

BOWLES'S NEW AND ACCURATE MAP OF THE WORLD, OR TERRESTRIAL GLOBE, laid down from the BEST OBSERVATIONS and NEWEST DISCOVERIES; particularly those of the celebrated CIRCUMNAVIGATORS: Illustrated with a variety of useful PROJECTIONS and REPRESENTATIONS of the HEAVENLY BODIES: the most approved ASTRONOMICAL and GEOGRAPHICAL DEFINITIONS, TABLES, and PROBLEMS. With an easy and familiar Explanation of the most curious and interesting Phenomena in the UNIVERSAL SYSTEM. Printed in F. Poole, Church-Yard, London.



Post-Traumatic Stress Disorder (PTSD) – A Malady Shared by East and West:

A Sri Lankan Look at Combat Stress and Trauma

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Sri Lanka

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Introduction by Dr. Ivan Welch, FMSO

The United States Army has been in continuous combat since late 2001. The impact of this prolonged exposure to the ravages of war is now broadly recognized by civilian and military leaders. Our military institutions are affected by the social, physical, and psychological consequences of this lengthy commitment of forces abroad. These institutions also provide the resources, guidance, and support to mitigate the real and substantial costs of combat.

Post Traumatic Stress Disorder is a known factor in the life of the contemporary US Army and in the lives of many veterans. Approaches to its prevention, treatment, and cures are being sought out across the domains of leadership, training, and medical care. All militaries share the challenges and outcomes of combat. Modern experiences of war are especially germane to the study of injury to our own soldiers.

In the island nation of Sri Lanka, three decades of brutal civil warfare exposed soldiers, families, and communities to prolonged trauma. During this long struggle the Sri Lanka Army came to grips with Post Traumatic Stress Disorder and acknowledged it as a major factor in military readiness and community health. The experience of the Sri Lankan armed forces in identifying and treating PTSD is a valuable source for all military leaders today. This article is meant to add to that foundation of knowledge necessary to move forward.

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Edited by Ivan B. Welch, PhD.

1. The History of PTSD¹

a. Antiquity

(1) Western Expression

Post-traumatic stress disorder (PTSD) is a relatively newly defined disorder with a very long medical history. Historical literature reveals clinical symptoms similar to PTSD dating back to the ancient Egyptian civilization. In 1900 B.C. an Egyptian physician eloquently described hysterical reactions of a patient after traumatic experience.² Great literature from around the world provides stories of individuals and peoples with extraordinary suffering due to the trauma experienced in great calamities.³ For example, the biblical story of Job records a heartbreaking story of human trauma. Job was subjected to extreme suffering, loss of material possessions, and psychological anguish. In his 1952 book *Answer to Job*, pioneer psychiatrist Carl Jung analyzed the psychological components associated with the nature of his emotional suffering. Job was deeply shattered by the trauma that fell upon him. He expresses self-pity and troubled desolation. The trauma left him feeling hopeless, and his mental agony is similar to one who suffers from



Photograph taken by Official War Photographer at an Australian Advanced Dressing Station near Ypres in 1917. The wounded soldier in the lower left of the photograph has the "thousand yard stare" indicative of shell-shock, which has been relabeled PTSD. [Public domain], via Wikimedia Commons

1 Ruwan Jayatunge, The History of PTSD, <http://www.srilankaguardian.org/2011/03/history-of-ptsd.html>
2 Figley, C. R. (1993). Coping with Stressors on the Home Front. *Journal Of Social Issues*, 49(4), 51-71.
3 Jayatunge, History of PTSD, <http://www.srilankaguardian.org/2011/03/history-of-ptsd.html>



PTSD. Job could very well be diagnosed with PTSD within today’s clinical definitions.⁴

Another ancient sacred text from a separate cultural tradition, the *Mahabharata*, describes vivid combat stress reactions exhibited by the ancient warriors. This epic tale of India chronicles a great war between the Pandavas and the Kauravas in 3139 B.C. The horrendous combat events described in the *Mahabharata* and the demeanor and death of the main warrior characters such as Jayadratha graphically illustrate the trauma and symptoms now recognized in the PTSD diagnosis.

4 Haughn, Clifford & John C. Gonsiorek. 2009. “The Book of Job: Implications for Construct Validity of Posttraumatic Stress Disorder Diagnostic Criteria,” *Mental Health, Religion & Culture* 12(8). 833-845.



A manuscript illustration (18th c.?) of the Battle of Kurukshetra, fought between the Kauravas and the Pandavas, recorded in the Mahabharata Epic. [Public Domain] via Wikimedia Commons

Homer's great epic, *The Iliad*, which was composed circa 730 B.C., narrates a series of harrowing episodes of battle stress that were experienced by the ancient Hellenic combatants. He clearly paints the picture of the horror of war and trauma of combat. Achilles, the archetypal warrior, cries out in anguish and rage at the death and mutilation of his friend Patroklos. *The Iliad* describes Achilles' survival guilt in a poetic outcry.

