health-some examples

Dimensions of Health	Causes	Symptoms	Diagnosis	Interventions
Physical	physical injury, infections, deficiencies, excesses	pain, fever, disability, somatization	Physical illness, Psychosomatic, Somatoform disorders	drugs treatment, physiotherapy, relaxation techniques, massage
Psychological	shock stress fear- terror loss trauma	tension, fear, sadness, learned helplessness	ASR, PTSD, Anxiety, Depression, Alcohol & Drug abuse	psychological first aid, psychotherapy, counselling, relaxation techniques, CBT, testimonial therapy
Family	death, disappearance, separation, disability, poverty	vacuum disharmony, negative dynamics, violence, scapegoating	Family Pathology	family therapy, marital therapy family support, family unity cohesion, mutual understanding, relationships
Social	unemployment, displacement, poverty, war, "repressive ecology", genocide	conflict, suicidal ideation, anomie, alienation, withdrawal, loss of communality, substance abuse, empty rituals	Parasuicide, Suicide, Violence, collective trauma	group therapy, testimonio, trust, rehabilitation, community mobilization, participatory methods, empowerment, social engineering, social cohesion, building social capital, collective efficacy
Cultural	racism, coloni-zation, majori-tarianism, cul-tural genocide, assimilation, domination, culture shock, acculturation stress	depression, suicide anger, violence helplessness, despair demoralisation, crime,	Fractured communities Drugs and alcohol Suicide, Cultural Bereavement, DV, Violence	strengthening communities cultural traditions, , practices, healing rituals, ceremonies, traditional healers, elders, narrative therapy, recognition of the culture.
Spiritual	misfortune, bad period, spirits, angry gods, evil spells, karma	despair, demor-alization, loss of belief, loss of hope	Possession, Dissociation	logotherapy, rituals, traditional healing, meditation, contemplation, mindfulness, middle way, harmony

PTSD, like all other medical diagnostic categories, is constructed as a condition that exclusively afflicts the individual self, the traumatic event impacting on the individual psyche to produce the PTSD. The World Health Report 2001, while pointing out that there is considerable mental morbidity among those exposed to severe trauma, warns that there is controversy regarding the cross-cultural validity of PTSD (World Health Organization 2001). It has been argued that PTSD is a recent western construct that does not apply in non-western societies (Bracken, Geiller et al. 1995). It is being increasingly recognized generally that we need to go beyond the individual to the family, group, village, community and social levels if we are to more fully understand what is going on in the individual, whether it be his/her development, behaviour, perceptions, consciousness, experiences or responses to stress and trauma as well as design effective interventions to help in the recovery and rehabilitation of not only the affected individuals but also their families and community (Harvey 1996; Landau and Saul 2004; Hoshmand 2007; Macy, Behar et al. 2004). In collectivistic societies, family or community members may join together in collective coping to pool resources, act cooperatively sharing the burden to resolve a single or common problem at the family, extended family or community levels.

We have found that when the family and/or community regained their equilibrium and healthy functioning, there is often improvement in the individual member's wellbeing as well. Family and social support, networks, relationships and the sense of community appear to be a vital protective factor for the individual and their families and important in their recovery. Cultural rituals and practices, like the North American Sweat Lodge ceremony (Wilson 1989), thuku kavadi in Northern Lanka (Derges 2009; Derges 2013) and Eastern Lankan oracle tradition (Lawrence 1999), can heal and provide meaning to suffering after trauma. It is also becoming clear that social and cultural values, beliefs and perceptions will shape how traumatic events impact on the individual, family and community and the way they respond (Wong and Wong 2006; Wilson and Tang 2007) . The meaning attributed to the event(s), the historical and social context, as well as community coping strategies determines the impact and consequences of trauma. Similarly, firm traditional and religious beliefs and social support has been shown to be a protective factor against the effects of trauma. Equally, community coping and resilience help individuals and families deal with and recover from the destructive effects of disasters. Thus family or community members may join together in collective coping to pool resources, act cooperatively sharing the burden to resolve a single or common problem at the family (extended family) or community levels respectively, exclusively or in combination.

Conventional understanding of stress and coping have been western individualistically oriented, emphasizing a sense of personal agency and internal locus of control, focus on problem solving, meeting challenges and overcoming obstacles through individual effort. However, Asian collectivistic values and coping styles maybe fundamentally different. Thus, *"coping strategies that confront and modify external stressors (e.g. behavioural or approach-focused coping strategies) are expected to be more common in individualistic cultures, whereas coping strategies that avoid external stressors and instead modify internal psychological states (e.g., cognitive or avoidance-focused coping strategies) are expected to more common in collectivistic cultures*" (Chun, Moos et al. 2006). Self-transformation through reframing and spiritual practices is possible in Asian communities (Chen 2006). Asian values that have been identified include importance of family, avoidance of family shame, conformity to family norms and expectations, deference to authority figures, filial piety, self-control and restraint, maintenance of interpersonal harmony, placing other's needs ahead of one's own, reciprocity, respect for elders and ancestors, holistic world view, collectivism, and self-effacement (Heppner, Heppner et al. 2006). Understanding of Asian style of coping would need to consider family support, religion-spirituality, forbearance, karmic belief system, respect for authority, and avoidance-detachment strategies (Yeh, Arora et al. 2006; Hoshmand 2007).

