Addressing collective trauma: conceptualisations and interventions

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Complex situations following war and natural disasters have a psychosocial impact not only on the individual, but also their family, community and the larger society. Fundamental changes in the functioning of the family and community can be observed as a result of these impacts. At the family level, the dynamics of single parent families, lack of trust among members, changes in significant relationships and child rearing practices are seen. Communities tend to be more dependent, passive, silent, without leadership, mistrustful and suspicious. Additional adverse effects include the breakdown of traditional structures, institutions and familiar ways of life, and deterioration in social norms, ethics and loss of social capital. Collective trauma can be studied using sophisticated multilevel statistical analysis, with social capital as a marker. A variety of community level interventions have been tried, though a scientifically robust evidence base for their effectiveness has yet to be established. This article advocates that post disaster relief, rehabilitation and development programmes need to address the problem of collective trauma, particularly using integrated holistic approaches.

Keywords: collective trauma, disasters, public mental health, war

Introduction

Disasters, both natural and manmade, cause a variety of psychological and psychiatric sequelae, ranging from adaptive and resilient coping responses in the face of catastrophic events and understandable non pathological distress to maladaptive behavioural patterns and diagnosable psychiatric disorders (Green, Friedman & de Jong, 2003). In addition, disaster stricken communities often experience disruption of family and community life, work, normal networks, institutions and structures.

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. Additionally, the western tradition of seeking help from a counsellor or psychologist can be culturally inappropriate within a collectivistic community (Yeh, Arora & Wu, 2006). Equally, cognitive behaviour therapy (CBT), the most validated psychotherapy for posttraumatic stress disorder (PTSD) in the western world, may not be applicable in non western communities (Wilson, 2007; de Jong, 2011). Within low income and poor resource settings that lack trained mental health workers, yet have massive populations who have experienced trauma, western individual therapies would not be feasible. However, public mental health, community based programmes and culturally sensitive methods would be 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, 2010). Though a variety of innovative psychosocial interventions at collective levels (Psychosocial Working Group, 2003) have been tried, as described regularly in this journal, robust scientifically acceptable evidence in the form of quantitative, randomised controlled trials (RCT) studies for their effectiveness are yet to be established (Tankink, 2014). Thus, the conceptualisation and theory of collective impacts and acceptance

of effective community level interventions have not yet entered mainstream psychology or psychiatry.

Modern health related approaches have a western medical illness model perspective that is primarily individualistic in orientation (de Jong, 2004). Geertz (1983, p. 59) described the western concept of the individual self as '*...a bounded, unique, more or less integrated . . .whole... a peculiar idea within the context of world cultures*'. In contrast to western dualism, which separates the body from the mind and the individual from society (reducing phenomena to the micro level), other epistemological approaches and ways of experiencing the world, society, self and body tend to incorporate these poles into an integrated whole, known as a '*social body*' (Scheper-Hughes & Lock, 1987). According to Losi (2000, p. 13), '*The term 'egocentric self' refers to an understanding of the individual being as a self-contained, autonomous entity... This idea disregards the social origins of mental illness. Most of the world's populations, however, hold a more socio-centric conception of the self, where individuals exist within networks of social relationships*'. Significantly, the central teaching of Buddhism is of *annatta*, that there is no self, no essential, underlying substance, while Hindu metaphysics points to a different perspective of the self, that it is a pale reflection of the universal self (Haritayana, 2008). Collective events and consequences may have more significance in collectivistic communities than in individualistic societies like the USA and Australia. It may also be important to bear in mind that societies are, by their very nature, in flux and changing. With modernisation and globalisation, collectivistic societies are also increasingly becoming more individualistic and consumer oriented. There may also be traditional subcultures within the bigger, individualistic culture. In collectivist societies, the individual becomes embedded within the family and community so much so that traumatic events are experienced through the larger unit, with the impact also manifesting at that level. The family and community are part of the self, their identity and consciousness. The demarcation or boundary between the individual self and the outside becomes blurred. For example, within Tamil families, close strong bonds and cohesiveness within nuclear and extended family contexts means they function and respond to external threat or trauma as a unit, rather than as individual members. They share the experience and perceive the event in a particular way. During times of traumatic experiences, the family will come together in solidarity to face the threat as a whole and will provide mutual support and protection. Over time, the family will act to define and interpret the traumatic event, give it structure and assign a common meaning. They will also evolve strategies to cope with the stress. There are variations in manifestation, depending on responsibilities and roles within the family. For example, in the father's role and responsibilities when mothers and women were killed in the tsunami, or in the mother's when males were killed, detained, tortured or disappeared during the war, and personal characteristics, meant that some became scapegoats, usually children or the elderly, in the family dynamics that ensued.

