“We Are All Alive . . . But Dead”: Cultural Meanings of War Trauma in the Tamil Diaspora and Implications for Service Delivery

Pushpa Kanagaratnam1,2,3, Joanna Anneke Rummens4,5, and Brenda TonerVA6

Abstract
Providing culturally appropriate mental health services to war-affected refugees residing in the West continues to pose many challenges. Gaining firsthand knowledge from the refugee communities themselves is crucial to improving our knowledge and guiding our interventions. The purpose of this study is to understand perceptions of war trauma in the Tamil diaspora. Fifty-one Sri Lankan Tamils living in the Greater Toronto Area, Canada, were interviewed. Transcripts were thematically analyzed using content analysis. Findings indicate that war trauma is not viewed by the diaspora as a pathological notion. Positioned within a moral context, and independent from isolated events of war, manifestations of war trauma were discussed at an interpersonal and collective level. Diagnostic categories, including post-traumatic stress disorder (PTSD), do not seem to fully capture the breadth of war trauma in this diaspora community. Implications for service delivery, and for incorporating the unique aspects of suffering resulting from a fragmented community, are discussed.

Keywords
war trauma, refugees, Tamil diaspora, PTSD, mental health interventions

Introduction
Although the notion of psychological trauma has been used as a broad concept to cover the aftermath of a variety of stressful events, responses to trauma may vary depending on exposure factors, and even the same war can have varying effects on veterans and civilians (Meichenbaum, 1994). The psychological impact of war has been shown to have a long-lasting impact on civilians (Brams & van der Ploeg, 1999). The effects of war and displacement in immigrants and refugees can translate into mental health issues (Miller et al., 2002; Miller & Rasmussen, 2017).

According to the United Nations High Commissioner for Refugees (UNHCR, 2007), there were 71,700 refugees resettled through humanitarian programs in 2006 in 15 resettlement countries, with the largest sponsors being the United States, Australia, and Canada. Refugees fleeing from war and conflict zones and arriving in the West are faced with the additional challenge of adapting to an unfamiliar culture and social system in their country of refuge and often experience various barriers to health care services. Differences in their understanding of mental health, expressions of distress, and coping behaviors that may be dissimilar from Western modes of thinking continue to be a major hurdle for mental health care providers who provide services for refugees affected by trauma and distress (Kanagaratnam et al., 2017; Kirmayer et al., 2011; Kleinman & Benson, 2006).

The use of psychological assessment tools in assessing refugee communities pose another major challenge (Kanagaratnam et al., 2017; Murray et al., 2010; Pain et al., 2014). Despite the more than two decade long acknowledgment of the limitations of conventional approaches to dealing with the psychological impact of war and displacement in immigrants and refugees, research continues to probe for diagnoses of trauma such as...
PTSD, using assessment tools that are developed and standardized in the West (e.g., Almedom & Summerfield, 2004; Bracken, 1998; Bracken, 2001; Kleinman, 1987; Pain et al., 2014).

The importance of incorporating the voices of refugee communities themselves has been pointed out as crucial to the field of refugee trauma (Silove et al., 2017). Except for some exceptions (e.g., Affleck et al., 2018; Knezevic & Olson, 2014; Pandalangat et al., 2013; Summerfield, 2003; Zur, 1996) psychology/psychiatry, in comparison to fields of public health, anthropology and sociology, generally lacks knowledge with reference to the lived experience of refugees.

Also, research in the field is seldom led by academics who belong to the ethnic groups that are subject to the studies (Crumlish & O’Rourke, 2010). This is obviously unfortunate, as the field would benefit from a broader approach, informed by knowledge derived from lived experiences of war which is naturally lacking in the contemporary Western context. As evidenced in other cases such as in Kashmiri people (Hanif & Ullah, 2018), internally displaced persons from Lebanon (Yamut & Chaaya, 2011), and Rwandans who lived through the genocide (Jansen et al., 2000), populations affected by armed conflict and war are affected as an entire society and perceive its impact both at an individual and collective level. A medical view on trauma, informed by PTSD, is narrow in its perspective, and is limited in its ability to incorporate the broader and more collective dimensions of lived experiences of war. As a means of coping with war trauma, Bosnian refugees were found to seek empathy and reciprocal help to regain a sense of belonging (Keyes & Kane, 2004). Somali refugee women were found to be bound by the cultural expectation that they suppress any expression of distress and be “strong” (Whittaker et al., 2005). The collective narrative of Liberian refugees appears to be based on spirituality; they were coping by adopting culturally sanctioned attitudes (Clarke & Borders, 2014). Manifestations of distress are thus shaped by different factors such as culture, religion, and gender.

Subjective interpretation is key to understanding how traumatic an event or issue is perceived. Such interpretations may differ depending on factors mentioned above, including different world views, and the social, political, and economic context of an individual or group. An example comes from the Quiche Mayan war widows from Guatemala and their response to war and atrocity, and the finding that they were more disturbed by the loss of livestock and other property than loss of kin (Zur, 1996). This form of expression should be understood by this community’s cultural sanctions on denoting grief publicly. As such, the public expressions, different from the private voicing of grief, may be more heavily shaped by discussions on the loss of livestock.

More recently, it has been noted that trust, humiliation, and betrayal in interpersonal relationships become more significant issues for refugees after the many encounters of trauma they face during war, flight, and resettlement (Lindert et al., 2016). Thus, in-depth knowledge of the unique challenges of refugee groups fleeing war is important when planning and implementing mental health interventions. While looking for commonalities among the different diaspora communities, it is also important to learn about each refugee community, as interventions targeting homogeneous groups have found to be more effective (Murray et al., 2010).

According to Gozdziak, to understand refugee trauma, one has to “learn from people [. . .] rather than study them” (Gozdziak, 2004, p. 207). This points to the importance of seeking to uncover the emic or internal perspectives and meanings of culturally different or distinct individuals and groups. Recognizing the inherent challenges and complexity involved in identifying mental health problems in a non-Western population, Kleinman (1988) recommends using qualitative methodology, and Hollifield et al. (2002) point specifically to methods such as in-depth interviews and focus groups rather than quantitative methods. Our study data were analyzed based on qualitative methodology which facilitates understanding people’s personal experiences, discovering the personal meanings of categories (Hare-Mustin & Marecek, 1997), and exploring associated variables when they have not previously been identified (Rossman & Marshall, 2006). The methodological emphasis is on understanding the social world from the point of view of participants, with theory derived from the data rather than preceding it (Cobb & Hagemaster, 1987; Crabtree & Miller, 1999).

As in many other diaspora communities, except for a few large-scale studies that identified psychological symptoms and barriers to health care (Beiser et al., 2003, 2011; Steel et al., 1999), we have little firsthand knowledge about the psychological impact war has had on the Tamil diaspora. This study aims to explore the concept of war trauma in the Sri Lankan Tamil diaspora in the Greater Toronto Area (GTA) of Canada and to understand the community’s views on the psychological impact the war in their home country has had on them. Canada is home to approximately 300,000 Sri Lankan Tamils, the largest Sri Lankan Tamil diaspora in the world (Amarasingam, 2013; Foster, 2007). The vast majority of them live in the GTA. As a result of more than two decades of civil war, many within this community have been exposed to traumatizing events, and have either directly or indirectly forced to leave their country of origin and resettle elsewhere. In Canada, they are faced with the simultaneous demands of adapting to a new environment and a very different culture while dealing with past war-related experiences.

By listening to the voices of the community members’ war-related distress and their perceptions and emotional responses to war, and examining the meaning given to manifestations of their distress and coping and their views on diagnosis and treatment, we sought in this study a more in-depth understanding of a displaced Tamil’s concept of “war trauma.”

Method

Upon study approval by the Research Ethics Board, study participants were recruited using a combination of purposive
and snow-ball sampling (Crookes & Davies, 1998; Grbich, 1999). Data collection started upon receiving both verbal and written consent, and was completed when we reached the saturation point: after interviewing 51 study participants, no new information or themes were emerging. Every attempt was made to achieve a gender balance and a representative age range of people who had fled or left Sri Lanka. Data gathered from the key informant interviews were analyzed for underlying themes and also used to inform the interview prompts for the subsequent focus groups and interviews with community members. The focus groups were conducted in settings where community members were already gathering for different purposes, such as community centers, English classes, and senior groups. This group setting was more culturally appropriate and community oriented and was found to be a comfortable space for participants to disclose and share their experiences. These focus groups served both to validate and help interpret the findings from the key informant interviews.