Thus, what may appear as maladaptive coping from a western point of view, for example, avoidance, passivity, silence and non-engagement; may, in an Asian setting, be adaptive and appropriate for the context. However, what maybe adaptive, aiding survival in a conflict situation, like silence and avoidance, can become maladaptive, inhibiting recovery, rehabilitation and development in a post-conflict setting. It would be as important not to undermine these traditional ways of coping by importing inappropriate western concepts and methods, as it is to consider the context.

It is equally important to "distinguish collective strategies (i.e., mobilizing group resources) from collectivistic coping style (i.e., normative coping style of collectivistic individuals)" (Chun, Moos et al. 2006). Individuals from collectivistic communities may not necessarily adopt collective coping such as seeking social support. They maybe more concerned with the impact of social consequences (relationships, group harmony, shaming the family). Strong family bonding may preclude community engagement. Interdependent individuals tend to define in-group members more narrowly and with more overt impermeability than independent individuals. They maintain tighter and longer bonds with in-group members, increasing the distance between in-group and out-group members (Yeh, Arora et al. 2006).

Collective Trauma

Kai Erikson (1976; 1979) gives a graphic account of Collective Trauma as 'loss of communality' following the Buffalo Creek disaster in the US. He and colleagues described the 'broken cultures' in North American Indians and 'destruction of the entire fabric of their culture' due to the forced displacements and dispossession from traditional lands into reservations, separations, massacres, loss of their way of life, relationships and spiritual beliefs (Erikson and Vecsey 1980). More recently, a number of discerning workers in the field have been drawing attention to the importance of looking at the family (Landau and Saul 2004; Tribe 2004; Tribe and Family Rehabilitation Centre Staff 2004; Ager 2006) and cultural dimension (de Jong 2002 ; de Jong 2004; Landau and Saul 2004; Miller and Rasco 2005; Ager 2006; Silove, Steel et al. 2006) following disasters. Abramowitz (2005) has given a moving picture of 'collective trauma' in six Guinean communities exposed to war.

The concept of collective trauma is being introduced for the first time in a modern mental health diagnostic classification in the draft of the WHO ICD 11th revision's guidelines for PTSD under cultural considerations:

"Large-scale traumatic events and disasters affect families and society. In collectivistic or sociocentric cultures, this impact can be profound. Far-reaching changes in family and community relationships, institutions, practices, and social resources can result in consequences such as loss of communality, tearing of the social fabric, cultural bereavement and collective trauma. For example, in indigenous and other communities that have been persecuted over long periods there is preliminary evidence for trans-generational effects of historical trauma.

Supra-individual effects can manifest in a variety of forms, including collective distrust; loss of motivation; loss of beliefs, values and norms; learned helplessness; anti-social behaviour; substance abuse; gender-based violence; child abuse; and suicidality. These effects, as well as real or perceived family and social support, can also impact on individual resilience and outcomes".

Though both the American DSM and WHO ICD classification systems have traditionally been exclusively individual based, it is argued that a collective approach becomes paramount from a public mental health perspective where large populations are affected and where resources are limited . Further, community based approaches maybe more effective and meaningful in collectivistic societies.

Yael Danieli (2007) has written eloquently about the transgenerational transmission of trauma: 'massive trauma shapes the internal representation of reality of several generations, becoming an unconscious organizing principles passed on by parents and internalized by their children'… 'the multigenerational, collective, historical, and cumulative psychic wounding or "soul wound" over time, both in their victims' life span and across generations'. The trauma can be transmitted through molecular genetics, parent child interactions, family dynamics, sociocultural perpetuation of a persecuted ethnic identity based on selective, communal memories (Wessells and Strang 2006) or 'chosen traumas' (Volkan 1997); narratives, songs, drama, language, political ideologies and institutional structures. The long lasting impact at the collective level or some have called it tearing in the social fabric would then result in the social transformation (Bloom 1998), of a sociopathic nature that can be called collective trauma (Table 2). The table explores the characteristics of collective trauma across 7 dimensions: Disasters; Causal Conditions; Ecological context; Symptoms; Coping strategies; Consequences; and, Community level Interventions. The 'x' between causal conditions and ecological context is to indicate the interaction between psychosocial (PS) effects of the disaster and what are sometimes called the indirect PS effects that is subsumed under the PS ecological context. The systemic nature of traumatogenic forces and their impact on family, community and societal systems has been described (Hoshmand 2007). Families and communities cope with the disaster in a multitude of adaptive and non-adaptive ways which can result in a variety of psychosocial problems or in positive resilience and growth. Community level interventions (Harvey 1996; Macy, Behar et al. 2004), particularly Mental Health and Psychosocial Support (MHPSS) (Galapatti, 2008), can be used to help communities affected by disasters.