We were able to observe these dynamics both after the tsunami (Somasundaram, 2014), and during the war (Somasundaram, 2010). As a result, in these cases, it was more appropriate to speak of family trauma, rather than of individual personalities.

Similarly, within the Tamil communities, the village and its people, way of life and environment provided organic roots, a sustaining support system, nourishing environment and network of relationships. The village traditions, structures and institutions were the foundations and framework for their daily life. In the Tamil tradition, a person's identity is defined, to a large extent, by their village or *uur* of origin (Daniel, 1984). Their *uur* more or less places the person in a particular socio-cultural matrix. A

word of caution is necessary if trying to romanticise or idealise the family, neighbourhood, village, collective and community. These are, in reality, vague, amorphous terms, and encapsulate considerable variation among members, as well as negative dynamics like scapegoating, marginalisation, exclusion, or not being allowed to take part in asocial activities, and hegemonic (being dominated by an other social group or organisation) tendencies. It is also very difficult to define community and collective with precision, as the lines of demarcation will invariably breakdown (Van de Put et al., 1997).

PTSD

PTSD has been constructed as a condition that afflicts the mind or *manas* of the individual self (*jiva*), the traumatic event impacting on the individual psyche to produce the PTSD. The core symptoms of traumatisation include: re-experiencing or reliving the traumatic event in the present, avoidance of reminders and hyper arousal (Maercker et al., 2013). However, PTSD does not adequately capture or explain the extent, nor wider ramifications of traumatic events on families and communities, particularly in non western collectivistic cultures (Hofstede, 2008; de Jong, 2004; Nisbett, 2003). Rather societies, communities and cultures shape, frame and remakes traumatic experiences to determine representations, manifestations of suffering through idioms of distress, and changes in social processes and dynamics (Kleinman, Das & Lock 1997). The social body (Scheper-Hughes & Lock, 1987) or collective unconscious (Jung, 1969) becomes the site of the collective trauma.

A better understanding of supra-individual levels can be sought through the ecological model of Bronfenbrenner (1979) with the micro, meso, exo and macro systems. In other words, the individual nested within the family, which is nested within the community, which is nested within the wider society (Hobfoll, 1998; Dalton et al., 2007). The Bronfenbrenner model fits the World Health Organization (WHO) definition of health and wellbeing, which also emphasises the need to look beyond the micro or individual level:

> *'Health is a state of complete physical, mental, (familial),[1] social, (cultural), (spiritual) and (ecological) wellbeing, and not merely an absence of disease or infirmity'.*
>
> - WHO (1948, Preamble to Constitution)[2]

More recently, a growing consensus has emerged on the need to look at these wider dimensions in order to understand the dynamics of the effects of disasters, and to design interventions at different systemic levels (Harvey, 1996; de Jong, 2002; Psychosocial Working Group, 2003; Landau & Saul, 2004; Hoshmand, 2007; Macy et al., 2004). This paper attempts to describe the phenomena of collective trauma, the systemic nature of forces that cause or convey trauma and their impact on family, community and societal systems (de Jong, 2011; Hoshmand, 2007), and community level interventions (Harvey, 1996; Macy et al., 2004).

