Scarred Communities and Collective Healing: Review of Prof. Daya Somasundaram's Frameworks for Psychosocial Recovery, Community Resilience and Peacebuilding

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Abstract

Armed conflict often leads to consequences that extend far beyond physical destruction and deeply affect psychological wellbeing, social cohesion, cultural identity and collective functioning. Sri Lanka's three-decade civil war profoundly produced widespread psychosocial suffering, particularly within the Northern and Eastern provinces, where communities experienced repeated displacement, violence, losses and social fragmentation. This paper critically revisits the scholarship and field work of Daya Somasundaram and examines its relevance within the contemporary ICD-11 framework for Post-Traumatic Stress Disorder (PTSD) and Complex PTSD (C-PTSD). The study aims to explore how trauma in collectivistic societies extends beyond individual psychiatric symptoms and becomes embedded within families, communities, cultural practices and collective memory. A narrative review methodology was employed using peer-reviewed journal articles, interdisciplinary studies and field reports collected from Scopus, PubMed, Google Scholar and ScienceDirect. The review synthesized literature related to collective trauma, psychosocial recovery, community resilience, ICD-11 trauma classifications and post-conflict peacebuilding in Sri Lanka. The findings reveal that ICD-11 diagnostic categories are valuable for identifying individual-level suffering but remain insufficient to fully explain the collective trauma experienced in war-affected Tamil communities. The review highlights how prolonged conflict disrupted family systems, weakened social capital, eroded communal trust and damaged collective identity. At the same time, resilience emerged through cultural rituals, communal mourning practices, women-led initiatives and community-based support networks. Cyclone Ditwah is also discussed as a contrasting case of an acute natural disaster compared to the prolonged collective trauma of the civil war. The paper concludes that sustainable recovery and peacebuilding need culturally grounded and community-centred psychosocial interventions that address healing at individual, family, community and societal levels simultaneously.

Keywords: Collective trauma, Community resilience, ICD-11, Post-conflict recovery, Psychosocial recovery

Introduction

War rarely ends when armed conflict ceases. The psychological and social consequences of violence often persist across generations, particularly in Sri Lanka's Northern and Eastern provinces following nearly three decades of civil war. Although ceasefires may be declared and reconstruction initiated, These communities continue to experience grief, displacement, disrupted relationships, loss of identity and weakened social trust, making recovery a long-term psychosocial process rather than only a political or economic one (Miller & Rasmussen, 2010, 2017).

The Sri Lankan civil war (1983–2009) caused widespread human suffering through displacement, bereavement, disappearances and chronic exposure to violence, with impacts extending be-

yond individuals to families, cultural systems and community structures. Research shows that such organized violence disrupts social cohesion, intergenerational stability and collective functioning, especially in collectivistic societies where wellbeing is closely tied to relationships and community networks (Betancourt & Khan, 2008). Within this context, the work of Daya Somasundaram is highly significant, as it shifts trauma understanding from individual psychiatric diagnosis to a socio-ecological and collective framework (Somasundaram, 2007). His field studies in Northern Sri Lanka show that war trauma is embedded in families, communities and cultural systems, manifesting as mistrust, social fragmentation and weakened resilience structures.

Subsequent research supports this view, showing that post-war distress in Sri Lanka is closely linked to collective trauma, social capital depletion and weakened community efficacy rather than only individual PTSD symptoms (Somasundaram & Sivayokan, 2013). Recent studies also highlight persistent psychological distress years after forced displacement, emphasizing the need for community-level psychosocial recovery approaches (Morina, Akhtar, Barth, & Schnyder, 2018). Sustainable recovery therefore requires culturally grounded, community-based interventions that rebuild social trust, strengthen resilience and address trauma at individual, family and societal levels simultaneously.