The impact of catastrophic events on the individual has been well established internationally (American Psychiatric Association 1980, 1994; World Health Organization (WHO) 1992) and was quite clear in Northern Sri Lanka (Somasundaram 1993; Somasundaram 1998) such as PTSD (13%), anxiety (49%) and depression (42%) in the recent Vanni IDP's (Husain, Anderson et al. 2011). There have been some observations on the family level too in Northern Sri Lanka (Jeyanthy, Loshani et al. 1993). However, it was when it came to addressing mental health problems after mass trauma that the impact on the community became evident. Conventional interventions at the individual level were inadequate. The problems at the community level too had to be understood and addressed if the individuals were to be fully helped. Further, families and communities had to recover if any meaningful socio-economic rehabilitation programmes were to succeed. In fact, in time most long-term programmes, as in other post disaster settings around the world began to include a community based psychosocial component, what is now being termed MHPSS, within the larger socio-economic rehabilitation and reconstruction efforts (World Health Organization (WHO) 2003; Sphere Project 2004; Inter-Agency Standing Committee (IASC) 2007).

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Table 2 Collective Trauma-Theoretical model

Disasters	Causal Conditions	Ecological context	Symptoms	Coping strategies	Consequences	Community level interventions
Man Made (e.g. War)	Displacements Separations Massive destruction	Social chaos, uprooting Breakdown of social structures and institutions	Insecurity Terror Impunity, social injustice	Silence, Withdrawal, isolation, Benumbing Suspicion	Dependency, learned helplessness, passivity Loss of trust, paranoia Despair, disbelief, amotivation, hopelessness	Psychosocial education-Awareness Training of community workers Community interventions-Family, Groups Encourage indigenous coping strategies, cultural rituals and ceremonies Expressive (emotive, creative) methods Psychosocial Rehabilitation, Multi-sectorial collaboration, networking Promote resilience, Prevention
Natural (e.g. Tsunami)	Multiple deaths Injuries Losses Cultural & social bereavements	Un/under employment, poverty Starvation, hunger, malnutrition Lack of medical care, diseases, epidemics 'Repressive ecology', violence, torture, abductions, detentions, disappearances, extrajudicial killings	Breakdown of law and order Inequity, discrimination Helplessness, hopelessness Rumours, disinformation Psychosomatic, Somatoform disorders	'Fight, flight or freeze', Survival, escape, Suicide Cultural practices, rituals Adaptation, facing the challenge, problem solving	Loss of communality, decrease in social cohesion, tearing of social fabric, Loss of social capital Adaptive changes in memory, reframing, meaning, realism Resilience, forbearance, new networks, friendship, relationships, hope Regeneration, development, progress	

Social Capital

The construct of social capital is becoming increasingly recognized as an important factor in mental health (Cullen and Whiteford 2001; McKenzie and Harpham 2006). Disasters such as a massive natural catastrophe or a chronic civil war can lead to depletion of social capital(Kawachi and Subramanian 2006; Wind and Komproe 2012 (in press)). According to Bracken and Petty (1998) modern wars deliberately destroy social capital assets to control communities. The covert goals may become elimination or co-option of leaders as well as control and coercion of groups, media, governance structures and institutions and in the final analysis, the minds of ordinary people.

In fact, understanding the destruction of social capital by long term civil conflict is crucial for describing collective trauma. However, contemporary social analysts caution against a simplistic or superficial view of social capital and call for a deeper, detailed, fine grain analysis of social transformation at the community level to look for positive, negative and 'perverse' changes (Goodhand, Hulme et al. 2000). Social capital encompasses community networks, relationships, civic engagement with norms of reciprocity and trust in others that facilitate cooperation

and coordination for mutual benefit (Cullen and Whiteford 2001). Fundamentally it looks at social institutions, structures, functions, dynamics, the quality and quantity of social interactions; it is a reflection of social cohesion, the glue that holds society together. Theoretically, positive social capital would increase the community's capacity to withstand disasters, its' resilience and respond constructively.

Although traditional Sri Lankan community had high levels of social capital, this was mainly in the form of social, family and intra-ethnic bonding. The root cause of civil conflict would stem from the lack of bridging social capital, that is competitive and antagonistic inter-ethnic relations as a result of polarized and exclusive ethnocentric perceptions. This could arise from a myriad of further sub-causes like horizontal inequalities (Stewart 2001) in opportunity, income and economic resources (poor linking), ethnic suspicions and tensions (poor bridging), group exclusion, disparities in political access and participation, weak civic engagement with the government leading to weak community links with the state, polarization between ethnic communities and experiencing ethnic based discrimination and humiliation. The driving force for the conflict would have been ethnic identity (Somasundaram 1998). The insecurity, fear and strong feelings aroused when a group's identity, culture and way of life, its' access to resources and survival are perceived as being threatened are mobilized into collective actions, defiance, resistance, militancy and violence. The power differentials between the rulers and the governed in a hierarchical society; the poor or absent access to sources of power, decision makers, control over opportunity structures and resource distribution; and discrimination as a group are indications of lack of vertical or linking social capital among the minority Tamils that were the sources of growing frustrations and rebellion.