Collective trauma

The phenomena of collective trauma, described in the first article of the first issue of this journal[3] (Somasundaram, 2003), initially became clear to the author when working in the post war recovery and rehabilitation context of Cambodia (Van de Put et al., 1997). During the Khmer Rouge regime, all social structures, institutions, family, educational and religious orders were razed to *'ground zero'* deliberately (so as to *'rebuild a just society anew'*!) (Vickery, 1984). A whole generation missed out on schooling and education. Mistrust and suspicion arose among family members as children were forced to report on their parents to the authorities. The essential unity, trust and security within the family system, the

basic unit of society, were broken. The communal trauma continued during the subsequent decade with the invasion by Vietnam. These events in Cambodia highlighted the impact on families and communities, and illustrated how they respond and act during extreme situations, in culturally resonant ways (Hinton, 2007). Similar changes at the family and community levels became discernable within the northern Sri Lanka (Somasundaram, 2014), as a result of the armed struggle between 1982 and 2009. At the family level, the dynamics of single parent families, lack of trust among members, and changes in significant relationships and child rearing practices were seen. Communities tended to be more dependent, passive, silent, without leadership, mistrustful, and suspicious. Additional adverse effects included the breakdown of traditional structures, institutions and familiar ways of life, and deterioration in social norms and ethics. Previously Kai Erikson (Erikson, 1976; 1979) had given a graphic account of *collective trauma* as *'loss of communality'*, following the Buffalo Creek disaster in the USA (where a dam burst and floods impacted a population of 5,000 people). He and colleagues described the *'broken cultures'* in North American Indians and the *'destruction of the entire fabric of their culture'* due to forced displacements and dispossession from traditional lands into reservations, separation of families, massacres, loss of way of life, relationships and spiritual beliefs (Erikson & Vecsey, 1980). Similar tearing of the *'social fabric'* has been described in Australian indigenous populations (Milroy, 2005).

Maurice Eisenbruch used the term *'cultural bereavement'* to describe the loss of cultural traditions and rituals in Indochinese refugees in the US (Eisenbruch, 1991). More recently, a number of discerning workers in the field have been drawing attention to the importance of looking at family (Landau & Saul, 2004; Tribe, 2004; Ager, 2006) and cultural dimensions (de Jong, 2002; 2004; Miller & Rasco, 2005; Ager, 2006; Silove & Steel, 2006) following disasters. Collective trauma has also been described by Abramowitz (2005) in six Guinean communities exposed to war, and by Saul (2014) after 9/11 in the USA. Saul (2014) defines collective trauma as a larger social impact, occurring at multiple levels, with *'shared injuries to a population's social, cultural, and physical ecologies'*, emphasising the *'impact of adversity on relationships, families and communities and societies at large'* and the loss of social trust. Maercker & Horn (2012) have also put forward an interpersonal and socio-ecological model of trauma, where the multi-level interactions, relationships and social processes are taken into account.

Refugees and migrants from collectivistic communities remain either locked into their relationships with extended families and kinship groups back home, or who have been displaced to neighbouring countries and suffering feelings of responsibility and guilt at leaving extended families behind (Somasundaram, 2011). Modern technology keeps the collective trauma alive and present in their lives. They maintain close contact through mobile phones, keep abreast of current news through television, internet, other media and other travellers. In fact, they continue to live more within their home network, undergoing all the uncertainty, insecurity, terror, agony and trauma of those left behind, than in the reality around them in the new, host country. An adverse event back home has an immediate and immense effect on the family. A parent, sister, brother or child sobbing over the phone, or the sound of gunfire and explosions in the background, would haunt them for weeks. These refugees and migrants would experience the consequences of a suicide bomb attack within their country of origin being shown on television, as if it was happening to them. For example, the flare up of fighting in Iraq in 2014 spread a deep sense of gloom, despair and reactivated many past traumatic memories in migrant Arabic communities. Migrant communities spend much of their

time, money and effort in trying to bring those left behind across to the host country. Long drawn out visa procedures, unfriendly authorities and common refusal of asylum applications were shown to compound a collective sense of helplessness, futility and cultural bereavement for their home culture (Eisenbruch, 1991; Bhugra, Wojcik & Gupta 2011). Individual level trauma therapy in the host country for the migrant will be insufficient or appropriate with this vivid presence of the ongoing collective trauma.

