Coping with Experiences of War in Sri Lanka: Perspectives from Tamil Immigrants Living in the UK

A.S. Dharmaindra

A thesis submitted for the degree of Doctorate in Clinical Psychology

Department of Health and Human Sciences

University of Essex

Date of Submission June 2016

Acknowledgements

Firstly I would like to thank all of the people who committed to participating in my research, without you this study would not have been possible. I was really humbled by your willingness to share your stories with me and I was deeply moved by them. I have learnt so much through your experiences and your resilience and I am grateful to you all.

I would like to extend my thanks to my thesis supervisors Dr Danny Taggart and Dr Frances Blumenfeld. You have offered invaluable guidance and advice over the past three years and have played a vital role in the completion of this thesis. Your faith in me has really been appreciated.

Lastly I would like to thank my family, friends and in particular Raheel for keeping me motivated and believing in me. Your continued support has kept me going through my thesis and my Doctoral training and I could not have done it without you.

I would like to dedicate my thesis to all the Tamil victims of war both in the UK and further afield. Most of us will never comprehend what you have lived through and how in spite of all your struggles, you keep going. This is for you.

Contents

List of Tables and Figures

Abstract

Sri Lanka was involved in war for nearly three decades, which has had a profound effect on the Tamil community. The number of Tamil people living in the UK continues to grow, yet the mental health needs of Tamil immigrants and their coping behaviours remain poorly understood. Understanding the needs of war-affected communities seems particularly important given the current migrant crisis and potentially high levels of unmet mental health need.

This study aimed to understand how Tamils living in the UK have coped with their experiences of war, exploring coping both in Sri Lanka and the UK.

A total of 10 participants with experience of war in Sri Lanka were recruited from a variety of Tamil community organisations across London. Snowball sampling was also utilised given participants came from a hidden population. Semi-structured interviews were conducted and a critical realist perspective was adopted during the research process. Data was analysed using thematic analysis with the assistance of MAXQDA software.

Results identified six key themes: survival at all costs, the power of the mind, with the help of others you survive, the value in talking, improving life for yourself and others and searching for a different life in the UK. Within these themes, 16 sub-themes were identified.

The findings suggest that Tamils in the UK utilise a range of individual, spiritual, and social coping strategies. Coping strategies differed between Sri Lanka and the UK and the findings suggest limited use of professional help-seeking. The findings highlight the particular importance placed on collective coping within this community through resource accumulation and membership to Tamil community organisations. For many Tamils their personal struggles increased their desire to contribute to their host country and country of origin through education and work.

Given coping is largely facilitated through social support, community interventions should focus on increasing social capital and promoting coping strategies at both an individual and group level.

Chapter 1 Introduction

This thesis explores the experiences of coping amongst Sri Lankan Tamil survivors of civil war and political conflict. This chapter is organised into three sections. The first section provides an overview of public mental health promotion and presents literature on mental health in black and minority ethnic (BME) communities. It considers coping and help-seeking behaviours within these communities, provides an overview of current policy and explores theoretical perspectives from critical, cross-cultural and clinical psychology. The second section considers the impact of war and conflict, conceptual models of trauma and the socio-political context in Sri-Lanka. The third section provides an overview of help-seeking and coping in the Tamil community. It summarises a systematic review of the research on coping within the Tamil community and considers the impact of war on coping behaviour. It also provides a rationale for the research study and outlines its aims.

Section One

Public Mental Health Promotion

In recent years public health has been given more consideration given its potential benefits to society and its value in terms of cost-saving (Royal College of Psychiatrists, 2010). The idea behind public mental health strategies is that universal interventions are applied to entire groups, communities and populations rather than restricted to those with mental health problems. By not restricting interventions to those with a diagnosis it ensures that the health risks for the rest of the population can also be addressed and minimised (Bhui, 2013). Public mental health strategies to date have tackled violence and abuse in early life and gender-based violence (Royal College of Psychiatrists, 2010). Public health promotion is essential as research has shown that social and economic inequality is a major determinant of mental illness and the greater the level of inequality, the worse the health outcomes (Sainsbury Centre for Mental Health, 2007). Public health approaches highlight and can address social, educational and employment factors linked to poorer health.

The impact of mental health on socio-economic outcomes has been recognised at a political level, an example is the government's 'National Wellbeing Programme' (Office for National Statistics, 2010). The Conservative manifesto and former coalition government budget pledged to develop a broad range of indicators of well-being and sustainability which

encapsulates the social value of action. Furthermore it has been recommended that strategies are developed to manage sub-threshold symptoms of anxiety and depression which do not meet current ICD-10 diagnostic criteria but cause impairment to functioning (Rai, Skapinakis, Wiles, Lewis & Araya, 2010; van Os, Linscot, Myin-Germeys, Delespaul & Krabbendam, 2009). It has been argued that intervention at the sub-threshold symptom level can reduce future disability and generate societal savings.

In terms of health inequality, public mental health promotion strategies aimed at the population level should not remove or prevent action from services in mental health care at a professional level, as inequalities still exist within mental health care (Bhui, 2013). Targeted interventions are often aimed at the most socially excluded groups who experience the highest level of health inequality, such as children in care, those who are unemployed or homeless, those with addictions, or intellectual disability, and other groups subject to discrimination, stigma, or social exclusion (Royal College of Psychiatrists, 2010).

Current UK Context

According to the most recent National Census (Office for National Statistics, 2011), the number of individuals from non-White British communities living in the UK was 11 million, approximately 20% of the population. However, this may not be accurate as it does not take into consideration the growing refugee and immigrant population which is expanding due to international conflict, climate change, and socioeconomic instability. It was estimated at the end of 2010 that 43.7 million people worldwide were forcibly displaced by war and political conflict (United Nations High Commissioner for Refugees, 2011a). An estimated 126,000 refugees now live in the UK which makes up 0.19% of the total population (British Red Cross, 2016). According to the British Red Cross, the majority of refugees are from Syria and Afghanistan and have fled due to war, conflict, and disaster.

Most individuals from ethnic minority groups tend to live in cities and urban areas (Policy Exchange, 2015) and over 300 languages are estimated to be spoken in London alone (Johnson, 2003). Given the growing UK population, it is important to acknowledge increasing cultural and ethnic diversity within the UK as well as the health and social needs of migrants living in the UK.

BME Mental Health Policy

There has been mounting evidence to suggest that clinical psychology services have been failing to meet the psychological and mental health needs of individuals from BME communities (Williams, Turpin & Hardy, 2006). Williams et al. suggest that BME communities are often excluded from clinical psychology services due to referral conventions, professional misunderstandings, cultural factors and value placed on ethnocentric conceptual frameworks of distress. Many policies have been developed over the years aimed at reducing health inequalities in the UK such as the Delivering Race Equality (DRE) agenda (Department of Health, 2005). In 2006, the Improving Access to Psychological Therapies (IAPT) service was launched for people experiencing depression and anxiety across the population. One of its key aims was to improve access to services for hard to reach groups including BME communities. In 2009, a Positive Practice Guide (Department of Health, 2009) on commissioning services for BME communities was published. What most of this research and policy guidance has in common is that it highlights the need for more culturally sensitive services and focus on service delivery improvement to ensure a greater uptake of services. There is however, less focus on the existing strengths within specific communities and the resources they tend to utilise.

Furthermore, the clinical psychology profession provides guidance on ethics and professional conduct and explicitly states that professionals should work with individuals from a range of backgrounds with specific reference to ethnicity and culture (British Psychological Society; BPS, 2009). In addition, core competency frameworks for clinical psychologists explicate the importance of working sensitively and appropriately with diversity (Centre for Outcomes Research and Effectiveness; CORE, 2011).

BME Mental Health

Terminology in literature. In BME research, it is common to see the use of broad terms such as 'Asian' or 'South Asian' to reference ethnic groups. There has been wide criticism of research in the UK regarding collective terminology where markedly different Asian sub-groups are clustered together under the common category of 'Asian' (Aspinall, 2002). Such a broad conceptualisation often assumes homogeneity amongst sub-groups of South Asians (e.g. Bengali, Indian, Tamil, and Pakistani) and overlooks distinct aspects of individual sub-cultures. Often there are major differences in terms of cultural and religious practices, for example Bengalis and Pakistanis predominantly practice Islam whereas the

majority of Tamils and Indians practice Hinduism. Furthermore, Pakistanis and Indians often share common languages (Punjabi, Hindi and Urdu) whereas Bengalis and Tamils have their own distinct languages (Bengali and Tamil). These sub-groups also differ in terms of dietary practices, migration histories and there are variations in terms of education, familial income, and geographical area (Anand & Cochrane, 2005). In relation to health there are often key differences in terms of health needs, illness beliefs, and support seeking and health-related behaviours. The wide distinction across the South Asian population is being increasingly recognised in mental health research and it seems there is a need for further research within distinct South Asian sub-groups. This research project will focus on a particularly under-researched South Asian sub-group: Sri Lankan Tamils.

Mental health research. Given the paucity of research on mental health and coping in the Tamil population, this chapter will draw on literature relating to other BME communities and South Asian sub-groups before reviewing literature on coping in the Tamil community. Early epidemiological research suggested lower rates of mental illness among South Asians in comparison to the general population, particularly in terms of anxiety and depression (Cochrane & Stopes-Roe, 1977; Stopes-Roe & Cochrane, 1987). These studies however were largely based on hospital admission rates of Indian and Pakistani women and revealed little about prevalence rates in the wider community. The studies have also been criticised for inaccurately recording ethnicity and excluding some sub-groups such as Bengalis, so the accuracy of these findings have been questioned. Lower rates of mental health problems among the Chinese and higher rates of mental health problems in the Irish (with particular reference to psychosis, anxiety and depression) have also been indicated (Kai & Bhopal, 2003).

Since the 1970s there have been a number of studies comparing South Asian women to indigenous white women and findings remain contradictory. Several of these studies have suggested higher rates of depression, suicide and parasuicide in young South Asian women (Bhugra & Bhui, 2001; D'Alessio & Ghazi, 1993; Fazil & Cochrane, 2003). Ahmed, Mohan and Bhugra's (2007) literature review indicated rates of self-harm among South Asian women in the UK were much higher than among their white indigenous counterparts. Cultural factors such as the level of acculturation, cultural conflict within and between communities, interpersonal relationships, and stigma were associated both with distress and resilience (Ahmed et al., 2007). However some studies suggested South Asian women had

comparatively lower rates of anxiety and depression in comparison to indigenous white women (Nazroo, 1997). Indian, Bangladeshi and Pakistani women took part in this study and when the sub-groups were aggregated, lower rates of mental illness were found in comparison to white women. When sub-groups were compared however, rates of depression in Pakistani and White British women were comparable whilst rates in Indian and Bangladeshi women remained lower.

There are several limitations with the studies described above which are important to highlight. Firstly, the studies tend to use the broad term 'South Asian' and fail to distinguish South Asian sub-groups which are heterogeneous. Secondly, many of the studies utilise measures to assess prevalence which can be considered insensitive in conceptualising terms associated with distress. Words commonly used to describe or diagnose depression in English for example 'depression' or 'anxiety', have no direct translation into many South Asian languages (Anand & Cochrane, 2005). Thirdly, many studies tend to use female samples and far less is known about mental health and coping in South Asian men.

It is important to consider possible explanations for the contradictory findings in prevalence rates. Firstly, different South Asian sub-cultures may have distinct risks of mental health problems. Different Asian sub-cultures will have different social and economic contexts which may affect mental health and well-being and contribute to divergent conclusions of studies (Bhui, Bhugra, Goldberg, Sauer & Tylee, 2004). Secondly, variability in prevalence rates may be related to whether individuals were British born or immigrated to the UK. Nazroo's (1997) study suggested that second generation immigrants (British born or those who migrated before the age of 11) had higher rates than migrants who had come to Britain after 11 years of age. Research has also shown that second generation South Asian adolescents who deliberately self-harm hold less traditional aspirations to their parents in terms of work, marriage, eating habits, and mixed race relationships (Bhugra, Bhui, Desai, Singh, Baldwin, 1999a). These factors may explain the disparity between illness rates in British born South Asians versus migrant South Asians. It is possible that British born Asians tend to hold views in conflict with their tradition which acts as a risk factor whereas migrants tend to hold on to traditional views which acts as a protective factor. Second generation individuals may be more affected by intergenerational conflict, negotiating cultural identities, career development, and racism-related stress (Shea & Yeh, 2008).

Furthermore first generation migrants may have strong links with the community and cultural bonds may act as a protective factor, particularly for BME migrants (Beliappa, 1991). It is important that research differentiates between help-seeking in first and second generation individuals from BME communities. Low prevalence rates may also be due to the pluralistic help-seeking traditions of South Asians (Dein & Sembhi, 2001) discussed later in this chapter. Health pluralism promotes help seeking from non-health agencies such as traditional healers, as well as the use of self-help through religious prayer and ritual, and folk remedies for misfortune (Dein & Sembhi, 2001).

Nazroo's (1997) research suggests that BME migrants are at lower risk than BME individuals born in the UK. Such findings however fail to acknowledge unique risk factors for BME migrants and their potential impact on mental health and well-being. Some research has shown that depressive diagnoses were more common among South Asians with greater exposure to life in Britain, suggesting that acculturation is associated with depression (Anderson, Moeschberger, Chen, Kunn, Wewers, & Guthrie, 1993; Hener, Weller, & Shor, 1997). It has been suggested that BME individuals may face more social isolation (Rao, 1992), language barriers and discrimination (Chew-Graham, Bashir, Chantler, Burman & Batsleer, 2002), gender-role expectations, and socio-economic and political disadvantages (Bhugra and Desai, 2002), and these issues may be particularly problematic for migrants versus British born BME individuals.

The role of culture in assessment and diagnosis. Race and culture can play a huge role in the assessment and diagnosis of mental health problems in BME individuals. For many years, African Americans have been diagnosed with schizophrenia at a much higher rate than their white counterparts (Minsky, Vega, Miskimen, Gara & Escobar, 2003; West, Herbeck, Bell, Colquitt, Duffy, Fitek, Rae, Stipec, Snowden, Zarin & Narrow 2006). Additionally, BME representation is significantly higher in secure mental health services (Sainsbury Centre for Mental Health, 2006) and BME individuals are subject to more compulsory admissions (Ali, Dearman & McWilliam, 2007).

It is important to consider whether diagnostic labels are an appropriate and accurate way of conceptualising distress in non-western cultures. Research has shown that race and culture can influence how mental health professionals understand symptom presentation and suggest that cultural factors impact on how services conceptualise distress within different cultural

groups (Gregg & Saha, 2006; Qureshi, 2013). It is this form of scientific essentialism that led to the development of modern notions of race whereby different categories were constructed for different races. Whilst it is possible that cultural factors may influence the expression of mental distress (discussed below) a criticism of this research is that it differentiates individuals on the basis of arbitrary demographic characteristics (Qureshi, Collazos, Ramos & Casas, 2008). Furthermore, trying to define cultural boundaries or norms can often reinforce racial and ethnic biases and stereotypes (Gregg & Saha, 2006). There have been calls for the rejection of the term 'race' in an attempt to move away from the biological determinism associated with constructs of race (American Anthropological Association, 1998).

Such an essentialist view fails to consider the complex sociocultural contexts in which individuals live. Although the UK is considered a multi-cultural context people are still viewed as different in terms of their race. Apart from culture there is a tendency for 'race thinking' (Barzun, 1965) defined as singling out traits which are then used to define the character of members of a particular group. Unfortunately in clinical settings many stereotypes still exist, for example the notion that black people are violent and dangerous (Loring & Powell, 1988) which feed into decisions about diagnosis and treatment. In multicultural settings it may be more appropriate to assess individuals from a social perspective than to rely on diagnostic criteria.

Cultural idioms of distress. Many western health-care interventions have been based on the concept that psychological distress is culturally neutral and therefore psychological interventions were applicable to all clients (Burr & Chapman, 1998). Culture can affect the way in which symptoms are expressed and understood by health professionals. Sheikh and Furnham (2000) found that the way people conceptualise their distress is related to their cultural beliefs.

Somatisation is the expression of psychological distress as physical symptoms (Bhugra & Bhui, 2001; Bhui, 1999). Research has shown that individuals from some ethnic minority groups, particularly South Asians, have a greater tendency to report the presence of physical symptoms rather than psychiatric ones. They are more likely to visit their GP for such complaints in comparison to their white counterparts. The practice of somatisation is evident from the terms some BME groups use to describe distress, for example Punjabi women

frequently describe anxiety and distress in terms of 'developing gas' or a 'sinking heart' (Bhugra & Bhui, 2001).

Research has shown that somatisation is not unique to South Asian communities and that other ethnic groups may express psychological distress in physical forms such as the Chinese (Zhou, Peng, Zhu, Yao, Dere, Chentsova-Dutton & Ryder 2016) and South Koreans (Zhou, Min, Sun, Kim, Ahn, Peng, Noh & Ryder, 2015). Aragona, Rovetta, Pucci, Spoto and Villa (2012) compared rates of somatisation in a large sample of immigrants attending a primary care centre across four continental groups (Europeans, Asians, South Americans and Africans). They found somatisation was most prevalent in the South American group and that Asians (particularly Sri Lankans and Filipinos) and Europeans (particularly Eastern Europeans) demonstrated lower rates of somatisation. The main limitation with this study is that it used large continental groups. The heterogeneous nature of the comparison groups makes it difficult to draw meaningful conclusions about differences in somatisation.

The influence of culture on symptom presentation has been consistently reported in the UK and may affect detection rates of mental health problems in BME communities. Studies have shown that BME patients are more often diagnosed with physical, somatic symptoms or 'sub-clinical disorders' than mental health problems (Bhui, Bhugra, Goldberg, Dunn & Desai, 2001; Jacob, Bhugra, Lloyd & Mann, 1998).

These findings contradict early epidemiological research which suggests higher prevalence rates within South Asian communities (Ahmed et al., 2007; Cochrane & Stopes-Roe, 1977), but supports Nazroo's (1997) findings. These results need to be interpreted with caution, as Bhui et al. relied heavily on screening measures; the General Health Questionnaire (GHQ) and the Amritsar Depression Inventory (ADI). The use of clinical interviews in conjunction with screening measures to verify diagnoses can be considered more reliable and has shown contradictory results. Bhui et al. (2004) used the ADI in conjunction with the Clinical Interview Schedule-Revised and found that diagnosis was more common in Punjabis, including those with physical complaints and lower scores for somatic symptoms.

In conclusion, lower prevalence rates in South Asian communities may reflect issues such as: misdiagnosis of symptoms, culturally insensitive diagnostic tools and higher rates of

somatisation. It may also indicate the use of resources and support within BME communities and less reliance on professional help-seeking.

Bhui et al.'s (2001) study suggests that South Asian individuals experiencing distress often present with physical symptoms. The lack of the body-mind distinction in non-western cultures may explain high rates of somatisation in BME groups. Tseng (1975) cited in Bhugra and Bhui (2001) suggests that somatisation is common in Chinese communities because of the heavy influence of Chinese traditional medicine in Chinese culture. Symbolic emphasis is placed on the relationship between body organs and human emotions with a lack of distinction between the two. Psychological distress is often expressed in bodily form as bodily complaints are considered more socially acceptable than psychiatric complaints. High rates of somatisation in Asian individuals may originate from principles relating to Ayurvedic medicine (Fernando, 1991). The principle at the heart of Ayurveda is holism, the connection of the body, mind, and the environment. Individuals are considered in terms of physical, psychological, religious and philosophical aspects, and disorders of the mind are treated in the same way as disorders of the body.

Explanatory models of illness. Culture can shape attitudes and beliefs towards illness and there is a large body of research which suggests that non-western communities may hold unique explanatory models of illness which are different to the bio-medical model adopted in the west. These illness beliefs are often reflected in help-seeking attitudes and behaviours (Swami, Arteche, Chamorro-Premuzic, Maakip, Stanistreet & Furnham, 2009). Furthermore, research has shown that illness beliefs not only influence help-seeking behaviours but pathways into care and compliance to treatment (Bhugra, 1999b; Fernando, 1991). In many non-western cultures the cause of mental illness can often be attributed to the supernatural (witchcraft, demonic possession, and ancestral spirits), religion (punishment for breaking moral taboos), and natural causes such as disturbance of natural equilibrium ('yin and yang'). Particularly salient to South Asian cultures is the idea that illness can be caused by a humoral imbalance of the three humors bile, wind and phlegm (Mamtani & Mamtani, 2005). However, research has shown that Asian communities tend to hold higher superstitious causal beliefs of illness and lower biological causal beliefs, compared to indigenous western populations (Jobanputra & Furnham, 2005). Lower biological causal beliefs appear to be linked to more negative attitudes towards professional help-seeking (Sheikh & Furnham, 2000).

Bhugra, Corridan, Rudge, Leff and Mallett (1999b) compared belief systems and pathways into care for Asian and white patients with first onset schizophrenia in West London. Asian patients were more likely to view their presenting problem as spiritual or magical rather than medical, and more likely to spend time in religious places following the onset of symptoms. Bhui, Chandran and Sathyamoorthy (2002) found in a sample of South Asian men, religious beliefs heavily influenced coping styles. Despite this, religion was rarely discussed with them and they identified that it would be extremely helpful to explore this in the assessment process. Spiritual beliefs have been shown to play a positive role in mental health and suicide prevention (Coghlan & Ali, 2009). Spirituality has also been shown to promote coping strategies, and help with recovery (Mohr & Huguelet, 2004). Individuals from BME communities may seek alternative methods of treatment such as spiritual healers, astrologists, holy men, and advocates of traditional medicine based on their cultural, religious or spiritual beliefs (Bhugra, Lippett & Cole, 1999c). Bhui, King, Dean and O'Connor (2008) explored coping styles in six ethnic groups and found that 'religious coping' promoted resilience and recovery. This is in contrast to western approaches to coping particularly after the enlightenment period. It has also been shown that individuals from South Asian communities tend to utilise complementary and alternative medicines (CAM) and informal social support systems such as family and places of worship (Gupta, 2010).

Sri Lankan Tamils may therefore use a wide range of coping strategies to manage their distress based on a range of explanatory models of illness they value.

Stigma and BME communities. Stigma and discrimination can often act as a barrier to help-seeking, particularly within BME communities (Knifton, 2012). Some individuals from BME communities are exposed to family absence, acculturation, and migration trauma (Myers, McCollam, & Woodhouse, 2005), and reduced social integration (Gurbiye, 2011a), which will have an impact on their mental health needs. In addition, many studies found that individuals only tended to access mainstream services at a point of crisis when their distress or behaviour could no longer be managed by other means. Stigma, shame and a lack of close working with communities also prevented professional help-seeking (Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak 2005, Chew-Graham et al. 2002). Chew-Graham et al. (2002) and Knifton (2012) found that fear of the community grapevine, a distinct lack of understanding of Asian culture, and culturally inappropriate services reduce help-seeking. Knifton has suggested help-seeking among BME communities may be improved if services

respond to the socio-cultural needs of communities. This may involve placing greater emphasis on community development, increasing community dialogue and engaging with diverse beliefs.

Migration, acculturation and mental health. Research in mental health has also focussed on the impact of culture and acculturation on mental health and symptom presentation (Koneru & Weisman de Mamani, 2006; Weisman et al., 2000). Acculturation is a term used to describe the process of cultural and psychological change that results from the meeting of different cultures. It occurs when groups of individuals from different cultures come into continuous first-hand contact which may then lead to changes in the original culture patterns of either group. Research remains contradictory with some findings suggesting a beneficial association between acculturation and mental health and other research suggesting a detrimental or no association with mental health (Dhillon & Ubhi, 2003). Studies which show a detrimental association have suggested that acculturation may increase stress or conflict between two competing cultures (Nguyen & Peterson, 1993), or in some cases can lead to a reduction in family support (Gil, Wagner & Vega, 2000). In contrast, research which shows a beneficial association suggests that acculturation may facilitate daily social interaction (Balls Organista, Organista & Kurasaki, 2003), and increase awareness of treatment options (Rodriguez-Riemann, Nicassio, Reimann, Gallegos, & Olmedo, 2004).

Bhugra et al. (1999c) found that South Asian adolescents who self-harmed maintained traditional attitudes towards religion. It has been suggested that often religion and religious practices are the most significant aspects of an individual's ethnic and cultural identity, and are the most likely features to be retained even after leisure activities and dietary habits have changed (Stopes-Roe & Cochrane, 1987). Stopes-Roe and Cochrane have suggested that whilst some changes are linked to the type of religion practiced, other changes are related to social and peer acceptance. This argument may simplify the process of acculturation. It is possible that there may be a complex interaction between religion and social acceptance or that religious, social, and cultural factors may facilitate change rather than prevent it. Bhui et al. (2001) compared help-seeking behaviours between Punjabi and white patients and found that there were no significant differences in terms of the type of care first sought. It is possible that help-seeking may be influenced by cultural practices within host countries and level of acculturation.