Literature Review

Traditional psychiatric models define trauma mainly at the individual level through categories such as PTSD, depression and anxiety, but recent literature shows that in conflict settings trauma extends to families, communities and cultural systems (Miller & Rasmussen, 2017; Silove, Ventevogel, & Rees, 2017). In this context, Daya Somasundaram introduces a psychosocial-ecological model where trauma is embedded in relationships, collective memory and culture (Somasundaram, 2007). Collective trauma theory highlights that war disrupts social cohesion and identity (Erikson, 1976), with long-term impacts such as mistrust, fragmentation and weakened community functioning in post-conflict societies (Morina et al., 2018; Steel et al., 2009). In Northern Sri Lanka, these effects persisted well beyond the war period.

Recent studies reinforce community resilience as central to recovery, particularly social capital, collective efficacy, family systems and cultural practices (Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008; Ungar, 2011). Somasundaram and Sivayokan (Somasundaram & Sivayokan, 2013) similarly show that rituals, kinship networks and women-led initiatives strengthened post-war psychosocial recovery in Sri Lanka. Culturally grounded approaches are increasingly recognized as essential, as Western models often overlook local meanings and coping systems (Summerfield, 1999; Betancourt, Meyers-Ohki, Charrow, & Tol, 2013). Contemporary literature further links psychosocial wellbeing with sustainable peacebuilding, emphasizing trust rebuilding, community participation and social capital restoration (Committee, 2007; Jordans, Pigott, & Tol, 2016; Wessells, 2015).

Methodology/Design/Approach

This study employed a qualitative narrative review approach to synthesize existing literature on collective trauma, psychosocial recovery and community resilience in post-conflict Sri Lanka. Key focus was placed on the psychosocial-ecological framework proposed by Prof. Daya Somasundaram. Two core studies (Somasundaram, 2007; Somasundaram & Sivayokan, 2013) were critically analyzed and compared with contemporary interdisciplinary literature from psychology, sociology and peacebuilding domains to derive thematic insights on post-war community recovery.

Results and Discussion

Rethinking Trauma Through an ICD-11 Lens in Collectivistic Societies

For most of the twentieth century, the clinical understanding of trauma was secured to a single individual: the veteran, the survivor or the patient in the consulting room. The ICD-11, introduced by the World Health Organizationin January 2022, kept this individual-centred architecture in its definition of Post-Traumatic Stress Disorder

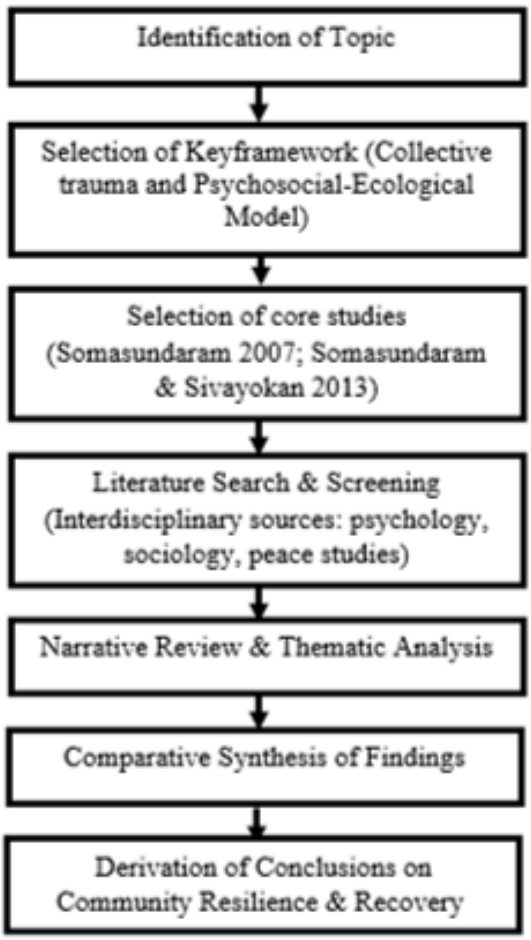

Figure 1: Process Flow Analysis

(6B40). The disorder requires three core symptom clusters following exposure to an extremely threatening or shocking event: re-experiencing the trauma in the present through vivid intrusive memories, flashbacks or nightmares; deliberate avoidance of traumatic reminders, whether thoughts, memories, activities or people; and a persistent sense of current threat manifested as hypervigilance or an exaggerated startle response. These symptoms must last for at least several weeks and cause significant functional impairment (World Health Organization, 2022a).