Wilson (2004) talks of the unconscious manifestation of collective trauma as the *trauma archetype* that is universal and common to all cultures. Yael Danieli (2007) has written eloquently about the trans-generational 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 trauma can be transmitted through epigenetic processes,[4] parent–child interactions, family dynamics, sociocultural perpetuation of a persecuted ethnic identity based on selective, communal memories (Wessells & Strang, 2006) or '*chosen traumas*'[5] (Volkan, 1997), narratives, songs, drama, language, political ideologies and institutional structures.

The term collective trauma represents the negative consequences of mass disasters at the collective level, that is on the social processes, networks, relationships, institutions, functions, dynamics, practices, capital and resources; to the wounding and injury to the social fabric (Somasundaram, 2014). The long lasting impact, at the collective level, or the tearing of the social fabric would then result in social transformation (Bloom, 1998) of a sociopathic nature, this could be called be called collective trauma.

Table 1 explores the characteristics of collective trauma across seven dimensions: disasters; causal conditions; ecological contexts; signs and symptoms; coping strategies; consequences; and community level interventions. The '*x*' in the Table, between causal conditions and ecological context, indicates the interaction between psychosocial (PS) effects of the disaster and what are sometimes called the indirect PS effects that absorbed within the PS ecological context. Families and communities cope with the disaster in a multitude of adaptive and non adaptive ways that can result in a variety of psychosocial problems, or in positive resilience and growth.

We have found that when the family and/or community regained their equilibrium and healthy functioning (see WHO definition of health above), there is often improvement in the individual member's wellbeing as well. A sense of community (communality or social cohesion) provided by social support and strong relationships among community networks act as a vital protective factor for individuals and families facing disasters, and aids in their recovery. It is also becoming clear through studies that social and cultural values, beliefs and perceptions shape how traumatic events impact on the individual, family and community, and the way they respond (Wong & Wong, 2006; Wilson & 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. For example, 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. Therefore, family or community members may join together in *collective coping* to pool resources, act cooperatively to share the burden of resolving a single or common problem at the family (extended family) or community levels respectively, exclusively, or in combination. Abramowitz (2005) found that members of communities that had developed wholesome collective narratives and resisted social disintegration had fewer post traumatic symptoms and distress compared to

Table 1. Collective trauma theoretical model

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

communities that had narratives of abandonment, isolation, disregard of community rituals and social supports and the dislocation of local morals and ethics.

Acceptance of the concept and impact of collective trauma

The concept of collective trauma is now being introduced, for the first time in a modern mental health diagnostic classification, in the draft of the WHO International Classification of Diseases (ICD) 11th revision's guidelines[6] 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 Diagnostic and Statistical Manual of Mental Disorders* (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.[7] Further, community based approaches maybe more effective and meaningful in collectivistic societies, as shown above. Community level interventions (Harvey, 1996; Macy et al., 2004), particularly mental health and psychosocial support (MHPSS), can be used to help communities affected by disasters. Several suggestions of practical implications and examples are given later.

Social capital as a proxy for collective trauma

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 & Whiteford, 2001). Fundamentally, it looks at social institutions, structures, functions, dynamics and 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 ability to respond constructively.

The construct of social capital is becoming increasingly recognised as an important factor in mental health (Cullen & Whiteford, 2001; McKenzie & Harpham, 2006; Scholte & Ager, 2014). Disasters such as a massive natural catastrophes or chronic civil war can lead to a depletion of social capital (Kawachi & Subramanian, 2006; Wind & Komproe, 2012). According to Bracken & Petty (1998), modern wars deliberately destroy social capital assets in order to control communities. The covert goals may become elimination or cooption of leaders, as well as control and coercion of groups, media, governance structures and institutions, which leads in the final analysis, to the minds of ordinary people.