As a consequence of the long drawn out conflict, the '*common* **community coping strategy** *was to fall back on group based networks and family ties. The most resilient sources of social capital are socially embedded networks and institutions, particularly those based on caste and religion'* (Goodhand, Hulme et al. 2000). This had resulted in strengthening social bonding within groups while weakening bridging social capital between groups. The goal of PS rehabilitation and national reconciliation would be rebuild these bridges that were once there.

Conflict entrepreneurs, that is, social actors with vested interest in maintaining ethnic tensions, had socially engineered 'perverse' social capital gaining power, legitimacy and social control. The resulting social transformation had 'led to the emergence of a new leadership, it had altered gender and generational hierarchies and created a 'new rich', entrepreneurial class in a 'dirty war' context (Nordstrom 2004; Somasundaram 2010). However, in the long term with competing regimes of control and terror, even the bonding social capital has been eroded, bridging social capital between groups consistently undermined and people have lost trust in social institutions, structures and governance. Thus, *"social capital may represent a powerful social glue when there is a clearly defined enemy, but when conflict becomes protracted, the fault lines become less clear and bonding may break down. Conflict entrepreneurs on either side are aware of these tensions and exploit them accordingly. Political and military support for the Tamil paramilitary groups, for example, represents an attempt to harness tensions within Tamil civil society and so undermine LTTE attempts to create an ideology which transcends local loyalties. Therefore, social capital may be manipulated and strengthened for perverse outcomes. While a political economy perspective points to the primacy of 'interests', rather than 'passions', one should not ignore the importance of the 'emotional economy' of violence, and the processes through which hate is constructed and mobilised. Conflict entrepreneurs appear to have an intuitive understanding of such processes and how to destroy social capital and create 'anti-social' capital. The LTTE for instance have either co-opted or destroyed pre-existing institutions and created new ones to win hearts and minds. Propaganda and violence have been used to nurture an emotional economy based on a currency of fear, victimhood and a sense of grievance. Showcase killings and 'theatrical' violence have been used strategically to cow populations, provoke reprisal killings and deepen ethnic fault lines. Another important element of the affective economy is the mythology of the 'heroic death'. Its most extreme version is the LTTE's female suicide bombers which draws on this symbolism of valour to recruit and mobilise young men. "* (Goodhand, Hulme et al. 2000).

Communities under stress manifest with social disorganization, unpredictability, low trust, fear, high vigilance, low efficacy, low social control of anti-social behaviours and high emigration which lead to anomie, learned helplessness, thwarted aspirations, low self-esteem, and insecurity. Social pathologies like substance abuse, violence, gender based and child abuse can increase and health problems like heart disease, depression, stress related conditions, behaviours contributing to chronic illness and reduction in immunity to infection and cancer develop with breakdown of social capital (Cullen and Whiteford 2001). Civil conflict causes community trauma by the creation of a *'repressive ecology'* based on imminent, pervasive threat, terror and inhibition that causes a state of generalized insecurity, terror and rupture of the social fabric (Baykai, Schlar et al. 2004).

"*Unlike interstate conflict, which often mobilizes national unity and strengthens societal cohesiveness, violent conflict within a state weakens its social fabric. It divides the population by undermining interpersonal and communal trust, destroying the norms and values that underlie cooperation and collective action for the common good, and increasing the likelihood of communal strife. This damage to a nation's social capital-the norms, values, and social relations that bond communities together, as well as the bridges between communal groups (civil society) and the state-impedes the ability of either communal groups or the state to recover after hostilities cease. Even if other forms of capital are replenished, economic and social development will be hindered unless social capital stocks are restored"... Such an understanding could enhance the abilities of international actors and policymakers to more effectively carry out peacebuilding-relief, reconstruction, reconciliation, and development.* (Colletta and Cullen 2000).

There have been more recent developments towards community level interventions for massive trauma (Somasundaram 1997; de Jong 2002 ; Psychosocial Working Group 2003). The United Nations with the experiences and collaboration of over 200 organizations working worldwide in situations of mass trauma came out with the IASC Guidelines on Mental Health and psychosocial Support in Emergency Settings (Inter-Agency Standing Committee (IASC) 2007) that recommend considering the socio-political and cultural context to maximize the participation of local population, building on available local resources and capacities and integrating close collaboration between support systems when responding. An excellent conceptual framework for building community resilience as a process of dynamic adaptation with a positive trajectory to buffer the adverse effects of disasters and promote community wellbeing has been developed (Norris, Pfefferbaum et al. 2008). Some of the principles include ensuring commitment from the community; engaging the entire system of the community in an inclusive process; identify scripts, themes and patterns across generations and community history, foster creativity as the central process of healing; maintain sensitivity to issues of culture, gender and spirituality; encourage access to all natural and ancillary resources; building on existing resources; collaborating and networking across all systems; relate program needs to goals, future and best interests of the community; encourage natural change agents and leadership within the community; empower families and communities; and develop ownership by the community (Landau and Saul 2004).