I would die here and now, in that I could not save my comrade. He has fallen far from home, and in his hour of need, my hand was not there to help him. What is there for me? Return to my own land I shall not, and I have brought no saving neither to Patroklos nor to my other comrades of whom so many have been slain by mighty Hector; I stay here by my ships a bootless burden upon the earth.⁵

Battle scenes and human suffering occupy much of *The Iliad*. When exposed to the atmosphere of combat, soldiers have feelings that become more intense and unpredictable. They may include amplified emotional responses or the reawakening of past mental disturbance. Homer artfully captures such responses. In *The Iliad* some combatants suffer from extreme confusion and experience feelings of insecurity. Their reactions are similar to modern-day combat-related PTSD.

5 Homer. *The Iliad of Homer*. Rendered into English prose for the use of those who cannot read the original. Samuel Butler. Longmans, Green and Co. 39 Paternoster Row, London. New York and Bombay. 1898 Scroll 18, lines 97-104 <http://www.perseus.tufts.edu/hopper/text?doc=Perseus%3Atext%3A1999.01.0217%3Abook%3D18%3Acard%3D97>

The Iliad epitomizes another tragedy of war: the agony of war widows when encompassed with physical and mental trauma. The pages of *The Iliad* echo the woe and affliction of the Trojan women. Homer expounds their lamentation and helplessness comprehensively. Trojan women have become the ultimate symbol of the consequences of war on the survivors.

(2) Buddhist Jataka Stories

According to archaeological and literary evidence, the Jataka stories were compiled in the 3rd Century B.C. to the 5th Century A.D. The *Khuddaka Nikaya* contains 550 stories the Buddha told of his previous lifetimes as an aspiring Bodhisattva. According to Professor Rhys Davids, Jataka stories are one of the oldest fables.⁶ The Jataka stories deeply analyze the human mind. They contain profound psychological content. The renowned Sri Lankan writer Martin Wickramasinghe once said psychoanalysis was not initiated by Freud but by the Jataka storyteller.

In the Jataka stories there are numerous characters who have displayed hysteria-type reactions. For instance, in the Maranabheruka Jataka one monk shows anxiety-based reactions that are similar to modern day PTSD. This monk displays extreme fear, hyper-arousal, avoidance, frightful mental pictures (flashbacks?) and emotional anesthesia.

b. Early Modern and Modern Period Characterizations

(1) Shakespearian Work and British Experience of PTSD

The eminent English poet and playwright William Shakespeare created many characters who appear to be afflicted by psychological and psychiatric disorders. Shakespeare had an extraordinary ability to grasp the dynamics of the human mind and fathom the dysfunctions of the human psyche. Indeed, Shakespeare was very comprehensive in his descriptions of various psychological and psychiatric symptoms. Shakespeare's influence on psychopathology was immeasurable. Many of Shakespeare's lead characters seem to be having mental disorders and even psychoses.

⁶ T.W. Rhys Davids, translator. *Buddhist Birth Stories; or Jataka Tales. The Oldest Collection of Folk-Lore Extant: Being the Jatakathavannana*, Boston: Houghton, Mifflin, & Co. 1880.

Macbeth, probably written sometime between 1603 and 1607, reveals an act for which the perpetrator is subsequently filled with guilt, one that is emotionally overwhelming, replete with nightmares, hallucinations, and disturbing reminiscences. Macbeth was a Scottish Army general who wanted to rise to nobility and become the king of Scotland. To fulfill his ambition he was pushed to kill King Duncan by his ambitious wife. Macbeth murders Duncan while Duncan is a guest at his castle. After the murder Macbeth and his wife become emotionally unstable. Lady Macbeth sleepwalks (a form of dissociation that is evident in trauma). She continuously washes and wrings her hands in an attempt to make them clean (an obsessive-compulsive disorder type of behavior that could be co-morbid with PTSD). Her nights are full of disturbances and she becomes hyper-vigilant. Following the distressing mental condition, Lady Macbeth commits suicide.

Around half a century after Shakespeare's death English civil servant Samuel Pepys witnessed the great fire of London in 1666. His diary famously and vividly described nightmares, intrusions, and flashbacks, all of which are associated with what we today call PTSD.⁷

(2) PTSD victims of Russo-Turkish War

From 1676 to 1681 a series of military conflicts occurred between the Russian and Ottoman Empires. Professor V.I. Buganov, a renowned Soviet Historian, described unusual events that occurred during the war between the Turkish troops and the forces of Peter the Great. According to Buganov, some soldiers lost their voices (became aphonic as a result of an hysteria-type dissociative reaction). Some manifested fear feelings and became insane (possibly a stress-related behavior following acute stress disorder).

(3) Railway Hysteria

In 1800 a condition was identified that bore a remarkable resemblance to modern-day PTSD. It was called railway hysteria or railway spine. The sufferers of this condition showed anxiety and somatoform symptoms after having been in catastrophic railway accidents. Railway spine was a nineteenth-century diagnosis for the post-traumatic symptoms. A large numbers

⁷ Daly, R.J. (1983). "Samuel Pepys and Posttraumatic Stress Disorder," *British Journal of Psychiatry*, 143, 64-68.