Communities under stress manifest with social disorganisation, unpredictability, low trust, fear, high vigilance, low efficacy, low social control of antisocial behaviours and high emigration which lead to anomie (the

breakdown of social bonds between an individual and the community), learned helplessness, thwarted aspirations, low self-esteem and insecurity. Social pathologies, like substance abuse, violence, gender based violence and abuse, and child abuse can all increase, as can health problems like heart disease, depression, stress related conditions, behaviours contributing to chronic illness and reduction in immunity to infection and cancer, also all develop with breakdown of social capital (Cullen & 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 generalised insecurity, terror and rupture of the social fabric (Baykai et al., 2004).

As social capital and collective trauma appear to share many commonalities, at this early, preliminary stages of research into collective trauma, loss of social capital could serve as a useful proxy for collective trauma. Parameters such as social cohesion, trust, network densities, perceived and received social support, relationships, structural and cognitive social capital and collective efficacy can be quantified and studied using sociometric analysis (a quantitative method for measuring social relationships), multilevel approaches and social modelling statistical techniques (McKenzie & Harpham, 2006; Kawachi & Subramanian, 2006; Wind & Komproe, 2012). Significant social parameters can help to operationalise collective trauma. Interventions can be designed to foster social capital by improving these parameters through rebuilding relationships and networks, trust, civic participation, collective efficacy and cohesion.

Community level interventions

Traditionally, post disaster interventions have been conceptualised and categorised into rescue, relief, rehabilitation, reconstruction and development, depending primarily on the time course after disaster. Different organisations, government departments and international bodies like international nongovernmental organisations (INGOs) and the UN have all been responsible for the implementation of interventions, depending on the phase of the disaster. The phase of long-term, post disaster interventions, deal with issues surrounding 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 Inter-Agency Standing Committee (IASC) Guidelines (2007) recommend considering the socio-political and cultural contexts in order to maximise the participation of local populations, building available local resources and capacities, and integrating close collaboration between support systems when responding to disasters.

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 & Fernando, 2011). International law recognises the *Principle of Restitutio ad integrum* (a restoration to original condition) 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 nonrepetition (UN General Assembly, 2005). This should also include psychosocial rehabilitation (Somasundaram, 2010).

The widespread problem of collective traumatisation following disasters is most cost effectively approached through community level interventions, or sociotherapy as has occurred, for example, in group settings in post conflict Rwanda (Scholte & Ager, 2014). Furthermore, community based

approaches will enable interventions 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 the community itself. The WHO (2003) and other international organisations created the *Sphere Project Humanitarian Charter* and minimum standards when dealing with mental and social aspects of health (Sphere Project, 2004). A worldwide panel of trauma experts (Hobfoll & Watson et al., 2007) have identified restoring connectedness, social support and a sense of collective efficacy as essential principles in interventions after mass trauma.

A comprehensive and useful conceptual model (Figure 1) for psychosocial and mental health interventions is the inverted pyramid (de Jong, 2002). At the top of the pyramid are societal interventions designed for an entire population, such as laws, public safety, public policy, programmes, social justice, and a free press. Descending the pyramid, interventions target progressively smaller groups of people. The next two layers in the figure concern community level interventions, which include public education, support for community leaders, development of social infrastructure, empowerment,