This formulation is clinically precise and diagnostically useful. Yet, when set against the realities of communities in Northern Sri Lanka who endured three decades of civil war, it becomes incomplete. Somasundaram's surveys found that 92% of primary school children had been exposed to potentially terrorizing experiences, and roughly 25% of that population met criteria for PTSD (Somasundaram, 2007). In a society where 47% of children directly exposed to the 2004 tsunami met PTSD criteria, and another 15% who had not been directly exposed also met the threshold after living inside a war context, the individual diagnostic frame does not fully map the suffering. Trauma was not happening to isolated individuals; it was saturating the entire social environment.

In the Northern Sri Lankan context, these disturbances were not exceptions but widespread social realities. Somasundaram and Sivayokan (Somasundaram & Sivayokan, 2013) documented community-wide hopelessness, learned helplessness, withdrawal from social engagement, the collapse of self-worth among male breadwinners who had lost the ability to work, and shame-laden silence around disappeared relatives. C-PTSD's category of affective dysregulation maps onto what Somasundaram's Trauma Grid described at the individual level, while Complex PTSD's relational disturbances map onto what he observed at the family and community levels simultaneously.

The critical insight that neither ICD-11 PTSD nor C-PTSD fully captures, however, is that in collectivistic Tamil society the individual self and the community self are not readily separable. As Geertz observed and as Somasundaram drew upon, the Western concept of a bounded, unique motivational and cognitive universe set against its social background is culturally specific rather than universal (Somasundaram, 2007).

The Architecture of Collective Trauma: From Individual Symptoms to Social Pathology

Individual-Level Suffering and Its Social Overflow

Somasundaram's foundational 2007 study is worth rereading not only as a theoretical text but also as a field report from inside one of the most sustained civilian traumatization events of the late twentieth century. The distribution of war stress he documented was extraordinary in scope. In community surveys, 50% of respondents had experienced the death of a friend or relation, 70% had been displaced, 78% faced economic difficulties and 56% had lacked adequate food. Among psychiatric outpatients, the figures were higher still (Somasundaram, 2007). These

were not outliers; they were the baseline experience of daily life.

The ICD-11 criterion for PTSD requires that re-experiencing symptoms involve trauma relived in the present, not merely remembered, but re-experienced with the emotional and physiological intensity of the original event. In Northern Sri Lanka, this distinction often collapsed. Only approximately 5% of the population with what would have constituted diagnosable PTSD presented to psychiatric services. The rest absorbed their distress in silence, somatised it as *perumuchu*, the Tamil idiom of deep sighing breath signifying emotional burden, or sought relief through traditional healing (Somasundaram, 2007). This does not mean that the suffering was less severe; rather, it shows that the diagnostic apparatus was never designed for suffering at this scale.

The C-PTSD criterion of beliefs about oneself as diminished, defeated or worthless found its cultural expression in the learned helplessness that Somasundaram described. Communities that had once prided themselves on self-reliance and educational achievement had, under chronic trauma, retreated into dependency, passivity and what Lifton identified in Hiroshima survivors as a pervasive tendency to sluggish despair (Somasundaram, 2007). Men who had been farmers and fishermen now waited in relief queues. Intellectuals and community leaders had been systematically eliminated, killed or driven out by both state forces and Tamil militants in what Somasundaram described as a process of autogenocide among the most able members of the community.