Kearney's men wounded at Fredericksburg 1864 by James Gardner [Public Domain], via <http://memory.loc.gov/>

of casualties were reported on Britain's Victorian railways between the 1840s and the 1860s. The medical experts regarded "Railway as a condition produced by a jolted and shaken spinal cord to one of traumatically-induced mental and nervous collapse fraught with implications of hysteria, neurasthenia and degeneration."⁸

(4) Neurasthenia

In 1879 neurologist George Beard called a group of symptoms he observed "neurasthenia."⁹ This was characterized by chronic fatigue and weakness, loss of memory, and generalized aches and pains, formerly

thought to result from exhaustion of the nervous system.

(5) Soldier's Heart

In 1876 US Civil War physician Dr. Mandez Da Costa introduced the term "soldier's heart," which illustrated the physical and emotional symptoms displayed by Civil War veterans, including startle responses, hyper-vigilance, dyspnea (difficulty in breathing), palpitation, chest pain, fatigue, faintness and heart arrhythmias. Soldier's heart or Da Costa's syndrome is considered the manifestation of an anxiety disorder, and treatment is primarily behavioral, involving modifications to lifestyle and daily exertion.¹⁰

(6) Effort Syndrome

The term "effort syndrome" was introduced in 1900. This condition was characterized by chest pain, dizziness, fatigue, palpitations, cold moist hands, and sighing respiration. The condition is often associated with soldiers in combat, but occurs also in other individuals. The

8 Harrington, Ralph. "The Railway Accident: Trains, Trauma and Technological Crisis in Nineteenth-Century Britain," In Micale, Mark S.; and Lerner, Paul. *Traumatic Pasts*. Cambridge University Press, 2001. pp. 31-56

9 Beard, George. (1879). "Neurasthenia as a Cause of Inebriety," *Quarterly Journal of Inebriety* (September 1879) Treat.

10 Da Costa, JM. "On Irritable Heart; a Clinical Study of a Form of Functional Cardiac Disorder and Its Consequences," *American Journal of Medical Science*, 1871;61: p.7-52

pain often mimics angina pectoris, but is more closely associated with anxiety states and occurs after, rather than during exercise.

(7) Chronic Fatigue Syndrome (introduced in 1900)

Chronic fatigue syndrome is a complicated disorder characterized by extreme fatigue that may worsen with physical or mental activity, but does not improve with rest. There are many theories about what causes this condition, ranging from viral infections to psychological stress.

(8) Shell Shock

By 1918 British military doctors identified a group of symptoms that included tiredness, irritability, giddiness, lack of concentration and headaches among the soldiers who fought in World War I. Colonel Fredrick Mott, a British pathologist, coined the term “shell shock,”¹¹ and he considered it an organic condition produced by miniature hemorrhages of the brain. Between 1914 and 1918 the British Army identified 80,000 men as suffering from shell shock. Shell shock was generally seen as a sign of emotional weakness or cowardice.

Wilfred Owen was a Captain of the British Army and witnessed the atrocities of WW 1 first hand. He wrote his famous anti-war poem “Dulce et Decorum Est” while receiving treatment for shell shock in Craiglockart.

*Bent double, like old beggars under sacks,
Knock-kneed, coughing like hags, we cursed through sludge,
Till on the haunting flares we turned our backs
And towards our distant rest began to trudge.
Men marched asleep. Many had lost their boots
But limped on, blood-shod. All went lame; all blind;
Drunk with fatigue; deaf even to the hoots
Of tired, outstripped Five-Nines that dropped behind.*

*Gas! Gas! Quick, boys! – An ecstasy of fumbling,
Fitting the clumsy helmets just in time;
But someone still was yelling out and stumbling,
And flound'ring like a man in fire or lime . . .
Dim, through the misty panes and thick green light,
As under a green sea, I saw him drowning.
In all my dreams, before my helpless sight,
He plunges at me, guttering, choking, drowning.*

11 Mott, Frederick W. *War Neuroses and Shell Shock*. London: Oxford University Press, 1919.

(9) Combat Fatigue

Over 110 million persons were mobilized for military services in World War II. The term “combat fatigue” was introduced to describe the combat trauma reactions that occurred during the war. Combat fatigue was characterized by hypersensitivity to stimuli such as noises, movements, and light, accompanied by overactive responses that include involuntary defensive jerking or jumping, easy irritability progressing even to acts of violence, and sleep disturbances, including battle dreams, nightmares, and inability to fall asleep. A longitudinal study of Harvard University alumni found 56% of World War II veterans who experienced heavy combat were chronically ill or dead by age 65.¹²

c. Early Clinicians

(1) Pierre Janet on Trauma

In 1889 Pierre Janet published *L'automatisme psychologique*, his first work to deal with how the mind processes traumatic experiences. Janet coined the word “dissociation” and explained the effects of dissociation of the traumatic memories and their return as fragmentary reliving experiences.