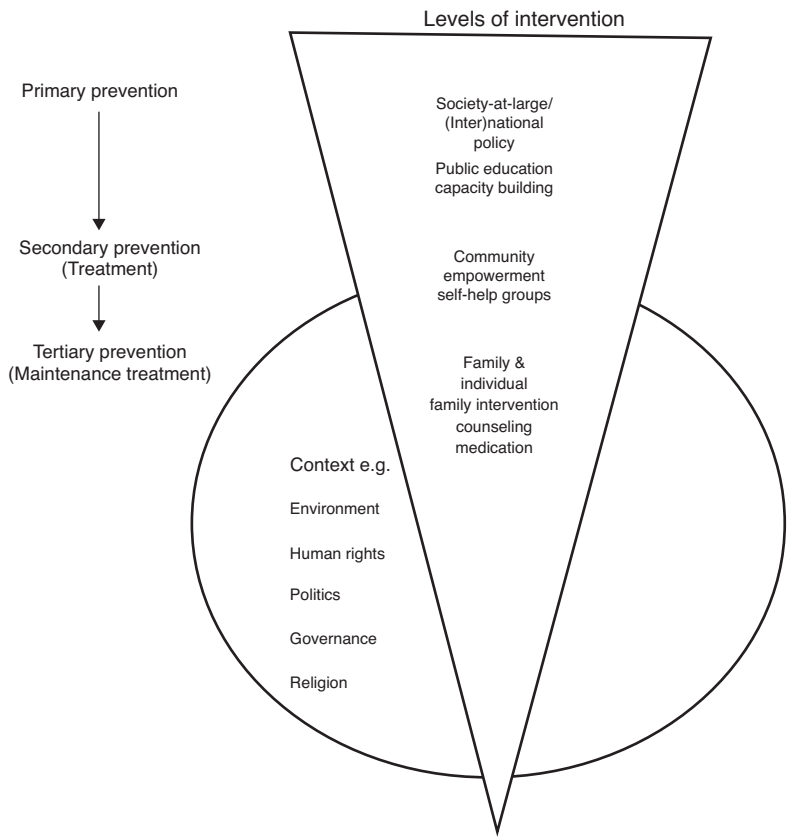

Figure 1: Conceptual model for psychosocial and mental health interventions (de Jong, 2002).

cultural rituals and ceremonies, service coordination, training and education of grass root workers and capacity building. The fourth layer are family interventions, which focus both on the individual within a family context and on strategies to promote wellbeing of the family as a whole. The bottom layer of the pyramid concerns interventions designed for the individual with psychological symptoms or psychiatric disorders.

These one to one interventions include psychiatric, medical, and psychological treatments, which are the most expensive and labour intensive approaches and require highly trained professional staff. Some examples of community level interventions, which are mass public mental health strategies and approaches that are hypothesised to work through social healing processes and dynamics are given in Box 1.

Psycho-education Basic information about what has happened, where help can be obtained, instructions about available programmes and assistance is essential. Psycho-education about trauma for the general public, what to do and not to do, can be done through the media, pamphlets and popular lectures. These are essentially public mental health information that empowers communities to look after themselves in (post) disaster situations. A pamphlet we have used extensively during the war, post war and post tsunami is an adaptation of the pamphlet, *'Coping with Stress',* issued after the Ash Wednesday fires,[8] published by the Royal Children's Hospital and Prince Henry Hospital in Australia.

Box 1: Community approaches

- Psycho-education, awareness
- Training of community workers
- Public mental health promotive activities
- Encourage indigenous coping strategies
- Cultural rituals and ceremonies
- Community interventions
  - o Family
  - o Groups
  - o Expressive methods
  - o Rehabilitation
- Prevention

Source: (Somasundaram, 1998)

Training community mental health workers Community level workers and human resources can be trained to increase local awareness on how to deal with common mental health and psychosocial issues (de Jong, 2002; Somasundaram & Jamunanantha, 2002; Somasundaram, 2014). At the same time as they address individual level problems where necessary, such as through counselling or referral for professional mental health treatment, community level workers are also trained to think and work at the family and community levels (Somasundaram, 1997). They do this by 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, networks, relationships, leadership, decision making, planning and implementation to rekindle collective hope, trust and efficacy to rebuild community agency and resilience.