Such contradictory findings may reflect the fact that acculturation cannot be formally operationalised easily and is therefore difficult to measure. This may account for inconsistencies in relation to how, and what aspects of, acculturation are measured (Salant & Lauderdale, 2003). The discrepancies in the findings may also reflect whether or not acculturation is viewed as a dimensional construct. Whilst many support a one dimensional view of acculturation in which changes occur in the original culture patterns of either or both groups, others propose that acculturation may in fact be a multidimensional construct in which the identities of the culture of origin and the host culture vary independently, and change can take place psychologically as well as culturally (Berry, 2005). Furthermore, research has suggested that individuals can maintain or strengthen some values from their culture of origin, whilst also acquiring or adapting to values of the mainstream culture, or the process of acculturation (Kim & Abreu, 2001).

Theoretical Perspectives

Social capital theory. Social capital theory provides a useful framework through which collectivist cultures may be understood and Fernando (2005) argues it is particularly relevant to the Sri Lankan context. Social capital theory suggests that changes in relationships within a social structure facilitate action within the structure (Coleman, 1988). Social cohesion leads to mutual benefit, however the individuals who generate capital get very little individual benefit as the emphasis is on the benefit to the wider group. Social capital is centred on trustworthiness, information sharing within the social structure and social norms accompanied by social sanctions. Social capital theory predicts that social bonding is most likely to occur in individuals who share similar demographic characteristics (Fernando, 2005). It is therefore possible that individuals who are bonded by culture, religion, and language may also be bonded by shared experiences of trauma (Fernando 2005). In Tamil culture it seems that individuals find meaning through social groups and the family is the prime unit of identity (Durvasula & Mylvaganam, 1994). In western social theory, ‘mutual benefit’ or reciprocity is considered the key element in terms of community, however within Eastern cultures a sense of responsibility towards others is also important (Somasundaram & Sivayokan, 2005).

Community psychology. Community psychology is a field within the psychology discipline which aims to understand people within their wider social contexts (Orford, 1992). Community psychology has moved away from individual-centered mainstream psychology

and can be considered as the applied psychology of working with both whole, and sections of, different communities (Kagan, Burton, Duckett, Lawthom & Siddiquee, 2011). Psychology in this sense is seen as dependent on social relations including interpersonal, collective, and social-systemic relations (Kagan et al., 2011). Many community psychology ideas have emerged from the field of mental health, but have moved away from traditional individualistic approaches to understanding individuals. It has been argued that intervening at an individual level is inappropriate as it fails to address the underlying causes of problems (Rappaport, 1977). Furthermore intervening at an individual level risks blaming individuals for their difficulties rather than acknowledging the role of the social context. Community psychology understands the causes of problems as an interaction and interdependence between individuals and social settings and systems (Orford, 1992). It focuses on social settings from the micro-level to the macro-level, particularly at a community and neighbourhood level. In relation to mental health service delivery, community psychology differs to other traditional approaches in that it assesses the needs of high risk groups in the community and adopts a preventative rather than treatment-based approach. Community psychology posits that practice should take place within relevant social contexts and move away from large institutions, for example community mental health services or acute in-patient services.

The current study adopts a community psychology approach as it considers the importance of the wider social context in which Tamil people live, and considers interpersonal and collective relations. The community psychology approach also provides an appropriate framework for working with marginalised groups and hidden populations such as Tamil war survivors. The approach lends itself to and acknowledges that professional interventions have their limitations and lay interventions may be more acceptable and appropriate for some communities (Kagan et al., 2011). The Tamil community appears to utilise a variety of non-professional help-seeking behaviours which will be discussed further in this chapter. This approach also acknowledges that the arrival of people from other countries continues to alter the cultural make-up of communities which are constantly changing. Finally, community psychology is concerned with interventions which move beyond the level of the individual and their immediate social context.

Bronfenbrenners's ecological model. Bronfenbrenner's ecological model (1979) is a helpful way of conceptualising some of the ideas from community psychology and looking

beyond the individual. In this model, supra-individual reality can be understood by looking at the micro, meso, exo and macro systems. Every individual is part of a microsystem (families) which in turn influences mesosystems (neighbourhoods and communities) and macrosystems (wider communities and societies). It is in essence a way of understanding the individual within wider contexts such as the family, community, and wider society. As Somasundaram (2007) suggests, this ecological model fits in line with the World Health Organisation's definition of health where the emphasis is beyond the individual. They describe health as "a state of complete physical, mental, (family) social and spiritual well-being and not merely an absence of disease or infirmity". Such a statement suggests that family and other social systems are protective factors in health and well-being.

Section Two

The Impact of War and Conflict

It is estimated there have been 250 major wars and armed conflicts since 1945, in which over 50 million people have been killed, tens of millions have been made homeless, and countless millions injured and bereaved (Peace Pledge Union, 2015). It is estimated that of these, 160 wars occurred in developing countries including Sri Lanka (Zwi & Ugalde, 1989), although this figure is likely to have increased considerably since then. Furthermore, the United Nations High Commission for Refugees (UNHCR) estimates there were 19.5 million refugees worldwide at the end of 2014 and that during this year, 42,500 people per day were forced to leave their homes due to conflict and persecution (UNHCR, 2015). It seems particularly important to acknowledge the impact of war given the political conflict in Syria at present, with it estimated that 1 in 4 refugees worldwide are of Syrian origin. The countries which make the most asylum applications to the UK include Pakistan, Iran, Sri Lanka, Afghanistan and Libya (UNHCR, 2011b).

Refugees and Asylum Seekers

Research on the prevalence rates and risk factors of mental health problems within refugee and asylum seeker populations remains limited. Refugees and asylums seekers leave their own countries for many reasons including: famine, war, persecution due to religious and political beliefs, imprisonment, and fear of death. In many cases they have experienced bereavement, torture and trauma. On entering their host country, a refugee may face detention, deportation, poverty, and discrimination. Issues such as housing, asylum status,

employment, and language often need to be tackled, alongside social isolation and discrimination. These issues make integration and adjustment into the host country very difficult.

Refugees and asylum seekers may also have had different experiences of, and hold different views towards, health care (Karmi, 1992). Many will be unfamiliar with the British medical system and may have low expectations of health care due to frameworks of mental health in their own culture. They may not expect or seek treatment at all.

Asylum seekers may also avoid mental health services due to a fear that consultations will not be confidential and information will be passed to the Home Office, jeopardising their chances of gaining refugee status. Many individuals have claimed they have been asked for passports, immigration documents, or proof of identity which can deter help-seeking (Levenson & Coker, 1999). Gerritsen et al. (2006) assessed the health of adult asylum seekers and refugees from Afghanistan, Iran, and Somalia living in the Netherlands. They found that poorer mental health outcomes such as anxiety, depression and post-traumatic stress disorder (PTSD) were highly prevalent among this group.

Refugees may also cope with their experiences in unique ways. Mozambican refugees for example, describe 'forgetting' as their usual means of coping with difficulties and Ethiopians use 'active forgetting' to deal with difficult experiences (Summerfield, 1996, cited in Burnett & Peel, 2001).

Research has shown that integrated rehabilitation programmes, increased social support, and family reunion where possible, have been highly recommended for refugee communities (Gorst-Unworth & Goldenberg, 1998). Refugee community organisations need to work closely with mental health services to support refugees by acting as advocates, providing information, directing them to appropriate services, and allowing them to meet people from their own culture and religious backgrounds (Burnett & Peel, 2001). Although some refugees may wish to tell their story as this may be therapeutic, it should not be assumed that people must go through this in order to recover (Summerfield, 1995).

Additionally, it is important to remember that not all of the individuals exposed to war and conflict will need a psychological intervention and there is a danger of pathologising these

individuals. The National Institute for Health and Care Excellence (NICE) highlight that a 'refugee' is not a diagnostic label and many refugees may not have psychiatric disorders (NICE, 2006).

Trauma: Limitations of Conceptual Models of Illness

Many refugees, asylum seekers, and immigrants have experienced traumatic events in their country of origin. Trauma has been linked with PTSD, depression, anxiety, alcohol and drug use, and somatoform disorders (Green, 1994). The aim of the current study is to explore experiences of coping with war in the Tamil community. Current conceptual models of understanding trauma may not be relevant or applicable to Tamil and other BME communities. It is important to consider the impact of trauma in non-western communities given that trauma resulting from war, political conflict, and natural disasters predominantly affects developing countries (Zwi & Ugalde, 1989) such as Sri Lanka.

It is common for trauma programmes to be implemented in war zones in order to support those with 'post-traumatic stress'. In terms of intervention, often agencies have tried to implement western approaches of treatment to other cultures irrespective of their preferred methods of coping. In such programmes, individuals tend to be 'passive recipients' and the active participation of those involved in war and political conflict is often absent (Weerackody & Fernando, 2011). A critique of trauma-focussed therapy is that it can inadvertently minimise the survival skills and resourcefulness of people who have lived through war and disaster (Tribe, 2013).

Whereas some believe that war and conflict can traumatise entire communities, others argue that very few people develop symptoms of PTSD (Summerfield, 1999). Research has suggested that the prevalence rate of PTSD among refugees living in western countries is actually lower than reported (Fazel, Wheeler & Danesh, 2005). This includes those exposed to severe and prolonged trauma (Yehuda & McFarlane, 1995) such as Sri Lankan Tamils. Such research suggests that PTSD is actually a relatively rare response to trauma. Furthermore, some have argued that symptoms of PTSD can be considered a normal human response to difficult events (Tribe, 2013), and that it is unhelpful to detach the distress from the individual in a way that the psychological model of trauma does (Summerfield, 1998). Summerfield also suggests that the label of PTSD serves not only to pathologise but de-humanise individuals by failing to acknowledge the complexity of their circumstances

(Summerfield, 1998). He argues that suffering is expressed and resolved in a social context rather than by the individual in isolation, and therefore recommends that interventions should be based on social rehabilitation frameworks which allow victims of war to manage their suffering and recovery on a collective basis.

In any case, many have questioned the robustness of diagnoses such as PTSD, particularly in non-western cultures. Summerfield (2001) argues that diagnostic manuals such as the DSM-IV are western cultural documents which determine what a disorder is based on ontological notions. Summerfield (1998) suggests that PTSD can be an inappropriate diagnosis reflecting a specific cultural context and should not be extrapolated to other contexts, particularly contexts of war. In other words, PTSD is an example of how the conceptualisation of distress may be culture specific, for many reasons. Firstly those involved in war are viewed with "a gaze borrowed from a psychiatric clinic" (Summerfield, 1998). Secondly, there may be cultural differences in terms of the meanings attributed by individuals and communities affected by war and the support systems around individuals. It has been suggested that the prevalence of PTSD is distorted because there is a tendency for research to be based on clinical samples (Summerfield 2001). Therefore, data on recovery in both individuals and communities is often underestimated or excluded from research because it does not fit with the disease model.

PTSD is predominantly considered a disorder which affects the individual self and impacts on the individual psyche in the form of numerous distressing symptoms following the trauma (Somasunderam. 2007). This is despite the fact there are many social and political factors involved in trauma responses (Turner & Gorst-Unsworth, 1990). Based on this, the focus of an intervention for someone with PTSD is often individual therapy implying that recovery predominantly occurs at an individual level. Individualised trauma counselling may be an alien concept within many communities, where community reconstruction may be more effective and culturally appropriate **(**Tribe, 2007).

In many communities trauma often afflicts a much wider social group. The limited consideration of group processes can be attributed to the fact that psychology and psychiatry are predominantly based on a western illness model which is individualistic in orientation. The western perspective is centred on egocentrism, autonomy, independence, and the concept of the 'nuclear family' (Fernando, 1991). In contrast, non-western approaches are based more

on sociocentrism, generational interdependence, and the role of the extended and joint family (Bhurga and Bhui, 2001). Furthermore, within Asian cultures great emphasis is placed on obedience, conformity, and obligation (Durvasala & Mylvaganam, 1994). It can be argued that psychiatric disorders based on western illness models are individualistic in orientation because they focus on distress caused at an individual level. Laugani (2007) proposes four inter-related factors which distinguish between eastern and western cultures and may also influence how psychological distress is understood, presented, and managed in different cultures. The first feature is individualism to communism, which differentiates whether personal goals are prioritised over group goals. Individuality is therefore subordinated to collectivism. The second feature is cognitivism to emotionalism, in which relationships can be based on shared interests and goals versus relationship-centred societies. Free will to determinism relates to whether cultures believe they have a choice in their future or whether it is pre-determined by the spiritual realm. Finally, materialism to spiritualism relates to whether the world can be known through what can be measured or through relationships and a variety of different contexts. Furthermore, Bracken, Giller and Summerfield (1995) discuss Eastern culture and state that "in such cultures the intra-psychic is not isolated and emphasized as it is in the West and the physical and mental are not separated to the same degree as in Western experience" (p. 1074).

Many Tamils have experienced recurrent threats to survival and consequently symptoms such as hyper-vigilance can be viewed as a protective mechanism rather than hyper-arousal phenomenon. Additionally, some survivors of war may have features of complicated grief and it is difficult to make a clinical distinction between PTSD and complicated grief. Some have suggested they have features in common and can co-occur (Prigerson, Shear & Jacobs, 2000), and both disorders can develop in the aftermath of a traumatic event. Finally, it has been suggested that assessing clinically significant distress in displaced persons can be difficult (Rajkumar, Premkumar & Tharyan, 2008).

Sri Lankan Tamil Community

Socio-political context. It is important to consider the unique experiences of the Tamil community as well as the socio-political context through which many Tamil Sri Lankans have lived. The majority of Sri Lankans living in Sri Lanka (74%) are Sinhalese and predominantly Buddhist. Tamils are considered a minority and constitute 18% of the population and are predominantly Hindu. The majority of Tamils in Sri Lanka occupy the

north-east of the country. Sri Lanka has been involved in armed and political conflict since 1983 and ethnic conflict between the Sinhalese government and the Liberation Tigers of Tamil Eelam (LTTE) has officially lasted 26 years (1983-2009). The LTTE have been fighting the Sri Lankan army for the north-east region of the country to create a separate Tamil state called Tamil Eelam. The Sri Lankan Civil war has resulted in the deaths of approximately 64,000 people from various ethnic groups (Reuters, 2006). The deepest impact was felt in the Northern and Eastern provinces of Sri Lanka (Kanagaratnam, Mason, Hyman, Manual, Berman & Toner, 2012). 1.8 million people were recorded to have been uprooted by the civil war (United Nations High Commission on Refugees; UNHCR, 2003). However this data was collected over a decade ago and it is estimated the figures are now much higher. Many Sri Lankan Tamils have also been exposed to and affected by natural disasters. The tsunami in December 2004 resulted in 230,000 families losing family members, homes and livelihoods (Save the Children, 2006). It is evident that the Sri Lankan population (Tamils as well as other ethnic groups) have been exposed to multiple traumatic events and human rights abuses including assassinations, bomb attacks, sexual and physical violence, as well as natural disasters. In 2009, the year the civil war ended, 300,000 individuals living in the Vanni region in Northern Sri Lanka experienced multiple displacements, death, injuries and shortages of food, water and medical aid (Somasunaram, 2010). Many men and women were forcibly recruited to fight against the Sri Lankan state and military.

The roots of conflict between Sri Lankan Tamils and the Sinhalese date back to the British colonial rule when the country was known as Ceylon. Initially there was little tension between the two largest ethnic groups. The British were involved in creation of the Sri Lankan state, and following independence, the Sinhalese dominated government. British Governor William Manning actively encouraged the concept of "communal representation" and he created the Colombo town seat in 1920 which inevitably created conflict between the Tamils and the Sinhalese (Sabaratnam, 2012). Furthermore, when the Sinhalese were elected to the State Council in 1936 they demanded the replacement of English as the official language to Sinhala, and Tamil. However by 1944 the state council wanted Sinhala to become the official language. In addition, the Ceylon Citizenship Act in 1948 discriminated against Tamils making it difficult for Indian Tamils to obtain citizenship in Sri Lanka and over 700,000 Indian Tamils were made stateless (International Centre for Ethnic Studies, 2016) creating further tension between the ethnic groups.

Mental health and the Tamil community. The impact of the events relating to war and political conflict has had a profound effect on those affected by it. Chokkanathan (2009) undertook a study exploring the stressors associated with psychological distress and found that stressful life events and experience of abuse positively correlated with depression. Somasundaram and Sivayokan (1994) found there were high levels of trauma-related psychiatric morbidity in communities living within the war zone. It is important to acknowledge that many Tamils exposed to the war did not develop psychological problems and it is important to consider potential protective factors.

Tamil diaspora. The number of Tamil people living in the UK was estimated at 150,000 (Dissanayake, 2008) and continues to grow. Despite this, the mental health needs of Tamil immigrants remain poorly understood. The Tamil population as with many other BME communities in the UK, remain under-represented in primary and secondary care mental health services and the reasons need to be understood (Loewenthal, Mohamed, Mukhopadhyay, Ganesh & Thomas, 2012). A mapping exercise carried out by Race on the Agenda (ROTA; 2013) suggested that a low uptake of services may be due to practicalities of seeking support such as paperwork, obtaining an interpreter, feeling monitored through IT administration processes, and professionals' limited understanding of the historical context through which many Sri Lankans had lived. It is important not to assume that these individuals require mental health services but what is clear is that many experience psychological distress which may be exacerbated if neglected. Silove, Steel, McGorry and Mohan (1998) compared psychiatric morbidity across three groups of Tamils: Tamil asylum-seekers, Tamils with authorised refugee status, and Tamil immigrants who had been exposed to trauma. Although asylum-seekers did not differ from refugees in terms of past trauma experiences or psychiatric symptoms, they had much higher levels of post-migration stress, and the study suggested that asylum-seekers may be a high-risk group due to on-going stress post-migration. A recent study in Norway explored how negative events in the country of origin can influence Tamil individuals residing abroad (Stige & Sveaass, 2010). They found exile-related difficulties, former exposure to trauma, and limited social support independently contributed to mental health difficulties in this group.

Section Three

Tamil Help-seeking Behaviours

Little is known about how the Tamil community manage psychological distress. Somasundaram and Sivayokan (2005) have suggested that priests and indigenous healers, local rituals, and traditions can have an important role in managing distress as a result of war and natural disaster. They recommended that healing practices should be informed by cultural context and common health beliefs. Many have suggested that religio-cultural beliefs and practices account for how a large proportion of Sri Lankans adjust to adversity and that religious and cultural practices can have a significant 'healing effect' (Fernando, 2005; Samarasinghe, 2002). Furthermore the village ('uur') in Tamil culture refers to the community and relationships within the community and is considered a fundamental unit within Tamil culture (Somasundaram & Sivayokan, 2005). Finally, given that Tamil culture has a strong, anti-authoritarian populist element, self-sacrifice is considered an important quality among Tamils (Wadley, 1980).

Health pluralism is widely found in Sri Lanka, where the people identified as 'healers' would not typically be ascribed this role in the west (Lawrence, 2000). Health pluralism is defined as a "multi-layered range of explanatory health beliefs, and a concomitant range of coping strategies or help-seeking behaviours, as well as a varied range of designated healers" (Tribe, 2007, pp. 21-22). Tribe has suggested that within the Sri Lankan context, western medicine, traditional medicine, the use of rituals, and the skills of healers are often intertwined. It has also been suggested that working with these individuals and resources may be more appropriate in assisting communities than western models of conceptualising distress. Such findings have important clinical implications and Samarasinghe (2002) argues that health pluralism based on locally identified needs may be the most useful approach in managing distress in the Sri-Lankan community because it is the most preferred approach amongst Sri-Lankan survivors of war. This may be due to the fact that the cultural and social aspects of wellbeing are related to treatment choice (Landy, 1977). It is also thought that the individualised model of western diagnosis and therapy are not only culturally inappropriate, but in countries such as Sri Lanka can also be resource inappropriate (Tribe, 2007). Health pluralism may also explain why psychological therapy is not widely taken up by Tamils even when available in the UK. It seems further research is needed in order to consider how

Tamils cope with distress, and whether there are high levels of unmet mental health need within this community.

Coping

Coping can be considered as a way through which people understand, make sense of, and deal with critical situations (Lazarus & Folkman, 1984). Coping styles are not the focus of this research and will only be discussed briefly. Coping strategies can be defined in many ways, for example private versus public coping (Mitchell et al., 2006), problem-focussed coping (Lazarus & Folkman, 1984), avoidance coping (Amirkhan, 1990), and passive or emotion focussed coping (Meyer et al., 2010). Often a dichotomy is considered in relation to coping strategies in which strategies appear to take an active or passive form. Some have suggested that active forms of coping are associated with a lower level of psychological distress and are considered more superior than passive strategies (Kemp et al., 1995).

Collective Trauma and Collective Coping

Traumatic events can have a marked impact on the family, community, and wider society as well as at an individual level within any community. In other cultures, expressions of coping and resilience may occur at a group level, such as the family and the wider community. It has been argued that in collectivist cultures where the emphasis is on the family and the community, collective events may have more significance than in more individualistic societies (Somasundaram, 2007). This may be because in collective cultures, like the Tamil culture, the individual becomes embedded within their nuclear and extended family and therefore 'become submerged in the wider concerns'. Somasundaram & Sivayokan (2005) suggest there is a marked difference between western and eastern cultures, arguing that in western communities great importance is placed on individuals and their welfare, whereas in eastern communities the welfare of the family and the community is paramount.

Fernando (2003) worked with survivors of trauma and found the greatest concerns were psychosocial consequences such as social isolation and difficulty in fulfilling family roles, rather than concerns relating to the individual. Existing research suggests that Tamils may respond to distressing experiences more as a unit due to the cohesiveness within the family and thinking and acting together, rather than individually (Somasundaram & Sivayokan, 2005). Collective trauma is particularly relevant to the Tamil community because many basic

social institutions of Tamil culture have been destroyed as a result of war and natural disaster (Somasundaram & Sivayokan, 2005).

A collective response may be attributed to the fact that in collective cultures, the focus is on the family rather than the individual as the unit of analysis (Shon & Ja, 1982). Individuals from such cultures may never become fully independent from their families due to levels of enmeshment and the roles and responsibilities they are obliged to adopt. This is most evident when considering the process of individuation during adolescence which is not as clearly defined in Asian culture compared to western cultures. This may be because the role of parenting in such cultures is not to provide children with the skills to leave the family, but to instil a sense of obligation and duty (Durvasula & Mylvaganam, 1994).

Fernando (2005) has suggested that communities which experience collective trauma use their interdependence to develop new or modified identities and find meaning in their lives. In contrast, it can be argued that in some western communities the emphasis is on personal growth and recovery (Linley & Joseph, 2003). Others argue that following large-scale trauma a 'war-time spirit' can develop in which communities feel strengthened and motivated by a sense of purpose and support (Tribe, 2013).

In summary, researchers in the field of collective trauma believe that trauma can lead to non-pathological distress as well as a variety of psychiatric disorders, and it is the former which is of most interest yet rarely explored. In the west, although methods of coping may involve the family unit, for many accessing healthcare seems an important aspect of managing distress. In the Tamil community, the community itself seems to have a key role.

It is important to note there is as much variation within communities as across them, and not all individuals will respond to distress in the same way. As the literature suggests many Tamils may also use traditionally more western methods of coping with distress, and coping strategies may be influenced by factors described above such as migration and acculturation (Miller, Yang, Choi & Lim 2011; Tribe, 2007).

The limited research available on collective coping amongst Tamils highlights the importance of utilising resources within the community to overcome adversity. Existing research suggests that interventions aimed purely at supporting the individual may not be helpful. It

has been suggested that relief, rehabilitation, and development programmes aimed at supporting Tamils, may want to consider group interventions and multi-level approaches (Somasundaram, 2007). Most of the research undertaken has been in Sri Lanka, and therefore the needs of the Tamil population in the UK will be considered in this study.

Critical Appraisal of Literature on Coping in the Tamil population

A systematic literature review was undertaken because a preliminary examination of relevant literature indicated a paucity of research on coping and help-seeking in the Tamil community. In order to identify literature on methods of coping in the Tamil population, 3 databases were searched for the review: CINAHL Complete, MEDLINE with full text, and PsycARTICLES. Given time-constraints, grey literature was not explored for this review.