(2) Jean-Martin Charcot

In 1901 the Parisian clinical neurologist Jean-Martin Charcot, known as “the founder of modern neurology,” described traumatic memories as parasites of the mind. He formulated a comprehensive, neurogenic model of “the great neurosis.” For Charcot, hysteria was strictly a dysfunction of the central nervous system. In Charcot’s view, traumatic hysteria and male hysteria were identical. He acknowledged the relevance of psychological traumas, dissociated from the patient’s consciousness, in determining the nature of its symptoms. Charcot’s views immensely affected Sigmund Freud’s early theory of hysteria and the notion of psychological trauma.

12 Lee, KA, Vaillant GE, Torrey WC, Elder GH. “A 50-Year Prospective Study of the Psychological Sequelae of World War II Combat,” *American Journal of Psychiatry*. 1995 April; 152(4):516-22

(3) Sigmund Freud and Traumatic Neurosis

Sigmund Freud used the term “traumatic neurosis,” to describe the condition that resembles the present-day PTSD. The term designates a psychopathological state characterized by various disturbances arising after an intense emotional shock, either immediately or even sometimes long after the event occurred. Freud specifically wrote about effects of traumatic memories and traumatic shock. In Freud’s words, “The symptomatic picture presented by traumatic neurosis approaches that of hysteria in the wealth of its similar motor symptoms, but surpasses it as a rule in its strongly marked signs of subjective ailment . . . as well as in the evidence it gives of a far more general enfeeblement and disturbance of the mental capacities.”¹³

Freud’s understanding of trauma was well represented in his works, mainly in *Mourning & Melancholia* (1917), *Beyond the Pleasure Principle* (1920), and *Symptoms, Inhibitions & Anxiety* (1926). Freud assumed that the negative emotional energy associated with traumatic memories unconsciously converted into the somatic manifestations of hysteria. Freud’s lectures in 1917–1918 eloquently described the broad clinical picture of what we know today as PTSD.

In one of his famous lectures, *Traumatic Fixation - The Unconscious*, which he gave in America, Freud states:

The closest analogy to this behavior in our nervous patients is provided by the forms of illness recently made so common by the war – the so-called traumatic neurosis. Of course, similar cases have occurred before the war, after railway accidents and other terrifying experiences involving danger to life. The traumatic neuroses are not fundamentally the same as those which occur spontaneously... The traumatic neurosis demonstrates very clearly that a fixation to the moment of the traumatic occurrence lies at their root. These patients regularly produce the traumatic situation in their dreams, in case showing attacks of a hysterical type in which analysis is possible; it appears that the attack constitutes a complete reproduction of this situation. It is as though these persons had not yet been able to deal adequately with the situation, as if this task were still actually before them unaccomplished.¹⁴

In 1910 Freud stated that hysterical patients suffer from intrusive reminiscences. There is much evidence to suggest that Sigmund Freud knew the spacious clinical picture of PTSD.

13 Freud, Sigmund. *Beyond the Pleasure Principle*, The International Psycho-Analytical Library No.4, London, 1922.

14 Freud, Sigmund. *A General Introduction to Psychoanalysis*. New York: Boni and Liveright, 1920

d. US Codification of PTSD: Diagnostic and Statistical Manual of Mental Disorders (DSM)¹⁵

(1) 1952 DSM 1 – Neurotic Reaction (Stress Response Syndrome)

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM 1) was published in 1952 by the American Psychiatric Association and provided new diagnostic criteria for neurotic reaction (stress response syndrome).

(2) 1968 DSM 2 Transient Situational Disturbance

Transient situational disturbance is defined as a form of maladaptive reactions to identifiable psychosocial stressors occurring within a short time after the onset of the stressor. They are manifested by either impairment in social or occupational functioning or by symptoms (depression, anxiety, etc.) that are in excess of a normal and expected reaction to the stressor.

(3) 1980 DSM 3 PTSD

In 1980 the American Psychiatric Association added PTSD to the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) nosologic classification scheme. In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience.

(4) In 1993 World Health Organization (WHO) Recognizes PTSD

The *International Statistical Classification of Diseases and Related Health Problems 10th Revision* (ICD-10) is a coding of diseases, signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO). ICD-10 was endorsed by the Forty-Third World Health Assembly in May 1990 and came into use in WHO member states. The ICD is the international standard diagnostic classification for all general epidemiology, and is used for many health management purposes and clinical use. In 1993 it recognized PTSD as a separate diagnostic entity.

¹⁵ American Psychiatric Association (APA) (1994) . *Diagnostic and statistical manual of mental disorders: DSM-IV*. Washington, DC: American Psychiatric Association

(5) 1994 DSM 4

The *Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition* (American Psychiatric Association, 1994) defines PTSD as a constellation of symptoms and behaviors that includes three core clusters: re-experience of the trauma in the form of intrusive thoughts, dreams and images; avoidance of thoughts or reminders of the trauma, together with emotional numbing and withdrawal; and signs of increased central and autonomic arousal.