As the functioning family is the basic building block and foundation of most communities, it would be essential for the community workers to promote 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, correct misunderstandings among members, re-establish hierarchical responsibilities, create income generating opportunities for the family and generally encourage unity and positive dynamics. Problems of domestic violence, child abuse, alcoholism, unwanted pregnancies, extra

marital relationships, suicide and self-harm, as well as difficulties of the elderly and widows, could all be addressed within the functioning family structure, as well as at the community level.

A sense of agency and control, determining their own future and a belief in their collective efficacy has to be restored to families and communities (Norris et al., 2008). 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 communal trust, motivation and hope are re-established. Linking social capital where communities have access to power, decision making and resources are vital for building resilience, particularly among disadvantaged and marginalised community members, such as minorities, aboriginal and indigenous populations (Kirmayer et al., 2009). Even where they do not have direct access to power, communities can navigate adverse structures of power by changing subjectivities (Lindegard, 2009) through collective narratives and creative arts. 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, community workers have to work towards creating opportunity structures for education, vocational and skills 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.

Cultural rituals and ceremonies 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. Although some of these ritual maybe performed for an individual, they often involve the family and community, and thus set in motion family and community processes and dynamics. They give opportunities for expression of communal emotions, provide relief from the grief and guilt, create faith, meaning and social support and networks. Wilson (2007, 1989) describes the *Sweat Lodge Purification Ceremony* among Native American nations to heal altered maladaptive states following war trauma. Patricia Lawrence (2000) highlighted the psychosocial value of the traditional oracle practice of '*vakuu choluthal*' in eastern Sri Lanka, particularly in cases of disappearances, where the families are told what has happened to the disappeared person in a socially supportive environment. In cases of detention by the security forces in northeastern Sri Lanka, the relatives take vows (*nethi kadan)* at Temples to various Gods, which they will fulfil if the person is released. The practice of *Thuukkukkaavadi,* a propitiatory ritual involving hanging from hooks, have increased dramatically after the war and maybe especially useful after detention and torture (Derges, 2009; 2013). In the post war context of strict military prohibition against psychosocial programmes,[9] *Kovalan Koothu* (a popular folk drama), provided a therapeutic outlet and was performed all over the Vanni in northern Sri Lanka with large attendances and community participation (Jeyashankar, 2011; Somasundaram & Sivayokan, 2013). Similarly, in the traditional folk form of *Opari* (lament), recent experiences and losses from the Vanni war were incorporated into community grief performances (Duran, 2011).

Encouraging and teaching cultural relaxation methods at the community level is another useful method to regain resilience (Somasundaram, 2002; Hobfoll et al., 2007). As we found during the war and after the

tsunami, creative arts are valuable conduits for the expression of emotions (Wilson & Drozdek, 2004), finding meaning and developing community narratives (Somasundaram, 2007). However, ritual cleansing ceremonies like *mato oput* in northern Uganda (Allen, 2008) and various psychosocial interventions in Liberia (Abramowitz, 2014) both post war contexts, can also be performed with the aim of imposing ill-conceived political agendas, traditional justice and *'post conflict peace subjectivities'*.

Prevention Preventive medicine uses large scale public health measures to protect populations and eradicate or mitigate causative agents of collective trauma. Tragically, much of the deaths, destruction and psychosocial consequences caused by natural disasters can be avoided or at least, mitigated. This is even truer for manmade (or technological) disasters and war. In many cases of natural disasters, poor and excluded communities are often located within vulnerable areas, warnings were not issued or followed, or plans forgotten. In the heat of battle, protagonists usually fail to maintain maps of where they laid landmines as they are expected to do by international convention, making it very much harder to de-mine and protect civilians during resettlement.

Wars and conflict can be prevented and psychosocial wellbeing ensured by appropriate conflict resolution mechanisms (Rupesinghe & 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, families and communities, which can be prevented if international conventions, humanitarian law and treaties are observed. Health workers in areas of conflict have started emphasising that as health professionals, we need to consider ethics and take a principled stand for victims and society (Armenian, 1989; Zwi & Ugalde, 1989). At times, these could involve considerable risks, as this author has been labelled a *'traitor'* by different protagonists to the conflict in Sri Lanka for advocating for basic human rights and exposing violations that discreetly and nonviolently challenge whole systems of unhealthy power and world views (Somasundaram, 2014).