The interviews were conducted in Tamil. Some key informants conversed in both English and Tamil. A trained clinician (first author) conducted the interviews and was sensitive to minimizing the risk of re-traumatizing any participant. If a participant experienced any distress during the interview, the person had the option to stop the interview; we were also prepared to provide appropriate support including immediate referrals to mental health professionals as needed. The interview questions were developed keeping in mind how they would translate into conversational and comprehensible Tamil. Participants were queried about stressors and manifestations of distress resulting from the war, and their perceptions on mitigating and compromising factors associated with war trauma. Key informants who were health professionals/frontline workers were additionally questioned about their views on war trauma in the community, addressing war trauma, and the diagnostic concept of PTSD as it applies in their work.

Our questions were open-ended and functioned as prompts for the interviews. The key informants’ perspectives, knowledge, and experience on the subject matter helped to formulate and optimize questions for the focus group interviews. These group interviews had a threefold goal: to receive feedback regarding emerging themes identified in the individual interviews, to elicit additional information and insight, and to serve as a validity check. To fully capture participants’ experiences and expressions during these data collection sessions, all interviews were audio-taped, transcribed verbatim, and the text was subsequently translated into English for parallel analysis by the second author.

**Data Analysis**

Data collection was implemented using a staggered qualitative research design, which maximizes information gathering, permits ongoing reflective analysis, and ensures repeated cross-triangulation validity testing. A thematic analysis approach was used to study the data (Marks & Yardley, 2004). The transcriptions were coded independently by the first and second authors, and the developed coding templates were subsequently compared. All analytic codes were then clustered to emerging themes. The common themes and trends were then explored in greater depth using content analysis (Marks & Yardley, 2004). Validity was ascertained via questioning of multiple informants, repeated cross-triangulation, and comparative analyses across investigators and all participant groups.

The transcripts were jointly analyzed for content by carefully examining the interview transcripts in conjunction with detailed interviewer field-notes. The key informant interviews were undertaken first, and the transcripts analytically coded using the long-interview method (McCracken, 1988). Findings from these initial interviews also served to frame interview prompts for subsequent focus group interviews that were both exploratory and confirmatory in nature. These focus group transcripts were analytically coded to also consider the various views of individual participants as expressed throughout each group interview session. Findings from both types of interviews were merged to yield further data and compared to examine whether and how group dynamics affected responses. Detailed observational notes taken by the lead author immediately after each individual and group interview served to clarify individual contributions, meanings, or intents where needed and to record any group dynamics for consideration in the later analysis of the written interview transcripts. These notes also served to check for potential biases on part of the lead researcher.

Responses to the open-ended interview questions were carefully read, re-read, analyzed, coded manually, and reviewed. All qualitative transcript data were analyzed independently by two investigators (the first two authors) to identify common themes and trends. The latter were coded separately by both investigators and then jointly discussed and explored in greater depth to ensure reliability (see Kanagaratnam et al., 2012; Mays & Pope, 1995).

**Findings**

**Sample**

To uncover the meanings of exposure to war in the Tamil community, both from a service provider and a layperson perspective, in-depth, semi-structured interviews and focus groups were undertaken with members of the Tamil diaspora who had been exposed to political violence in Sri Lanka. Our study sample consisted of 51 refugees/immigrants (21 men and 30 women between 17 and 86 years of age) living in the GTA. We interviewed 13 key informants, followed by focus group interviews with 38 participants. Data were collected over a 1-year research period (2003/2004). Key informants in the community included psychiatrists/service providers.
and community members. All participants including the key informants had direct experiences of war, ranging from extensive personal and material loss to direct exposure to violence.

A thematic analysis of obtained data from our study participants revealed both collective and individual expressions of distress resulting from the war. Taking a pragmatic approach and community strength were identified as attenuating factors in regard to individual distress. Participants mentioned severity of exposure to war events, patriotism (defined as affection toward one’s people and homeland), settlement challenges, and repressed memories (this mentioned solely by service providers) as causal factors in their distress. Service providers noted that approaches to treating war trauma in the Tamil community are inadequate as they do not focus on the here and now, instead focusing on specific events that are considered traumatic by the service provider, taking a restricted perspective that does not capture the spectrum of distress in this community.

**Manifestations of Distress**

Participants spoke about how the Tamil diaspora community has been affected by the consequences of war and displacement. Their responses ranged from the heart or the mind being affected by trauma, to becoming mentally ill. When discussing the distress resulting from the war, both key informants and focus group participants expressed the manifestations at a collective and relational level.

**Collective manifestations.** The impact of exposure to war was typically experienced and expressed as a collective, and as presented below, included the sharing of collective memories and identity, collective numbness expressed as becoming “stone-hearted” and “thick-skinned,” and collective anger that was seen as leading to creative writing and artistic expression or to getting recruited to fight for the cause. The underlying commonality in these expressions were that participants voiced their distress collectively as “Tamils” and as resulting from belonging to a group—that is, Tamils as an ethnic group—rather than as individuals.

**Memories.** The feeling of having had a collective past and the pain and suffering from almost three decades of war in their country of origin was readily identified by almost all participants. The experiences, though agonizing, were also part of their painful reality which they cherished as being part of their identity and were not ready to let go of. A community member said the following: “for many of us, we do not want to forget (what happened) . . . it is like losing a part of ourselves.”

Analogous to the above, the experiences of war and displacement brought forth many collective memories that were of significance to the participants. These memories extended beyond the individual level and included a range of emotions, as shared below by a community member about her experience of evacuation:

It was such an experience, the evacuation. We walked and walked for 2 days. This Navakkuli Bridge. . . We had not slept. Such a suffering, so many people, goats, cows and the crowd. . . . We were crossing this bridge. It was only this broad, just planks of wood put together. It has been raining. And it was slippery. Below is this deep river. People were falling down, dying. We were telling each other to be careful. Taking step by step. . . Walking slowly. . . we were so many. We could not move. My mother had wheezing. She could not walk. I was carrying books. When you see what each and every one carries, one will bring goats. . . another will carry books. Each one has a story. . . then this akka (“sister” referring to a lady who was travelling with them) . . . she had a new-born baby. She was walking in front of me and was saying, I am going to drop the baby, and I am going to drop the baby. We were saying not to look down. She looked down, and then dropped the baby. The river washed the baby away! Coming to the other side of the bridge, it was such an experience. But then there were shell attacks on the other side. We finally came to Chavakachcheri. Then we did not have water. I remember when it rained we took water in our umbrellas and drank. The whole thing was like an epic. . .

The above quote illustrates the various elements embedded within collective suffering, the experience of unique but shared losses, the comradeship, and the resilience of people who have the strength to endure the destructive nature of war when together, in spite of the overwhelming circumstances that they are faced with. Despite the repugnant nature of the trauma, as a community, people strive to process, make sense of, and appear to find meaning in calamity (Davis et al., 1998). Collective trauma leads to the creation of a community narrative and identity, and by doing so may facilitate in constructing meaning by providing a sense of collective purpose, worth, and value (Hirschberger, 2018). As seen in the above excerpt, characteristics of these collective memories extend beyond the primary fear/anxiety paradigm that is emphasized in the medical model of understanding trauma.

**Numbness.** All community member respondents expressed at some point during the interviews about the plight of Tamils and the consequences of war, leading to collective numbness or a sense of apathy having become the norm of the whole community. This is reflected in the following quote by a community member:

It is as if we are alive. . . But dead; People. . . this life. . . Why are we born? . . . Born as Tamils. . . So much sorrow. . . No happiness. We are alive. We are eating. That’s all. Almost all Tamils here are alive, but dead.

The majority of participants explained how the community as a whole has in some way become “thick-skinned” or “stone-hearted” due to the prolonged exposure to loss, violence, devastation, and chaotic conditions that come with
more than two decades of political unrest and war. Many had horrendous experiences but indicated that they have learned to live with it.