It becomes vital to take into consideration the complex effects of civil conflict on social capital and address programmes to repair the damage if reconciliation and development are to succeed in the current post war situation.

Coping and Resilience

Community resilience can be seen as positive, collective adaptability despite high levels of adversity, in this case, the impact of the natural disaster, the Asian Tsunami, and the chronic civil war. Instead of looking only at pathological negative outcomes, resiliency looks at adaptation and withstanding adversity. Community Resilience has been defined as the "*Community's capacity, hope and faith to withstand major trauma and loss, overcome adversity, and to prevail, usually with increased resources, competence and connectedness"* (Landau and Saul 2004). Community values, beliefs and traditions can provide bulwarks against mass trauma (Harvey 1996). Adversity-Activated Development (AAD) describes salutary social transformation, post-traumatic growth and progressive changes following challenging circumstances (Papadopoulos 2007). The analysis of social protective and risk factors, the social dynamics of coping and growth can help understand social processes and identify collective competency factors that can be built upon. For a qualitative assessment of the current post-war situation in Northern Sri Lanka, we adapted the trauma grid (Papadopoulos 2007) as a tool to organize the data and conceptualize the functioning of the community in the context of different levels: individual, family, community and society/culture, as these maybe affected in different ways, positively, negatively or varying combination of both (Somasundaram 2012; Somasundaram and Sivayokan In press). The findings (see Table 3) were divided into expected ordinary reactions to human suffering, more distressful psychological suffering which would benefit from community and family support and diagnosable psychiatric disorders needing professional help. These could be understood as a continuum and not discrete categories with rigid boundaries of exclusion. Positive effects included resilience and beneficial transformative or adaptive change. The identified changes were located as belonging to the individual, family, community or social/cultural levels. Some responses overlapped, saddling several levels

There was widespread exposure to potentially traumatizing events that under normal conditions would be considered extreme and would cause distress in most people. Commonly these traumatic events had been multiple and chronic. Thus forced displacement in extreme situations was universal and commonly multiple (up to 10 or more in many cases). The unexpected and sudden death of a close family member(s), relation(s),

Table 3 Trauma Grid (Adapted to the Sri Lankan context from Papadopoulos, 2007)

	Negative effects		Positive effects		
Levels	**Ordinary human suffering**	**Distressful psychosocial reactions**	**Psychiatric disorders**	**Resilience**	**Adversity Activated Development**
Individual	Sorrow, worries, normal grief, fear, stress, anger, uncertainty, magical thinking, psychological trauma, injuries, handicap, losses, low educational attainment	Intense and extreme levels of suffering, complicated grieving, adjustment disorders, maladaptive coping, alcohol & drug (including non-prescription medication) use, somatization, help seeking behaviour, change in ideology/faith, fear of future, suicidal thoughts/ behaviour	PTSD, Depression, Anxiety disorders, Prolonged Grief Disorder, Alcohol & Drug Abuse, Complex PTSD, DSH, Brief (reactive) psychosis, Dissociative episodes, Personality disorders	Independent, mature personality, adaptive coping mechanisms, flexibility, establishing and maintaining relationships, planning for their future, socialization and networking skills, entrepreneurship	Post Traumatic Growth, female leadership, empowerment, liberation, creative activities, non-traditional thinking, innovativeness, involving in nontraditional jobs
Family	Displacements, separations, deaths, handicap, loss of properties and structures (buildings). disappearances, orphans, single parents, family disharmony, break-up of extended family system	Grief, family conflicts, domestic violence, separations, divorces, extra-marital relationships, unwanted pregnancies, child & elder abuse, poor parenting, scapegoatism	Dysfunctional family units, morbid jealousy, family pathology, child psychiatric disorders or emotional and behavioural problems among children, homicide-suicide pack,	Unity of nuclear families, cohesion, extended family ties, support system, new relationships, continuous of goals and aspirations	Functional female headed households, diversity in marriages, Split families
Community	Displacements, up rootedness separations, destruction of normal systems and structures, dysfunctional structures & institutions, loss of buffer system, reshuffled neighborhood, depleted social capital, poverty and unemployment/ underemployment	Denial, rationalization, intellectual dissonance, hopelessness, helplessness, powerlessness, herd instinct, silence, suspicions, distrust, uncertainty, breakdown of ethical and moral values, catharsis, sexual abuse,	Collective trauma, suicide mass hysteria, impulsiveness and antisocial behaviours.	Rituals, revival of traditional arts (koothu), ceremonies, remembrance observations, monuments and grave stones, social functions	Acceptance of female leadership, female empowerment & liberation, new ways of thinking and breaking of traditional boundaries, entrepreneurship, awareness of global trends emerging new form of arts (like cinema, short films), meaningful narratives, practical (problem solving) support, micro finance schemes and economic development
Society/Culture	Depleted social capital, dysfunctional structures & institutions, patronage, authoritarian personalities, corruption	Hopelessness, helplessness, powerlessness, silence, suspicions, distrust	Collective trauma, suicide	Rituals, ceremonies, remembrance observations, social functions, increasing tolerance about others view, culture and life style,	Reduction of caste barriers, female leadership, empowerment, liberation, Multi-cultural milieu, rights oriented thinking and behaviour