As conceptualised by Joop de Jong (2002), at the top of the inverted pyramid of interventions (Figure 1) and therefore most effective and affecting whole populations, there should be plans at local, provincial, national, regional and international levels for disaster preparedness and emergency response, because many disasters affect multiple communities, regions or entire countries. Such plans are typically formulated by committees at the appropriate level, and may involve collaborative efforts between formal emergency management agencies, public health agencies and citizen groups. Health professionals should be members of these committees and participate in the planning. 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. Increasing powers to the UN Security Council and General Assembly to intervene with sanctions and peace keeping forces. The International Conventions and Court,and the principles of Right to Protect (R2P) (Evans, 2008), are both promising developments. Therefore, preventive measures would have to address those at the top, the governance processes and culture. Jung (1947) in acknowledging political, social, economic and historical reasons for war, describes war as an epidemic of madness, as an animation of the collective unconscious where the inherent evil is projected onto the neighbouring tribe, the *'other'*. The only way to prevent *'outbreaks of the collective unconscious'* is to bring it into consciousness, to develop insight and understanding. Political leaders have always

been able to manipulate public opinion to suit their power aspirations and rule according to their agenda. Even in so called functioning democracies, political leaders have been able to sell and mobilise an unwilling populace to go to war and train recruits to do the killing (Woodward, 2002; Woodward, 2004; Somasundaram, 2009) In the long term, there is a need to create a '*culture of peace*' by social peacebuilding (Large, 1997), and reducing horizontal inequalities[10] (Stewart, 2001) that lead to war.

Conclusion

The effects of disasters, particularly massive, chronic trauma goes beyond the individual to the family, community and wider society. Social processes, dynamics and functioning can be changed fundamentally by disasters. It is important to recognise the manifestations of collective trauma, so that effective interventions at the community level can be used in these complex situations. Integrated holistic community approaches that were found useful in rebuilding communities are: creating public awareness, training of grass root workers, encouraging traditional practices and rituals, promoting positive family and community relationships and processes, rehabilitation and networking with other organisations.

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[1] The words within parenthesis are my additions. In many collectivistic societies, the family would include extended family.

[2] 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

[3] Then under its earlier name, "International Journal of Mental Health, Psychosocial work and Counselling in Areas of armed Conflict", published from Jaffna.

[4] Epigenetics refers to heritable changes in gene activity that are not caused by changes in the DNA sequence, but can occur, for example, due to environmental events or factors.

[5] If members of a group who have been traumatised have problems with competing certain psychological tasks, they convey such tasks to their children. This is often connected with conscious and unconscious shared wishes that the next generation(s) has to solve. The shared mental representation of the historical traumatic event may evolve into what Volkan calls a "*chosen trauma*" (1997). This chosen trauma becomes a significant marker for the large-group identity. It can be important for the development of a contry, the ideology or political programmes.

[6] Unpublished document of the WHO ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress.

[7] Although the author is a member of the WHO ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress, reporting to the WHO International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, the views expressed in this presentation are those of the author and, except as specifically noted, do not represent the official policies or positions of the International Advisory Group or the World Health Organization.

[8] Ash Wednesday fires,were a series of bushfires that occurred in south-eastern Australia on 16 February 1983, which was Ash Wednesday in the Christian calendar.

[9] Apparently the authorities feared that psychosocial programmes would promote narrations and other accounts of what happened that could expose and then be used as evidence for war crimes (Somasundaram & Sivayokan, 2013; Samarasinghe, 2014).

[10] Horizontal inequalities refers to economic, social status, education, power and other marked differences between groups in a society. These horizontal inequalities can cause civil wars (Stewart, 2001).

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