Keyword and Phrase Searching. The word 'Tamil' was used to define the ethnic group of interest. The terms 'cope' and 'help-seeking' were used to define coping as these were the terms most commonly used in the literature.

Truncation: The word Tamil* was used as a search term in order to include alternative terms (synonyms) such as Tamils and Tamilian. Similarly cop* was used to include the alternatives such as coping and coping behaviour.

AND/OR function: the OR function was used to collate results for the terms 'cope' and 'help-seeking'. The AND function was used to combine the search results for ethnic origin and coping terms.

NOT function: in the initial search numerous articles with the word 'copper' emerged because the term cop* had been used. The researcher felt it appropriate to exclude articles including the word 'copper'.

Although the aim of the research was to look at experiences of coping with war and conflict, the terms 'war' and 'conflict' were not used as search terms in the search strategy as research on this topic was extremely limited and the researcher felt it may be useful to consider coping in general terms than simply in relation to war.

The search terms were searched in all fields and the use of limiters in the search strategy was not considered appropriate given limited research on this topic. Therefore, no limits were applied as the researcher considered this necessary to broaden the initial search.

Databases: CINAHL Complete, MEDLINE with full text and PsycARTICLES

Search date: 5.10.15

Years: all

Table 1

Database Search Summary

Database	**Search No**	**Search term**	**Results**
CINAHL Complete, MEDLINE, PsycARTICLES	1	Tamil*	16,406
	2	Cop* AND help-seeking	624,152
	3	#1 AND #2	441
	4	NOT copper	197
	5	*#3 AND #4*	244

A total of 244 articles were identified and 234 remained after removing duplicates (n=10). International research was included but papers not published in English, were not. The abstracts of the identified articles were carefully screened and selected if appropriate.

Given the number of papers identified through the screening process, it was not considered appropriate to reduce the search further according to specific inclusion and exclusion criteria, for example year of publication, age of participant, or methodology. All papers were included in the final selection for review including papers on Tamils and other ethnic groups. 11 articles were found in total. The reference lists of the selected articles were also screened and a further 2 articles were found. Therefore, a total of 13 articles were reviewed (see Appendix A for study details).

Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) tool on qualitative research (CASP tool, 2014) and quantitative studies were assessed using guidelines on critical appraisal (Greenhalgh, 1997a; 1997b). Greenhalgh's approach considers several criteria when assessing quality in terms of design, research participants, sample size and outcomes measures. Given the limits of this review, only factors considered the most appropriate were chosen to evaluate the studies.

Religious and Spiritual Coping

Eight studies suggested Tamils used religion and spirituality to cope with distress. This included repeating meaningful phrases and mantras, prayer, prayer beads or religious stones, and meditation. Somasundaram (2007 & 2010) suggested these indigenous coping strategies were encouraged as part of rehabilitation programmes, as they had a protective factor in coping with war and natural disaster. Somasundaram's (2007) study was phenomenological in nature and therefore the outcomes of different strategies were not collected in a systematic way. This makes it difficult to consider the efficacy of particular strategies and was acknowledged by the authors who recommended a randomised control trial (RCT) in future studies. Somasundaram (2010) used a variety of measures including participant observation, in-depth interview, key informants, and focus groups. However, details of the recruitment strategy, sample size and characteristics, and data collection and interpretation, were not detailed in the study.

Rajkumar, Premkumar and Tharyan (2008) found that following the tsunami, many Tamils viewed their survival as a 'gift from God' and some held the belief they had been chosen to survive. Rajkumar et al. (2008) used a convenience sample, often adopted in research with hard to reach groups and hidden populations. In convenience sampling, the researcher inadvertently excludes a great proportion of the population because they use subjects that are accessible or willing to participate. Therefore, it is important to acknowledge the type of participants that may be over-represented, which Rajkumar et al.'s study did not consider. Tribe (2007) found that cultural and religious practices in dealing with emotional difficulties were common, particularly in rural and war torn parts of the country. Tribe stated that although such practices might not commonly be associated with 'treatment', they were considered to provide a healing function. Beiser, Simich and Pandalangat (2003) found that 9.3% of Tamils who completed survey questionnaires on mental health and coping, used religion particularly prayer using religious stones or beads. Bhushan and Kumar (2012) found that proactive coping strategies were linked to spiritual change and led to post-traumatic growth. Fernando (2012) looked at resilience in the Sri Lankan community affected by the tsunami and found it was associated with faith, and religious beliefs and practices were considered important for all Sri Lankan ethnic groups. Finally, Kanagaratnam et al. (2012) found that Tamil women who were victims of intimate partner violence, often relied on their religious beliefs as a method of coping. The findings however must be considered in light of the recruitment strategy adopted. There was limited diversity in the sample and aspects such

as religion, employment, and education level were homogenous, making the findings less transferable to the wider Tamil community.

In terms of research design, four of these studies (Kanagaratnam et al., 2012; Rajkumar et al., 2008; Somasundaram, 2007 & 2010) used focus groups to gather information from participants. Although focus groups can help access the views of marginalised or hidden groups (Liamputtong, 2007), they have limitations as they are usually time-limited and with several individuals, which may limit the amount of data collected from each. Focus groups may not facilitate in-depth follow up of individuals' views or experiences, whereas individual interviews can be considered private and more ethical given the nature of particular topics. Despite making attempts to ensure all individuals participate actively, it is possible that more vocal individuals may dominate discussions. Focus groups can also create social desirability bias and participants may limit the information disclosed in front of an audience, given the sensitive nature of the topics explored.

Herbal and Ayurvedic Coping

Two studies (Beiser et al., 2003; Tribe, 2007) found that Tamils used herbal remedies and ayurvedic medicine as a coping method. Tribe found that ayurvedic medicine was practised widely, particularly in rural areas, and many people utilised allopathic and ayurvedic medicine concurrently with other eastern and western coping methods. Many Tamils believe that disequilibrium causes illness and therefore treatment involves system of healing based on holistic and spiritual methods. Beiser et al. (2003) looked at the help-seeking behaviours of Tamils in Toronto, Canada. They found that 15.3% of participants relied on traditional herbal remedies for support with 'psychological problems'. This study utilised an extremely large sample size (n=1110) and used a stratified sampling technique to ensure participants were more representative of the wider Tamil population. Beiser et al. (2012) however did not take into consideration the effect of migration and acculturation in their analysis. It is possible the length of time spent in their host country may have affected their mental health needs, the type of coping strategies used, and their frequency (Myers, McCollam, & Woodhouse, 2005).

Psychological Coping

Six of the identified studies found that Sri Lankan Tamils adopted a number of psychological coping mechanisms to manage distress. Fernando (2012) used focus groups to elicit Tamil, Sinhala, and Muslim Sri Lankans' views about the components of resilience in relation to

natural and human-made disasters. The data revealed many themes relating to resilience which differed across ethnic groups. Tamils found that avoidance of rumination, letting things go, and not dwelling on worries were extremely important. It seemed that being content and mental strength were also important factors. A limitation with this study is that it represented a broad range of ethnic groups from a wide range of geographical locations, with different religious and cultural beliefs, rather than from specific groups. This makes it difficult to draw conclusions about specific ethnic groups in the study. A further limitation, is the use of focus groups which may have made it difficult to discuss particular issues and the perceived status difference amongst group members may have exacerbated this.

Bhushan and Kumar (2012) looked at post-traumatic stress and growth in female relief volunteers and found a variety of proactive coping strategies were utilised to manage experiences of trauma. These included finding new challenges, visualising dreams, problem solving and finding a way around obstacles, and taking control of the situation, all of which related to post traumatic growth. Furthermore, post-traumatic growth was linked to appreciation for life and consideration of new possibilities. The sample size for this study was relatively small (n=25), limiting the generalisability of the results. Bhushan and Kumar identified that a control group within the study would have been useful, but it was difficult to find a suitable comparison group. Finally, the Coping Inventory used only measures proactive coping mechanisms rather than a wider range of coping mechanisms, including those considered harmful such as the use of alcohol, drugs, and self-harm. Russell, Subramanian and Russell (2012) corroborated Bhushan and Kumar's findings looking at the relationship between psychopathology, traumatic life events, and coping skills among primary care adolescent patients. Emotion-focussed coping styles (optimistic and emotive) were used most frequently amongst adolescents rather than problem-focussed styles (confrontative and supportant). Furthermore, adolescents with psychopathology tended to use more emotion-focussed coping styles compared to adolescents without pathology. Optimistic coping involved thinking about the good things in one's life, trying to think positively, and trying to see the good side of the situation. It is important to note that participants were recruited from an adolescent health clinic which may not reflect the true prevalence of psychopathology or coping styles within this population. The authors also acknowledge that constructs like 'coping' may change over time and it may be difficult to draw conclusions based on a one point measure. The sample size (n=100) was considered relatively small for quantitative data

analysis, however it must be acknowledged that given the nature of the research many individuals would not want to speak about their experiences of trauma.

In contrast, Kanagaratnam et al. (2012) and Gurbiye (2011b) found that some Tamils coped with traumatic events by actively focussing on them. Gurbiye found rather than trying to forget past traumatic events, Tamils seemed to make great effort to remind themselves, often feeling cowardly and guilty for leaving their homeland and family behind. Gurbiye found many Tamils felt obliged to remember the sacrifices of Tamil heroes and martyrs for the cause, through rituals such as Great Heroes Day and Annai Poopathy Remembrance Day. Kanagaratnam et al. (2012) found although Tamils did "divert the mind" in order to cope with distress, they often used self-blaming, normalising the abuse, and attempting to understand the abuser, to cope with intimate partner violence. Other women viewed their experiences as something which they needed to endure and women showed a marked preference for 'passive' modes of coping rather than 'active'.

Somasundaram (2010) looked at collective trauma in northern Sri Lanka following war and the tsunami. Somasundaram found that many Tamils reacted to their traumatic experiences using psychological strategies. These may have had survival value during periods of intense conflict such as suspicion and mistrust in others, particularly government forces and the law. Many individually and communally became 'silent' and would 'stay in the background', unable to speak out against the atrocities. Others attempted to accept their situation (considered a form of helplessness) and did not resist difficult experiences.

Avoidance and Isolation

Somasundaram (2010) found that many torture survivors, when returned to their families, became isolated and socially withdrawn. Attempts to manage mass destruction included fleeing the immediate situation, and escaping to other parts of the country or to different countries. Kanagaratnam et al. (2012) found that women coping with domestic violence often tried to avoid certain situations in order to reduce exposure to harm. An implicit finding from two of the studies on Tamil refugees suggested that many individuals flee the country in an attempt to find safety (Gurbiye, Sandal & Oppedal, 2011; Gurbiye, 2011a).

Coping Strategies Detrimental to Health

Two of the studies reviewed found alcohol and other strategies detrimental to health were adopted by Tamils to cope with trauma and distress. Rajkumar et al. (2008) found alcohol consumption amongst Tamil Indians living in Tamil Nadu increased after the tsunami, which also increased rates of domestic violence incidents. Somasundaram (2010) found suicide, alcoholism rates, and sexual negligence increased amongst the Tamil community in Northern Sri Lanka as a result of the civil war.

Professional Help-seeking

Only four of thirteen studies suggested Tamils access professional help to cope with distress. Kanagaratnam et al. (2012) used focus groups to interview women on their experiences of intimate partner violence. Women across all age groups agreed that it was their responsibility to seek help from mental health professionals for their partner's difficulties. Women across all age groups also identified seeking professional help for themselves as a coping strategy, however barriers were identified including risking separation or divorce, impact on their children, and the shame of having to disclose abuse. Tichy, Becker and Sisco (2009) also found that Tamil Indian female victims of domestic violence who perceived their experiences as abusive, were likely to seek professional help but that help-seeking was linked to socioeconomic status. Status was negatively correlated with help-seeking and therefore women of higher socio-economic status were less likely to report domestic violence or seek help. Beiser et al. (2013) looked at help-seeking in the Tamil community in Toronto and found that 70% of participants had seen a physician in the past year relating to their experiences of war and forced displacement, however less than 1% had seen a psychiatrist or mental health professional. They also found that 29% who had visited hospitals had reported practical barriers to seeking professional help including language problems and the logistics of travelling. The findings also indicated a mistrust in the health care system and participants felt health professionals did not understand their culture and ethnic background. Finally, Tribe (2007) found that western medicine, traditional medicine, and the use of rituals and healers are interwoven within the Sri Lankan context and rarely used in isolation.

Coping with Family and Friends

Many articles reviewed identified the family system as a valuable coping resource**.** Somasundaram (2010) found that following the war, Tamil families developed more cohesion and interdependence. Somasundaram suggested that families wanted to 'heal' together

following trauma. Furthermore, as males were most at risk of being targeted, arrested, killed, or joining military groups, women took on greater responsibilities within the household. Other research suggested that following war and exposure to trauma, fundamental changes in the functioning of the family were observed (Somasundaram, 2007). Family dynamics were affected by the loss of a caregiver and significant changes were also noticed in terms of child rearing practices as male widows often struggled and children were looked after by other relatives. Fernando (2012) found that in response to natural and man-made disasters, Tamils developed closer relationships with family, became more involved in family and parental duties, and spent more time visiting relatives. Many chose to raise a family so they could work and live for the 'sake of their family' and so that their children could take care of them. During the war, Tamils became more protective of their families, some even sacrificing themselves for other family members, for example by joining the rebel group so that other family members would not have to (Gurbiye, 2011a). A few studies highlighted the importance of friendships in dealing with difficult experiences. Fernando (2012) found sharing problems, forming close relationships with friends and maintaining social obligations contributed to resilience when faced with adversity.

Community and Collective Coping

Many of the articles highlighted the use of collective strategies in coping with disaster and distress. Many found that sorrow and loss as well as coping were collectivised (Gurbiye, 2011b; Rajkumar et al., 2008; Somasundaram, 2007 & 2010). Individuals tended to view themselves not as lonely sufferers but part of a much larger traumatised society (Rajkumar et al., 2008). Many individuals took collective responsibility for their future and wellbeing, and increased co-operation towards desired outcomes was observed. Tamil communities were seen to unite more and have less communal conflicts following war and natural disaster. More social gatherings took place in which the Tamil community shared their psychosocial gratitude and participating in cultural and religious community practices became a priority for many. Social support and membership to community organisations were considered extremely important resources (Gurbiye, 2011a).

Some studies found that it was important for Tamil refugees, firstly to integrate themselves within their host country and community, and secondly work with members of the Tamil community to improve social conditions for Tamils in their home country, which became shared goals (Gurbiye et al., 2011; Gurbiye 2011b). Individual traumatic experiences were

channelled into collective causes and personal struggle led to social commitment. Therefore, many Tamils accumulated their resources and dedicated time and effort to volunteer at community centres to share knowledge, resources, and skills with Tamil community members. These studies also demonstrated that Tamils integrated well into the labour market and did not seem to rely on social welfare. In fact they were often characterised as 'super immigrants'. The authors of these studies acknowledge there are limitations which must be considered. For example, little consideration is given to the relationship between individual and communal coping strategies which assumes strategies may be categorised as either. It is possible the communal goals can become individual and vice versa, and that there are pay-offs associated with individual and communal strategies. Tamil individuals involved in these studies all had access to support organisations and therefore the findings may not be transferable to Tamils without similar access to collective resources.

Many studies found that parents encouraged their children to do well academically and go on to higher education, as education allowed access to more resources which could benefit the Tamil community both in their host country and in Sri Lanka (Gurbiye, 2011b; Gurbiye et al., 2011). Long term aspirations for individuals and their children seem to be strongly linked to their experiences of hardship.

Somasundaram (2007) found that following war and natural disaster, communities became more dependent on charity aid, reducing their ability to be self-reliant. It was suggested that they became more passive in fighting for their rights, accepting their circumstances as part of normal life.

Study Aims and Objectives

There is a large body of literature which looks at mental health within South Asian communities. However, very little is known about the mental health needs of Sri Lankan Tamils, or their experiences of coping. Many have experienced prolonged war and political conflict in Sri Lanka and many immigrate to the UK or seek asylum due to this. Understanding the unique needs of this community seems important yet very few studies have looked at the impact of war, particularly for Tamils now living in the UK.

There appear to be several limitations within existing literature which the current study aims to address. Firstly, this research does not assume homogeneity within South Asians and will

therefore look at the experiences of a specific sub-group, rather than multiple sub-groups as previous studies have done. Secondly, the study acknowledges some of the limitations of previous qualitative research studies which primarily utilise focus groups whereas the current study uses individual qualitative interviews. Finally, the study also looks at the experiences of Tamil men, as studies often only involve Tamil women, as well as individuals with a range of demographic characteristics.

The current study explores how Tamil immigrants living in the UK have coped with their experiences of war in Sri Lanka. The study considers the coping strategies adopted by Tamils both in Sri Lanka and in the UK. A community sample is used because the study adopts a community psychology approach. The study assesses the needs of a potentially high risk group and considers the importance of the wider social context in which Tamil people live.

The wider objective of the research is to consider whether current public health service provision is able to meet the needs of Tamils in the UK, particularly those who may have high levels of unmet need and experience distress at a non-clinical level. These individuals may not be able to access mainstream services due to restrictions relating to eligibility, and may not consider health services appropriate. Findings from this study may inform wider service development in the UK aimed at supporting individuals who have experienced war-related trauma from particular ethnic groups.

Chapter 2 Method

This chapter considers the methodology used in the study. It introduces the epistemological stance adopted by the researcher and provides an overview of the research procedure, recruitment process, sample, and ethical considerations of the study. Finally this chapter considers the method of analysis used and quality assurance.

Philosophical Positioning

It is important to be clear about the philosophical assumptions made about this research. Ontology refers to theories about the nature of reality and "concerns what there is to know in the world out there" (Harper, 2011, p. 4). In essence it determines whether we think reality is entirely separate from human practices and understandings of the world (Braun & Clarke, 2013). Epistemology relates to the nature of knowledge (Burr, 2003) and considers what it is possible to know. A number of philosophies exist along a continuum in relation to ontology and epistemology. Some positions assume there is one objective truth to be known (realism) and this has been described as a 'mind-independent truth' (Tebes, 2005). Madhill, Jordon and Shirley (2000) have suggested that in its extreme form, realism is a 'correspondence theory of truth' in the sense that what is observed is assumed to mirror reality. In contrast, other positions suggest that reality is dependent on human interpretation and the ways in which we come to know it (relativism). Relativism argues that multiple constructed realities exist rather than a pre-social reality and that it is not possible to get beyond these constructions (Cromby & Nightingale, 1999).

In between the realist and relativist positions lies the critical realist position which argues that data does not directly mirror reality, but rather needs to be interpreted in order to consider the underlying structures that constitute the data (Willig, 2012). This position postulates that participants may not always be fully aware of what underlies their experiences and may require the researcher to move beyond the data and draw on knowledge, theory and evidence from outside a study to account for what is observed within the study. It has been argued that the critical realist position differs from relativism as it suggests that it is not reality itself that is socially constructed but rather individuals' notions of reality are socially constructed (Bhaskar, 1978). Bhaskar argues it is not possible to compare what reality is like in itself with a scientific representation of reality. The critical realist approach underpins numerous qualitative approaches including some versions of grounded theory, interpretative

phenomenological analysis, discourse analysis, and thematic analysis (Braun & Clarke, 2013).

The researcher has taken a critical realist position to the current research because this position argues that a pre-social reality exists which can only ever be partially known. In other words, it assumes there is a real world which sits behind the socially-located knowledge available to the researcher (Madhill et al, 2000). The current research aims to understand the unique coping experiences of individuals exposed to war. The researcher believes they take an active role in unearthing hidden meanings through discussion and interaction with participants. Additionally, the researcher acknowledges that to understand coping behaviours, they may need to draw on knowledge and theory from outside the study. A critique of this approach regarding the current study is that there is limited literature on this topic and as the knowledge base develops, understanding of this topic will change. In other words knowledge is temporally relative and subject to change with evolving knowledge. The conclusions reached will therefore need to be interpreted with caution.

The Rationale for the Qualitative approach

The researcher adopted a qualitative framework for the study which felt appropriate given their ontological and epistemological position. Qualitative research can be used to refer to both techniques and paradigm which are both relevant to this study (Braun & Clarke, 2013). It was considered appropriate because qualitative research "tends to prioritize depth of understanding over breadth of coverage" (Willig, 2012, p. 2) in contrast to quantitative research. In other words, qualitative approaches involve gathering detailed and complex accounts from a smaller number of individuals rather than a broad range of information from a vast number of individuals. Qualitative research also values the personal involvement of participants and allows the researcher to capture rich and detailed data about the experiences and perspectives of their participants (Braun & Clarke, 2013). The qualitative approach allows the researcher to work in a 'bottom-up' fashion using small amounts of data to derive theoretical frameworks in contrast to the quantitative approach. Finally, the qualitative approach values context and how participants make sense of their specific experiences within specific contexts.

The researcher was interested in Tamils' experiences of coping with war. Qualitative interviews were considered appropriate in order to explore sensitive issues, collect data

within hidden populations and to explore complex accounts of participants' experiences (Braun & Clarke, 2006). The researcher argues that the methods of coping adopted by Tamils to manage their experiences of war may be complicated and that a quantitative approach may limit the exploration of this topic. It has been suggested that interviews may be better designed to tap into the lived experience of participants (Madill, 2007), and that quantitative methods attempt to quantify human experience which can lead to a reductionist view (Henwood & Pidgeon, 1992).

Recruitment Methodology

The researcher initially recruited participants through one voluntary organisation: the Tamil Community Centre (TCC) based in Hounslow. The TCC provides information, advice, and signposting to Tamils as well as running a programme of activities. A number of other organisations supporting the Tamil community across London were involved in recruitment at a later stage of the research process (discussed below). Advertisements and information sheets (Appendices B & C) were provided to the organisations with the researcher's contact details. Given the researcher's knowledge of this community, they were aware that to increase their profile and help facilitate engagement with potential participants, they needed to spend time within the community. It was considered appropriate for the researcher to visit organisations on a number of occasions to talk to service users about the research. This ensured that potential participants were aware of the researcher's identity prior to contacting them. Informed consent was still sought from all participants prior to their involvement to ensure participants did not feel coerced.

On the information sheet, interested participants were invited to contact the researcher directly by phone or email, or request the researcher contact them. Participants were told about the study and an initial screening questionnaire was undertaken to ensure they met the criteria for participation (Appendix D). Participants were given an opportunity to ask questions at this point before an interview was then arranged. Consent and confidentiality forms (Appendix E) were completed and basic demographic information was collected before interviews commenced. Participants were informed they would be offered a brief report outlining the findings of the research once the thesis was complete.

Although the researcher aimed to recruit through the advertisements at voluntary organisations alone, only one participant responded in this way. Therefore, the researcher

utilised snowball sampling to increase recruitment for the study. Snowball sampling is often adopted when recruiting from hidden populations that can be difficult to access. The process involves vertical networking from the existing sample of participants. In other words, asking participants to identify potential participants who meet the selection criteria (Ritchie & Spencer, 1994). The researcher initially anticipated that recruitment through one organisation would be challenging but possible. However, due to difficulties with recruitment the researcher made the decision to widen the age range for recruitment from 18-65 years to 18+ and to recruit from a wider range of voluntary, community, and religious organisations which could still provide support to participants. A University of Essex Ethics amendment application was made and this was granted on 13th October 2015 (Appendix F).

The diagram below (Figure 1) outlines the organisations where participants were recruited from.