Solomon and Mikulincer (2006) draw parallels between the collective and individual reactions to a history of trauma, indicating that collective manifestations are frequently similar in many respects to individual post-traumatic reactions. The above excerpt speaks to the helpless acceptance of a new normality, and emotional numbness at a collective level, which is one of the core criteria included in PTSD. Aside from the violence and loss, collective trauma is also a crisis of meaning (Hirschberger, 2018). The unbearable brutality of war and the resulting silencing and collective numbness of communities, such as among the Kashmiri people, is noted by Hanif and Ullah (2018).

Based on many years of involvement working with the Tamil community, this is the response from a psychiatrist illustrating this point:

Our people, from the 1958 ethnic riots (in Sri Lanka), have been slowly injected (with war experiences), gradually . . . whatever they got to eat, they ate, and they had become used to a life in which they were ready to evacuate their homes with short notice . . . they carry a small bag with medicines, food and a dress to change . . . they have become used to it. We cannot imagine this. Even after all these difficulties, they come to Canada, and life is still not easy here. So they just carry on.

Anger. Community members spoke about their anger toward the government and the military. Many spoke about the violence and loss that they have been witness to. Community members spoke about how an individual’s anger could transform into collective anger, an anger against the authorities and the government which oppresses Tamils as an ethnic group. Observations of resentment, anger, and distrust have been made in many other societies and communities living in conflict zones such as the Kashmiri people (Hanif & Ullah, 2018). The anger as identified by our study participants was reported as leading to a range of consequences, from constructive creative writing, to joining a Tamil rebel group to fight for the cause:

A girl who is raped, she will have the scar in her heart until her death . . . and she will be labeled by the community as the girl who has been raped . . . she will be perplexed, in fear, anger, losing her confidence, be suspicious. Rather than committing suicide . . . she may sacrifice her life to the cause.

In this example, at one level, the nature of the rape trauma and its response is purely individual, but at another level, given the time and political context, a sanctioned and even valued response by a community which magnifies sacrifice (Wadley, 1980). In a culture with clear expectations on gender roles (Kanagaratnam et al., 2012), war does not seem to override the requirements of how a “proper” Tamil woman should be.

Victim blaming is unfortunately common in many societies. Investigating about Tamil female rebels, Gowrinathan (2017) points to an environment of dual militarization, where women are oppressed both from the rebel group and state. As a raped woman in a country raging with war, her only solace is to regain the lost virtue among her people and raise herself to martyrdom by sacrificing herself to the cause. This is what Gowrinathan eloquently words as the rebel group becoming “. . . a militarized space within which women’s personal grievances found a politicized home (p. 335).” In war and conflict, women become the markers of collective boundaries, and a symbolic representation of their ethnic collectivities (Lentin, 1999). This positioning of women helps to understand how individual responses become embedded in the collective.

The double victimization and silencing is not unique to Tamil women who share many commonalities with women who suffered through what is termed as “the gendered wars” in countries such as Rwanda, Bosnia, Iraq, Algeria, and Kosovo (Lentin, 1999). Furthermore, the gender constructions and their influence in sanctioning expressions of distress in Tamil women is also observed in the Truth and Reconciliation Commission testimonies of South African women (Ross, 2003) and the narratives of Bosnian rape survivors (Močnik, 2019). Höglund (2019) comments on the gendered dimensions of the public Lessons Learned and Reconciliation Commission (LLRC) testimonies by Tamil women from the war-torn North and East of Sri Lanka. The author reflects on the trend in the majority of these testimonies that women’s experiences are told primarily in relation to the men in their lives, particularly husbands and sons. In spite of the plight of women in a brutal war, very few women addressed their own experiences of violence and displacement. Furthermore, these women, somewhat similar to the Mayan widows of Guatemala (Zur, 1996), expressed the economic insecurity in connection to the disappearance of their family members. These testimonies are seen as reaffirming the existing gender constructions in Sri Lanka, in which women define their suffering in relation to the loss of others. Generally, this also points to the societal expectations of what is acceptable to express in a public sphere versus in private sphere.

Individual/reational manifestations. The respondents, including most of the key informants, had distressing experiences of political violence in their home country that consisted of the death of family members, witnessing brutal killings, loss of their homes and livelihoods, and experiences of torture. They discussed the impact of war and displacement on individuals, emotional difficulties, and mental illness as possible consequences of the war and immigration. Expressions of distress resulting from exposure to political violence were seen as affecting the heart or the mind of community members. Community members used the words “heart” and “mind” interchangeably to explain how war-related distress
affects an individual and the community; for more serious conditions, they were inclined to also mention the “brain” as being impacted.

“Depressed” or weakness in heart or body. Many community members reported how people become depressed or weak due to war experiences such as material and personal loss:

Your mind is affected, it is when you have this frustration, like you are frozen, become weak, cannot talk . . . those who see their children being killed, cry and scream non-stop. You can identify them by their way of being, walking, clothing, expression. They will not dress well, will not eat good food, they will be quiet, will not talk about their problems.

Although the interviews were conducted in Tamil, many participants alluded to the English-language term “depressed” when referring to sadness or weakness of the heart/body. At the time of the study, there was no culturally equivalent commonly used indigenous wording for depression, hence the use of an English word.

Guilt. All participants spoke about the guilt of having left their home country, leaving behind family and friends and those in need, particularly recollecting events during war and evacuation. A community member expressed the following:

When evacuating at the time of bombing and shelling, you are on the move and people die on the way. We have to leave them and go on. We do not know even if we will survive. So these things will affect us. People have been injured. We have passed by people whom we knew were dead. The dead bodies . . .

Fear. Symptoms of both fear and anxiety were frequently mentioned when the participants recalled experiencing past events amid the war in Sri Lanka, and when thinking about their family back home:

If something happens to them there, you are affected; you feel “depressed,” sort of sick; you get scared, restless, as if your arms and legs have gone weak, get high blood pressure . . . it is as if something is pressing your head.

Some respondents expressed distress associated with past memories, and some of them recalled with humor how they reacted to the sound and sight of airplanes and police officers in their first years in Canada. Many participants spoke about their sense of relief after coming to Canada.

Post-traumatic stress symptoms. Key informants who were mental health professionals shared their views about PTSD as a diagnostic condition when talking about the impact the war has had on Tamils. One psychiatrist mentioned how symptoms of PTSD are ignored in the community, as people only spoke about this when asked and yet did not feel they needed treatment for these symptoms. He opined that post-traumatic symptoms were perceived by many in the community as falling within normal range of behavior, not indicating illness. He stated the following:

I was at a friend’s place on Canada Day. His elderly mother was there. When they started fireworks, she got so nervous; she just left the living room and went inside. She got reminded of the events back home. Such as boys shooting and dogs barking and stuff . . . there was no dogs barking, but she got a flashback I think. Then I told my friend, this is what is happening. But their mother or the family did not feel they needed help. It was like something funny for them.

Thus, intrusive symptoms and hyper-vigilance, among the core criteria in fulfilling a diagnosis of PTSD, were reportedly not perceived by the community as pathological symptoms to be concerned about. Likewise, none of the community members in our study spontaneously mentioned the core symptoms of PTSD as expressions of distress. Numbness was reported as being a collective manifestation, avoidance was not mentioned, and nightmares were not considered as something abnormal or as associated with emotional problems. This quote is from one of the community members:

We do not see nightmares as affecting us mentally. It comes and goes, but do not have a lasting impact . . . In Sri Lanka, you do not take these things (nightmares) seriously. But if you talk here about having nightmares, people will think that you are “depressed” or you have a problem and that you should see a psychiatrist.

Becoming “mental.” Community members’ responses indicated that one could become “mental,” meaning mentally ill, when frustration and grief escalates or is prolonged and affects the mind or the heart, as this can lead to the brain becoming affected. Confusion or distraction of the brain was viewed by some participants as the beginning of a continuum, developing into becoming a serious state, mentioned by many in English as “mental.” Becoming “mental” was frequently associated with the brain, which indicated serious psychopathology and abnormal behavior. This was expressed from a social context of interpersonal miscommunication rather than from an intra-personal perspective:

When we tell something to someone, if they do not understand and become angry, then it is a sign of mental illness; they throw, hit and do such things; some isolate and can be like “a dead man alive.”