In 2000 the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR).¹⁶ The diagnostic criteria (A-F) are specified in the box below.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

16 American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.

Criterion E: duration
Duration of the disturbance (symptoms in B, C, and D) is more than one month.
Criterion F: functional significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify if:
Acute: if duration of symptoms is less than three months
Chronic: if duration of symptoms is three months or more
Specify if:
With or without delay onset: Onset of symptoms at least six months after the stressor

a. US Focus on PTSD

The US military's historic concern with PTSD was revived during combat operations in Afghanistan and Iraq, as over two million personnel have served in these theaters since 2001. Of that total, 1,353, 627 have since left the military and 711,986 have used Veterans Administration (VA) health care between fiscal year 2002 and the third-quarter fiscal year 2011.¹⁹

The National Vietnam Veterans Readjustment Survey (NVVRS) report provided the following information about PTSD among Vietnam War veterans: the estimated lifetime prevalence of PTSD among American Vietnam theater veterans is 30.9% for men and 26.9% for women. An additional 22.5% of male Vietnam veterans and 21.2% of female Vietnam veterans have had partial PTSD at some point in their lives. Thus, more than half of all male Vietnam veterans and almost half of all female Vietnam veterans - about 1,700,000 Vietnam veterans in all - have experienced "clinically serious stress reaction symptoms." 15.2% of all male Vietnam theater veterans (479,000 out of 3,140,000 men who served in Vietnam) and 8.1% of all female Vietnam theater veterans (610 out of 7,200 women who served in Vietnam) were diagnosed with PTSD at the time the survey was conducted (1986-1988).²⁰

There is not a consensus on the PTSD rates for the Afghanistan and Iraq conflicts. Science magazine reports that of the total American military personnel deployed to Iraq and Afghanistan,

17 DSM Criteria for PTSD. <http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp>
18 Marsella, Anthony J. Ethnocultural Aspects of PTSD: An Overview of Concepts, Issues, and Treatments
Traumatology December 2010 16: 17-26, first published on November 28, 2010 doi:10.1177/1534765610388062
19 <http://abcnews.go.com/Politics/us-veterans-numbers/story?id=14928136#1>
20 Richard A. Kulka et al., *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (New York: Brunner/Mazel, 1990; ISBN 0-87630-573-7)

4.3% of troops developed PTSD. This is a composite of the deployed combatants, (7.6% of whom developed PTSD) and the deployed noncombatants (1.4% of whom developed PTSD).²¹ A fact sheet from the RAND Center for Military Health Policy Research concludes the true rates of PTSD are not known and that studies existing as of 2010 vary too widely to be helpful.²² The United States Department of Veteran Affairs asserts that 11-20% of veterans of the Iraq and Afghanistan wars have PTSD.²³ The VA estimate could point to 20,000 to 40,000 current cases of PTSD.

b. Americanization of Mental Illness

There is a growing critique of the conventional Western psychological approaches to trauma and PTSD. Voices from academia, clinical practice, and victims themselves are joining to proclaim the “widespread variations across ethno-cultural boundaries.”²⁴

Author Ethan Watters examined trauma and cultural factors in depth. He states that the Western conception of mental health and illness might be shaping the expression of illnesses in other cultures, and that this is rarely discussed in the professional literature. Many modern mental health practitioners and researchers believe that the scientific standing of Western drugs, Western illness categories and Western theories of the mind have put the field beyond the influence of endlessly shifting cultural trends and beliefs. Others still seek to understand the cultural context as a diagnostic factor.

Dr. Sing Lee a psychiatrist and researcher at the Chinese University of Hong Kong watched the Westernization of a mental illness firsthand. In the late 1980s and early 1990s, he was busy documenting a rare and culturally specific form of anorexia nervosa in Hong Kong. Unlike American anorexics, most of his patients did not intentionally diet nor did they express a fear of becoming fat. The complaints of Lee’s patients were typically somatic — they complained most frequently of having bloated stomachs. Lee was trying to understand this indigenous form of anorexia and, at the same time, figure out why the disease remained so rare.²⁵

21 McNally, R. J. (2012). “Are We Winning the War against Posttraumatic Stress Disorder?” *Science*, 336 (6083), 872-874.

22 http://www.rand.org/pubs/research_briefs/2010/RAND_RB9509.pdf

23 <http://www.ptsd.va.gov/public/pages/how-common-is-ptsd.asp>

24 Ibid, p.18.

25 Watters, Ethan. The Americanization of Mental Illness. <http://www.nytimes.com/2010/01/10/magazine/10psyche-t.html?pagewanted=all>

c. PTSD: Universal Experience and Cultural Treatment

War is institutionalized violence that has intrinsically unique elements. It is a multidimensional manmade disaster. War can be an individual as well as a collective form of trauma.²⁶ Wars represent a mental health emergency. Mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. War trauma can shift the parameters of mental health towards the negative side. The circumstances of the armed conflict can produce a range of emotional and behavioral stress reactions among soldiers and civilians alike.

In a war situation combat stress is an inevitable factor. Combat stress is a specific stress factor that can affect both mental and physical health. It is a form of psychological pathology that results from traumatic exposure to battle events. Combat in most cases involves fear, despair, shock and anxiety.