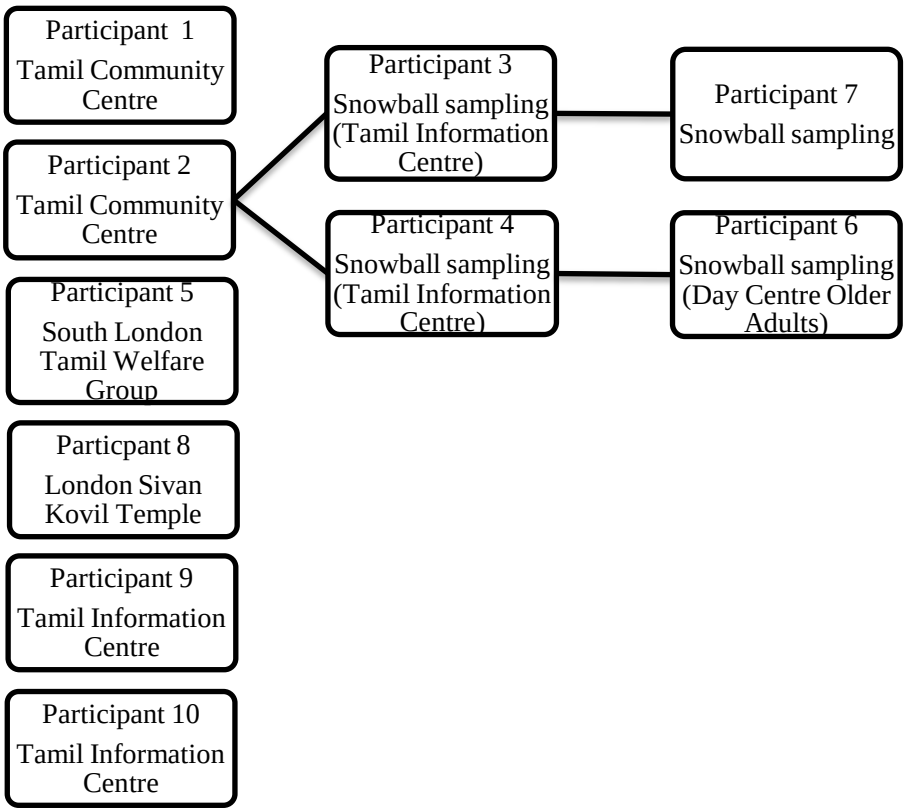


Figure 1. Diagram of recruited participants

Inclusion Criteria

Participants were those of Sri Lankan Tamil origin with personal experience of war and political conflict in Sri Lanka. Participants had to be able to communicate in English to take

part in the study. Participants initially needed to be of adult working age (18-65) which reflects the standard referral age to adult National Health Services. However due to recruitment difficulties, this was later amended to adults over 18 years.

Exclusion Criteria

Individuals were excluded from the study for three reasons:

1. If they needed an interpreter to communicate with the researcher. The researcher is not fluent in Tamil and the use of an interpreter was not considered appropriate as discussed below.

2. Individuals were excluded from the study if they had been diagnosed with an acute or chronic mental health problem or currently under the care of mental health services. This was considered for several reasons; A. Within the Tamil community, having a mental health problem is stigmatised and being associated with mental health services has social implications for the individual and their family. Existing research has shown that mental health diagnoses can hinder marriage prospects and affect the reputation of the family (Ranawake, 2003 as cited in Tribe, 2007). It was anticipated that individuals diagnosed with a mental health problem may be reluctant to participate in the research. B. There is a tendency for trauma research to be based on clinical samples (Summerfield, 2002) which means that coping and recovery in individuals at a non-clinical level is given little consideration. Furthermore, this study adopts a community psychology approach and therefore a community sample was considered most appropriate. C. It is argued here that individuals within the health system are already being given support and that there are many individuals with unmet needs within the community. D. There are ethical considerations of working with someone currently receiving support and exposing them to potential further distress through participation in the study, which considers the impact of the trauma they were exposed to. E. The researcher was of the opinion that the study of trauma experience is highly nuanced making a community sample viable. F. There are a large proportion of Tamils who experienced trauma but have not entered the UK through the asylum seeking route and have not been diagnosed with a psychiatric disorder.

3. Individuals who had worked in mental health services either in Sri Lanka or the UK, were excluded from the study. This is because it is possible that those with

professional knowledge and clinical experience of mental health may have developed alternative coping strategies and beliefs about trauma and wellbeing, which are influenced by their professional training and roles.

The Use of an Interpreter

The use of an interpreter was carefully considered by the researcher. Although the researcher can understand Tamil, they were unable to speak it fluently enough to conduct the research interviews. However, the researcher's ability to understand Tamil was useful when some interviewees chose to speak it in parts of the interview. The researcher chose not to use an interpreter because in exploratory research of this nature, the use of an interpreter can be limiting. Using an interpreter can affect the flow of communication which is important given the interviews involved discussing distressing experiences. The researcher felt that the interviewee may not feel truly listened to or excluded if there was a constant dialogue between the researcher and the interpreter. Secondly, Tamils may have been reluctant to talk about personal issues in front of others from the same community due to fear of this information being shared within the community. The use of an interpreter may have influenced the responses provided by participants and their willingness to be open.

Furthermore, the critical realist position adopted in this study acknowledged that knowledge is context dependant and that location within the social world influences the way in which the world is viewed. In qualitative research, the researcher's interpretation of the data is influenced by their own personal background, experiences and beliefs, which the researcher must be mindful of throughout the research process. Interpreters also form part of the process of knowledge production and there is no neutral position from which the interpreter can interpret from (Temple & Young, 2004) as their values and beliefs may influence the way they interpret and translate the responses, creating more opportunities for bias in the data. When using interpreters there can also be disagreement between researchers on a 'correct' version of a text and many researchers have argued it is not possible to ensure a 'correct' version as translation is less about syntax and more about the meaning constructed through discourse (Simon, 1996).

Interview Format and Schedule

All the interviews undertaken began with the researcher providing a rationale for the study followed by a discussion about confidentiality, consent and withdrawal (see Appendix E for a description of what was said to participants). When the researcher was satisfied that confidentiality and consent were fully understood, a semi-structured interview was undertaken which lasted between 60 to 90 minutes.

The interview schedule (Appendix G) was developed by the researcher based on a review of existing literature and in consultation with research supervisors. Feedback was also sought from family members, researchers, and professionals with experience of working with Tamils, and with experience in qualitative data collection. A pilot interview was not carried out as the researcher was aware of the limited pool available to recruit from.

The schedule aimed to explore participants' experiences of living through war and political conflict and to consider their experiences of coping. Factors such as British culture and acculturation and their impact on coping were also considered. The main focus of the interviews was not the source of trauma but rather how participants coped with their experiences.

The interviews were semi-structured to allow exploration of issues which emerged during the interviews and to provide opportunity for additional questions if appropriate or prompted by interviewee responses. The interview schedule was modified as interviews were undertaken and the researcher gained more knowledge on the topic and keys themes emerged. Wording and terminology were also modified to make more relevant and accessible to participants. For example, initially the word 'coping' was used which many participants did not identify with and this was explicitly discussed in subsequent interviews.

Interview Transcription

Interviews were recorded using an Olympus digital voice recorder and transferred onto a USB device which only the researcher had access to. The interviews were transcribed by the researcher using Express Scribe Transcription software programme. The researcher used orthographic transcription, reproducing spoken words, hesitations, false starts and cut-offs in speech. Laughter, pauses and strong emphasis on words was also recorded in line with this transcription method (Braun & Clarke, 2012). In the results chapter, data extracts were edited

for brevity. Details considered unnecessary were removed but acknowledged by the researcher, as recommended (Sandelowski, 1994).

Analytic Method

Pattern-based approaches. There are a number of pattern-based analytic methods which explore themes across qualitative data including interpretative phenomenological analysis (IPA) and grounded theory (GT). Each approach views data through a different theoretical lens. IPA is a phenomenological approach which is interested in exploring people's lived experiences and the meanings they attach to those experiences. This method was not considered appropriate as it involves a dual interpretative process in which the researcher relies on their own interpretative resources to make sense of participants' meaning making (Smith, Flowers & Larkin, 2009). Furthermore, IPA involves idiographic analysis, concerned with the specifics of individual experiences through small samples. Given the limited research on coping in the Tamil community, the researcher felt it was appropriate to use a larger sample and to search for themes across the data.

GT aims to construct theory that is grounded in qualitative data (Pidgeon & Henwood, 1997). It is particularly useful in the study of sociological and social psychological processes rather than individual experience. The researcher did not consider this an appropriate analytic method as the research topic was under-researched and the researcher was interested in gaining a broad understanding of coping amongst Tamils. Furthermore, the focus of GA is on theory development which is not the aim of the current research.

Thematic analysis. Thematic Analysis (TA) is a method of analysing data rather than a methodology in itself. This is unique among qualitative analytic methods as TA can be used with any methodology, and is epistemologically and theoretically flexible. Furthermore, it is accessible to researchers new to qualitative research.

TA is a method which allows the researcher to systematically identify and organise themes and patterns in data sets. A theme is defined as one which "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). Although previously some have considered it poorly defined, it is now an increasingly popular method of qualitative data analysis because it is accessible and flexible (Braun & Clarke, 2013). It is

now a widely recognised and accepted method of qualitative analysis (Joffe, 2011; Stainton Rogers, 2011). TA was considered appropriate by the researcher because they wanted to make sense of collective and shared experiences by looking at common themes and areas of difference across the interviews.

TA is considered a flexible approach because it can be used in a number of different ways, as it is able to position itself along three main continua associated with qualitative research. TA can take an inductive or deductive approach, an experiential versus critical orientation, or can assume an essentialist versus constructionist theoretical perspective (Braun & Clarke, 2012).

Forms of thematic analysis. In TA, analysis can be data-driven (inductive) meaning codes and themes derive from the data themselves. In this instance, what is mapped by the researcher during analysis closely resembles the data. Inductive TA uses this approach. Alternatively, TA can be theory-driven (deductive). In this approach, the researcher brings to the data a series of concepts and ideas which are used to inform data interpretation. In this instance, the codes and themes derive from existing theory the researcher brings to the data and what is mapped by the researcher may not closely resemble the data (Braun & Clarke, 2012). Theoretical TA uses such an approach. Experiential TA focuses on the participants' viewpoint and their experiences and understanding of the world. Finally constructionist TA focuses on how topics are constructed. Inductive TA is often experiential and deductive TA is often constructionist.

However, Braun and Clarke (2012) acknowledge that in reality, coding and analysis use a combination of both inductive and deductive approaches as researchers always bring prior knowledge to the data they analyse and it is difficult to ignore the semantic content of data, despite holding a particular theoretical construct in mind. They also acknowledge that in both approaches, analysis is shaped to a certain extent by the researcher's standpoint, disciplinary knowledge and epistemology. The researcher adopted an inductive analytic approach to thematic analysis in which analysis of the research data was shaped by the data itself. The researcher therefore looked for themes and patterns inherent in the raw data. This was considered appropriate given the limited research on the topic. Furthermore, this approach acknowledges that the analytic process will inevitably be informed by the researcher's views and wider knowledge within the discipline of clinical psychology. The researcher held knowledge about coping and beliefs about distress in BME communities, as well as factors

which influence coping such as migration and acculturation. The researcher considered it appropriate to develop researcher-derived and data-derived codes during the analysis. However, coding was not explicitly based on pre-existing theories or questions and remained closely linked to the semantic data content. The researcher kept an audit-trail of decision-making and their reflections throughout the analytic process.

Stages of analysis. Although TA can be conducted in a manner of ways, Braun and Clarke's (2006) six phase approach is outlined here. The researcher chose this particular approach because of their limited experience of qualitative methodology and because the approach provides a clear and coherent method of undertaking TA. Furthermore, it has been argued that other methods of undertaking TA are less theoretically flexible (Bernard & Ryan, 2010).

Phase one: Familiarising yourself with the data. The researcher familiarised themselves with the data by listening to the audio data, transcribing the interviews, reading the interview transcripts, and making notes on the data, highlighting items of particular interest. Transcripts were read repeatedly in order to become familiar with the data.

Phase two: Generating initial codes. Initial codes were then generated from the data. Some of these codes remained close to the content of the data and the meaning of the participants (semantic or data-derived codes), whilst others provided interpretation about the content of the data (latent or researcher-derived codes). It is recognised that during this phase of analysis, whereas some codes may mirror participants' language, others may mirror the researcher's frames of reference (Braun & Clarke, 2006). Where possible, the researcher differentiated semantic and latent codes when labelling and coding in the analysis, however acknowledged that this separation was not always pure and that some codes could have both semantic and latent meaning (Braun & Clarke, 2013).

Phase three: Searching for themes. In this phase of analysis there was a shift from codes to themes in the data. Codes were organised into potential candidate themes and coded extracts of data were organised within these themes. A theme was defined as one which captures something important about the data in relation to the research questions at hand. The researcher acknowledged that searching for themes is an active process and the themes are constructed by the researcher rather than 'discovered'. The researcher was mindful of the

relationships between codes and themes and their own influence in the organisation of them. As previously mentioned, the researcher kept an audit-trail of decision-making and their reflections throughout the analysis phase. This was achieved by using memos and audit trail functions within MAXQDA (version 12) as well as a reflective journal.

Phase four: Reviewing potential themes. The potential themes were then reviewed in relation to the data set and the coded data and refined accordingly. This phase was a recursive process and involved re-reading all collated extracts as a form of quality checking. Themes were checked against the collated extracts of data to consider whether the themes worked or needed refining. At this stage, some themes and codes were discarded as they did not meaningfully capture the data and some themes were collapsed or split.

Phase five: Defining and naming themes. The themes were defined depending on the elements of the data they captured. During this phase, theme and subtheme names were developed for the key themes identified.

Phase six: Producing the report. The final phase involved writing about the data. The report identified key themes which were supported by data extracts. Aspects of the report writing occurred throughout the analysis process and not only at the end, so the reflective journal and memos were also referred to. During this phase similarities and differences within the dataset were discussed as were possible explanations for the emergent themes.

Participants

A total of 16 participants expressed interest in the study. Three participants did not meet the recruitment criteria. The researcher made several attempts to contact one participant but they did not respond. Furthermore, two participants initially agreed to participate, however decided not to, following a request for further information. One participant stated they had changed their mind whilst the other had spoken to their family who advised them to withdraw as it was considered unhelpful to talk about past experiences.

Data was collected from 10 interviews with Sri Lankan Tamil adults with experience of living through war in Sri Lanka. Six women and four men participated, and all were living in the UK at the time of the research. The participants were aged between 31 and 82 years at the time of interview. The overall mean age of the participants was 51.9 years. The mean age of

the women participants was 50.3 years and the mean age for men was 54.25 years. Eight participants were married, one was widowed and one was single. Four had claimed asylum in the UK whilst six had immigrated for work and study purposes. Participants spent varying lengths of time in Sri Lanka (16 to 56 years) and in the UK (from 5 to 26). All participants were fluent in English and described themselves as Sri Lankan Tamils. In terms of religion, all 10 participants considered themselves Hindu. Finally the participants all met the study's inclusion and exclusion criteria. For the purposes of the research, all participants were given fictitious names (see table 3.1, p.61 for participant details).

Participants' Experiences of War

All participants involved in the study had direct experience of war and lived in areas of Sri Lanka which were considered war-zones including Jaffna and Vanni. All participants knew of relatives, close friends and community members who were murdered during the war and many had witnessed assaults and murders. One participant's father was assassinated by the Indian army for assisting the Tamil Tigers during the war. Another participant's husband was assassinated in their family home by members of a militant group due to their involvement in Tamil politics. The participant heard shots and discovered his body along with those of his colleagues. Threats were also made to her son's life. Another participant's brother was killed when he was 30 years old, fighting as a member of the LTTE. This participant worried that her and her family through association would endure the same fate and fled to India. Another participant witnessed a colleague (and close friend) shot dead in front of her by an army officer for not following instructions correctly.

Many participants lived in fear of shelling, bombings and shootings and some sustained injuries during the war. One participant who was a former member of the LTTE was injured so severely that he was paralysed and spent six months in hospital. Another participant recalls a bomb being detonated outside his children's nursery school and fearing that his children had died, however they had taken refuge in a church nearby. Most participants had bunkers which they would hide in during air raids, however this came with its own risks as often snakes or poisonous insects lived in them. Many participants were forced to move home, sometimes living in the jungle and returning when it was safe to do so. One participant remembers doing this at a young age and being responsible for her younger siblings as they fled in the night. Many participants lived in fear that they or their relatives would be kidnapped, sexually abused, attacked, detained in army camps or murdered. One participant

witnessed a relative being kidnapped by army officers and remembers her family were able to get him released from an army camp shortly before he was due to be executed. The same participant experienced sexual abuse during army searches and patrols. Others had spent time in Internally Displaced People camps where they experienced violence, torture and starvation.

All participants experienced food and water shortages, power cuts and transport difficulties during the war. Medicine and medical supplies were also difficult to obtain and raising children was extremely challenging in this environment. Given that main roads were often closed, goods could not be imported into war zones and therefore the prices of rations inflated considerably and only the wealthy could buy goods. One participant recalls seeing the bodies of orphaned children in the street that had died from starvation. Most participants endured disruptions to their education and employment due to closures of roads and buildings and having to flee the area during periods of conflict.

Ethical Considerations

Researchers should adhere to ethical principles and guidelines and minimise harm and risk when conducting research with human participants (British Psychological Society, 2009). The steps undertaken to ensure ethical guidelines were adhered to are described in detail below. The application for University ethics approval was sought from the Faculty Ethics Committee at the University of Essex. The approval for the study was granted on 4th June 2015 (see appendix H).

Consent. The researcher sought informed consent from all participants prior to their participation. Participants were provided an information sheet (Appendix C), and given sufficient time to consider whether they wanted to participate and provided an opportunity to ask questions. Participants completed the consent form prior to the interview (Appendix E).

Confidentiality and anonymity. Confidentiality was discussed with each participant prior to their participation. Given the participant group and their previous experiences, it was emphasised that information would not be shared outside the research team. The need to break confidentiality due to the emergence of risk issues was also discussed. It was also explained that the data collected would be anonymised so that it could not be linked back to specific individuals.

Preventing or undoing psychological harm. Although a community sample was used in the study, given the research topic was highly sensitive in nature, the potential for generating distress needed to be considered. Individuals were recruited from specific organisations which are able to provide community support and signposting for individuals in distress. The researcher also used snowball sampling and acknowledged that some individuals may not have had access to a support service (although this was not the case). The researcher informed participants of their rights to withdraw from the research at any stage of the process. If the researcher recognised that a participant became distressed during the interview they would terminate the interview or give the participant the opportunity to have a short break. The researcher endeavoured to handle the information gathered sensitively and as a trainee clinical psychologist has developed clinical skills which helped them to explore distressing topics safely and to provide appropriate support if participants became distressed.

The researcher followed the risk protocol outlined by the North East Partnership Foundation Trust if during the interviews, issues of risk or safeguarding emerged. In these instances, issues were discussed immediately with research supervisors and the risk protocol was followed. Where serious issues of risk were raised, the researcher planned to inform the community organisation the participant was recruited from in order to provide or signpost to appropriate support.

Information was provided to research participants on a number of organisations which could provide information, advice and support to individuals from the Tamil community should they require it at any time during the research process (Appendix I).

Debriefing. All participants who were interviewed were offered a de-brief following the interview. Firstly it was thought that some participants may be suspicious about the purpose of the research and the researcher wanted to ensure the rationale for the study was properly understood. Debriefing also involved a therapeutic component, allowing participants to talk about their experience of participating in the research and to discuss the impact of participating and any difficulties encountered. The researcher discussed issues which emerged during the de-briefing with their research supervisor.

Risks to participants. During the interviews, if risk or safeguarding issues emerged, the risk protocol was followed as discussed above. No issues of risk or safeguarding were encountered whilst collecting the data and none of the participants requested additional debriefing following interviews.

Risks to researcher. The researcher regularly used supervision from their research supervisors to debrief and reflect on interviews. The data collection process involved lone working, occasionally in the evening, and therefore the lone working policy was followed (Appendix J). The researcher was mindful of time and location when conducting interviews. Where possible interviews were undertaken within community settings rather than participants homes.

Power imbalance. If participants asked about the researcher's own story, this was discussed following the interview. The researcher did not feel it was ethical to expect participants to share their experiences and not disclose anything about their self in relation to the research topic of interest. The researcher explained that they were born and brought up in the UK so had no personal experience of the war in Sri Lanka. The researcher also explained that their family immigrated before the war however had some experience of ethnic conflict before this. The researcher was mindful of the potential implications of sharing information prior to the interviews on the research data and therefore chose to disclose this at the end of interviews.

It was also important to consider there may have been a power imbalance between researcher and participant in terms of social class, educational and professional status. Bearing this in mind, the researcher highlighted the confidentiality policy, the participant's right to withdraw from the study and was mindful that individuals did not feel obliged or coerced into participation.

Reflexivity

In qualitative research, the researcher takes an active role in the research and becomes a part of the research as well as involved in the construction of knowledge (Braun & Clarke, 2013). In fact qualitative researchers aim to maximise the benefits of actively engaging with participants (Yardley, 2008). McLeod (2001) suggested that reflexivity implies a certain capacity for "bending back" or "turning back" one's awareness on oneself. Qualitative

research is concerned with interpretation and meaning is always given to the data rather than being discovered (Willig, 2012). The researcher recognised that their values, beliefs and assumptions can shape interactions with participants and influence how the data is analysed and interpreted and that this could be both limiting and facilitating (Willig, 2001).

The researcher felt it was important to acknowledge their own background in the research study and possible implications for the research. At the time of conducting this research, the researcher was a trainee clinical psychologist in their final year of training. The researcher was mindful that clinical training may have shaped both their professional and personal understanding of mental health, distress and coping

The research topic chosen has been heavily influenced by their own ethnic and cultural identity. The researcher takes both a professional and personal interest in the research topic, particularly in the current UK climate which has seen a rise in war-affected refugees and asylum seekers entering the UK, with high levels of unmet need as a result of their experiences. The researcher did not have personal experience of the phenomenon under investigation which may have framed the researchers approach to the topic (Willig, 2001) and perhaps the participant's perception of the researcher. This will be discussed further in reflection section of the discussion chapter.

Although the researcher was a Sri Lankan Tamil, they had lived and been educated in the UK and had limited prior exposure to the Tamil community. This may have provided multiple perspectives which inform the interpretation of the data (Somasundaram, 2007). These differences and their impact on the research process are explored further in the discussion chapter.

The researcher developed their reflective capacity through 'field' notes before and after each interview reflecting on their personal reactions to participants and documenting key features of the interactions and salient aspects of participant responses. In doing so the researcher attempted to reduce the potential for bias in the data. A reflective journal was also completed during the research process documenting the struggles and dilemmas encountered in the research and academic supervision provided a space to explore my own perspective and position and potential implications.

Given the researcher's knowledge of the Tamil community, they were aware of the importance of respect and therefore made the decision to refer to older participants as 'Aunty' and 'Uncle' in line with Tamil tradition.

Qualitative Rigour

Transferability. Validity, reliability and generalisability are often used to assess the rigour of quantitative research, however their relevance and application to qualitative research has been questioned (Willig, 2012). Reliability is a term which tends to be associated with positivist and realist views about reality. Quantitative approaches are often based on the notion that knowledge can be acquired through observation and seek to develop generalisable ideas and minimise the influence of the researcher who may be considered as a source of bias. Qualitative approaches depending on the epistemological position assumed by the researcher are often based on multiple realities and the idea that reality can be context specific. Qualitative research acknowledges the role of the researcher in the research process and does not seek to minimise their role (Yardley, 2008 & Yardley, 2000). Reliability may therefore not be a useful way to assess the rigour of qualitative research.

Transferability is a term more frequently used in qualitative research and refers to the extent to which qualitative results can be applied to other contexts and to other groups of individuals (Lincoln & Guba, 1985). Lincoln and Guba (1985) suggest that the key to enhancing transferability is to describe in detail the specific context, the setting of the study and the participants so that the reader can evaluate whether the results can be applied to other contexts and participant groups.

Credibility. When multiple realities are constructed by research participants, it is important that they are represented as authentically as possible. Member checking or respondent validation is the practice of checking the data analysis with participants and confirming or challenging the validity of the data. It is regarded as a means of establishing credibility and dependability of the findings (Johnson & Waterfield, 2004) but can also gather additional original data which requires further analysis (Mays & Pope, 2000). It usually involves presenting a draft version of the research or analysis (oral or written), and asking some or all participants to comment on the trustworthiness of the analysis produced. It is hoped that in seeking validation, participants may recognise aspects of their world within the research findings (Horsburgh, 2003). It is considered important to have a good fit between the

interpretations of participants' experiences and the participant's own understanding of their experiences and correct inappropriate interpretations of their subjective experiences. Lincoln and Guba (1985) suggest member checking is a way to establish the research data and analysis is credible. Due to time constraints and difficulties in recruiting participants who met the selection criteria, it was not possible to use member checking within this study.

Braun and Clarke (2006) identified a checklist of 15 criteria which can be used to assess the quality of thematic analyses, many of which can be applied to more general qualitative research. These criteria were considered by the researcher (see discussion chapter).

Auditability. Although qualitative research cannot be easily replicated to prove reliability, it can be audited. A qualitative study should therefore provide detailed data and a pathway of the decisions made during the collection and analysis of the data that other researchers can follow (Giacomini & Cook, 2000). This study aims to provide reasons for the theoretical, methodological and analytic choices made by the researcher in order for the reader to understand why decisions were made.