There were also some responses pointing to serious mental health conditions in which mental health professionals gave examples of community members suffering from psychosis and having delusions or hallucinations with war content. The
illness was not always considered to be a direct result of war experiences, even if the content of these delusions or hallucinations often consisted, for example, of being followed by the Sinhalese [the ethnic majority in Sri Lanka] or by members of the Sri Lankan military:

They develop disorders such as Paranoia or Bipolar Disorder, and their symptoms are often coloured by war experiences . . . such as them being Sinhalese or being followed by the Government forces.

Strangling her baby to death . . . one woman did this. It is . . . I don’t know . . . may be postpartum depression . . . (It) could be leaving the family back home, she felt isolated here, I am not sure . . . After killing the baby . . . she said that the government forces came, so she had to kill the child.

Yet other mental health professionals preferred to associate conditions such as the above with less stigmatizing diagnoses—in their view—with PTSD, rather than with a psychotic disorder. They expressed their dissatisfaction about mainstream service providers who are not able to understand the impact of war on Tamils:

The mainstream mistakenly identifies the symptoms as psychotic, when it is in fact due to the war. Among our people, the hearing of voices and delusions are all associated with PTSD and not with schizophrenia. This results in wrong medication and wrong treatment.

Mitigating Factors

Explanations were given by the study participants in response to the attenuating factors that in their view prevent people from the worst consequences of war. Along with having a pragmatic view, key informants gave community strength as a factor that serves to mitigate the negative impacts of war.

Pragmatism. The community was viewed as having a pragmatic understanding of collective distress resulting from war. Many participants spoke about how emotional distress is seen as a norm when people have gone through traumatic events both at an individual and collective level. This phenomenon is likely linkable to being “stone-hearted” or “thick-skinned,” as mentioned elsewhere when participants spoke about the collective manifestations of war trauma in the Tamil community.

One key informant who worked with survivors of torture stated the following:

When you question them, mostly young men, about the torture they had gone through, they never mention about the daily interrogations, the military check points, the harassments; they only talk about the month-long arrests and imprisonment. So many things happened to them on a daily basis . . . just because they were Tamils. But they do not talk about these things as an issue. They talk about it as a matter of fact . . . When they get re-united with their families, they try to take it easy and move on. Just to go through the immigration, they have to disclose certain things, and they do. I see they shed tears when talking . . . They do not name it as sadness or depression. It is as if they want you to understand what they have gone through, and they want to get the necessary help. That is it. No one comes back requesting treatment.

Community strength. Participants spoke about close connections in the community in the form of family bonds, attachment, and affection as mitigating aspects, keeping community members resilient. This aspect of gaining strength from one’s own community is also documented in other refugee populations such as the Bosnian (Keyes & Kane, 2004) and Liberian populations (Clarke & Borders, 2014). A key informant shared her experience of working with newcomers who have been exposed to the war and explained,

Compared to many other war-affected communities, I see strength in many of our people. They have this will power. They want to move on. After all the struggles they have gone through, they want to re-establish themselves here because there are opportunities. And they have the support within the community, some far-relative or a friend. Nobody is left alone in our community.

Compromising Factors

In sharing their perspectives on factors that may make it harder for people to cope with war-related distress, study participants referred to the severity of war exposure as an issue that can exacerbate individual distress. This observation is consistent with findings in other refugee populations as well (Yamut & Chaaya, 2011).

Severity of exposure. War events like the destruction of one’s home, witnessing violence, having one’s children killed, and being raped were viewed as leading to people later on developing mental health conditions. However, such conditions were also considered as linked to the heart or mind being severely affected (not the brain) and was not always perceived as resulting in mental illness per se. The absence of such exposure was seen as associated less with psychological impact from the war.

The loss of one’s land and home appeared to be a cause of significant distress and was expressed by all participants. This is consistent with what has been referred as a “biological link” that Tamils have with their home and village (Uur) (Somasundaram & Sivayokan, 2000), which is so integrally intertwined with a Tamil’s identity and sense of belonging. Particularly, when experienced by elderly people, this was considered as having a severe impact on their mental well-being. Many participants spoke about returning to their villages after evacuations and seeing their houses destroyed resulted in many elderly collapsing at the sight. Although not considered by the community members as abnormal behavior,
but more as prolonged grief, they still termed the resulting emotional state upon losing one’s home or land, as becoming “mental”:

My grandfather . . . when the military took over, we moved to Vanni (another town in the North). So leaving all the land and the family, he was thinking a lot . . . became kind of withdrawn, had no interest in anything and got “mental.” He had to take tablets for his condition.

As mentioned above under collective manifestations and collectively funneled anger in women who are raped, the social ramifications of sexual assault, or even the slightest speculation that a woman might have been assaulted are profound, as illustrated in the following example by another community member:

I remember this girl who told me how the military had dragged her and locked her into a room in their house. They had mocked her and had shoved her with their guns but did not assault her sexually. However, no one, including her mother, believed that she was not raped.

The significance of exposure factors, such as the loss of one’s home and land, and the contextual framework within which sexualized violence against women is perceived were flagged by the participants as a key to understanding the emotional impact of war on a Tamil person’s mental well-being.

Patriotism. Suffering from the aftermath of war was considered a norm strongly associated with being patriotic. Being patriotic and having affection toward one’s people and homeland were considered as factors that would naturally be connected to distress in any Tamil. A community member stated the following:

You know. Some people they do not have this feeling. This attachment to their people, to the struggle . . . They complain, saying why these boys are fighting unnecessarily. They accuse them saying they had destroyed the peace in the country. You cannot count on these people. They are not patriotic you know. All they care is about their own children and family. That is life for them. They will not have any sorrow or impact. We have some people like that in our community.

Making connections between the interpersonal and social aspect of distress and mental illness, the expression above reflects the tendency in the community to link patriotism with war-related distress, which can also go to the extent of demeaning those who are outwardly seen as nonsufferers. This tendency was also observed during the focus group sessions where some participants voiced disagreement and anger at patriotic opinions from others, as they were interpreted as implicitly aligned with the militancy movements. Disagreement was also voiced at perceptions that some had not suffered as much as others, or had not contributed as much to “the cause” as others.

Settlement challenges. Stressors in Canada, particularly temporary status in Canada and threats of deportation, were seen as triggers to falling ill, whereas successful integration and having financial security were seen as mitigating factors when it came to mental illness. One community member said the following about his brother:

After all the things he had gone through back home, he seemed to be doing okay. But then his case (application for refugee status) was rejected and he started worrying. He was reminded about all the incidents in the past and he started becoming anxious about being sent back to Sri Lanka. Then we appealed and he was allowed to stay. But he never became the same. He continues to take medication. He isolates himself and is obsessed about his mouth odour.

Another key informant explained how the process of migration itself can overshadow the effects of war:

It is very difficult to separate out the effects of war on our people. Because to emerge oneself into the Western way of living, that process, it is like a big challenge! You have to locate yourself in this country, you have to find a way of living, and you have to find your identity. It is not at all easy. Your head will just go in circles. Particularly, for those who come in their 30’s and 40’s, it is so tough on them. They have to start from scratch, from earning a living to finding their culture and identity. Our culture has not found a way as yet to cope with this collectively. When even their existence is questionable. . .When you are hungry, you will not think about mental health, right.

A quote from one of the mental health professionals clearly illustrates how integrally the perception of success in Canada has been linked to better mental well-being:

So many affected by war experiences come to us; they come to get a report for immigration. But I will not say that their trauma haunts them. It is kind of temporary, and they overcome these things. When other things are successful here, they have the ability to overcome the impact of war.

Repressed memories. Some mental health professionals, however, expressed concern that despite normal functioning at the present time, issues may be repressed and people can suffer at a later time in life, if they do not deal with their past trauma:

You choose not to talk about certain things, to avoid all the issues. I think this happens in our community. You can talk about war. But you cannot talk about what the war did to you . . . Maybe living for others is easier than living for you. Then you can just go on . . . you get married. You have children. And then you say you live for them. You just bury your things deep inside. You cross that bridge. Maybe the right time has not come yet for
things to kind of explode. Then it comes out as a drinking problem and domestic violence.