and friend(s) in distressing ways was again almost universal experiences. Experiencing injuries, disappearances, separations, internment, arrests, detentions, beatings, bombings, shellings, shootings as well as witnessing these events were common. Undergoing extraordinary physical hardships like thirst, hunger, long marches, and lack of medical attention or shelter were experienced by most families and communities. As such these experiences were considered for the purpose of this study as norms for the population and placed under 'Ordinary human suffering'. When these experiences caused observable behaviour or complaints of a psychosocial nature amounting to distress they were placed under 'Distressing psychosocial reactions'. When the signs and symptoms met criteria for a diagnosable condition, they were categorized as 'Psychiatric disorders'.

It is noteworthy that examples of mass hysteria symptomatic of underlying insecurity and 'repressive ecology' (Baykai, Schlar et al. 2004) in the post war context, such as aspects of the grease putham phenomena (Hariharan 2011), were reported. A group of mental health workers who were returning late at night from field work were set upon by a community vigilante groups that had been formed to ward off the alleged grease putham attacks and barely escaped being man handled. They were told that was an occupational hazard of working late! Herd instinct in election voting or strikes was mentioned. The exodus of Tamils seeking to escape to Australia by boat was called a mass hysteria (Brewster 2012; Davis 2012) but a more apt terms would have been herd instinct. It could be observed during this period that ordinary people talked about fleeing to Australia by boat to escape the hopeless situation. A more recent example was in relation to the recruitment of Tamil females from Killinochchi into the army where several developed possession states and conversion hysteria (Christopher 2013).

Where individuals, families or communities showed any positive response, coping, adaptation or growth, these were placed under 'Resilience' or 'Adversity Activated Development (ADD)'. Under the circumstances, the lack of adverse reactions to these extraordinary experiences, termed here as 'Ordinary human suffering' could be considered positive coping. *It is good to keep in mind that communities may find 'meaning in their suffering and are able to transmute their negative experiences in a positive way, finding new strengths and experiencing transformative renewal'*(Papadopoulos 2007). These categorizations have pubic mental health implications and how it is dealt with, particularly in a resource poor setting to rebuild community resilience.

Important characteristics of resilient communities include availability of family, extended and neighbourhood support systems and networks, that is bonding social capital; community resources like respected and functioning elders, traditional healers and cultural practices, religious leaders and organizations, institutions like schools, health facilities, governmental and non-governmental organizations, community level conflict resolving mechanisms and functioning structures like judiciary and judicial system, democratic practices and access, free media, and reliable information. Economic and income stability, employment, occupations and traditional vocations, food, shelter, security, and other essential needs being met would help communities cope with adversities and shocks to the system. Norris et al. (2008) identify four primary sets of adaptive capacities for community resilience — economic development, social capital, information and communication, and community competence. Community competency refers to the capacity, resources and skills within the community to act together, cooperatively and effectively, to meet challenges. Unfortunately in disaster situations, particularly chronic war contexts some or many of these resources and support systems would be affected, dysfunctional or not available. Community responses and coping may thus become compromised. A vicious resource loss cycle (Hobfoll 1998) where breakdown of social support, networks, leadership, economic resources and material goods will create a downward spiral of a deteriorating situation of increasing needs and dysfunction, one lack feeding the other deprivation.

Yet, critical challenges and adversity may just provide the impetus, catalytic stimulus for change and social transformation. Thus the breakdown of traditional forms of oppression and rigid hierarchical structures like caste, feudal ownership and patriarchal female suppression could lead to more positive emancipation and development. New organizations, networks, relationships, friendships, forgetting of old quarrels and conflicts, shared memories and experiences could lead to community growth and enhancement. Motivated and vibrant leadership may emerge while older, ineffective and anachronistic methods are shed. There can be radical and revolutionary alteration in the social trajectories due to critical challenges. A common enemy can forge social unity and cohesion. Common people, oppressed and excluded minorities could gain more power and access to resources due to shifts in the social system or out of collective action. Collective consciousness can be awakened leading to more awareness and knowledge. According to the Social Policy Analysis and Research Centre (SPARC) of the Faculty of Arts, University of Colombo, the breakdown in social structures and institutions creates an opportunity for empowerment, collective transformation and re-alignment of social dynamics, *"challenging existing structures of power and achieving a shift in power relations, ultimately resulting in the transformation of the existing social order"* (Psychosocial Assessment of Development and Humanitarian Interventions (PADHI) 2009).