Confirmability. Although it is not possible for the researcher or the data in qualitative research to be neutral, confirmability ensures that other researchers may reach the same interpretations of meaning as the original researcher (Chard & Gaberson, 2001).

Chapter 3 Results

The results of the study are presented in this chapter with data extracts from 10 participant interviews.

Study Sample

Although demographic information was provided in chapter 2, Table 3.1 below provides an overview of the study sample with pseudonyms and details pertinent to the analysis.

Table 3.1

Overview of the sample

Participant Pseudonym	Age (Years)	Duration lived in the UK (Years)	Original Status in UK	Relationship to Tamil organisation
Gayathiri	39	10	Asylum Seeker	Volunteer
Balakumaran	63	16	Immigrant	Service user
Aravan	31	6	Asylum Seeker	Volunteer
Gajendran	67	25	Asylum Seeker	Service user
Arulini	36	15	Immigrant	Volunteer
Jothipriya	82	26	Asylum Seeker	Service user
Rajalakshmi	31	5	Immigrant	Volunteer
Nithiran	56	25	Immigrant	Service user
Shivani	53	16	Immigrant	Volunteer
Vanaja	61	25	Immigrant	Volunteer

Analysis

Themes from the data were developed using thematic analysis and Braun and Clarke's six phase approach (Braun & Clarke, 2006) outlined in chapter 2. Table 3.2 (p.62) provides a summary of the themes and subthemes. Six themes were identified incorporating 16 subthemes. Temporal and geographical distinctions are specified within themes and subthemes and are made explicit throughout the discussion of the results. The chapter begins with consideration of themes pertinent to a Sri Lankan context. It then explores themes relevant to both Sri Lanka and the UK, followed by themes unique to the UK. All sub-theme names are direct quotes from participant interviews.

Table 3.2

Identified themes and subthemes

Theme	**Sub-Theme**
Survival at all costs	"We tried to avoid any encounters"
	"Day to day survival itself has become a challenge"
	"We have to meet violence with violence"
The power of the mind	"You have to accept it, you can't do anything about it"
	"It's a sad story we don't want to go back"
	"Now we are better off than others so be thankful"
With the help of others you survive	"You'll tell each other I'm with you, I'll look after you"
	"Not only me, how many of them suffered"
	"It's all because of our kids"
The value in talking	"They will tell their stories and they have peace of mind"
	"You want to share your experiences in the proper manner"
	"Before I was not a talking person"
Improving life for yourself and others	"If we empower the people then they will make a change in their society"
	"I do contribute my part to my people"
Searching for a different life in the UK	"We have a safe life here"
	"The first year wasn't that great here"

Theme One: Survival at all costs. It seemed that during the war in Sri Lanka, participants did whatever was necessary to help themselves and others survive. The subtheme *we tried to avoid any encounters* reflects the idea that participants had to keep a low profile and did so in a number of ways including withdrawal from normal routine and isolation, changing their appearance, and hiding and fleeing war zones. Basic essentials of life were

either extremely limited or expensive during the war and participants had to be resourceful in order to access food, shelter, and safety. This often involved working together with family and community members which the subtheme *day to day survival itself has become a challenge* captures. Finally, the subtheme *we have to meet violence with violence* describes how militant and political groups were idealised during the war and how many felt that only militants were able to provide safety and security in war zones.

We tried to avoid any encounters. For many, survival was the only priority during the war-time. Many participants had to keep a low profile in order to avoid army personnel and conflict-zones. This involved restricting their movements, spending long periods of time at home, and changing their daily routine which many described as 'boring'. Most participants remember living under a curfew between 6am and 6pm and most were aware of the consequences of breaching it:

> Rajalakshmi: After 6 o'clock no one will be out, 5:30 they all come together we just close the doors
> Researcher: Is this the curfew you gave yourself or the curfew of-
> Rajalakshmi: No they put the curfew after 8 o'clock, but we just made it before it gets dark yes so 6 o'clock you would all be in, they put the curfew as well if they see you at night you shot

Other participants even restricted their movements outside curfew times, particularly those who felt their lives were in danger. Such participants feared if their routines were predictable, they had less chance of survival and so gave the army and militant groups less information to rely on as illustrated by Gajendran who discovered that his name had been placed on a hit list:

> I don't leave home at a particular time, if there is a particular pattern only say if you leave at nine o'clock and come back at ten o'clock only, I don't leave at a particular time maybe eleven o'clock maybe seven o'clock, no one can predict my movements. (Gajendran)

A few participants tried to keep safe by isolating themselves in certain areas and avoiding areas that were populated by Sinhalese army troops. This at times meant they could not undertake any leisure or social activities as Nithirin recalls:

> We tried to avoid any encounters as much as possible we tried to confine to an area rather than going everywhere, we in the university area our friends should know where I am and parents will know that I am in the university area, rather than going to the town or going to the movies or anything. (Nithirin)

Even at home, participants did not feel safe and had to keep a low profile as the army frequently did spot checks. This made family life extremely difficult and participants constantly lived in fear as Rajalakshmi recalls:

> Even if your own voice if they hear you they will kill you, how will they accept the movie voices and things sounds so we never had the chance to watch movies, even though we listen to the radio it's like hearing effects and things like that we hear it in a very less voice […] if army comes then your family will be destroyed. (Rajalakshmi)

A few female participants recalled needing to keep a low profile particularly during their adolescence when they were most at risk of sexual abuse and exploitation. In Tamil culture, girls have a coming of age ceremony which they felt made them targets to army men. Participants' families responded to this in a number of ways for example, having low key ceremonies to avoid interest from others, removing their daughters from school, restricting their movements, and in some cases arranging marriages as illustrated by Gayathiri:

> They not allowed us to go out much outside the home […] I had Poopathy [coming of age ceremony] you know I had reached coming of age so they had to keep us inside the house for I don't know for security […] even my older sister she did not go to school as well, after age 12 she had Poopathy you know, coming of age you know they get scared, after that they don't go outside they get married and that is it you know. (Gayathiri)

Other occasions such as birthdays and Christmas were also celebrated minimally so that participants would not draw unnecessary attention to themselves and many families feared the consequences of being caught:

> Rajalakshmi: One of my cousin's birthday actually we wanted to celebrate it […] only answer that we get 'you know army will catch you, do what you want they will catch you, then don't cry' so then you wouldn't do that
> Researcher: You are constantly in fear aren't you?
> Rajalakshmi: So you wouldn't do that, so what happened that's his birthday and then we wanted to really put balloons on and the candles on

A few participants found that being able to disguise their identity was a protective measure during the war. They found that looking like members of a different ethnic or religious group meant they were less restricted and less likely to be stopped, searched and questioned. This is illustrated by Gajendran who remembers why resembling a Muslim person was helpful during the Colombo riots:

> Those days I wear a beard as a teenager so people always misunderstood me as a Muslim so I look like a Muslim (laughs), so I was safe so I was going around and having a look at what had happened. (Gajendran)

Some found that their distinctive appearance and dress-sense easily identified them as being Tamil and this associated them with militant groups as Rajalakshmi describes: "even though I am in Colombo the army identify easily you are from Jaffna so even though I am a small girl because that's your tradition" (Rajalaksmi). This participant completely changed her appearance to avoid being arrested or harmed:

> Rajalakshmi: I changed myself my complete appearance
> Researcher: Why do you think you did that?
> Rajalakshmi: Because I don't want everyone asking me 'are you Jaffna so are you an LTTE', everyone asking me that question it sounds terrible to me and then I thought because of my appearance they just asking me this bloody questions […] then I started not having the Pottu [marking on forehead], I don't wear the earrings and then I started doing that like other Singhalese

Some participants kept a low profile by fleeing war zones and seeking refuge during periods of bombing and shooting. Some participants recalled retreating to bunkers despite this being filled with its own dangers: "any sudden noise heard everyone goes to the bunker, at the same

time bunker inside has a snake in there, then we throw the kerosene and then the snake goes out" (Balakumaran). Other participants remember having to leave their homes and travelling to rural areas or the 'jungle' with their families during armed conflict, returning when it was safe to do so. One participant describes the pattern that many participants were familiar with:

> I left my village in Jaffna in the night time I told you, you know I take my two sisters and my relatives and we go through the jungles you know, the jungle in the night time bombing you know, and if they bomb we have to lay down on the floor and after they go silent you know we have to walk. (Gayathiri)

For many this process of moving and returning became a formalised operation as one participant describes:

> Arulini: It was called liberation operation yeah so we had moved we always moving moving moving
> Researcher: Moving, what do you mean moving home or moving town?
> Arulini: Moving town even to somewhere and living 10-15 days, and then come back to home

Other participants left war-zones such as Jaffna because of the scarce resources available which made it difficult to survive. Many went to live in the capital city Colombo because of the resources and opportunities:

> We left the Jaffna and go to Colombo […] difficult to stay there it is problem for cooking, staying without current no medicine can't cook because fresh wood only because the fresh trees only available dry ones never, you can't get it because if transport is available only the dry wood will come to our place, if the transport stops everything stops, no food no medicine and no electricity. (Balakumaran)

All participants made the decision to leave Sri Lanka and move to the UK and although for some this was for education and employment purposes, for many it was because the war made it impossible to stay. Some participants' journeys to the UK were complicated and lengthy, particularly for those seeking asylum or travelling illegally. Gayathiri recalls her journey to the UK via several countries:

> Gayathiri: We left in '92 Sri Lanka, we can't come through you know we haven't got any visas you know, you have to pay money and go you know immigration, asylum seeker
> Researcher: So you sought asylum?
> Gayathiri: Yes asylum in Denmark you know, I went through first Singapore then Thailand and Malaysia it's not easy way

It was common for participants to flee to India before coming to the UK and although some went to study, participants acknowledged they fled for safety as Aravan illustrates in his description of how he travelled to the UK via India:

> Stayed for two months and returned to Sri Lanka, stayed there for one month and then came to the UK, it was also very complicated because of the arrangement for illegal immigrants. (Aravan)

Some participants still believe it is unsafe to return to Sri Lanka: "my eldest son even now he doesn't visit Sri Lanka and we also didn't go don't want him to go there" (Jothipriya). A few participants tried to keep a low profile by refusing to join militant groups as illustrated by Shivani: "I don't want to go with join the LTTE, I don't like to". Others were forced to abandon militant groups in order to survive which included surrendering to the Sinhalese army: "actually we surrendered to the army in 2009" (Aravan).

***Day to day survival itself has become a challenge*.** During the war participants had to be extremely resourceful in order to remain safe and stay alive. Food and resources were extremely scarce and participants coped by being inventive. One participant remembers having to play with 'mud' and 'coconut husks' in the absence of toys as a child (Gayathiri). Many participants remember growing their own food and living simply as food was difficult to buy due to the high cost and short supply:

> In front of my house a large mango tree is there, we pick all the mango and make a pickle and one brinjal [aubergine] I grafted that gave us 25 to 30 brinjals then we cut it and cook that one, in front of my house a coconut tree give 35, 40 young coconuts at the same time I pick all those things and cooked all the meals, those are the things we

> have done, you can't buy the vegetables in the market, you can't buy the fish in the market, you can't buy the rice in the market even oil you cannot buy. (Balakumaran)

Some participants went long periods without food and coped by drawing on their experiences of fasting for religious purposes to manage food shortages:

> In our culture our Hindu religion, they fasting you know, they are all used to fasting that one is also helping our people you know, we can't take 3 times there like breakfast lunch dinner but people that time very difficult get the food or anything they used to fasting, do you know like no breakfast or lunch and sometimes they take dinner that one is also helping enna [isn't it]. (Shivani)

At times when there were power cuts, participants would find their own creative methods of producing power: "radio listening, radio no current, then you put the bicycle and dynamo and conduct the current and listen to the radio" (Balakumaran). In order to cope with their circumstances, participants had to live minimally and ensure nothing was wasted: "we don't want to waste anything or we don't want to go any big, like big party or big food like everything is very simple" (Shivani). Where necessary, participants responded to bribes for their own safety. Many participants recalled they would have to pay militant groups as they feared for their lives. They also described that there was no law and order so participants had no authority to report such crimes:

> They come to my office and ask, give me 500 rupees or 5000 rupees, otherwise so there is no law and order normal police and army security is broken even if you go and complain to the police and army, next day they will come and shoot you. (Gajendran)

Others bribed those in law enforcement to remain in areas of safety or faced having to return to war zones: "we came back to Colombo and then we bribed the police there we paid some 50000 or something" (Rajalakshmi). Bribery created a dilemma for participants and whether they paid bribes or refused them there were implications to consider. One participant described it as a "very tight balance" (Gajendran) because if you were caught paying militants you were arrested and if you refused to pay you faced being killed. Gajendran illustrates this:

> Even if we give illegally 50 rupees or 100 rupees, if they come to know they will arrest us for supporting terrorists, if we don't give those fellows they will come and kill. (Gajendran)

Most participants reported coping collectively in Sri Lanka during the war sharing resources, which were scarce, or knowledge with each other in order to survive. One participant recalls members of militant groups were given special provisions and that he would often share this with community members:

> We are injured people so we have some special treatment, like they will give some food for us for the LTTE. So we have some food, healthy foods […] yeah so if they give the food then I will give to the small kids you know, walking around cause they are starving enna [isn't it] they are dying. (Aravan)

Other participants gave money from their own salaries to those less fortunate as Shivani illustrates: "I have some salary or money or something I have, then I gave to people like ok you don't have food today then you can have money" (Shivani). Some Tamils did not have safe places to stay during times of conflict and participants would invite them to stay in their homes and often shared living space with strangers, as Vanaja illustrates:

> My brother friends they came and we always provide the food and everything, sometimes they didn't have a place to sleep they came our house to sleep. (Vanaja)

It seemed this problem-solving approach was passed down from one generation to the next: "and my mum always teach me like that 'ok you have this problem you have to think how to solve this now, how to solve this, how to come out of it' so that's how my mum teach me actually" (Rajalakshmi). Many participants adopted a problem-solving approach to help other Tamils think about how to access the resources they needed during the war-time. Shivani illustrates this as she remembers the advice and practical support she would give to others:

> It's ok we can manage don't worry yeah, ok you want money you want any food or you want this one or you want this one or you want any help or you are sick. (Shivani)

For a few participants it felt important to teach life skills to younger generations based on the limited resources available at the time and threats to survival:

> I am teaching the life skills whatever things are available you must live with them […] that will only help them in their life. (Balakumaran)

A few participants acknowledged the value of international aid offered to victims of war which helped many to survive during times when food and medical assistance were in short supply. Some participants remember being provided medical care by foreign charities such as the British Red Cross or Medecins Sans Frontiers. One participant describes some of the support such agencies were able to provide: "one time the helicopter, which country I don't know that one, they put the parcels on the roof pasta packets and everything" (Shivani). Another participant describes international aid agencies intervening during extremely desperate times: "and then in the 90s it became more severe you know, then only the international aid organisations got involved and supported the victims" (Nithirin).

We have to meet violence with violence. For some participants, it seemed the only way to cope with the war was to idealise and identify with militant groups, particularly the Liberation Tamil Tigers of Eelam (LTTE), and by trying to fight for political change in Sri Lanka. People chose to fight for change in a number of different ways including non-violent means such as protests. Some participants recall participating in hunger strikes as students describing it as a "moral obligation":

> Nithirin: You know the hunger strikes were very common those days
> Researcher: Amongst the students?
> Nithirin: Amongst the students yes, very common for you know if your batch mates were arrested and they go and complain to the university vice chancellor and ask him to speak to the higher authorities in the Ministries […] then they say ok, if you don't get the answer or if they don't release him immediately we are going to go on hunger strike

Others became members of political organisations and participated in demonstrations particularly during government elections. Their work involved contesting elections, attending meetings, and delivering speeches about political change. Where possible, supporting

political and militant organisations continued in the UK. Gajendran describes how he pursued his interest in Sri Lankan politics once in the UK:

> Because of these problems, one thing is I am involved in politics I am a politician not armed struggle the political side I used to work for EROS […] Eelam revolution organisation of students EROS and it was run from London […] so for elections I used to address meetings. (Gajendran)

Others coped by joining militant groups and actively participating in armed struggle. One former member of the LTTE illustrates his motivation to join the militant group:

> I was in the LTTE movement I was a fighter I took gun to shoot people however, but I killed in humanitarian way to people to save their lives to recover from their problems and also my heart was very soft, even if I had a gun in my hand my heart was soft, the gun I took the gun but always I think how to save people, how to help people how to help disabled people, also how to help people to get out of their situations. (Aravan)

Some participants suggested joining militant groups was a reaction to the difficulties many Tamils had to endure as part of the civil war as illustrated by Gajendran: "they were recruiting very easy the Tamil boys because of the atrocities performed by these people the Tamil boys went and joined the armed struggle" (Gajendran).

Even if participants did not actively join militant groups or participate in their activities, many participants seemed sympathetic to their cause and passively supported them as they felt helpless and unable to protect themselves against the Sinhalese army. Many believed that the only way they could survive was to retaliate: "so we have no other alternative because you are hitting us so we have to hit back" (Gajendran). This participant explains why Tamils felt they needed to support the LTTE:

> The whole of Tamil population tolerated the whole of these things because the atrocities by the Singhalese government and army is more so during the 80s especially in the 83 riots, so they thought maybe we have no other alternative other than support these people they are only fighting these people. (Gajendran)

For other participants thinking about avenging the army and fantasising about this seemed to help them cope with their distressing circumstances. For those who were abused by army men and women, their only comfort was to think about how they could get revenge whether it was achievable or not: "I did tell my mum straight I will definitely join LTT and kill these people, I will kill that lady I did tell her I will kill that lady" (Rajalakshmi).

Participants also spoke about fantasising they would be rescued by the LTTE:

> We had hope that LTTE will save us soon so this is the first thing that as I'm a child I was thinking 'oh one day Prabhakaran [Leader of the LTTE] mama [brother] will fight with them and then they rescue us […] mamas [brothers] will come and fight and kill these idiots and they will just rescue us', this is what we think. (Rajalakshmi)

Whether participants were for or against the militant group, most acknowledged that militants were able to provide safety and control in war zones which enabled them to survive. Some participants described having more freedom as the LTTE provided security in the town. It seemed that in the absence of police, militant groups took over the role of establishing law and order in war zones. This is illustrated by one participant:

> No it's like when we were in Jaffna in my age of 11 that was LTTE's control at that time Jaffna Northern East where we had our safe life until 11 years, that you can walk in the midnight on the road you can wear gold jewellery and then walk alone on the road that's how the LTTE have given the security to us. (Rajalakshmi)

Other participants remember that militants shared information with them which kept them safe and helped them to avoid areas which the Singhalese army occupied. One participant remembers:

> We have access to the LTT cadre [officer] they know where the Indian army is moving so they guided us 'don't go this way or that road go to that way' so I we are lucky I think I was lucky so that support. (Vanaja)

Theme Two: The power of the mind. Most of the participants described using a wide range of "mental" strategies to cope with their experiences. These strategies, some of a

psychological nature, were adopted both during the war in Sri Lanka and when participants moved to the UK and adjusted to life after it. There were times in Sri Lanka when participants were unable to change or improve their circumstances in war zones and dealt with this by accepting the reality of the situation. The subtheme *you have to accept it, you can't do anything about it* depicts this. Most participants spoke about wanting to forget about painful experiences and the thoughts and feelings associated with them both in Sri Lanka and the UK, which the subtheme *it's a sad story we don't want to go back* explores. For many participants, positive thinking was extremely important in coping with experiences of war. The subtheme *now we are better off than others so be thankful* illustrates the positive attitudes and positive self-talk which participants relied on in the UK.

You have to accept it, you can't do anything about it. For many participants, in Sri Lanka there were times when their best efforts were futile and they experienced repeated ordeals which they could not avoid or escape. Some therefore learnt to accept that no matter what they did they had very little control over their circumstances; a psychological concept commonly known as learned helplessness. For some, being realistic about the situation meant they could prepare for the worst: "we couldn't imagine that we could escape that situation we thought that it is our last days at the time" (Aravan). For some, acknowledging the possibility that they could die at some point during the conflict seemed to make the uncertainty easier to tolerate, as illustrated:

> They shooting you can see the army man he is shooting so you see that and then it's coming in front of you or behind you and then you say oh I'm dead I'm dead this is what we think. (Rajalakshmi)

Despite feeling afraid, acknowledging they had little control over their circumstances was an important process for some: "actually we prepared mentally yeah mentally like ok then anything happen it's ok that's fine" (Shivani) and being prepared to face the worst in many ways made day to day living easier in the war zones:

> I'm not scared about myself 'it's ok if anything happens it's ok that's fine' because otherwise we can't go anywhere or anything we can't then manage this war and everything. (Shivani)

Some also believed that over time, people were able to accept their circumstances in order to move on: "you have to accept it no you can't do anything about it no" (Gajendran). However, participants also recognised that the process of accepting loss and suffering took time:

> Time heals they say no, if somebody dies your father somebody dies, the first week you are very sad after one month you have all these ceremonies and I think all these ceremonies are designed not for the benefit of the dead person, for the benefit of the living they coming to terms with their loss you see. (Gajendran)

A few participants were involved in extremely traumatic incidents and subsequently developed trauma memories. When death seemed a reality some individuals experienced severe physiological stress responses, as one participant described: "the blood freeze […] we were scared so many things happened in my body and mind you see" (Vanaja). Another participant described her reaction to hearing her relative's voice from a detention camp and fearing he would be killed. She was able to vividly recollect this trauma memory:

> 'Please let Anna [my older brother] come out don't kill him' and things like that but when we went to the camp we can hear our Anna screaming, I think I had fainted and that's it I don't know what happened after that, I think my mum took me there is no hospital at that time only a doctor who lived in our village she took care and then she said 'that because of […] scared and shock and hearing the voice of her brother'. (Rajalakshmi)

Although this can be well understood in the context of a trauma, the participant's reaction to severe emotional stress can also be understood in the context of learned helplessness. This may occur in environments of repeated or on-going threat and submission. Such responses may facilitate separation from the present moment or dissociation from painful emotions, enabling self-preservation. Many Tamil individuals, through their experiences lost hope after they endured on-going difficulties and other coping resources became unavailable. This is explored more in the discussion chapter.

It's a sad story we don't want to go back. Most participants wanted to avoid ruminating over painful experiences both in Sri Lanka and the UK and talked about "diverting my mind" or "converting my mind" in order to cope. One participant was shot

during the war and seriously injured. He nearly died as a result of his injuries and spoke about how he managed this through deciding not to think about dying:

> I decided that and I completely convert my mind at that time. I never think about this I am going to die or anything […] I completely I decided I am going to I can sometimes I can try or I can fight with death so I decided. […] Yes I can fight with it sometime I can overcome from this situation, so I change my mind for that and I prepare for that. (Aravan)

For others, engaging in activities in Sri Lanka was a helpful distraction as it enabled them to focus on other aspects of life, even if for a short while.