Combat stress is the result of internal and external stresses. Combat stress does not come from the enemy action alone. Some stress is generated from the soldiers' own unit leaders and mission demands. Combat stress symptoms and reactions interfere with mission performance. Battle stress affects both combatants and civilians, especially those living in the war zone. War disrupts the existing social structure. The major impact of war includes disintegration of psychological well being, creating a specific calamity subculture that often generates vicious cycles that echo even after the war.²⁷



Fingers gently grasp identification tags during a memorial service 28 April 2006 at Camp Fallujah's Chapel of Hope. DoD Photo by Gunnery Sgt. Mark Oliva, via <http://www.dvidshub.net/image/19507/060428-m-8112o-perez6#.UDzQJ6M4KkM#ixzz24qkZvCeF>

26 Fernando, N. & Jayatunge, R (2011) . Combat Related PTSD among the Sri Lankan Army Servicemen. Retrieved from <http://www.srilankaguardian.org/2011/02/combat-related-ptsd-among-sri-lankan.html>

27 Warfare and Mental Health. Posted on February 8th, 2011 <http://www.lankaweb.com/news/items/2011/02/08/warfare-and-mental-health/>

3. Sri Lankan Experience: Cultural Factors and Combat Trauma²⁸

Sri Lanka experienced a prolonged armed conflict that changed the psychological landscape of the islanders. From 1983 until 2009 a large number of government combatants, civilians and members of the separatist Liberation Tigers of Tamil Elam (LTTE) underwent the detrimental repercussions of combat trauma. The concept of trauma in general was not new to the Sri Lankans. Throughout history Sri Lankans have experienced natural and manmade disasters. The religion and culture have provided great resilience to cope with trauma. Culture consists of traditions, values, customs, folklore, rituals and artifacts that help give meaning to the physical world. It is transmitted primarily through language and everyday interactions. These cultural factors sometimes act as buffers to trauma and assist in coming to terms with psychological trauma.

a. Combat Trauma in Sri Lanka

Combat trauma, a notion that is not new to Sri Lankans, has been of profound historical, cultural, social, and religious significance to them. The written history of Sri Lanka dates back to 600-500 BC.²⁹ According to the Mahavamsa, the great chronicle history of Sri Lanka and one of the oldest chronologies in the world, the great Battle of Vijithapura that occurred in 205 B.C. was hard fought, with great carnage and death. The triumphant King Dutthagamani experienced severe depression soon after the battle.



Little Anulians Show Their Warmth to War Heroes. Photo Copyright © 2011 Sri Lanka Army via <http://www.army.lk/subGallery.php?galid=27#12>

28 Dr Ruwan M Jayatunge. Cultural Factors and Combat Trauma in Sri Lanka. <http://www.lankaweb.com/news/items/2012/06/18/cultural-factors-and-combat-trauma-in-sri-lanka/>

29 K.M. de Silva. *A History of Sri Lanka*. Colombo: Vijitha Yapa Publications, 2008. P.9

Throughout the Sri Lankan history there were foreign invasions and internal conflicts in which the islanders had to fight fearsome battles. Western nations arrived in 1505 AD, and until 1815 AD the Sri Lankans fought against three of them: Portugal, the Netherlands and England. Some of the local warriors who fought against the foreign invaders later became the victims of combat trauma.

The Portuguese came to Sri Lanka in 1505 and launched a massive armed campaign against the islanders. King Seethawaka Rajasinghe (1544 A.D – 1593 A.D) was a great warrior who came to the battlefield at the age of 16. He fought against the Portuguese invaders and witnessed many deaths and much destruction. He was a fearless fighter who used proficient war tactics and overpowered the fully equipped and fully trained Portuguese Army, considered a superpower in the 16th-century world. He defeated the Portuguese in a number of decisive battles. His military campaigns prevented Sri Lanka from becoming a Portuguese colony. Following long years of combat King Seethawaka Rajasinghe was exhausted and unquestionably suffered from battle fatigue. In later years he displayed outbursts of anger, irritability, deep mistrust, alienation, emotional numbing and various other PTSD-related symptoms. Just as we see in the Western world's early recording of PTSD-like symptoms in 1666, King Seethawaka Rajasinghe is believed to have suffered from combat-related trauma. The king's abnormal behavior pattern was described by the Portuguese historian Fernão de Queyroz in his multivolume work, *Temporal and Spiritual Conquest of Ceylon*.

b. PTSD Denial in the Modern Era

The culture and history of Sri Lanka reveals that PTSD types of illnesses were common in the ancient days, and the recognition of this malady was not unique to the West. Ancient and modern narratives tell of the posttraumatic symptomatology of the trauma victims.

Over 200,000 members of the Sri Lankan armed forces and police had been directly or indirectly exposed to combat situations during the recent 30-year conflict. Traumatic experiences include seeing fellow soldiers being killed or wounded, seeing unburied decomposing bodies,

hearing screams for help from the wounded, and helplessly watching the wounded die without the possibility of being rescued. Following the combat in Sri Lanka, a significant number of combatants suffered from PTSD, but remained undiagnosed by medical personnel and were left untreated.