Thus, participants who were in a service provider role alluded to the lingering of emotional difficulties and distress in the community, and pointing out that when this is not dealt with at the right time, it could lead to interpersonal difficulties later in life.

**Challenges in Treating War Trauma (as Expressed by Service Providers)**

*Event-focused* treatments. Participant responses related to their views on the emotional manifestations of war trauma in the community were primarily expressed in a relational/interpersonal and collective context, rather than at an intra-personal level. Key informants who were mental health professionals and service providers reflected this in their responses when discussing this aspect of manifestations of distress among Tamils exposed to war. They pointed to the possibility of Tamils not placing the same emphasis on war events that are considered as typically traumatic by the mainstream, such as incidents that provoke terror, anxiety, and helplessness. One of the key informants stated the following when he spoke about the impact of interpersonal issues resulting from war trauma in contrast to the impact of war events itself:

... and for our people, it is mostly not about the shelling, bombing, torture and blood ... the impact of displacement, the disappointments, the betrayals, being obliged to seek refuge in other people’s houses, getting help from unknown people (during evacuations) ... this is what concerns them.

As such, service providers alluded to the misfit of treatment approaches dealing with trauma that are primarily targeted toward helping individuals overcome the impact of specific traumatic events.

*Emphasis on the here-and-now.* According to service provider participants, the focus of treatment, if a member of the community seeks it at all, is not on working through past war-trauma:

I have heard about people going for counselling for depression or for issues related to domestic violence. But I have not heard about them going to get help to deal with issues related to war trauma. They want help for issues related to their life here.

Similarly, a key informant who works as a psychiatrist explained that the concerns of community members seeking help are often related to relocation and resettlement and not to war trauma per se:

The suicides we see here ... it is not as a result of PTSD, but due to other difficulties and depression ... when they come to Canada, they have so many concerns. They have paid the agents to come here and they have debts. They have to take care of their families back home ... so war trauma is just a small part of their lives.

Although service provider participants voiced their concerns about how people generally repressed their traumatic memories (not wanting to deal with them) and that such repression can lead to emotional difficulties in the long run, they did not always make connections to a potential relationship between war experiences and their current issues.

*Limitations of our framework.* Talking about limitations of conventional approaches in understanding the community’s distress resulting from the war, another service provider expressed the following:

This exile or displacement or whatever it is, the way we have been forced to come and depend on people who were in fact ruling us and oppressing us, from my point of view, this issue can never be captured adequately within the existing mental health framework. Because even we, who have experienced this, have not been able to digest all this ... The speed around us is such. So our experiences of flight, the guilt, the obligations, and the pain ... all this cannot be measured by mainstream tools. I am sure it helps the mainstream communities, but not us.

The above expressions point to the emphasis this community places on the impact of emotional distress on interpersonal functioning rather than on intra-personal distress, on the present rather than the past, and the interacting multiple layers in understanding the complexity of war trauma, including colonization, which all pose challenges to receiving adequate and efficient help within a mainstream context.

**Discussion**

Decades of ethnic tension between the Sinhalese majority and the Tamil minority in a post-colonial Sri Lanka—then Ceylon—erupted into a 26-year-long civil war, and its impact has resulted in both visible and invisible scars in the Tamil diaspora. The nature of the violence included torture, rape, bombing and unpredictable shelling, killing, missing people, roundup raids, arrests, explosion of mines, destruction of homes and villages, and violation of modesty. Such collective trauma does naturally result in both individual and collective manifestations of distress and is consistent with observations in other war-affected populations. The individual distress appears to be experienced and acknowledged in relational terms and is consistent with the social dimensions of mental well-being and illness in the Tamil community (Pandalangat et al., 2013), also observed in many collectivistic cultures.

Acculturation in this diaspora population seems to have led to a fusion of mental health concepts from the culture of origin with new terms and ideas increasingly integrated from the mainstream culture in response to social influences...
within the country of resettlement. As such, the original “idioms of distress” as expressed in this study appear to have been gradually replaced in the past two decades, by terminology that is more aligned with Western concepts of mental illness. Much is, however, unknown with regard to the long-term consequences of having to be “stone-hearted” or “thick-skinned” to cope with war trauma as indicated by our participants and what impact this has had on individuals, families, and the Tamil diaspora in the long run.

The service providers participating in this study reported that the Tamil community does not seek help for war trauma. Furthermore, they voiced their concerns that experiences from the war need to be processed, and if not, repressed memories may in the long-term return to haunt people. This finding is in fact consistent with what we see in clinical practice and confirms the issues raised by the service providers that repressed memories may in fact flare up to torment the mind. The paradoxical nature of collective trauma has been noted; with time, the construction of collective meaning is increasingly influenced by the experienced trauma. This is understood as a consequence of the collective memories shifting from the painful losses to lessons learned (Klar et al., 2013). As such, it is possible that the “stone hearts” and “thick skins” gradually cease to protect people from the atrocities of war.

The following case examples help illustrate these points. Some background data have been changed to preserve the anonymity of these individuals.

**Case Study 1**

Selvarajah is in his 70s. He lives with his wife and adult daughter. He arrived in Canada in 1997. In Sri Lanka, he had to stop attending school due to the war. He reported that as a child he witnessed the armed forces ordering his family members to line up. They were shot at and some of them died, including his father. Selvarajah saw a psychiatrist back home and was on medication for 3 years due to anxiety and poor sleep. But after coming to Canada, he was well and discontinued his medications. About 20 years after, he was referred to the clinic for an assessment and treatment due to emotional sequelae resulting from a motor vehicle accident. Selvarajah was diagnosed with a Major Depressive Disorder, Single episode, Severe; Anxiety Disorder Not Otherwise Specified; Pain Disorder Associated with Both Psychological Factors, and a General Medical Condition. Selvarajah reported being haunted by past experiences back home, which he stated were not bothering him at all as he was busy working and taking care of his family until the accident, including his daughter who had recently been diagnosed with Schizophrenia. He reported guilt related to not being able to save his family members from the armed forces and was convinced that if not for the accident and his inability to care for his daughter, she would not have been diagnosed with Schizophrenia. Selvarajah was, however, extremely reluctant to talk about the past trauma and due to severe depressive symptomatology was unable to engage in therapy. Although a sum was allocated for his psychological treatment when his claim settled, he discontinued the sessions.

**Case Study 2**

Mohan is a married man in his late 30s and was referred to the clinic by his lawyer due to him coping poorly following a motor vehicle accident. He came to Canada in 1999 at the age of 18 years and started working for his uncle to settle the debts his family had acquired to pay the agent who helped Mohan come to Canada. In Sri Lanka, he had lived away from his parents since the age of 12 years; due to the war, they were worried for his safety and had sent him to his grandmother in the capital city of Colombo. He was not able to continue school after Grade 8. Mohan said that he had forgotten his past, until he was asked questions about his childhood during the assessment. He explained having been happy, except for the war. Mohan lived close to a military base. When he was a child, he used to accompany his grandmother to the camp, and they would wait there for the whole day to see his uncle who was detained. He stated that he witnessed a lot at that time, and felt fear, but mentioned that he had managed well as a child. He also stated that he was apprehended by the armed forces for 3 months when he was around the age of 16 or 17 years. He explained that only now as an adult does he realize that he was abused by the army, emotionally, sexually, and physically. Mohan reported having marital problems after the accident, as he is not working and there is no money coming in, and having suicidal thoughts. He was also worried about his brother, an ex-combatant, who was detained in Europe and had developed mental health issues. He asked the assessor why he was depressed and how one gets into depression. He gave an unremarkable psychiatric history prior to the accident. He was as a result of the accident diagnosed with Major Depressive Disorder, Pain Disorder Associated with Both Psychological Factors & a General Medical Condition, and an Adjustment Disorder with Anxiety. Mohan was benefiting from psychological treatment but was not able to continue sessions after his claim settled.