> Children are coming to my house and I am giving the tuition for them and my wife's mother was a teacher for the Veena my mother she given tuition for the music, these are the things my wife she is talented for the Bharatanatyam [Indian classical dance], music and dancing everything she knows those are the things peacefully we can live without that one we will think about the war and everything our mind is always thinking back to those things. (Balakumaran)

For many participants, forgetting was enabled when they moved to the UK, which involved learning about a different culture and integrating into their host society. This allowed participants to immerse themselves into a new life, as one participant suggested "we have become British citizens and absorbed into this community now" (Gajendran). Moving to the UK also involved learning about practicalities and developing new skills:

> Moving here everything is completely different situation in London completely different situation […] transport, food, shopping, people, everything, so every day we managed and we practically moved on I think so every day and moved on yeah, everything is new for me really new for me completely different, so everyday day to day life we managed to move on. (Vanaja)

Since living in the UK many participants have wanted to forget or actively tried to forget their experiences. This was captured by one participant who stated: "we would like to move on yes, I try to tell people in many ways we should try to because things have now the war

has ended right so in 2009" (Nithirin). A few participants have tried to promote the message within their local community that forgetting may provide peace as a participant who was previously affiliated with a political organisation in Sri Lanka illustrated:

> Yeah enough 'so we will lead a peaceful life' so I'd go to meetings non-political meetings I used to go and speak about women and these things how you have to come up and you know you have to forget these you know the troubles and what happened. (Jothipriya)

Abandoning militant and political groups has already been discussed in the subtheme: *day to day survival itself has become a challenge*. However the participant above, whose husband was a leader of a political organisation in Sri Lanka and was assassinated, declined opportunities to continue her husband's work in the UK. It seemed that these activities reminded her and her family of their past and she wanted to move on:

> They invited me to come and join that TULF [Tamil United Liberation Front] and go on with 'your husband was there so you don't leave us and go' […] my youngest son he is also a doctor [redacted] he said 'no Umma [mother] we lost our dad that is what he did many he helped the Tamils' he did many things you can't do beyond what he did […] so we will lead a peaceful life'. (Jothipriya)

Furthermore, some participants identified that remembering fuelled hatred and continued to create animosity between the Tamils and the Sinhalese:

> The war has finished now there is a new regime, new set up, new thinking, things are looking more positive right so no point talking about it again and again and again that will only develop hatred if we keep talking it will because now I move with Singhalese people as well. (Nithirin)

Many participants attempted to forget their experiences of war by focusing on the future rather than re-living it by discussing it. A few participants acknowledged that remembering the past was often unhelpful as Aravan illustrates: "also if I meet people and our people actually I never start to talk the past, I start to talk about the future, the current situation or the future like positive talk you know" (Aravan). Some participants acknowledged that whilst it

was important to think about the present time and the future, for many Tamils it took time to develop this skill in the UK because they had lived through periods of such uncertainty during the war. Nithirin illustrates his struggle with trying to be future-focussed:

> Even now you know I wouldn't describe me as a very good organiser […] I think yeah because those days ok things were slow in general back home, not like here things were slow but still because of this war and the way we were treated due to the uncertainties in all aspects of life so you don't plan. (Nithirin)

For many participants, they "did not want to go back" and forgetting seemed like the only option available as the past was too painful to acknowledge:

> Yeah not think about that but it's a sad time enna [isn't it] it's a sad story yeah, we don't want to go back because actually it's sad it's very very sad story and difficult time and god how we managed that time, oh god we don't want to no it's very hard yeah, actually very hard. (Shivani)

Others spoke about using imagination and guided imagery to forget about distressing experiences:

> Meditation yes actually I use I found it on the internet some meditation Thianum in Tamil you know? […] yes a type of meditation close the eyes and breathe deeply, think about some positive things or think about some natural things like mountains, seas that is my meditation (laughs) no I know it is not the proper meditation but it helps me I close my eyes and then think of all some stories I put some imagination into it of how to do it, I build up some stories in my mind some beautiful stories. (Aravan)

In contrast, some participants used behavioural strategies and distraction techniques to avoid distressing thoughts and feelings. For example, activities such as listening to music or reading to keep the mind occupied. Other participants spoke about coping by doing physical exercise: "I do some yoga as well for my mind to relax" (Arulini). The relationship between the body and mind was echoed by another participant:

> If we make our body active then we can sometimes we can forget some past experience like things […] I feel that if you are active all the time, if you keep the body active the body and mind active, then sometimes I can forget I don't know if everyone, I don't know about others, I don't know about you but my experience I found this if I do exercise more and every day running and other exercise I can feel relief from some sort of thinking. (Aravan)

Some participants avoided and continue to avoid activities which trigger painful memories: "the books should be like love stories romantic stories and not the violent stories, if I read violence then I get some memory back" (Aravan).

Despite this, some participants acknowledged that forgetting could be difficult at times. A few spoke about triggers to remembering painful experiences, for example things they heard or saw. One participant spoke about how after several years of living in the UK she was still reminded of her experiences: "always remembering because if we heard any helicopter sounds or plane sounds we can't sleep we woke up" (Arulini). One participant remembers having nightmares when he first came to the UK because of what he had witnessed:

> I wasn't sleeping and nightmares and sometimes I'm hearing the crying voice of the people who were on the ground crying, and I feel I can feel the blood and smells. (Aravan)

Memories were often triggered by things people heard or saw which reminded them of their past. One participant stated they still struggle to see authority figures in uniform because of the negative connotations this had in Sri Lanka:

> I don't like now for example anybody who is in uniform right, cause armed personnel the army police they were all brutal to us and they were all in uniform so we hate any uniformed person, so even now at the airport wherever I see people, police I know they are very friendly, here they observe the rules and regulations but still you think police is police, army is army no matter where they are they are uniformed. (Nithirin)

Now we are better off than others so be thankful. Many participants described using positive self-talk, telling themselves "we have to manage" and "you have to live in hope".

These strategies were first adopted in Sri Lanka to deal with difficult situations. For example, using humour or trying to lift spirits during difficult times: "she never cried in front of me (laughs) she always laughing, always saying jokes (inaudible) and made the environment fun" (Aravan). The same participant acknowledged that a positive frame of mind kept him alive in Sri Lanka: "my confidence is high even when in that situation when I was dying I never give up my confidence" (Aravan).

Some participants suggested that maintaining a positive attitude was embedded in Tamil culture: "you are watching this is happening but it's part of the Tamil culture you don't give up you know, you work hard and you don't give up" (Nithirin). For a few participants this attitude helped them to leave Sri Lanka and also helped them to pursue their ambitions in the UK:

> But that's how I always think like if you think 100% at least you would achieve 50%, so I always think positively my mum grown me that way positive mind I'm always positive minded person. (Rajalaksmi)

When in the UK, participants found it extremely helpful to focus on how fortunate they were compared to others who had suffered more or continue to suffer in Sri Lanka. Many participants would remind themselves "now we are safe" which they took comfort in. For some who had near-death experiences they acknowledged this: "I really lucky or yeah it's by chance I am here today" (Nithiran). As well as attributing positive events to luck, some found more value in their life: "from that date a lot of peoples values for their life" (Arulini).

For others, they reminded themselves of the difficult conditions some still continue to live in due to war or natural disaster and despite acknowledging their own difficulties, are very grateful they are no longer in this plight:

> At least we are fortunate to see now when we compare to the other people, I see a lot of programmes on the TV about these people in the shanty's Filipinos shanty, how they are living or even in Sri Lanka how these Singhalese there are also very poor Sinhalese there up country estate Tamils living even in the North there are people living harsh lives so compared to them we are a thousand times better off see. (Gajendran)

A few participants felt that maintaining a positive attitude during times of crisis acted as a buffer against distress and in some cases, psychological problems:

> Some people can undergo all the problem but they will be smiling and face, face the problem and go to the next step, some people small problem and they are scared and so everybody is not having mental illness. (Gajendran).

Theme Three: With the help of others you survive. All participants seemed to acknowledge the significance of the help provided by others during difficult times. Participants spoke about the vital role family, friends and members of the Tamil community played during and after the war. Some also spoke about the importance of religion during hardship. The ways in which family members and friends provided help are discussed in the subtheme *you'll tell each other I am with you, I'll look after you.* This subtheme also highlights the actions of the wider community when civilians sometimes acted as a human shield protecting other innocent community members from harm. This subtheme highlights a tension between feeling protected at certain times and feeling let down at other times, and several participants were able to relate to this tension. The second subtheme *not only me, how many of them suffered* captures the sense of solidarity participants felt towards their own community which seemed important both in Sri Lanka and the UK. During times of crisis, participants found it helpful to acknowledge that others were also facing the same struggles and such ideas are illustrated within this subtheme. Even in the UK when participants were free from the impact of war, membership to the Tamil community and participation in Tamil events seems to provide peer support and a sense of belonging for many participants and they remained connected because of their experiences. Following experiences of war, participants seemed to have coped by putting their time and resources into looking after their family in the UK. To most participants, children and (grandchildren) were considered a blessing and gave them something to live for. These ideas are captured in the final subtheme *it's all because of our kids.*

You'll tell each other I'm with you, I'll look after you. Many participants commented that they relied heavily on family and friends during the war-time in order to cope with their experiences. Support from family members and friends took different forms such as practical help and advice:

> I didn't fear because I thought my brother and my father and then friends, I thought they will do something […] actually I thought they will decide what to do and they will look after me, that's the reason so I didn't think about much at those times I rely on them. (Vanaja)

Many participants received solution-focussed support from family in the form of money or accommodation. One participant recalls having to leave the war-zone in Jaffna but had limited options to support his wife, children, and parents. He received support from his family and fled to Colombo which other participants also related to: "my brother is there he has given a house for us, then we stayed in that house my parents stayed with brother" (Balakumaran). Many participants received information and advice from colleagues, friends, and family about which areas to avoid during the conflict. Interestingly, on some occasions the informants were Sinhalese rather than Tamil: "but my colleagues, my Sinhalese colleagues in the hostel said don't go out, don't go out we are afraid for your safety don't go out, stay inside" (Nithirin). A number of participants recall family members or friends using physical methods to intervene and to protect them from danger. The need for girls and women to keep a low profile due to risk of sexual abuse and exploitation has been described within the subtheme *we tried to avoid any encounters*. Female participants, particularly during their teenage years, were highly protected by their families. Participants and their families found creative ways to make their children appear older or married in order to reduce the risk of sexual abuse or abduction by members of the Indian or Sinhalese army.

> I can remember my mum she wore [gave] her sari for my sis because she was I think 14 or 16 at that time. So they [Sinhalese army] may try for my older sister because she is a teenager you know so they maybe can take her or do something, rape her that kind of thing. So my mum she wore [gave] her sari so maybe they can feel she is older or she is married. If she is not married they misuse her that's why. (Gayathiri)

One participant identified that this was a particular concern for female headed households: "so to protect me is a real hard thing that she thought and she is a single mum as well […] so that potential chance of abuse" (Rajalakshmi). Many wore a special necklace (Thali Kodi) or twine with turmeric (manjal kair) which typically symbolises marriage to protect themselves from abuse:

> Everybody every young girls they put the you know when I am married then we put the Thali kodi you know the Thali kodi […] or manjal kair because we scared for the Indian army otherwise they raped all the girls.

One participant recalls how men would position themselves physically when sleeping at night time in order to protect the women in the household:

> So men sleep around the house and the women we sleep in the room and things because they think that they protect women from the rape and the violations, sexual abuse and things like that. (Rajalakshmi).

Nearly all the participants talked about turning to God during times of crisis for example Nithirin remembers: "I've been questioned, stopped and searched, things like that but each time when I am stopped or searched we pray to God" (Nithirin).

Most participants felt protected by their community during the war and described incidents when the community acted as a human shield during periods of conflict providing strength through numbers. Most participants reported it was common practice for several families to sleep in one home or to travel around the town in large groups for protection. Shivani describes the procedure that most families followed at night: "not only in their houses but together everybody sometimes in the two houses, three houses because scared for army night time". Other participants also valued community protection highly:

> Even though you go as a group of people, you never ever go alone so when something happens that happened to the whole group the entire group, so that you depend on each other you hold their hands you always say that 'I am with you I am with you' […] So then we hold each other's hand and then we go. (Rajalakshmi)

In contrast, sometimes participants felt let down by others including God during times of crisis. Some participants recalled feelings of anger towards God at times: "sometimes we blame the God" (Nithirin). Others felt that their own community in Sri Lanka did not do enough to help them during the war but acknowledged that during such difficult times, people had to find their own way to survive. This is encapsulated by Vanaja:

> Community they are so selfish […] I think they find their own way to escape their own way, I don't think so other community people in our village people helped me, only friends and family members and the friends helped me, can't blame them because everybody need to find some way to go isn't it […] We shouldn't blame them I never blamed them because like me they want to escape for themselves first you see […] I understand because that's the reality I can't blame that because we have to find our way to go out, they have some relations in other places so they have their own way to go.

Other participants noticed a lack of social support in the UK. Participants experienced loss at multiple levels due to the absence of family, the loss of loved ones, and immigration which had reduced social support: "family also split one of my brother is in Canada, other brother is in Australia, my sisters three sisters are still in Sri Lanka so family is scattered all over the place […] separated yeah and also not a good thing you know" (Gajendran).

Not only me, how many of them suffered. Many participants held a communal understanding of their distress and reminded themselves of other Tamils who were suffering in the war when their lives were in danger in Sri Lanka:

> I mean I'm not alone, there are so many other people have been killed brutally killed or drowned or things like that so if it happens what to do it's my turn you think about the worst times. (Nithirin)

This sense of camaraderie was retained when they moved to the UK and many reflected on their experiences as part of a much wider sacrifice amongst Tamils which brought them closer together. Jothypriya described this as: "not only me, how many of them suffered so they will talk to me about those things also, so I'm also in this plight and others are also in the same plight". Aravan recalls that all Tamils living in the war zones had experienced loss in some form: "everyone every family in Vanni at that time they lost at least one single person".

Some participants reminded themselves that their experience was not necessarily unique to Sri Lanka and acknowledged that war and political conflict occur on a global scale. Therefore, their solidarity was not just with Sri Lankan Tamils but victims of war generally: "I always think it's happening not only for our country everywhere if you view the TV or

every news every country this happening isn't it" (Vanaja). Some even considered their experiences in light of the current situation in countries such as Syria. Nithirin illustrates this idea:

> So you know what is going on in other countries as well, so you sometimes you think ok these kinds of incidents are taking place in other parts of the world as well, so we are not alone so when compared to the situation we were in there are when you heard about Syrian refugees they drowned so many people drowned you know boatload of people. (Nithirin)

Most participants acknowledged that many people suffered as a consequence of the war and did not view themselves as lonely sufferers. They described both the impact of war and their resilience at a group level. It seemed that their shared experiences gave them strength to cope with further adversity and which has been explored in more depth in the subtheme: *day to day survival itself has become a challenge.*

Once in the UK, most participants attended Tamil community events and day centres, which provided a strong sense of belonging and access to support from those with similar experiences. This was particularly important for those who had left behind an extensive network of family, friends, and community members as outlined in the subtheme: *you'll tell each other I'm with you, I'll look after you.* One participant described their community centre as "a homely base, it is not a community centre, it is like your home" (Balakumaran). Community centres seemed to offer peer support as most of the attendees shared experiences of war and disadvantage. Balakumaran acknowledges that: "Sri Lankan Tamils, my friends, my age group all are coming here, we talk about worldly things we may discuss about the country matters everything we will discuss" and attending community events seemed to provide a way of staying connected to Sri Lanka and to Tamil culture. Attending community and cultural events with other Tamils in the UK also seemed to provide a sense of enjoyment for many.

It's all because of our kids. Many of the participants spoke about their families, particularly children and grandchildren and how they cherished them. When participants moved to the UK, these relationships often became their focus during times of crisis and

raising children helped them cope with their circumstances. This idea was demonstrated by a participant who came to live in the UK with her son following the death of her husband:

> To mix with people and that in a way it carries you out of those bad sad things you know, and even at home my grandson was my he was my only you know what do you say only for my happiness. (Jothipriya)

It seems that family relationships are an important part of Tamil culture as some acknowledged "if my kids ok then ok I am ok" (Shivani) and that such relationships are also highly valued in Sri Lanka: "we have a close relationship with parents" (Rajalakshmi). However, often their life-threatening experiences provided a different perspective and it seemed that once in the UK, having children gave participants a sense of purpose and provided something to live and hope for:

> What is any first generation parent if you talk to them you will realise that their mission, what is their mission here in this country because they will say they 'we are lucky to be alive we came to this country and worked hard it's all because of our kids' they say 'oh I prepared to work in a supermarket or cleaning job whatever I will take, but at least my children should live a proper life'. (Nithirin)

It seemed in part that this was due to the fact that many participants acknowledged that Tamils had extreme difficulties in bringing up children as a result of war: "you know young […] mothers you know they gave birth and how much of difficulty they had to bring up those children" (Jothipriya). For some participants who did not have children or siblings, they formed close relationships with other relatives: "yeah so it's like very close even though we are cousins we never feel like we are cousins, we feel like we are siblings" (Rajalakshmi).

Theme Four: The value in talking. Many participants found talking a powerful tool in dealing with their distressing experiences. The subtheme *they will tell their stories and they have peace of mind better* reflects the idea that in the UK talking is seen by many as positive because it helped to validate experiences of loss and suffering. In this sense, talking was often viewed as therapeutic and could raise people's spirits during difficult times. Some participants acknowledged the rules for both talking and not talking. The subtheme *you want to share your experiences in the proper manner* captures the benefits of remaining silent and

the criteria for talking about painful experiences. Finally the subtheme *before I was not a talking person* highlights the idea that attitudes towards talking have changed over time as a consequence of living in the UK.

They will tell their stories and they have peace of mind. It seemed extremely important for participants to talk about their experiences (both positive and negative) and for some this involved reminiscing on "good memories about my childhood" (Arulini). Participants mainly approached friends to talk to about past events and the emotional support provided was described as: "a shoulder to lean my head whenever I wanted to" (Aravan). The same participant highlighted the therapeutic benefits of talking to friends and suggested that sharing your story with close friends was a form of counselling:

> My counselling is talking with my friends close friends we talk about various things not only my experience and also they found a lot of positive things and a lot of inspirational things inside me. (Aravan)

The participant above seemed to suggest that the stories shared had moral messages which others could learn from and be inspired by. Others substantiated the idea that talking had therapeutic benefits. It allowed current concerns to be shared and facilitated problem-solving and one participant illustrates how she provides solution-focussed support:

> Some ladies they worried about that I'm just say ok relax ok don't worry like that like counselling (laughs) ok what do you want help you want to fill the form or you want anything introduced or you want to go anywhere, ok then I can help you which one I can then I do. (Shivani)

It seemed that reflecting on the past as well as current concerns with members of the Tamil community relieved distress as described by one participant: When they come here they will tell their stories and they have peace of mind […] yeah everyone shares their stories and tell their difficulties (Balakumaran). Others also shared this view as illustrated by Shivani:

> Yeah we I suppose speak to everyone and they speak together everyone 'oh one time we are all in one place' everybody tell their experience and they aware of what's going on like that they talk and are a little bit more relaxed at that time. (Shivani)

It seemed that sharing their stories with other Tamils who genuinely understood what they had lived through was particularly significant as it seemed to be a highly validating experience as illustrated by Jothipriya:

> Mixing with people you know they will tell all sorts of stories and even people suffered you know, not only me, how many of them suffered so they will talk to me about those things. (Jothipriya)

Sharing war-time stories with peers was something many participants engaged in as illustrated by Nithirin:

> Yes we can talk maybe every now and then a part of the conversation somehow 'can you remember those days' you know like that 'I ran away from this', 'you were there' that like that you know, even the other day I was speaking to them 'you remember we had this hunger strike when you were at the uni'. (Nithirin)

You want to share your experiences in the proper manner. Although participants acknowledged that talking had several benefits, they were also able to recognise that the content and those it was shared with, had to be carefully considered. Both talking and keeping silent took multiple forms. Many participants admitted that in certain circumstances "we can't be open" or "she doesn't share". For a few participants, silence provided protection for themselves and others. In the UK many participants did not voice their concerns or worries in order to protect their loved ones from distress: "I don't want to involve him because he is going to worry about it" (Gayathiri). As well as not wanting to alarm others, the same participant identified that Tamils in the UK were uncertain about what could be discussed, and with whom, and this prevented them from speaking out and seeking help:

> They don't know what they can do, how they can tell, how they can talk, who they can talk with. I could think what is the point if I tell her or him […] with some they are not allowed because family members get scared. (Gayathiri)

Not talking about difficulties often protected the honour of the family and this seemed to originate from Sri Lanka: "Sri Lanka sometimes if you talk depends who you talk, you have to be very careful" (Nithirin). Family honour was considered important in the UK too and

participants were aware that they could be judged negatively by members of the community if they found out about their problems illustrated by Shivani:

> In our culture anything happen we can't say like that it's 'oh look oh that family this problem that problem' then everybody talking about that in our culture. (Shivani)

For some, talking about the past also facilitated remembering and staying silent protected participants from distress, particularly if they were finding it difficult to cope: "I couldn't if anyone comes and talks to me I will cry I never talk to anyone" (Jothipriya). Other participants suggested that talking about the past meant re-living it and many wanted to put the past behind them as illustrated by Nithirin:

> So people don't often speak about what happened to them in the past while you were back home right that has become a thing of the past even though everybody had their own experience in the back of their mind. (Nithirin)

Finally, some participants expressed reluctance to speak with professionals about their difficulties, with a number of reasons suggested. As mentioned above, participants were keen to protect family honour and this was particularly the case for women:

> No we can't go we don't want to say anything to them because in our culture in our family is secret and ladies especially in our culture we don't we can't go out and say anything happen no. (Shivani)

Furthermore, practical problems such as language barriers and professionals not having an awareness of the Sri Lankan context made it particularly difficult to talk to professionals as illustrated by Aravan: "because the counsellors they don't know actually they don't know our background that is the problem" (Aravan).

It seemed that painful past experiences could only be discussed with certain people, in general those the participants felt closest to rather than strangers or those in a professional capacity. One participant described: "if I feel bad or I want to talk or express these things I call my friends very close to me" (Aravan). Some felt able to talk to their partners and their children but in contrast a few felt unable to share painful memories with certain family

members due to gender differences and their culture as illustrated by Gayathiri:

> With children it's ok but I don't think with my husband we sit and he listens and everything I don't think so (laughs) Sri Lankan Tamil husbands they are not like that you know. (Gayathiri)

Before I was not a talking person. The dimensions of talking appeared to have changed as a consequence of living in the UK. For some participants, attitudes towards talking have improved and some were now able to consider the detrimental effects of not talking as illustrated by Gayathiri:

> We are not sharing too much that is the main problem in our community you know. We are not sharing the information with each other. Everything they keep inside […] that's why they are affected mentally. (Gayathiri)

Some of the participants described talking as a process which took time and often talking about the past started when participants had moved to the UK. There were a variety of factors which enabled talking. For a few participants, being around other Tamils had facilitated the process of being "open", whether this was as a service user or in a voluntary capacity:

> At that time I was not very open you know. Even now I think only in the last 2-3 years since I volunteer in [redacted], after that I am very open and talk with everyone […] before I was not a talking person you know. (Gayathiri)

Other participants described similar experiences of feeling unable to talk but this slowly changed over time as they interacted with others and felt comfortable sharing:

> Jothipriya: At that time I couldn't open my mouth and talk
> Researcher: Cause you'd experienced such a loss hadn't you?
> Jothipriya: Yeah after 5 years only a friend of mine we shifted to Kingston from Liverpool to Kingston and then my friend she used to come and see me and one of my friends asked me she is no more she asked me to come to the club

A few participants suggested that living in a western country enabled talking. There was a suggestion that living in a different country meant there were fewer consequences for the family and in terms of safety which meant the past could be discussed more openly.

> Here everybody is open, yeah their culture is open talking about openly everything, and we safe and ladies especially are safe here yeah, and they can say their problems anywhere and they in our country and culture we don't want to say anything in our family problem to outside but here we can say anything happen. (Shivani)

A few participants also suggested that attitudes towards talking had perhaps changed across generations and that younger Tamils were able to discuss difficulties more openly with each other illustrated by Rajalakshmi: "they don't really talk anything about these things that are going through we talk to each other younger generation we talk" (Rajalakshmi). Other participants agreed that traditionally in Tamil culture children were not raised to discuss personal difficulties openly: "we can say even that is the way they are brought up you know by their parents" (Gayathiri).

Some participants found the experience of talking so liberating that it enabled them to talk about past events in Sri Lanka publicly despite this not being part of Tamil culture: "nowadays I think I have to be open and that is why I gave an interview to the BBC. So one of my relatives, they don't like it and say 'why did you give that?' " (Gayathiri). Other participants had similar experiences as illustrated by Gajendran and these accounts all suggest Tamils found their voice in the UK:

> I am involved in 3 radios here Tamil radio, 3 radio and one TV programme […] I describe the war how many widows are there, how many affected children are there, how many partly affected young people, young girls and boys are there (Gajendran)

Theme Five: Improving life for yourself and others. As a result of their experiences nearly all of the participants wanted to ensure both they, and others had a different life after the war. For many participants this meant ensuring their families had a better quality of life in the UK. For the majority however, this involved helping the Tamil community to help themselves. For most, this process of wanting to help others seemed to start once they had moved to the UK. There also seemed to be more opportunities to help

relief efforts in Sri Lanka from the UK and many participants actively helped members of the UK Tamil community too. The process of helping involved the Tamil community working together after catastrophes to develop their social capital in order to re-build their community. The subtheme *if we empower the people then they will make a change in their society* explores the idea that change occurs through empowering those most disadvantaged and providing access to information, support and resources. The subtheme *I do contribute my part to my people* explores the idea that Sri Lankan Tamils in the UK use their skills, resources and personal experiences of war as well as encourage the next generation of Tamils to facilitate change.