The Family as Both Wound and Resource

The family unit in Tamil society occupies a significance that Western psychological frameworks struggle to fully measure. The C-PTSD criterion of difficulties in sustaining relationships and feeling close to others manifested at the family level in multiple ways that Somasundaram documented with clinical precision. Torture survivors who returned home were socially withdrawn, irritable and unable to resume prior roles. In one case, role reversal between husband and wife led to a suicide attempt: the man, unable to tolerate feelings of inadequacy, had clear PTSD symptoms, yet the family refused mental health help. The family's conspiracy of silence around a disappeared relative who might have been taken by Tamil militants, where even acknowledging suspicion carried risk, created dynamics in which the widow suppressed her grief so completely that her husband eventually disappeared from her own consciousness. These are not simply family stress responses; they meet ICD-11 criteria for affective dysregulation, relational disruption and the self-concept damage characteristic of Complex PTSD, distributed across multiple family members simultaneously.

Somasundaram and Sivayokan (Somasundaram & Sivayokan, 2013) found that family-level disruption was a major driver of wider community dysfunction. Alcoholism among widowed men, domestic violence, child abuse, unwanted pregnancies and increasing rates of youth antisocial behaviour were all downstream consequences of family systems placed under intolerable strain. The case of Kavitha and Rajah in Mullaitivu, two young people shaped by war and carrying the combined weight of orphanhood, disability, forced recruitment, caste discrimination and social rejection, illustrates how trauma cascades. Two individuals meeting ICD-11 criteria for C-PTSD, and their deaths by joint suicide, express a form of suffering that no individual clinical intervention could fully address without also addressing the broken social world they inhabited.

Community-Level Trauma: Where ICD-11 Falls Silent

It is at the community level that the gap between ICD-11 nosology and Sri Lankan reality is most apparent, and where Somasundaram's contribution is most original. Collective trauma, what Erikson called the loss of communality and what Somasundaram operationalized as the destruction of social processes, networks, relationships, institutions and resources at the supra-individual level, has no diagnostic code in ICD-11 or any other international classification system (Erikson, 1976; Somasundaram, 2007). It is not a disorder; it is a social condition. Yet its consequences for mental health are as real and as devastating as any individual diagnosis.

What does community-level trauma look like in practice? Somasundaram's fieldwork offers a de-

tailed phenomenology. It looks like community-based organizations becoming inactive or defunct; people who once campaigned vigorously for civic positions now allowing them to go by default; and communities that had ranked first in the island for educational performance later ranking last. It also looks like silence: communities that had learned, through decades of living between state forces and Tamil militants, that silence was the only safe posture, and which could not easily unlearn that lesson once the shooting stopped.

Somasundaram and Sivayokan (Somasundaram & Sivayokan, 2013) captured this in their post-war ethnography through the concept of depleted social capital: the destruction of the norms, values and relational networks through which communities sustain collective action. Northern Sri Lanka in 2012 was a vivid illustration of this principle. Infrastructure was being rebuilt, but the communities that were supposed to inhabit that infrastructure remained passive, suspicious and depleted.

Contextualizing Collective Trauma: The Ditwah Cyclone Comparison

The comparative dimension of this analysis sharpens when placed alongside the editorial on Cyclone Ditwah, which affected Sri Lanka in late 2025 (Kodituwakku & Amaratunga, 2026). Ditwah caused extraordinary physical damage, including direct losses, destroyed and partially damaged houses, and major disruption to roads, rail, power and water systems across the island. It produced its own group of displaced persons, its own psychosocial disruption and its own demands for recovery planning.

A comparison with Somasundaram's war-affected communities reveals something important about the nature of collective trauma. Cyclone Ditwah was a single catastrophic event: intense and destructive, but bounded in time. Its displacement, while severe, had a recognizable endpoint; families knew where home was, even if they could not yet return to it. The social capital of affected communities, while strained, had not been systematically depleted over three decades. There were no disappeared relatives, no conspiracy of silence and no culture of authoritarian control suppressing grief and community organization. The internally displaced persons in Somasundaram's study, by contrast, had been displaced up to ten or more times. Recovery from a single natural disaster and recovery from thirty years of civil war are qualitatively different processes, not merely quantitatively different ones.