Recovered LTTE Dead Bodies, Weaponry and Mobile com centre. Photo Copyright © 2011 Sri Lanka Army via <http://www.army.lk/subGallery.php?galid=19#1>

For a number of years the Sri Lankan authorities denied the fact that combat-related PTSD was emerging in the military. PTSD was regarded as an American illness and there was an unofficial taboo to use the term PTSD. The tension of combat trauma was mounting in the Sri Lankan military over the years, and there had been suicides and incidents of self-harming reported from the battlefield. The soldiers affected by war trauma had behavioral problems and their productivity was plummeting. Many soldiers who had symptoms of combat-related PTSD, but without any physical disabilities, were compelled to continue to serve in the operational areas and engage in active combat. Some were charged with malingering when they sought medical attention. Many traumatized veterans deserted the army and even joined underworld criminal gangs. Until 2005 the Sri Lankan Army did not medically discharge any combatant on psychological grounds. The monumental work of Dr. Neil J. Fernando, the former consultant psychiatrist of the Sri Lanka Army, eventually provided insight to the authorities, resulting in having war trauma and PTSD thought of more seriously. The first soldier who was able to get a medical discharge with PTSD was a lance corporal with malignant PTSD. He was a POW who had been held by the LTTE for nearly five years.

c. Combat Trauma and Cultural Factors

Psychological trauma is a very complex and damaging factor to the human psyche. It is a unique individual experience and the individual's interpretation is mostly based on his subjective experience. Individual differences in posttraumatic response have been known to the mental

health clinician for many decades. Numerous psychologists indicate the close association between trauma and the cultural factors. Some argue that the impact of trauma and trauma recovery sometimes depends on cultural factors as well. Therefore the victims of trauma should be treated in a culturally appropriate manner.

Batista & Wiese argue that trauma must be considered within a culture, because it is the cultural context that shapes life experiences, including the ones that are considered traumatic.³⁰ No culture is immune to the pain and suffering caused by catastrophic or life-threatening events, but there are important cultural differences in how these events are interpreted and dealt with.³¹

The cultural impact of combat trauma in Sri Lanka can be followed from the earliest beginnings of the Tamil insurgency in the north. Combatants and civilians experienced the aftermath of combat trauma. It is significant that their religious beliefs played a key role in trauma management. Many Sri Lankan combatants believe in reincarnation and the effects of Karma. The victims believe that their physical and psychological symptoms are due to karmic actions in past lives. Often these concepts help them to come to terms with their trauma by providing an explanation and cultural context for the traumatic events.

During World War I conversion reactions (characterized by the presence of bodily symptoms having no discernible physical cause) were commonplace.³² Even Freud wrote about these war hysteria reactions, which he termed as “traumatic neurosis.” Sri Lankan combatants have more somatic ailments when they manifest anxiety and depression. Many combat trauma victims with depression get treatment for migraine or joint pains before seeking medical assistance for the psychological trauma that underlies the symptoms and ailments.³³

Although in Europe and North America the number of conversion reaction cases was minimal in WWII, the Vietnam War and the Iraq War, the Eelam War in Sri Lanka between

30 Batista, P. & Wiese, E. (2010). Culture and Migration: Psychological Trauma in Children and Adolescents. *Traumatology* 16: 142-152

31 Watters, E. (2010). *Crazy Like Us: The Globalization of the American Psyche*. Free Press.

32 Hart, Dijke, Son, and Steele. “Somatoform Dissociation Traumatized World War I Combat Soldiers: A Neglected Clinical Heritage,” *Journal of Trauma & Dissociation*, Vol.1(4) 2000, p. 33-66

33 Jayatunge, R. (2004). *PTSD Sri Lankan Experience*, ANL Publishers Colombo.

the government and the LTTE has generated a large number of such cases.³⁴ This could be due to several factors. In the Sri Lankan conflict soldiers had no psychological debriefing or similar trauma management soon after the traumatic combat events. The combatants were not informed about possible combat trauma reactions. Although the Sri Lankan Army had top surgeons and physicians throughout the war, for the last 30 years it did not have even a single combat psychologist. The field military doctors had little knowledge about traumatic combat reactions and the effects of PTSD. The psychological victims were often charged with malingering. In addition, the soldiers were reluctant to admit to emotional problems, which would have been considered cowardice. Therefore, many combat reactions were expressed through dissociative channels.

Dissociative reactions have a special cultural significance in Sri Lanka, especially in rural areas. Some combat-related dissociative reactions are often interpreted as disturbances created by “bad spirits.” In many rural parts of Sri Lanka psychogenic paralysis is considered an act of black magic, and traditional healers use a ritual called Thovilaya (this ancient ritual is a form of psycho drama) to treat the sufferers.

The possession state, which is categorized as a dissociative disorder, could be observed among soldiers with combat trauma. In possession the person enters an altered state of conscious and feels taken over by a spirit, power, deity, or other person who assumes control over his or her mind and body. In many rural areas the possession state is often regarded as mediation with the gods and goddesses. Some soldiers left the military in a possession state and became so-called spiritual mediators.

On most occasions cultural factors and religious beliefs have helped the victims of combat trauma to integrate their traumatic experience into a meaningful context, and have worked as a buffer to prevent further traumatization. After exposure to combat trauma many people have embraced their cultural and religious practices more holistically and completely. These individuals interpret their posttraumatic symptoms in spiritual terms. Somehow these traumatic experiences have been transformed into a meaningful attitude and non-self-destructive manner.