**Case Study 3**

Kamala is a widow in her early 60s and was referred to the clinic for a psychological assessment to support her application to remain in Canada on humanitarian and compassionate grounds. She came to Canada in 2016 on a visitor visa and was facing deportation due to having overstayed in the country. Kamala explained that she was living with her daughter and her family and was verbally abused and neglected by them. As a result, she noted that she was unaware of the restrictions on her visa and had nobody to help, as she was not fluent in English and unfamiliar with the system. As a child,
she reported having lived in poverty and fear as her father was an alcoholic and would frequently beat her mother. Kamala mentioned that her spouse was a very kind man who took good care of her, and crying, stated that he was shot by strangers right in front of her eyes; this was most likely the military, who came in search of their sons. Left alone as her sons were missing, Kamala said she would spend most of her time looking for them in the military camps, which led to her being detained twice. She was physically assaulted during the detention and stated crying that they “behaved with her as if she was family.” When queried further, Kamala explained that a community worker told her that she had been “sexually assaulted” by the army. She never disclosed this to anyone, including her family. She stated that people here laugh at her when they hear that she is terrified of the police. Crying, she stated that others do not know what she went through, and she cannot talk to anyone about her experience. She said her children would now know about the sexual assault as they have read her story when it was given to her legal representative. Kamala reported suicidal thoughts but mentioned that it is not good to kill herself, as her spouse too was killed. She was diagnosed with a Major Depressive Disorder, Single Episode and Moderate and an Unspecified Trauma- and Stressor-Related Disorder. She had never received any professional help to deal with her trauma and did not request psychological services beyond the assessment report as documentation for her appeal with the Immigration and Refugee Board.

Case Study 4

Radha is a single female in her late 20s who came to Canada with the help of an agent in 2015. She reported a past with multiple trauma; her father was killed in the war and she had to be separated from her mother who was raped by the armed forces. Radha spent most of her young life from as early as age 5 separated from her family, and to date has no contact with any of them. The only person who was close to her and living with her for a period of time was one of her brothers, who also went missing. Radha managed to survive with the support of her church, but was a victim of repeated sexual assaults including a gang rape perpetrated by armed forces. With the support of an aunt who lives in Canada, Radha managed to leave Sri Lanka. Her legal representative referred her for a psychological assessment to document her emotional difficulties if she were to be deported back to Sri Lanka. Radha reported having not sought professional help to heal from the trauma and stated that placing trust on others, including health professionals, has been a major challenge. Radha said all she wants in her life is to “forget her old pain.” When people get close to her, she feels they are out to harm her. It takes her to the past and she feels helpless. Crying, she said that she knows people have issues, but she asks herself why so many negative things happen to her. She said she hates herself when these thoughts come up and questions why she does not have anybody. She works temporarily at a factory and said having her aunt in Canada was a great support. She was diagnosed with post-traumatic stress disorder (PTSD) with symptoms of dissociation and a Major Depressive Disorder, Single Episode, Moderate.

As seen, the above individuals did not initiate treatment to address their emotional difficulties, consistent with the expressions of our study participants such as “carrying on” or “learning to live with it” and were in fact pressured to access mental health services recommended by their legal representatives. A qualitative investigation on Sudanese refugees in Australia similarly reported that the participants stated having no need to receive treatment for war related distress which was seen as a normal part of their lives (Savic et al., 2016). The primary motivation of Selvarajah, Mohan, Kamala, and Radha in accessing services was not to process their traumatic memories, but to resolve issues related to their status in Canada or follow through their insurance claims associated with the accidents. Other studies completed with Tamil participants at different points indicate the same, noting that individuals, regardless of significant distress resulting from having been a child soldier (Kanagaratnam et al., 2005) or a victim of domestic violence (Kanagaratnam et al., 2012), were not inclined toward or actively seeking mental health treatment.

The reluctance among the Tamil diaspora in receiving care to heal the scars of war could probably be understood within the broader context of a culture that emphasizes sacrifice rather than self-promotion (Kanagaratnam et al., 2005; Wadley, 1980) and views mental health as broader than the absence of mental illness. War trauma is not viewed by the diaspora as a pathological notion, and the war is seen by many as a struggle for the betterment of Tamils which gives it meaning and makes suffering associated with the consequences of it as something inevitable. Suffering is therefore seen as normal and as morally boosting the sufferer, even to the extent of demeaning those who do not appear to be suffering.

Moreover, as highlighted in the introduction, expressions of distress depend on what communities consider as significant and culturally acceptable (Zur, 1996). For a Tamil, the significance of the loss of one’s home in comparison to experiences of direct violence should be understood based on the fact that the home and the village (Uur) symbolize self-identity, security, and peace (Somasundaram & Sivayokan, 2000), and is also probably a more accepted mode of communicating distress. Correspondingly, the social repercussions of rape should be understood within the Tamil cultural context, where a woman’s morality is scripted as equivalent to her (perceived) sexual behavior (Tambiah, 2005). Whereas the research in the area of mental health treatment with refugee populations clearly identifies the lack of culturally informed interventions, and other barriers to receiving treatments, the sociocultural context of a refugee and the community expectations of what is permissible and acceptable in regard to expressions of emotional suffering needs to be understood.
A Fragmented Community

In the face of ongoing marginalization of Tamils in their post-war home country subsequent to “losing” the war or the struggle for the cause in 2009, the need to preserve the collective narrative and hold on to the collective memory is likely seen as important. This yearning for an acknowledgment of collective suffering is probably typical for communities like the Tamil diaspora that are not seen as “legitimate” victims by the mainstream, and rather as “terrorists” (https://www.theguardian.com/world/2010/sep/07/canada-tamil-refugees-racism-debate). This phenomenon is observed in our findings, and in the expressed urge of service providers for the mainstream to understand the community’s mental illness from a broader perspective, namely as a community that has unrightfully suffered for the cause.

However, in addressing the power of the presence of collective memories in shaping and reconstructing the past to reweave community connections, Hirschberger (2018) does question the assumption of a monolithic relationship between trauma, memory, and meaning. Drawing examples from the Holocaust and other war-affected societies, he points to the varied impact collective memories can have on people, depending on the experiences that color these memories. This is indeed applicable in the Tamil diaspora as well and is consistent with our findings.

The violent strife between the different rebel groups in the name of fighting for the cause, or the “Internecine Fratricide,” as labeled by Somasundaram (1998) in his book on the psychological impact of war on the Tamils in Sri Lanka was the seed to a fragmented Tamil society and led to a transformation from fear, terror, and tension of warfare to feelings of “disillusionment, demoralization, despair and apathy (p. 147).” He notes that the internal conflict led to a deeper psychological impact on Tamils than the war with the Sri Lankan state. The fragments seem to have never been put together and continue to divide the community, arguably more significantly in diasporas where the past becomes more static and frozen in time. There is an induction of guilt and endorsement of righteousness in the diaspora as to who should suffer and many are probably silent and silenced with their stories. Thus, collective memories are not serving the same purpose for its community members.

Applicability of PTSD

Our study findings support and extend previous research that did not find PTSD to be culturally relevant or sufficient enough in explaining war trauma in this community (Somasundaram, 1998; Somasundaram & Sivayokan, 1994). Referring to his own experience working as a psychiatrist with the Tamil population in war-torn Sri Lanka, Somasundaram found the symptoms presented by many did not fit into the fixed psychiatric classification system that had formed the core of his own professional training. He stated,

At times, [well-established clinical methods and treating along accepted lines] was the only stable bearing, a resort to familiar, comfortable terms in the face of uncertainty, powerlessness, impotence and fear created by the horrendous tales of the victims of war. (Somasundaram, 1998, p. 176)

In our study, the emphasis on exposure to traumatic events and the associated core symptoms of PTSD including intrusions, hyper-arousal, and avoidance specific to these events were not seen as prominent components of war trauma among Tamils. Similar findings were noted by Affleck et al. (2018) in a recent study of Tamil men in Canada. They found that Tamil men experienced direct exposure to war events as less traumatic than situations in which they could not protect their loved ones from suffering. The emphasis this community places on the relational aspect rather than the intra-personal aspect of mental well-being is in line with what scholars have identified in many non-Western cultures (Kakar, 1982) and is in principle discrepant with treatment approaches for PTSD.