Somasundaram's 2007 study found precisely this gradient: while the 2004 Asian tsunami caused significant individual trauma and distress, particularly where it struck communities already depleted by war, the collective trauma and the fundamental transformation of social functioning were far less severe than in war-affected areas. The tsunami was attributable to nature, karma or an act of God; it did not involve the systematic, intentional destruction of community life by other human beings. The man-made quality of the war's destruction appeared to compound its traumatic impact (Somasundaram, 2007).

The Ditwah editorial's attention to newly displaced communities with no previous experience of displacement, whose psychological trauma and resistance to leaving ancestral homes are significantly higher, is especially relevant (Kodituwakku & Amaratunga, 2026). After repeated displacements, the ancestral home ceases to be a stable anchor. The biological bond that Somasundaram described, the sense of peace and security that Tamils experienced simply by being in their *veedu*, was repeatedly ruptured until it became almost impossible to re-establish. The Ditwah cohort's distress at losing their homes for the first time is a reminder of what repeated loss of the same homes cost communities over thirty years.

Resilience as a Social Process, Not an Individual Trait

One of the most important correctives in Somasundaram's body of work is his insistence that resilience, like trauma, is a collective process. The community resilience framework developed by Norris et al. (Norris et al., 2008) and operationalized through Somasundaram's fieldwork identifies four adaptive capacities: economic development, social capital, information and communication, and community competence. These capacities form the foundations upon which recovery is built. Community competence, defined as the capacity to act together cooperatively and effectively to meet challenges, is exactly what

chronic war undermines most thoroughly and what post-conflict reconstruction must most urgently rebuild.

What is striking about Somasundaram's findings, both in the 2007 and 2013 studies, is the evidence of resilience that survived even the most extreme conditions. Despite everything, most nuclear families in the North remained functionally united. Despite restrictions on public gatherings and cultural expression, communities spontaneously turned to *koothu*, a traditional Tamil folk drama, and the *oppari* lament tradition to express and process their collective grief after the Vanni war. Despite being ostracized by traditional Tamil society, many widows organised themselves into powerful community groups that undertook joint economic ventures, arranged education for their children, celebrated festivals together and became models of female leadership and agency (Somasundaram & Sivayokan, 2013).

The Post-Cyclone Context and Lessons for Integrated Recovery

The Cyclone Ditwah reconstruction editorial identifies multiple areas in which the psychosocial lessons of Somasundaram's work remain directly applicable to Sri Lanka in 2026. The editorial's emphasis on participatory reconstruction, where beneficiaries are involved in the design and planning of new housing and where community involvement guards against quality mismatch and rejection of government-built housing, reflects the same principle that Somasundaram identified as central to psychosocial recovery: giving communities an active and deciding role, rather than a dependent victim role, promotes their overall sense of participation and psychological recovery (Somasundaram, 2007; Kodituwakku & Amaratunga, 2026).

There is also a critical lesson about sequencing. Kodituwakku and Amaratunga (Kodituwakku & Amaratunga, 2026) advocate anticipatory action and pre-disaster recovery preparedness. Somasundaram's work makes a parallel argument for psychosocial preparedness: community-level psychosocial programmes cannot be launched suddenly, gain trust and produce meaningful change in the immediate aftermath of a crisis. They require trained community workers, established trust, functioning social networks and cultural institutions that are already active. The time to build psychosocial resilience is, as the disaster resilience literature says about physical infrastructure, in the quiet months between disasters.

Conclusion and Contributions

This review highlights Daya Somasundaram's contribution to understanding trauma as a collective and socio-ecological experience rather than solely an individual psychological condition. His work shows that post-conflict trauma in Sri Lanka affects families, communities, cultural identity and social relationships beyond clinical symptoms. Although ICD-11 classifications such as PTSD and Complex PTSD help explain individual suffering, they do not fully capture collective trauma in war-affected communities.

The findings emphasize that effective psychosocial recovery requires culturally grounded and community-based approaches involving families, social networks, religious practices and communal healing. The review also highlights the importance of community participation, social cohesion and female leadership in strengthening resilience and reconciliation. Overall, sustainable post-conflict recovery depends on integrating mental health, peacebuilding and culturally informed psychosocial support.

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