³⁴ Ibid.

The relationship between trauma and culture is an important one because traumatic experiences are part of the life cycle, universal in manifestation and occurrence, and typically demand a response from culture in terms of healing, treatment, interventions, counseling, and medical care... The concept of traumatic stress and the multidimensional nature of cultures require a conceptual framework by which to address core issues that have direct relevance to understanding the nature of trauma as embedded within a culture and its assumptive systems of belief and patterns of behavioral regulation.³⁵

Summerfield argues that when it comes to the issue of cultural differences and posttraumatic syndromes (e.g., PTSD) it cannot automatically be assumed that advances in Western psychotherapeutic techniques can be exported and applied to non-Western cultures.³⁶

d. Treating Combat Trauma in Sri Lanka

Combat trauma can be identified soon after a traumatic combat operation or exposure to a violent combat-related event. Some combat reactions manifest themselves as immediate acute stress reactions and some take months, even years to develop. Many victims have clinical features, as well as behavioral issues, after facing traumatic combat events. Some go in to negative stress-coping methods, such as alcoholism, drug abuse, and social violence or self-harm. Traumatic post-combat reactions can cause significant distress to the victim and to his family, and in the long run it could negatively affect society.

In Sri Lanka the psychological victims of war trauma are treated with allopathic medicine (mainstream Western medical practice), traditional Ayurvedic medicine, psychotherapy and spiritual therapies. Psychiatrists treat war trauma victims with depression and PTSD and other anxiety-related disorders by using selective serotonin reuptake inhibitors and sometimes combine antipsychotics when there are signs of severe disturbed behavior with psychotic manifestations. Ayurvedic specialists use various types of traditional remedies to ease the anxiety.

35 Wilson, John. "The Lens of Culture: Theoretical and Conceptual Assessment of Psychological Traumas and PTSD," *International and Cultural Psychology Series*, Springer, 2007, Part 1, 3-30.

36 Summerfield, D. (1999). "A Critique of Seven Assumptions behind Psychological Trauma Programs in War-Affected Areas," *Social Science and Medicine*, 48, 1449–1462.



Ayurvedic shirodhara massage treatment at the Wedamedura Clinic in Kandy, Sri Lanka. The shirodhara massage is used to relax the mind and remove fear, anxiety, anger or irritability. Photo by Jurgen via <http://srilanka.for91days.com/2012/03/02/ayurveda-in-sri-lanka/>

Psychologists and psychotherapists often use cognitive behavior therapy, which is an effective form of insight therapy. Exposure therapy is one form of cognitive behavior therapy unique to trauma. It is a treatment which uses careful repeated, detailed imaging of the trauma (exposure) in a safe controlled context. This is meant to help the survivor face and gain control of the fear and distress that were overwhelming in the trauma.

Also used in Sri Lanka is eye movement desensitization and reprocessing (EMDR).³⁷ In a white paper published by the United States Department of Veterans Affairs the authors conclude that “...Eye Movement Desensitization Reprocessing is considered a first-line treatment for PTSD and has a strong

evidence base.”³⁸ The United States VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress states that, “Results of clinical trials, meta-analytic studies, review articles, and extant practice guidelines suggest that EMDR successfully treats symptoms of PTSD when compared to no treatment or delayed treatment conditions. When compared to other treatment modalities, most studies reviewed indicated that EMDR possessed comparable efficacy to other well-accepted cognitive behavioral treatments to include stress inoculation training (SIT) and exposure therapies.”³⁹

37 Jayatunge, Ruwan. *EMDR Sri Lankan Experience, Psychological Trauma Management through EMDR in Sri Lanka*. Sarasavi Publishers, 2008.

38 Overview of PTSD Treatment Research [NCPTSD] Jessica L. Hamblen, PhD, Paula P. Schnurr, PhD, Anna Rosenberg, MA, & Afsoon Eftekhari, PhD; Retrieved on 24 Jan 11 from: <http://www.ptsd.va.gov/professional/pages/overview-treatment-research.asp>

39 VA/DoD Clinical Practice Guideline For Management Of Post-Traumatic Stress, p.129 , Version 2.0 – 2010 <http://www.healthquality.va.gov/ptsd/PTSD-FULL-2010a.pdf>

Spiritual therapy frequently helps war victims to reduce their depression and anxiety- related symptoms. Many Sri Lankan clinicians have observed that spiritual therapy diminishes the suicidal ideation in combat trauma victims. Many combatants and civilians with war trauma are encouraged to practice meditation and yoga. Meditation methods such as metta meditation (meditation of loving-kindness) and vipassanna meditation (mindfulness mediation) are widely used in rehabilitation centers.

e. Conclusions

Every culture is unique and has distinctive ways of interpreting psychological trauma. The client's religious and cultural beliefs play an important role in the treatment process. Using these innate factors in trauma management obviously gives more effective results. Since war and its trauma are a universal human experience, every nation and culture would do well to learn from one another the successful means to treat PTSD.