After all, it seems that even within the well-established realm of PTSD and military trauma in the West, from which the need for a diagnosis of PTSD arose, those who suffer from the consequences of combat trauma as militants may not find themselves fully understood by this framework. This is fittingly voiced by Myke Cole, a veteran who was deployed in Iraq:

What I see are people embracing a definition that explains PTSD using the vocabulary of classical pathology. It implies that, like a disease, you can prescribe a course of treatment and fix it . . . Because PTSD isn’t a disease, it’s a world view. (Cole, 2013)

Implications for Health Promotion and Prevention

Our findings are consistent with research in this field, indicating that individual exposure to trauma cannot fully explain mental reactions in war-affected populations (Yamat & Chaaya, 2011). That the community’s perception of war is as collective trauma and a normal response to calamity, collective spaces may help to contain the trauma of individuals, where their distress is validated and incorporated at a collective level. Speaking about rape survivors in the former Yugoslavia, Močnik (2019) suggests creating spaces to listen and acknowledge the “broken silences” of the women, and Lentin (1999) writes about how these spaces should close the memory gap between the trauma of rape and its available expressions/discourses. According to Močnik, collective approaches are more functional in facilitating healing as they can acknowledge and incorporate the diversity of victimhood.

Given the value Tamils place on home and land, the flourishing of village-based (Uurr) community organizations in the Tamil diaspora is not surprising and could be utilized to promote mental health in the community. Creating collective spaces for refugee communities fleeing war, as early on as possible, could function as a preventive measure and also facilitate healing at an individual/relational level. One has to, however, acknowledge the challenges in creating spaces for people who have perhaps never verbalized their experiences...
due to the political frictions, or for women like Kamala and Radha, the gender-based oppression in the diaspora. In mentioning what women experienced during the partition of India, Butalia (2018) notes the following:

Even if the women wanted to remember, what would they remember? With whom would they remember? In order to be meaningful, memories have to be shared but if you are alone, if that memory is shameful, if there is no one to allow it as legitimate, how do you remember? . . . how would you struggle even to find a vocabulary that could adequately capture that pain and violation, if articulating the memory will not lead to any healing, any route to justice? (p. 267).

The moral aspect of the conceptualization of war among the Tamil diaspora is interesting when seen within the context of Summerfield’s criticism of our “politically and morally neutral” professional approaches to war and violence (Summerfield, 2003, p. 267). It seems that there could be a mismatch between the needs of refugee communities wanting to be acknowledged and appreciated for their suffering and endurance through injustice and oppression and our professional approach to their distress that is restricted to the psychological realm. Looking back at the Canadian government’s initiative in welcoming the Syrian refugees (Government of Canada, Immigration and Citizenship, 2017), the effort put forth by the government probably had a healing effect on this community, as they likely felt acknowledged and respected by the receiving country. Such an approach should become part of the process in welcoming other refugee groups as well, as it sets the stage for a positive start and a space for healing to begin.

The impact of acculturation on the well-being and in the understanding of mental illness among diaspora communities requires both attention and careful reflection, as attempts to create awareness based on a Western mental health model could result in an undermining or abandonment of natural coping mechanisms (Kanagaratnam et al., 2012; Miller, 1999).

**Limitations of Our Study**

This study provides a rare exploration into a diaspora community’s perceptions of war and trauma, an opportunity to learn from a refugee community itself that can inform our policies and practices in prevention and promotion of refugee mental health. However, based on our findings, the trajectory from war exposure to mental illness in the Tamil diaspora seems unclear, and its direction appears to be incidental. This needs to be explored further.

**Next Steps**

Future research should investigate the lingering relational manifestations of distress in this community as a result of the war, not surprising given that the war resulted in loss of education and led to the early separation of many young boys from their parents, leading to sexualized abuse and other forms of trauma, and unique challenges to girls and women. An aspect of this was uncovered recently in another study on war and its impact on masculinity among Tamil men in Canada (Affleck et al., 2018).

Our study design should be replicated to include refugees’ voices and understand war trauma in every newcomer refugee community and could be a starting point toward informing larger scale studies and interventions that acknowledge, treat, and promote mental health. In doing so, one should take into consideration the stage of acculturation of the respective refugee community and how collective memories are shaped and constructed from generation to generation (Hirschberger, 2018). Interventions should take into account the community dimensions (Hollifield et al., 2002; Yamut & Chaaya, 2011) and the social, cultural, and political considerations particular to each context (Summerfield, 2003).

More research is needed to better understand the effects of civilian trauma among immigrants and refugees both in Canada and worldwide. This will aid in exploring the uniqueness and commonalities of war trauma in diaspora communities and extend our findings in understanding how war trauma in diaspora communities could possibly be a different phenomenon from military trauma and civilian trauma of people who continue to live in conflict zones. The long-term goal of research in this field should provide a solid basis of data for developing evidence-based preventive and treatment approaches to addressing mental health problems across the displaced culturally diverse populations, which are informed by the refugee communities themselves.

**Acknowledgments**

This research was conducted during an International Research Fellowship in Canada, as part of the first author’s doctoral program completed and defended at the Department of Psychosocial Sciences, Faculty of Psychology, University of Bergen, Norway.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

**Human and Animal Welfare Statements**

No humans or animals were harmed during this research study.

**ORCID ID**

Pushpa Kanagaratnam https://orcid.org/0000-0001-5346-0789

**References**

Affleck, W., Thamotharampillai, U., Jeyakumar, J., & Whitley, R. (2018). “If one does not fulfil his duties, he must not be a Man”: Masculinity, mental health and resilience amongst Sri Lankan Tamil refugee men in Canada. *Culture, Medicine and Science*, **13**.
Almedom, A., & Summerfield, D. (2004). Mental well-being in settings of complex emergency: An overview. *Journal of Biosocial Science*, 36, 381–388.

Amarasingam, A. (2013). *A history of Tamil diaspora politics in Canada: Organizational dynamics and negotiated order*, 1978-2013. International Centre for Ethnic Studies.

Beiser, M., Simich, L., & Pandalangat, N. (2003). Community in distress: Mental health needs and help-seeking in the Tamil community in Toronto. *International Migration*, 41(5), 233–245.

Beiser, M., Simich, L., Pandalangat, N., Nowakowski, M., & Tian, F. (2011). Stresses of passage, balms of resettlement, and post-traumatic stress disorder among Sri Lankan Tamils in Canada. *The Canadian Journal of Psychiatry*, 56(6), 333–340.

Bracken, P. (1998). *Hidden agendas: Deconstructing posttraumatic stress disorder*. In P. Bracken & C. Petty (Eds.), *Rethinking the trauma of war* (pp. 38–59). Free Association Books.

Bracken, P. (2001). Post-modernity and post-traumatic stress disorder. *Social Science and Medicine*, 53, 733–743.

Bramsen, I., & van der Ploeg, H. (1999). *Fifty years later: The long term psychological adjustment of ageing World War II survivors*. *Acta Psychiatrica Scandinavica*, 100, 350–358.

Butalia, U. (2018). Looking back on partition. *Contemporary South Asia*, 26, 263–269.

Clarke, L. K., & Borders, L. D. (2014). “You got to apply seriousness”: A phenomenological inquiry of Liberian refugees’ coping. *Journal of Counselling & Development, 92*(3), 294–303.

Cobb, A. K., & Hagemaster, J. N. (1987). Ten criteria for evaluating qualitative research proposals. *The Journal of Nursing Education*, 26(4), 138–143.

Cole, M. (2013, March 18). *What PTSD is?* http://mykecole.com/what-ptsd-is/

Crabtree, B. F., & Miller, W. L. (1999). *Doing qualitative research* (2nd ed.). SAGE.

Crookes, P. A., & Davies, S. (Eds.). (1998). *Research into practice: Essential skills for reading and applying research*. Ballière Tindall, in association with the RCN.

Crumlish, N., & O’Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder in refugees and asylum seekers. *The Journal of Nervous and Mental Disease*, 198(4), 237–251.

Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefiting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology*, 75, 561–574. https://doi.org/10.1037/0022-3514.75.2.561

Foster, C. (2007). *Tamils: Population in Canada*. Diversity Watch, Ryerson University School of Journalism.

Government of Canada. (2017). #WelcomeRefugees: Canada resettled Syrian refugee [Press release]. https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees.html

Gowrinathan, N. (2017). The committed female fighter: The political identities of Tamil women in the Liberation Tigers of Tamil Eelam. *International Feminist Journal of Politics*, 19(3), 327–341.