Community level interventions

The widespread problem of collective traumatization following disasters is best approached through community level interventions, particularly in collectivistic, sociocentric communities. Further, community based approaches will enable one to reach a larger target population as well as undertake preventive and promotional public mental health activities at the same time. Individuals and families can be expected to recover and cope when communities become functional, activating healing mechanisms within itself. The WHO (2003) and other international organizations have come up with the Sphere Project Humanitarian charter and minimum standards dealing with mental and social aspects of health (Sphere Project 2004). A worldwide panel of trauma experts (Hobfoll and Watson et al 2007) have identified restoring connectedness, social support and a sense of collective efficacy as essential principles in interventions after mass trauma.

Traditionally, post disaster interventions have been conceptualized and categorized into rescue, relief, rehabilitation, reconstruction and development depending primarily on time course after disaster (see Table 4). Different organizations, government departments and international bodies like INGO's and the UN have been responsible for the implementation of interventions depending on the phase of the disaster. We are now in the phase of long-term, post-disaster interventions, dealing with resettlement, rehabilitation and development issues as well as long term mental health consequences like unresolved grief, depression, alcohol abuse, suicide and at the community level, collective trauma.

The IASC Guidelines recommend considering the socio-political and cultural context to maximize the participation of local populations, building on available local resources and capacities and integrating close collaboration between support systems when responding.

Table 4 Temporal dimension of disaster (Modified from Sims (1983) and Kinston & Rosser (1974))

Feature	Threat	Warning	Impact	Recoil	Post trauma
Duration	Time Months	Minute-Hours	Seconds-Minutes	Hours	Months-Years
Cognition	Expectation, anticipation, worry, threat, orearation	Warning messages, Emergency/ denial	Shock	Relief	Inventory, loss, reality, sense, coping
Emotion	Fear, anxiety, insomnia	Apprehension, arousal, panic	Panic, shock, helplessness	Daze, inhibition, numbing, euphoria, emotional release	Grief, sadness, anger, hostility, despair
Behaiour	Preparatory activity	protective action, seeking safety, dislacement	Self preservation, survival, Fight or flight	Hypo or phper activity, Rescue/Relief	Organised reconstruction, Adaptation
Mental reaction	Generalized anxiety disorder (GAD)	Panic	Shock	Acute stress reaction	Phobic anxiety, depression, Alcohol and drug abuse, anti-social personality, developmental disorder, suicide
Social	Family and friends, support and help, long term plans	Rumours, herd-instinct, gathering together, evacuation	Family unity, clinging, hierarchial roles	Therapeutic community, Social unity, Breakdown of ocial barriers, Loss of communality, social chaos	Refugees, rehabilitation, reconstruction, recovery, restitution, resettlement, social and cultural changes

The community and its members need to be able to benefit from the developmental programmes being undertaken. Economic recovery will not be sufficient, people need 'to reconstruct communities, re-establishing social norms and values' (Weerackody and Fernando 2011). International law recognizes the Principle of Restitutio ad integrum for the redress of victims of armed conflict to help them reconstitute their destroyed 'life plan' (Villalba 2009; Evans 2012). This justifies the need for rehabilitation as a form of reparation clarified by the UN 'Basic Principles and Guidelines on the Right to a Remedy and Reparations for Victims' as taking five forms: restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition (UN General Assembly 2005). This should necessarily include psychosocial rehabilitation (Somasundaram 2010).

The North, East and border areas have undergone a disaster of enormous proportion. As after the Tsunami, where a large relief, recovery, rehabilitation and development effort to address the needs of this population was launched, a concerted psychosocial rehabilitation has to be carried out. However, one has to take into account the sensitive post-war context of virtual martial law where psychosocial work is not permitted we would like to recommend the following based on experiences reported in the literature from similar post-war situation around the world, best practice principles from international organizations like the WHO, experiences gained during the war and after the tsunami as being practically feasible under the current circumstances:

1. Training Community Mental Health Workers

The IASC (2007) states that 'Useful responses include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs'. During the war and after the tsunami, we tried to do this through increasing local awareness and transferring knowledge and skills of how to deal with common mental health and psychosocial issues to local resources (Somasundaram and Jamunanantha 2002). This was done through training of community level workers and human resources in villages. At the same time, strengthening and expanding existing resources and capacities; capacity building of primary health care workers to deal with common mental health issues; and engendering local participation, leadership, decision making, planning and implementation to rekindle collective hope, trust and efficacy are urgently needed to rebuild community agency and resilience. An innovative community based programme was designed by the WHO after the tsunami by training large numbers of Community Support Officers (CSO's) to look after the mental health and psychosocial needs of families and implemented effectively all over the affected areas in Sri Lanka (Mahoney, Chandra et al. 2006; Psychosocial Forum of Consortium of Humanitarian Agencies (CHA) 2008; Kakuma, Minas et al. 2011). They were mobilized to work in the IDP camps in Vavuniya in 2009 and are being deployed in the resettlement process through a programme of the Sri Lanka College of Psychiatrists and World Vision, but in limited numbers. The numbers and training needs to be increased.