If we empower the people then they will make a change in their society. For some empowering the Tamil community started at home with their families. Some participants wanted their children's lives to be different in the UK based on their distressing experiences in Sri Lanka. A few participants had experienced loss of parents, siblings and other family members and as a result wanted their children to maintain close family relationships:

> So many things I missed, even I tell to my daughters now, please stay with your father and talk with him nicely and you know go out with him because I haven't got that experience. (Gayathiri)

Others, through their experiences of depending on others for support or having dependants during times of crisis, seemed to want their family members to become self-sufficient. Many participants wanted to instil this in their children so that they could take more responsibility for themselves: "you have to study and you have to do everything you know and they have to stand on their own feet" (Gayathiri). This was substantiated by other participants who felt positive that their children were now less dependent on them:

> In Sri Lanka I am the earning man and others they all depend on me here they are standing on their own legs, my wife is working, my son is working, my daughter is working, they have their bank accounts they separately, they are ok I am also a peaceful man because no responsibility for me, I can go anywhere anytime and come back no other family responsibility for me. (Balakumaran)

For others, they were comforted by knowing they were meeting expectations within the family describing this as: "I am paying my mortgage and the kids are educated things like that, so I am fulfilling my responsibilities as a father you know" (Nithirin) and felt they had done their duty by their children when they had educated them so they could have more choice in life as illustrated by Shivani:

> I am just relaxed now because my sons they going uni and then they are ok, then my second one also ok and third one is ok, then my family little bit ok they are studying, only my wish my sons they want to study they want education that one is first thing because…they kids they want to grow up any education they have they can grow up their own way. […] yeah they can go anywhere and they can go manage or they can get anything. (Shivani)

Apart from scaffolding family, it was evident that most participants wanted to help the Tamil community to help themselves. One participant described her way of helping as "it's a human rights way the humanity way". For most participants, the process of helping others, actively started once they had immigrated as they felt more could be done for Tamils 'on the ground' and at 'grass roots level' from the UK. Some participants felt that such work was "not just giving money" but involved helping to equip Tamils in Sri Lanka with the skills and resources to improve social conditions and facilitate community development. This is illustrated by Aravan:

> The focus is to empower them, by giving training and by giving investments, small investments to develop their lives and monitor them and just giving, like if they need anything like that we don't just keep the money. If they wanted a small livelihood programme we invest in the livelihood programme, investing yes then we give training we hire some experts from various fields they give the training how to manage these things. (Aravan)

The same participant explained that the focus of community development work was not to establish businesses at an industrial level but at a micro-level and that this method of working was effective:

> So people should earn money from their small things like not big factory but we can set up small shops or a small thing at their home, so they can take that and earn money so we succeed in the project. (Aravan)

The projects which participants were involved with were extremely varied but generally women and those injured during conflict were considered the most vulnerable and in need of help as one participant illustrated: "helping war widows disabilities paralysis and mental health so I am involved in those projects women empowerment all those so I help a little bit" (Vanaja). One participant emphasised during their interview that there were "62 000 widows in Sri Lanka" (Rajalakshmi) and other participants also supported the need to empower women, suggesting they were the most affected due to social isolation and limited finances:

> Because loads of war widows, loads of paralysed, they don't have food or any money or any penny, nothing for them, they don't have that especially ladies, the men sometimes they don't care about the family and the ladies care about their children and their family with mum or dad and we want to do something for the ladies and empower, we want to do empowerment for them because they don't like to come out first thing in our culture they don't like to go out or come out anywhere. (Shivani)

Some acknowledged that empowerment could transform communities: "so if we empower the people then people on the ground then definitely they will make a change in their society, in their community" (Aravan). The same participant felt that the way to make a real difference to the Tamil community was through education: "we have to empower them and we have to give training and we have to educate them. Education definitely will change their lives" (Aravan). Most acknowledged that sharing knowledge and spreading information was extremely important in order to improve the lives of Tamil people. A few participants even acknowledged that their participation in this research study could enhance knowledge: "by coming and telling my story and at least your report may help in future" (Gajendran) and encouraged the researcher: "you have to convey these messages to other nationals" (Rajalakshmi). Some participants have found extremely creative ways of sharing socio-political messages.

> The radio stations yes I participate with poems writing poems, I describe the war how many widows are there, how many affected children are there, how many partly

> affected young people, young girls and boys are there and all the details I go through with my poems and how can you help those people the people who are here how can we help them. (Balakumaran)

Some participants felt it was extremely important to inform Tamils about their human rights and encourage them to think about how they could fight against oppression:

> And then I started thinking about back home so I really wanted to go back and see them and tell them this is the life we live here, this is how you have to live you think forward, you have lots of opportunities, you have to study, you have to focus on your studies and be a lawyer or be a human rights defender or come and work with government so where you protect yourself and protect our community. (Rajalakshmi)

Some participants described a strong desire to help Tamils in the UK, particularly those who had recently moved to the UK and were not aware of the support available or how to access it. They offered help through community centres for Tamil people and identified them as an important way to meet practical and social needs as well as intervene in family and relationship issues. Some participants had themselves relied on such centres when they first came to the UK: "my income is limited so I go to the temple to meet people and have free meals" (Gajendran). One participant illustrated the function of Tamil community centres:

> Some people have difficulties with the Home Office, some people they cannot read the letters, some people they have benefit difficulties and we can all manage here, how to fill the forms and how to correspond to the home office problem and give free advice solving yeah, any problem husband and wife fighting, children fighting, children's studies, home office problem, benefit problem. (Balakumaran)

Another participant described their involvement in voluntary organisations and the work that both her and her husband did:

> The people here who recently came you know so many people they don't understand English, they don't understand the system, they don't even they want to go to the hospital or they can't read the letters from any social services or anything, we always my husband normally go and interpret and help them advise them. (Vanaja)

I do contribute my part to my people. For some participants their desire to help Tamils in Sri Lanka was based on their own experience of suffering during the war. Furthermore, participants contributed extensively to their community in a number of ways based on their skills, knowledge, and resources.

Sharing basic resources to enable survival was highlighted in the subtheme *day to day survival itself has become a challenge*. Many participants continued to provide resources and participate in problem-solving with other Tamils when they moved to the UK. This was often facilitated through the community organisations they attended or volunteered at and most participants had volunteered in some capacity. One participant described: "everyone shares their stories and tell their difficulties then we will say how you are going to manage those difficulties" (Balakumaran). Once in the UK several participants took collective responsibility in improving social conditions for Tamils and were involved in accumulating resources for Tamils in Sri Lanka. Many also financially supported relatives who continued to live there, despite having little themselves. Many viewed their contributions as minimal as Gajendran describes: "what we give is like giving popcorns to a hungry elephant but at least we are giving something". These participants learnt to accept they could not help everyone as the devastation caused by the war was so large, and they had to be satisfied with what they were able to achieve: "I really want to help we can't help hundred persons […] actually I want to help whatever I can if I change to one person that is my satisfaction" (Vanaja). However this was not always easy to tolerate and there was often a tension between feeling you had done your best and that you had not done enough:

> I feel I haven't done enough for the community, we haven't done enough for the community but whatever it is I am thinking but in future I want to be more involved and more help to the people. (Vanaja)

Participants were deeply affected by the impact of the war and were sympathetic to the suffering of Tamil people. This seemed to motivate them to make a difference:

> I have seen the LTT's camps where the injured people, wounded people they are in that camps without any medication, no facilities, no medicines at all these make me really sad because they fight for our community relief […] I thought to do something for them. (Rajalakshmi)

For a few, their membership to militant groups made them keen to help their own devastated community, particularly LTTE members who were injured during conflict or had limited means of support. For these participants, networking with the Tamil community helped to share information and encouraged community members to help by providing resources such a medical supplies, food, and equipment. One participant, who was seriously injured during the war and spent several months in hospital, had developed an interest in helping those injured during the war:

> We have so many projects at the moment, medical projects and also giving medical equipment to the paralysed people, many people there are paralysed people who are completely paralysed, yeah these para-body people so they don't have any facilities, no proper house, no proper toilet facilities, no proper bed so people every day one paralysis person dies or commits suicide because of the bed sores and because of these infections and also they don't have proper counselling or physiotherapy facilities […] we are now working closely with the district hospital and with the social service department and some other organisations. (Aravan)

Other participants decided to provide legal aid for example 'prepare statements' or 'interview people' who were appealing for asylum in the UK. A retired lawyer continued to provide this service stating: "I come here they have immigration problem I advise them" (Gajendran). It seems that participants were inspired to study and practice law based on their own experiences of injustice and the experiences of others:

> That's how my subject was law to help my people they being arrested in Colombo they being refused and abused these things I wanted to fight for them that's how I've chosen that law. (Rajalakshmi)

Some participants undertook humanitarian work. After her experiences of harassment by the Sinhalese army, one participant decided she wanted to make a difference and used her knowledge of human rights law to undertake humanitarian work:

> Why we slaves of Sri Lanka? Is it because we are Tamil, which is not fair so that's how I started attending the human rights sessions in Geneva, so I worked with other organisations they take me there as a victim because I've been gone through all this

> and come through hard times, I started talking to people get knowledge about these things and then and there are many things that I started doing and then after Geneva made a big turning point in my life, I met lots of UN officers where they work justice and peace in Sri Lanka so I am working with lots of prosecutors. (Rajalakshmi)

Finally, participants often provided financial aid to Tamils in Sri Lanka who did not have access to basic facilities:

> There about hundreds and hundreds of former soldiers, Tiger soldiers in prison so we send them money to provide telephone for them as they are locked up in the prison so they can't have connections with their parents. (Gajendran)

Participants' experiences also affected their career, education and lifestyle choices and many felt that they could make a difference to their community through their work or studies. For example, one participant, a former member of the LTTE, had got a scholarship to study Peace and Conflict studies due to the opportunities it would provide: "my ambition is to achieve something through the academical career pathway" (Aravan). Another participant was working as an immigration and benefits advisor at a Tamil welfare organisation and when asked about why this was important recognised: "Tamil people want help isn't it, they need help" (Arulini). Furthermore, one participant's decision to study human rights was based on the human rights violations she experienced in Sri Lanka: "I started studying human rights in Colombo because of these things that I have gone through, to know what are the rights we refused" (Rajalakshmi).

It seemed that many Tamil people had felt oppressed by the Sinhalese majority in Sri Lanka and had felt they had not been given equal opportunities in their own country which had been a longstanding issue which the war fuelled as Gajendran illustrates:

> Most of the businesses in Sinhalese area are dominated by Tamils having business concerns there and Tamils are educated there in high positions like during British time all the high positions when Englishmen were there leading doctors, leading lawyers leading (inaudible) all were Tamils so they were waiting for a chance to chase them away. (Gajendran)

Therefore many participants were motivated to do well academically and career-wise because this led to more control and choice in life as illustrated by Rajalakshmi:

> Study well then you will be a doctor then you wouldn't have these problems, you can go wherever you want because you can be a government servant so you have more freedom than others so study study study. (Rajalakshmi)

For some, their decision to study was precipitated by loss and disruption: "I lose so many years in the war" (Aravan) and it seemed to strengthen participants' desire to study and have a career as illustrated by Arulini: "because when we was in Sri Lanka I couldn't study so I thought I want to study well, I want to get a good job" (Arulini). Education was also seen as a way to fight against discrimination as Nithirin illustrates:

> I felt yes education is important, I have at least a degree I cannot get a job being a Tamil, it's very difficult right so at least I should have a certificate this is the only option to me because I really worked hard to get into the university because of the discrimination because of the educational system in Sri Lanka. (Nithirin)

Theme 6: Searching for a different life in the UK. All participants moved to the UK, some with their families and others alone. A number of factors were involved in the decision to move, including wanting to be safe, pursue ambitions and also wanting a different life to the ones they had lived in Sri Lanka. The subtheme *we have a safe life here* captures the idea that participants moved to the UK in search of security. This subtheme explores the aspects of British living which Sri Lankan immigrants find appealing including having access to benefits and resources which would be unavailable to them in the Sri Lanka as well as the safety the UK provides. It also explores the opportunities which some participants feel the UK provides. Many participants found moving to the UK and the process of acclimatising and acculturation difficult which the subtheme *the first year wasn't that great here* captures.

We have a safe life here. For most participants, the UK provided safety and security for those who had lived through war and the consequences of it. It was important for participants to feel that their life was no longer in danger: "here you have no sense that anyone will harm you or hurt you, kill you" (Rajalakshmi). Many participants valued the protection they were offered by the police, available to all citizens: "we can go to the police

at any time or call the police" (Jothipriya). However some participants reminded themselves of how different their lives would be if they lived in Sri Lanka and why they could not return to Sri Lanka, as Aravan illustrates:

> One main thing is safety so we can live in safety here, not any urgent problem outside or anything if I am living in Sri Lanka, we I definitely face threat by the government army. (Aravan)

Many participants found that the UK provided them with access to healthcare and social support which would not have been accessible in Sri Lanka and that such benefits improved their quality of life. Other participants felt that the facilities provided in the UK enabled them to have a 'very peaceful life'. They acknowledged that in Sri Lanka government funds were extremely limited whereas in the UK the government supported its citizens. One participant illustrates the benefits of living in the UK:

> Because shelter everyone has the shelter, everyone has work, everyone has the money, everyone has the free medicine, everyone has the good facilities to enjoy their life therefore peaceful life. (Balakumaran)

Others acknowledged the financial conditions in Sri Lanka and the lack of income describing: "if you go back the problem of how to live there without money here at least we get pension so whether you like to or not now you have to live here" (Gajendran). Some participants identified that having access to organisations was extremely helpful in terms of social support and there was a vast amount available in the UK as Gajendran illustrates:

> Tamil groups all over London they are about 30 or 40 groups, drop in they say all the over 60s go there once a week and meet and talk and they have small exercises and they have these some people talk from various fields, there are normal drop in also Indian and there are multi-cultural drop-ins. (Gajendran)

Other participants found that access to free transport through freedom passes and council transport helped people to access social support and enabled them to meet people particularly for those who are socially isolated or find it difficult to travel. This is illustrated by Jothipriya:

> So everywhere I go and I am given this opportunity that is dial-a-ride so we can book it or they will book it and send it […] even just think the dial-a-ride they offered the government is offering I think the Mayor they are offering dial-a-ride, no pay or anything, nothing we don't pay anything. (Jothipriya)

For others, they acknowledged that people had access to mental health services should they require it and that such facilities were not available back home in Sri Lanka as Nithirin illustrates:

> It's different because of the mental health system a well-developed system is available, treatment is available, counselling is available and people are sympathetic […] depending on the degree of mental health issue. (Nithirin)

Given that education seemed important to most participants and an important aspect of Tamil culture, a few participants spoke about the educational opportunities that the UK provided. Some participants had faced racial discrimination within the education system in Sri Lanka and acknowledged that there is also age discrimination in Sri Lanka as Aravan illustrates:

> Also we are aged people like nearly 30 actually we couldn't join universities to study because my ambition is to study a lot to become an academic but in Sri Lanka actually I couldn't do it because age limit, so here they are open yeah more open if I have skill then I can go university. (Aravan)

Finally, most participants acknowledged how cultural diversity in the UK had benefits and that since moving to the UK their attitudes as well as the attitudes of other Sri Lankan Tamils had generally become more liberal. Living in the UK has allowed many Tamil participants to meet people from different cultures which may not have been possible in Sri Lanka, as Arulini illustrates one of the benefits of living in the UK: "because I used to study college here so I have so many friends with other cultures yeah Chinese, white, black everything". It seems for participants being surrounded by people from different cultures has facilitated cultural integration which they have found beneficial. Jothipriya illustrates this in talking about the Tamil centre she attends and the programmes they facilitate:

> Jothipriya: Different communities came Argentinian and black community and Chinese all these people came and gave programmes
> Researcher: I guess you were saying people come along and they enjoy it, what do you think you get out of these things?
> Jothipriya: We mix with people and we come to know each other and we get the best of their culture and our culture

Others corroborated a change in attitude since moving to the UK and one participant illustrates this using a metaphor: "if I had lived in Sri Lanka I would have been like a frog in the well" (Gajendran). This particular participant described that since living in the UK his attitudes towards marriage, religion, and caste have changed:

> An additional new problem facing is the Sri Lankans when they try to give their daughters, when they find a partner in the university well and good otherwise proposed marriage some of the parents still looking into caste religion 'oh don't marry that girl because she is Christian or she is Hindu' or some Christian parents say 'oh don't marry this boy he is Hindu or they are from Batticaloa they are from Jaffna' after coming here it's broadened my view accept anybody as long as they are human beings. (Gajendran)

The first year wasn't that great here. Whilst all participants made the decision to move to the UK and acknowledged the benefits the country provides, many found the process of acclimatising and acculturation difficult. Many participants remember the first few months were the most difficult due to the difficulty in forgetting distressing experiences and because many had also left family and friends behind and were socially isolated: "you know I came here for 5 years I didn't get out" (Jothipriya). For these reasons, a few felt that initially coming to the UK was more difficult than living in Sri Lanka as Aravan describes: "one year I suffered a lot, but I didn't I didn't suffer like this when I was there (laughs) sad and also sometimes I wasn't sleeping and nightmares" (Aravan). For other participants, being surrounded by a new culture and having to learn a new language was frustrating, as Arulini illustrates:

> When I came here as a student I have really struggled life here, I couldn't settle down language, the culture different, the pronunciation even though you learnt English but the pronunciation is different and then you feel like you low or you just down and

> then I don't know what is this bloody language, I don't understand or I thought 'I can't cope'. (Arulini)

For many not having the support of their friends and family was a significant loss:

> Sri Lanka within the terrible situation I didn't feel that much friends support, family support and everything support, I think it's better than in this situation in here I don't think so people have time to support they support but friends they don't have time. (Vanaja)

Many acknowledged that as part of their Tamil culture they had been heavily protected by their family and that it was difficult to gain independence when participants moved to the UK, particularly women:

> So this is completely a different environment from your family, you been as protected as a broiler chicken so far, like we just been under your mum's sari every single day even I was an 18 years. (Arulini)

Chapter 4 Discussion

This chapter will discuss the research findings in relation to the study aims, existing literature, and theoretical frameworks. The research methodology and the researcher's positioning in relation to the study will also be considered. Finally, future research, clinical implications and recommendations for service and policy development will be discussed.

Study Aims

The current study aimed to explore how Tamil immigrants living in the UK have coped with their experiences of war. The study considered the coping strategies adopted by Tamils both in Sri Lanka and in the UK to manage distress. A thematic analysis identified six main themes incorporating 16 subthemes. It emerged that participants used a variety of individual, social and religious coping strategies and geographical variations were observed. Most research has been undertaken in Sri Lanka and this is the first according to the researcher's knowledge to explore experiences of coping using a UK sample.

Summary of Findings

Survival at all costs. Whilst in Sri Lanka participants' survival was the priority. The subtheme *we tried to avoid any encounters* suggests that many Tamils were forced to keep a low profile in war zones to avoid abuse, exploitation or harm. This replicates Somasundaram's (2007) findings that during the war, Tamils living in Sri Lanka were mistrustful and tended to 'stay in the background' which had survival value. From an evolutionary perspective, such behaviour can be considered a type of flight response (Cannon, 1932). Flight responses include avoiding capture which may involve disappearing within a place or to another location. This greatly improved participants' chances of survival during the war as they did not have internal or external resources to protect themselves.

In Sri Lanka, participants had to be extremely creative given basic resources were in short supply. Participants responded by sharing resources with each other, and responding to bribery which the subtheme *day to day survival itself has become a challenge* summarises. Previous studies have suggested that during the war, Tamils increased co-operation towards shared outcomes (Rajkumar et al, 2008) which the current study corroborates. The

implementation of pro-social acts such as co-operation and reciprocity amongst individuals can be understood through social capital theory and has been widely documented (Putnam, 1995). Co-operative and altruistic behaviours involve increasing levels of trust between individuals and may be guided by beliefs about the importance of reciprocity and about the growth of networks of civic engagement (Kagan et al., 2011). This seems particularly relevant given the life threatening situations many Tamils faced. This theory posits it is advantageous to share resources with others and predicts that in doing so, others may be more likely to share resources in the future. Norms of reciprocity allow communities to become interconnected by social networks, which are highly relevant to war-affected generations (Putnam, 1995). The findings can also be understood from a collectivist perspective which predicts that coping efforts become collectivised (Gurbiye, 2011b; Somasunderam, 2010).

Finally the subtheme *we have to meet violence with violence* describes how militant and political groups were idealised during the war. Support for the LTTE following war has been documented in previous literature involving this population (Gurbiye et al., 2011; Gurbiye, 2011b). In fact Gurbiye (2011b) suggested that many Tamils coped by reminding themselves of the sacrifices LTTE heroes had made for them.

The power of the mind. Participants used a number of "mental" coping strategies both in Sri Lanka and the UK. In Sri Lanka, as a result of repeated and prolonged experiences of trauma, many Tamils learnt to accept they were unable to avoid or escape their circumstances. The subtheme *you have to accept it, you can't do anything about it* suggests that many Tamils entered a state of learned helplessness (Seligman, 1972). Learned helplessness theory suggests that clinical depression and other psychological problems occur as a result of a real or perceived absence of control over the situation (Seligman, 1975). It seemed that whilst Tamils acknowledged they were persecuted, they accepted coping resources were depleted and they had limited influence over their circumstances. Many Tamils adopted a "we don't know what tomorrow will be" and a "you have to accept it" attitude. These findings substantiate previous research which demonstrated that Tamils became more passive in fighting for their rights, accepted their circumstances as part of normal life (Somasundaram, 2007) and displayed helplessness following war (Somasundaram, 2010). Research with other non-western war-affected populations has also suggested that loss of autonomy precipitates learned helplessness. This has been demonstrated in Liberian refugees (Hardgrove, 2009) and Yugoslavian survivors of war

(Basoglu, Livanou, Crnobaric, Franciskovic, Suljic, Duric, et al., 2005). Recent research with Syrian war survivors has suggested learned helplessness prevents recovery (Almoshmosh, 2016). Further research is needed to determine whether learned helplessness occurs in western war-affected populations.

Many Tamils felt it was important to "divert the mind" to cope with their experiences of the war in Sri Lanka and adjusting to life after it in the UK. Attempts to "divert the mind" corroborate previous research with this population (Kanagaratnam et al., 2012). Many wanted to avoid rumination of traumatic experiences. This was achieved through imagination, meditation and guided imagery whilst others relied on practical activities for distraction. Distraction has been shown to be effective for creating distance from difficult thoughts and feelings in many therapeutic interventions such as behavioural activation (Jacobson, Martell & Dimidijan, 2001) and mindfulness-based cognitive therapy (Segal, Williams & Teasdale, 2002). Mindfulness-based approaches are in fact currently used with victims of war (Refugee Council, 2016). These results support previous findings which showed that following disaster, Tamils found that avoidance of rumination was an important part of recovery (Fernando, 2012). The use of 'forgetting' in Tamils has not been previously documented however studies have shown it is used by other BME groups to cope with distressing experiences (Summerfield, 1996 as cited in Burnett & Peel, 2001).

The study found that when Tamils moved to the UK they utilised "positive" thinking captured in the subtheme *now we are better off than others so be thankful*. When distressed, participants relied on a positive attitude and frequently utilised positive self-talk strategies. This research supports previous findings which suggested that Tamils adopt optimistic coping strategies (Fernando, 2012; Russell, Subramaniam & Russell, 2012) Bhushan and Kumar (2012) also demonstrated that proactive coping strategies are often adopted following trauma and are linked to psychological growth. Finally there is a large body of evidence which suggests that focussing on positive aspects of one's self and growth and recovery has been linked to post-traumatic growth (Linley & Joseph, 2003).

The use of intra-psychic coping strategies corroborate Fernando's (2012) findings that Tamils may not be wholly collectivist and also utilise a variety of individual strategies. The current study is the first, according to the researcher's knowledge, to demonstrate the use of

psychological strategies such as avoidance of rumination and meditation to manage distress amongst Tamils in a UK context.

With the help of others you survive. Tamils placed great emphasis on social support during the war. Others were able to provide practical support, solution-focussed support and physical intervention. These ideas are summarised in the subtheme *you'll tell each other I am with you, I'll look after you* and suggest that Sri Lankan Tamils value collective coping. This supports the idea that expressions of coping and resilience for Tamils may occur at a group level and that in collectivist cultures, greater emphasis is placed on the welfare of the family and community rather than the individual (Somasundaram & Sivayokan, 2005). It corroborates findings that Tamil families may respond to distressing experiences as a unit (Rajkumar et al., 2008) and think and act together rather than individually (Gurbiye et al., 2011).