Gozdziak, E. M. (2004). Training refugee mental health providers: Ethnography as a bridge to multicultural practice. *Human Organization*, 63(2), 203–210.

Grbic, C. (1999). *Qualitative research in health: An introduction*. SAGE.

Hanif, S., & Ullah, I. (2018). *War trauma, collective memory, and cultural productions in conflict zones: Kashmir in focus*. SAGE Open. https://doi.org/10.1177/215824018800912

Hare-Mustin, R., & Marecek, J. (1997). Clinical and abnormal psychology: The politics of madness. In D. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introductory handbook* (pp. 104–120). SAGE.

Hirschberger, G. (2018). Collective trauma and the social construction of meaning. *Frontiers in Psychology*, 9, Article 1441. https://doi.org/10.3389/fpsyg.2018.01441

Höglund, K. (2019). Testimony under threat: Women’s voices and the pursuit of justice in post-war Sri Lanka. *Human Rights Review*, 20, 361–382.

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., & Westermeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *The Journal of the American Medical Association*, 288(5), 611–621.

Jansen, S., White, R., Hogwood, J., Jansen, A., Gishomal, D., Mukamanal, D., & Richters, A. (2000). The “treatment gap” in global mental health reconsidered: Sociotherapy for collective trauma in Rwanda. *European Journal of Psychotraumatology*, 6(1), Article 28706. https://doi.org/10.3402/epjt.v6.28706

Kakar, S. (1982). *Shamans, mystics and doctors*. Knopf.

Kanagaratnam, P., Mason, R., Hyman, I., Manuel, L., Berman, H., & Toner, B. (2012). Burden of womanhood: Tamil women’s perceptions of coping with intimate partner violence. *Journal of Family Violence*, 27(7), 647–658.

Kanagaratnam, P., Pain, C., McKenzie, K., Ratnamalingam, N., & Toner, B. (2017). Recommendations for Canadian mental health practitioners working with war-exposed immigrants and refugees. *Canadian Journal of Community Mental Health, 36*(Special Issue), 107–119. https://doi.org/10.7870/cjcmh-2017-010

Kanagaratnam, P., Raundalen, M., & Asbjornsen, A. (2005). Ideological commitment and posttraumatic stress in former Tamil child soldiers. *Scandinavian Journal of Psychology*, 46, 511–520.

Keyes, E. F., & Kane, C. F. (2004). Belonging and adapting: Mental health of Bosnian refugees living in the United States. *Issues in Mental Health Nursing*, 25, 809–831. https://doi.org/10.1080/01612840490506392

Kirmayer, L., Narasiah, L., Munoz, M., Rashid, M., Ryder, A., Guzder, J., . . . Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach to the patient in primary care. *Canadian Medical Association Journal*, 183(12), 1–9. https://doi.org/10.1503/cmaj.090292

Klar, Y., Sehori-Eyal, N., & Klar, Y. (2013). The “Never Again” state of Israel: The emergence of the Holocaust as a core feature of Israeli identity and its four incongruent voices. *Journal of Social Issues*, 69, 125–143. https://doi.org/10.1111/josi.12007

Kleinman, A. (1987). Culture and clinical reality: Commentary on culture-bound syndromes and international disease classifications. *Culture, Medicine and Psychiatry*, 11, 49–52.

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. Free Press.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLOS
Knezevic, B., & Olson, S. (2014). Counselling people displaced by war: Experiences of refugees from the Former Yugoslavia. The Professional Counsellor, 4(4), 316–331.

Lentin, R. (1999). The rape of the nation: Women narrativising genocide. Sociological Research Online, 4(2). http://www.socresonline.org.uk/4/2/lentin.html

Lindert, J., Carta, M. G., Schafer, I., & Mollica, R. F. (2016). Refugees mental health—A public mental health challenge. European Journal of Public Health, 26(3), 374–375.

Marks, D. F., & Yardley, L. (Eds.) (2004). Research methods for clinical and health psychology. SAGE.

Mays, N., & Pope, C. (1995). Rigour and qualitative research. British Medical Journal, 311, 109–112.

McCracken, G. (1988). The long interview. University of Guelph, SAGE.

Meichenbaum, D. (1994). A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder (PTSD). Institute Press.

Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. Journal of Contemporary Psychotherapy, 29(4), 283–306.

Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: An ecological model of refugee distress. Epidemiology and Psychiatric Sciences, 26(2), 129–138.

Miller, K. E., Worthington, G. J., Muzurovic, J., Tipping, S., & Goldman, A. (2002). Bosnian refugees and the stressors of exile; A narrative study. American Journal of Orthopsychiatry, 72, 341–354. https://doi.org/10.1037/0002-9432.72.3.341

Močnik, N. (2019). Collective victimhood of individual survivors: Reflecting the uses and impacts of two academic narratives two decades after the war-rapes in Bosnia-Herzegovina. East European Politics, 35(4), 457–473. https://doi.org/10.1080/10627790.2019.1676739

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. American Journal of Orthopsychiatry, 80(4), 576–585.

Pain, C., Kanagaratnam, P., & Payne, D. (2014). The debate about trauma and psychosocial treatment for refugees. In L. Simich & L. Andermann (Eds.), Refugee and resilience: Promoting resilience and mental health among resettled refugees and forced migrants (pp. 51–60). P. Li & B. Abu-Laban, (Series Ed.), International Perspectives on Migration, Springer.

Pandalangat, N., Rumens, J. A., Williams, C., & Seeman, M. V. (2013). The social dimensions of health and illness in the Tamil diaspora—Implications for mental health service delivery. Journal of Preventive Medicine, 1(3), 36–42.

Ross, F. C. (2003). Bearing witness: Women and the truth and reconciliation commission in South Africa. Pluto Press.

Rossman, G., & Marshall, C. (2006). Designing qualitative research (4th ed.). SAGE.

Savic, M., Chur-Hansen Mahmoud, M. A., & Moore, V. M. (2016). ‘We don’t have to go and see a special person to solve this problem’: Trauma, mental health beliefs and processes for addressing “mental health issues” among Sudanese refugees in Australia. International Journal of Social Psychiatry, 62(1), 76–83.

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. World Psychiatry, 16, 130–139.

Solomon, Z., & Mikulincer, M. (2006). Trajectories of PTSD: A 20-year longitudinal study. The American Journal of Psychiatry, 163, 659–666. https://doi.org/10.1176/ajp.2006.163.4.659

Somasundaram, D. (1998). Scarred minds: The psychological impact of war on Sri Lankan Tamils. SAGE.

Somasundaram, D., & Sivayokan, S. (1994). War trauma in a civilian population. British Journal of Psychiatry, 165, 524–527.

Somasundaram, D., & Sivayokan, S. (Eds.). (2000). Mental health in the Tamil community. Transcultural Psychosocial Organization.

Steel, Z., Silove, D. D., Bird, K., McGorry, P., & Mohan, P. (1999). Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants. Journal of Traumatic Stress, 12(3), 421–435.

Summerfield, D. (2003). War, exile, moral knowledge and the limits of psychiatric understanding: A clinical case study of a Bosnian refugee in London. International Journal of Social Psychiatry, 49(4), 264–268.

Tambiah, Y. (2005). Turncoat bodies: Sexuality and sex work under militarization in Sri Lanka. Gender and Society, 19(2), 243–261.

United Nations High Commissioner for Refugees. (2007). 2006 global trends: Refugees, asylum-seekers, returnees, internally displaced and stateless persons. Division of Operational Services, Field Information and Coordination Support Section.

Wadley, S. S. (1980). The paradoxical powers of Tamil women. In S. Wadley (Ed.), The powers of Tamil women (pp. 153–170). Manohar.

Whitaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An exploration of psychological well-being with young Somali refugee and asylum-seeker women. Clinical Child Psychology and Psychiatry, 10, 177–196. https://doi.org/10.1037/0002-9432.72.3.341

Yamut, R., & Chaaya, M. (2011). Individual and collective determinants of mental health during wartime. A survey of displaced populations amidst the July-August 2006 war in Lebanon. Global Public Health, 6(4), 354–370.

Zur, J. (1996). From PTSD to voices in context: From an “Experience-Far” to an “Experience-Near”: Understanding of responses to war and atrocity across cultures. International Journal of Social Psychiatry, 42(4), 305–317.