As the functioning family is the basic building block and foundation of Tamil communities, it would be essential for the community workers to promote the restoration of functioning family units. They could work with families to help them trace missing members, partake in cultural grieving ceremonies for the dead, improve relationships and correct misunderstandings among members, reestablish hierarchical responsibilities, create income generating opportunities for the family and generally encourage unity and positive dynamics. Problems of domestic violence, child abuse, alcoholism in the male, unwanted pregnancies, extra marital relationships, suicide and self-harm, elderly, and widows could be addressed within the functioning family structure as well as at the community level.

A sense of agency, control, determining their own future and a belief in their collective efficacy had to be restored to the families and communities. It is only by creating a sense of community, collective efficacy and confidence that social capital can be increased, leading to a gain cycle (Hobfoll 1998) where trust, motivation and hope can be re-established. Linking social capital where communities have access to power, decision making and resources are vital for building resilience. Negative aspects like lack of trust and uncertainty would need to be addressed. Efforts will need to be directed at rebuilding social capital through community networks, relationships, responsibilities, roles and processes.

At the same time, the community workers have to work towards creating opportunity structures for education, vocational and skill training, and capacity building particularly for youth and income generating programmes. It is by establishing some economic stability, livelihood and access to resources that families and communities will regain their dignity, faith and hope. Improvement in mental health and psychosocial wellbeing would motivate the population and enable better participation in rehabilitation and development programmes.

2. Cultural rituals and ceremonies

It was significant that in the post-war context, though under considerable restrictions and monitoring by the military, communities had resorted to traditional practices like opari and koothu to express their grief and find solace. It can be expected that communities will regain their natural resilience when performing customary rituals, observe ceremonies like remembrance days and partake in community gatherings and festivals. This would give some relief from the grief and guilt, create faith, meaning and social support and networks. Encouraging and teaching cultural relaxation methods at the community level is one way we have done this in the past (Somasundaram 2002). Community monuments that would help focus and express emotions after mass trauma have been called traumascapes (Tumarkin 2005). For example, a civil monument at Mullivaikal to all who died there (military, militant, civilian) by a sensitive sculptor and national ceremonies to be observed there annually would go a long way towards reconciliation.

As we found during the war and after the tsunami, creative arts are valuable conduits for the expression of emotions, finding meaning and developing meaningful community narratives (Somasundaram 2007). Koothu (Jeyasankar 2011), other dramatic forms, laments, poetry, writings and drawing should be encouraged and promoted.

3. School Based Programmes

One of the first positive structure and activity during the recovery phase in the Vanni IDP camps and resettlement was education related activities. The importance given to education in Tamil culture should be promoted and used to re-establish old routines, structures, and hope in the future. Teacher counsellors can function as community workers to organize activities in the classroom and schools such as play, group activities, creative endeavors, and inter-communal relationships. Several school based programmes were implemented during the war and after the tsunami where teacher counselors and befrienders were trained from all over the North and East (Somasundaram 2010; Tol, Komproe et al. 2012), who could now be used for the current situation.

4. Facilitate families and communities to settle in their own homes and villages.

The case studies and observations showed that families were eager to return to their familiar surroundings, home, neighborhood and villages. Some were shocked when confronted with destroyed homes and bare land. Resettling in their ancestral home , village or region will have healing effect (Norris, Pfefferbaum et al. 2008) and build resilience (Weerackody and Fernando 2011). The traditional identities for example the Tamil identity based on veedu and uur (Daniel 1984) may need to be re-established in the post-war context.

PREVENTION

In the long term, collective trauma should be prevented from occurring in the first place. Tragically, much of the deaths and destruction caused by natural disasters can be avoided or at least, mitigated. This is even truer for human-caused (or technological) disasters and war. In many cases of natural disasters, poor and excluded communities were located in vulnerable areas, warnings were not issued or followed, or plans were forgotten. In the heat of battle, none of the protagonists maintained maps of where they laid landmines as they are expected to do by international convention, making it so much harder for demining and safe civilian resettlement. Wars and conflict can be prevented and psychosocial well-being ensured by appropriate conflict resolution mechanisms (Rupesinghe and Anderlini 1998), equitable access to resources (Stewart 2001), power sharing arrangements, social justice and respect for human and social rights (Psychosocial Assessment of Development and Humanitarian Interventions (PADHI) 2009). Techniques such as torture and disappearances cause long-term sequelae in individuals, their family and communities (Doney 1998; Somasundaram 2008; Sivayokan 2011) which can be prevented if international conventions, humanitarian law and treaties are observed. It is worthwhile planning beforehand to prevent or mitigate the impact of disasters at the community and family levels. There should be regional and international mechanisms to protect civilians in times of conflict and/or when powerful leaders and states overstep boundaries of good governance and observation of basic rights.

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