Many Tamils relied on prayer or religious practices and viewed their survival as a "gift from God". Such findings fit with the suggestion that Tamils adjust to adversity through religious and cultural practices, considered to have a 'healing effect' (Fernando, 2005). The current study provides further evidence for the use of self-help through religion in South Asian communities (Dein & Sembhi, 2001).

According to Bronfenbrenner's ecological model (1979) and understanding of human development in relation to systems theory (Kail & Cavanaugh, 2010), individuals do not exist in isolation but form part of much wider systems. At a micro-level, individuals were practically and psychologically supported by family, friends and neighbours and, used religious and cultural practices to cope. At a meso-level the need for meaning making and protection facilitated an interaction between families, friends and neighbours. At an exo-level, support was also extended to wider community members. This ecological model may explain the communal actions of Tamils and the importance of social factors on mental health and wellbeing. The current study expands on previous research by suggesting that social resources are essential for recovery (Fernando, 2005) but also enhance intra-psychic coping. Social interactions may improve problem-solving abilities and reduce feelings of hopelessness and rumination.

This subtheme also highlighted a tension for many Tamils who felt let down by other Tamils which had not previously been highlighted in other studies. It seems that for a minority of Tamils, during times of extreme stress, survival instincts were activated and individualised methods of coping adopted. Others experienced difficulties coping in the absence of loved ones. This seems appropriate given that in collective cultures individuals become embedded within their nuclear and extended family (Somasundaram, 2007), and find meaning through social groups (Durvasula & Mylvaganam, 1994). They may therefore feel the considerable impact of this loss when they immigrate.

The subtheme *not only me, how many of them suffered* captures the sense of solidarity amongst Tamil survivors of war. It seems participants reminded themselves that they were not alone in their suffering. This idea fits with previous findings which have shown that following disaster Tamil people view themselves as part of a much larger traumatised society rather than as lonely sufferers (Rajkumar et al., 2008). Some participants acknowledged that their experiences of war were not unique to Sri Lanka and that their solidarity was with victims of war generally, particularly in light of current conflict in countries such as Syria.

Many participants found that after they had immigrated to the UK, community membership provided this sense of belonging and peer support which helped them cope. It seemed that for many Tamils in the UK it was important to participate in community and cultural events and share their gratitude. This supports previous findings which show that Tamil communities became more united and more social, religious and cultural gatherings took place following disasters (Rajkumar et al., 2008). These findings suggest that rebuilding social networks and enabling social connectedness is an important part of rehabilitation for Tamil survivors of war. This approach seems highly appropriate given theories of collectivism which suggest that mass trauma has community meaning and leads to re-establishing social relationships (Tumarkin, 2005).

The changes which occurred within families during and following the war are captured in the final subtheme *it's all because of our kids*. War seemed to increase individuals' involvement in their family, particularly their parental duties. Following war many Tamils put their efforts into working and living for the 'sake of the family'. It seemed that having children gave individuals something to live for, and looking after relatives provided a focus during times of crisis. This supports previous studies which have shown that following adversity, many

Tamils chose to raise a family to give them a sense of purpose and did not want their children to live in fear (Fernando, 2012). This can be understood from a collective coping perspective which argues that following trauma, individuals use their interdependence to find meaning in their lives (Fernando, 2005). Tamil culture, like other South Asian collectivist cultures are based on sociocentrism, generational interdependence and the role of the extended and joint family (Bhurga and Bhui, 2001). Such cultures promote interdependence and co-operation, and the family is often the focal point of societal structures, with family members being more involved in caring for each other in comparison to their western counterparts (Chadda & Deb, 2013). The findings suggest that individuals from war-torn countries may cope by becoming further embedded within family structures. With Bronfenbrenner's (1979) ecological model in mind, at a micro-level, parent-child relationships were strengthened as a result of war-related experiences. Preventative interventions therefore need to consider the protective nature of family dynamics and family bonds.

The value in talking. Nearly all participants identified positive aspects of talking which the subtheme *they will tell their stories and they have peace of mind* captures. Many identified the therapeutic value in sharing experiences. Whilst many studies with this community have highlighted the importance of friends and family, few have highlighted the importance of the talking process. The current study suggests that sharing similar lived experiences with other Tamils is highly validating and has a healing effect as many participants reported that it gave them 'peace of mind'. Problem-sharing with friends was also considered important during times of crisis which has been previously reported (Fernando, 2012).

The subtheme *you want to share your experiences in the proper manner* describes the benefits expressed by some participants of staying silent. This subtheme also captures the idea that it takes time to discuss painful experiences and that experiences can only be discussed with select individuals. A variety of explanations were provided including not wanting to worry others and not knowing who to approach.

Most participants did not talk to health professionals about their difficulties. Professional help-seeking was considered inappropriate due to language barriers and professionals' limited understanding of Tamils' experiences, replicating the findings of Beiser et al. (2013). Some spoke about the importance of protecting the family honour and the role of stigma. This is in

line with previous findings which suggest that stigma can often act as a barrier to help-seeking, particularly within BME communities (Knifton, 2012). Many studies with BME communities have shown that stigma and shame can prevent professional help-seeking (Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak 2005, Chew-Graham et al. 2002) however the role of shame in help-seeking prevention has not been explored in the Tamil community.

Protective factors among BME groups may also account for the reduced uptake of health services. Maintaining strong links with their own community and cultural bonds which is particularly important for migrants (Beliappa, 1991). Furthermore studies have also shown that individual, social and spiritual coping strategies are more valued than mainstream services (Rajkumar et al., 2008). From a community psychology perspective, this suggests that cultural, religious and contextual factors mediate responses to trauma. The findings suggest that BME populations have ample resources within their own community to enhance their resilience. Health professionals including clinical psychologists need to work collaboratively with community and religious organisations to develop and implement community interventions which promote wellness in trauma survivors.

Finally the subtheme *before I was not a talking person* depicts how attitudes regarding talking have changed over time and across generations. Tamils seem to have been influenced by British culture and values. Since living in the UK many Tamils were able to consider the detrimental effects of not talking and highlighted that living in the west created openness and acceptance.

Improving life for yourself and others. All of the participants through their experiences wanted to ensure others as well as themselves had a better life in the UK. For the majority of participants this was at a community level and there was a strong desire to empower Tamils by providing access to information and resources, and organising meetings and seminars in line with previous research (Gurbiye et al., 2011; Gurbiye, 2011b).This process of wanting to help seemed to gain momentum once participants had moved to the UK as more opportunities and resources were available to help relief efforts back in Sri Lanka. These findings are illustrated by the subtheme if *we empower the people then they will make a change in their society***.** Tamils were keen for their children to have different lives in the UK and put great efforts into their education. This was to provide Tamil children with more

life choices as many themselves had been victims of discrimination. Additionally education seemed to provide access to resources which other Tamils could benefit from as previously documented (Gurbiye, 2011b).

Following catastrophes, the Tamil community developed a strong desire to help each other. They subsequently worked together to develop their social capital in order to re-build their community which corroborates previous findings (Gurbiye et al., 2011). It seems that a number of Tamils accumulated resources to improve social conditions for Tamils at a 'grass roots level'. Some were also involved in community development work in Sri Lanka and establishing small sustainable businesses. Collective responsibility and forming common goals to achieve desired outcomes has been reported in previous literature (Gurbiye et al., 2011; Rajkumar et al., 2008). Social capital theory provides a useful framework in understanding the actions of Sri Lankan Tamils and other collectivist cultures (Fernando, 2005). Social capital theory suggests that changes in relationships within a social structure facilitate action within the structure (Coleman, 1988). The importance of helping Tamils to develop social capital is discussed further below. It seems Tamils in the UK worked together in order to re-build their community in Sri Lanka and to improve social and living conditions for Tamils in their home country, supporting previous studies involving Tamil refugee populations (Gurbiye et al., 2011). Similarly to Gurbiye et al., the current study found that many Tamils living in the UK dedicated their time volunteering and supporting their own community in their host country.

Participant's experiences seemed to influence their future life trajectory and they seemed to draw specifically on their strengths and personal resources to make changes within their community which the subtheme *I do contribute my part to my people* captures. It seemed that the projects participants contributed to were directly linked to their own personal experiences in the war. Tamils also seemed to make decisions about their career or education based on their experiences in Sri Lanka and their desire to contribute to their community. For those in the UK educating themselves and their children was a key priority as education was linked to freedom and life choice. Given their experiences during the war, they viewed education and employment as a protective factor against adversity, supporting previous studies which have shown that following experiences of hardship, Tamils integrate into their host society by becoming actively involved in education and employment (Gurbiye et al., 2011). Such research has suggested that choosing professions such as medicine or engineering allow

individuals to contribute to development and health projects in Sri Lanka (Gurbiye et al., 2011).

Searching for a different life in the UK. The study suggests that for many individuals, who lived through war, it became extremely difficult to remain in their home country and they fled due to concerns over safety. Escaping danger can be understood in evolutionary terms according to the fight-or-flight response (Cannon, 1932). When repeated threats are made to survival and an individual believes they do not have the resources to cope, they escape. Others fled in search of better opportunities which can be understood from a number of theoretical perspectives. Migration theory suggests that migration is driven by a set of 'push factors' operating from the country of origin such as poverty and political repression, and 'pull factors' operating from the country of destination such as job prospects, better education, welfare systems and political freedom (Lee, 1966).

Most participants identified that the UK provided a number of advantages including access to health and social care, employment, and education opportunities. Above all, safety was vital and allowed many to live a 'peaceful life'. The practical benefits of living in a different country have not been highlighted in previous research and participants spoke highly of the welfare support system and the UK government. At the same time, Tamils seemed keen to maintain self-reliance which other studies have corroborated (Gurbiye et al., 2011).

Many Tamils spoke about the positive benefits of cultural diversity and community integration but acknowledged that the process of acclimatising and acculturation was extremely difficult. Lee's (1966) migration model suggests that there may be a set of 'intervening obstacles' which have to be overcome including: physical distance, cost of making the journey, cultural barriers such as language, and different ways of life. Lee also suggests that personal factors influence how people react to combinations of push and pull factors for example economic status, life-stage, and personality. Reported difficulties in acculturation supports previous findings that BME immigrants are exposed to family absence and acculturation and migration trauma which impacts on their mental health and wellbeing (Myers, McCollam, & Woodhouse, 2005). For most it seemed that a reduction in family support was the most important factor which supports existing literature (Gil, Wagner & Vega, 2000).

The current study did not find evidence to suggest the use of herbal coping methods in Tamils living in the UK in contrast to previous studies (Beiser et al., 2003) nor did it evidence of the use of ayurvedic medicine as previously documented (Tribe, 2007). Finally the study did not find evidence to support the use of non-adaptive coping behaviours such as drug or alcohol use in contrast to previous research (Rajkumar et al, 2008).

Research on war-affected populations continues to grow however, research on coping and resilience within such populations remains extremely limited. It is important to consider whether the findings from the current study are similar or distinct to research with other populations as this may have important clinical implications. Nuttman-Shwartz and Dekel (2009) explored coping behaviours in Israeli adult students exposed to continuous threat associated with war. High levels of a sense of belonging to the community and acceptance of the situation were protective factors against PTSD. Sousa (2013) looked at coping strategies adopted by Palestinian women to manage political violence and found religious support and participation in religious activities was a significant protective factor. Research with Bosnian refugees re-settled in the US has highlighted the importance of family, spirituality, and community social support services in enhancing resilience (Sossou, Craig, Ogren & Schnak, 2008). Research with individuals from the Congo and Sierra Leone has also highlighted the value of increasing resilience through sharing experiences in groups (Liebling, Winter, Ruratotoye, Slegh & Brown, 2014). Finally, some research has suggested that education may contribute to healing broken narratives within refugee families affected by war and genocide (Lin, Suyemoto & Kiang, 2009). These studies suggests that many of the findings from the current study may be transferable to other war-affected populations however further UK-based research is needed to corroborate this.

Methodological Strengths

It is important to acknowledge the methodological strengths of the current study. Much of the research on the Tamil population remains international and, this is the first UK based study to the researcher's knowledge, exploring the coping behaviours of Tamils, albeit it Tamils who came to live in the UK. The researcher incorporated several quality assurance measures within the study design. All interviews were transcribed by the researcher who checked a number of the transcriptions for accuracy as recommended (Braun & Clarke, 2013). Not all transcriptions could be checked however due to the time-constraints of the project. Following the process of coding and searching for themes, codes and themes were checked

against collated extracts of data and then against the entire data set. A pilot analysis was also undertaken and reviewed with research supervisors to improve confirmability. These measures were to ensure that other researchers would reach similar interpretations of meaning as the original researcher (Chard & Gaberson, 2001). Furthermore, the researcher met most of Braun and Clarke's (2006) quality criteria in relation to transcription, coding and analysis. The researcher also went to great lengths to access individuals from a hidden and hard to engage population. They travelled to a range of community locations and participant's homes across a wide geographical location. They were flexible with interview times, conducting interviews early morning or evening to suit participants. The researcher also understood the importance of establishing trust with participants. Many were curious about the researcher's background and the researcher felt it was ethical to disclose some information about their cultural background and interest in the research topic. This was also made explicit on the information sheets for the study. The researcher considered self-disclosure an important way of establishing a relationship and developing trust with participants. Finally, the researcher also invested a significant amount of time visiting community organisations, speaking with community members and being available to answer questions to facilitate recruitment. Participants were recruited from a range of organisations across London and the sample varied greatly in terms demographic characteristics.

Critique of Methodology

Sampling issues. There were significant issues with sampling and therefore, the sample size achieved was smaller than anticipated (n=10). Due to limited uptake from potential participants, the range of organisations for recruitment was amended (following University Ethics approval) to be more inclusive. The upper age limit (65 years) was also removed to widen recruitment. The researcher relied heavily on snowball sampling to access research participants which seemed to reflect a key finding in the study that Tamils rely on other Tamils for support. It seems that a number of participants had been encouraged to participate based on the positive experiences of previous participants.

Furthermore six participants expressed interest but three did not meet the recruitment criteria, one could not be contacted and two refused when contacted. It is important to consider why Tamils were reluctant to participate in a study of this nature. Firstly there may have been suspicion about the purpose of the research and participants may have had concerns that

information including their immigration status or involvement in militant groups may have been shared with organisations such as the Home Office. Although the researcher emphasised confidentiality and anonymity, individuals may have had concerns about their identities being revealed. Individuals may also have found talking about the past too distressing. Finally it is possible that the exclusion criteria (English fluency, mental health diagnosis and experience of working in mental health) affected recruitment.

It has been suggested that a minimum of five participants are required for a reasonable student project (Smith & Osborn, 2003) and the final sample size was still within the recommended range for a qualitative study of this nature (Braun & Clarke, 2013; Fugard & Potts, 2015). Furthermore, although the sample size may be considered small, the research topic was of a sensitive nature and participants came from a hidden and marginalised population.

Self-selectivity. Despite utilising snowball sampling, the sample was self-selective and therefore there was a possibility of self-selection bias (Krishna, Maithreyi & Surapaneni, 2010), i.e. the decision to participate in the study may have reflected inherent characteristics in participants. Furthermore, many participants disclosed their involvement in Tamil organisations and theoretical or purposive sampling strategies might have elicited a broader range of views. It is unclear whether the individuals who dropped out shared similar or different experiences of the war and coping compared to those who participated in the study.

Participant demographics. All of the participants described themselves as Hindu and there was little variation in terms of faith across the sample. Whilst this was to be expected as a majority of Sri Lankan Tamils are Hindu, religio-cultural practices were considered an important way of coping with war. It would be interesting to consider whether Tamils from different religious and spiritual backgrounds had similar or distinct experiences of coping. However, although the intention of thematic analysis is to highlight themes across the data, it is also important to capture rich and detailed data about participants' experiences (Braun & Clarke, 2013).

The researcher collected demographic information from participants however acknowledged during the research process that it may have been useful to collect information on socio-economic status, caste and involvement with non- health related services (e.g. social care or

domestic violence agencies) to consider whether these contribute to individuals experiences of coping. It is possible that caste may have influenced religio-cultural beliefs about coping. The researcher was aware that participants may have been reluctant to share information on caste and socio-economic status due to issues of stigma and discrimination. However, given that generational differences were highlighted in relation to talking as a coping mechanism, it is possible that other demographic characteristics may affect coping behaviour.

Member checking. Some have suggested that 'member checking' is an important process in order to enhance rigour in qualitative studies (Johnson & Waterfield, 2004; Lincoln & Guba, 1985). Due to both time constraints and recruitment difficulties, it was not possible to utilise member checking within this study. However, given the epistemological position adopted in the current study this was considered acceptable. The critical realist position proposes that individuals experience different aspects of reality and that reality may change over time. Therefore no experience can be considered the same across participants or across time-points. Member checking in many ways relies on the assumption that there is one fixed reality that can be captured by the researcher and verified by the participant. There were other ways in which the researcher added to the rigour of the study for example undertaking a pilot analysis of the data which was reviewed with research supervisors for confirmability, using MAXQDA to view and review codes and themes against the data set and the use of memos to record decision making throughout the analysis. Findings from the research will be disseminated to participants following examination of the research (see below).

Interviews. Due to recruitment difficulties, interviews were sometimes carried out in close succession, often on the same day. The researcher was therefore not able to listen to interviews and transcribe them before the next interview took place as is considered good practice in qualitative research (Rubin & Rubin, 1995). Instead, the researcher kept a research journal and recorded their thoughts both before and immediately after interviews. Where possible the researcher listened to audio recordings of some interviews to inform subsequent ones.

The researcher also acknowledged that there was a lot of information gathered, particularly at the beginning which was briefly explored but not analysed. This was because it was not considered the focus of the interview or pertinent to the research question. The researcher in particular refers to participants' experiences of war and political conflict. The researcher felt

it was extremely important for this community to have their stories witnessed and felt to not do so was prioritising the researcher's agenda over the needs of the participants. The researcher also felt unethical exploring coping strategies without giving participants an opportunity to describe what it is they had experienced. Finally the researcher felt that exploration of experiences of the war helped participants to focus on their experiences of coping which may otherwise have been difficult.

The use of an interpreter. The researcher carefully considered the use of an interpreter for the current study and is aware that language barriers may have limited recruitment. The researcher understood Tamil which was useful when participants used Tamil words or phrases and noticed it made participants feel more comfortable. It was thought that an interpreter might affect the flow of communication during interviews, make the participant feel excluded and reduce participation as individuals may be reluctant to talk about personal issues due to fear of this information being shared within the community. The use of an interpreter may also have influenced the responses provided by participants and their willingness to be open and created a social desirability bias (Paulhus, 1991).

Furthermore, as discussed in the methods chapter the critical realist position adopted in this study posits that knowledge is context dependant and that location within the social world influences the way in which the world is viewed. Interpreters also form part of the process of knowledge production and there is no neutral position from which the interpreter can interpret from (Temple & Young, 2004). The researcher acknowledged that interpreters have their own values and beliefs which may influence the way they interpret the responses, creating more opportunities for bias in the data.

Self-Reflexivity

I kept a reflective journal as part of my research which I often used to think about participants before and after interviewing them and to record my experiences throughout the research process.

Although I am of Tamil ethnicity, I have spent my whole life in the UK and have been educated in the west. My values and beliefs have largely been influenced by western culture. Before undertaking this research I had very little contact with the Tamil community.

Furthermore, in the past I had always identified more with the British aspects of my identity than the Tamil aspects. Whilst this may have been helpful to my research as I was able to adopt both an 'insiders' and 'outsiders' perspective (Somasundaram, 2007) during the research process, it also presented its challenges. A key theme in my reflective journal was anxiety regarding how I might be perceived by participants, an issue I discussed on several occasions with my family and research supervisors. I had particular concerns about the values and beliefs participants would bring to the research encounters and was concerned they would be markedly different to my own. In particular, I feared assumptions participants would make about my British accent, appearance and limited ability to speak Tamil. In fact many participants found my attempts to speak Tamil amusing when I first introduced myself or attempted to arrange interviews which I felt embarrassed by. I also worried whether participants would judge me for not being married or not having children which seemed important as I was often asked about this at the beginning of interviews. Upholding traditions is an important part of Tamil culture and my lack of adherence may have affected the development of the participant-interviewer relationship. On reflection, I was concerned that participants would view me more as an 'outsider' than an 'insider' within the Tamil community and that this would make them reluctant to engage with me however ethically, I felt it was important to be explicit about my background.

Another recurrent theme I reflected on was my belief that participants would think I was unable to relate to their experiences based on my professional training and felt a sense of guilt at the disparity between my life and the lives of my participants. Participants often expressed feelings of guilt that so many people had died during the war and as interviews progressed, I found myself feeling thankful but guilty about my personal circumstances. It seems that through the interviews I had developed a vicarious form of survivor's guilt (Mitchem, 2012). I was however surprised at participants' willingness to share their experiences with me despite our differences and as interviews progressed I was able to draw on empathy and containment skills I had developed during training to support participants during interviews. During the de-briefing participants also commented on the therapeutic nature of the research interview which I attribute to clinical training.

Furthermore, at the time of undertaking this research I was in my final year of clinical training and had worked in mental health services for many years prior to training. I was informed by western concepts of distress, coping and treatment and had knowledge of

theoretical concepts such as learned helplessness (Seligman, 1972) and post-traumatic growth (Linley & Joseph, 2003). This may have informed the coding process and the development of researcher-derived codes. Given the critical realist position I adopted I am aware that the study findings need to be interpreted with caution. I interpreted the data based on my knowledge of mental health and knowledge is temporally relative and subject to change. Furthermore, individuals' notions of reality are socially constructed and therefore multiple realities will exist.

On several occasions my participants shared extremely distressing material with me relating to their experiences which, although I was expecting, was not necessarily prepared for. My clinical training has helped me to develop skills in containing my own distress which I relied on heavily during the research process and undertaking personal therapy and my reflective journal also allowed me to explore the impact of interviews. Occasionally, the content of the interviews resonated with me deeply. Many participants spoke about their experiences of loss and bereavement of family members and at those times I was reminded of the loss of my father as well as my role as a carer. It was during these moments I felt more able to identify with some of my participants experiences.

Through my research I have become more aware of the role of race in both my professional and personal life. This process has allowed me to acknowledge the impact of object relations which are deeply imbedded within our western culture but also our psyche. Research has suggested that the 'black' and the 'white' are both part objects which form a destructive object relation inherited from the history of slavery and colonisation (Lowe, 2008). Whilst this research refers specifically to individuals of black African origin it is highly relevant to other BME populations who have also been affected by colonisation. Having lived in the UK all my life I considered myself British despite my Sri Lankan Tamil heritage. This research has helped me realise there are perhaps aspects of my cultural and ethnic identity which are 'split off' and can be defensively avoided against. Undertaking interviews with Tamils and reflecting on my own position in relation to the research has helped to highlight the defensive function of focussing more on the 'white' aspect of one's identity when living as a person of colour in the UK. I have become more interested in Tamil culture as a result of this research and appreciating that individuals may hold multiple identities. I have also become more aware of the dilemma immigrants in Britain face in wanting to maintain their cultural identity

whilst attempting to integrate into British culture. Based on my own experiences, it feels there can be a risk of neglecting your 'Asian' identity in order to integrate.

I have always maintained a strong interest in ethnic minority mental health and cross-cultural psychology but prior to this study my interests have always maintained my intellectual curiosity. Undertaking this research has helped me to consider wider social and political issues relating to immigration as well as how migrants are portrayed in the media. My clinical training emphasises the impact of life experiences on psychological well-being with a focus on psychological difficulties. Through this research I have become more aware of the unique strengths and resources of migrant populations and the knowledge and skills they bring to their host countries.

Future Research

As discussed previously, recruitment was much more problematic than anticipated. Given the time-constraints of the study, participants were generally recruited from London however future studies may want to consider expanding geographical location and consider the use of telephone interviews to increase recruitment. A majority of the sample were female and it would be helpful to recruit more males in future studies in order to consider whether gender influences coping styles. Furthermore, as previously mentioned all participants were Hindu and it would be useful to recruit individuals from other faiths however the researcher acknowledges that culture and religion are inter-related.

The current study is one of the very few studies which have looked at coping experiences of Tamils in the UK, it would be useful to see whether future studies with this population can confirm transferability of the findings from the current study. Future studies may also want to consider the extent to which the findings can be applied to other contexts and to other groups of individuals (Lincoln & Guba, 1985), particularly other war-affected populations.

Given the nuance of this research topic and the anticipated difficulties with recruitment, the researcher utilised relatively inclusive recruitment criteria however acknowledges that there will be differences in experiences of war and coping related to the period and duration of war lived through, age, and duration spent in the UK as well as other factors. Future studies could examine the effect of these factors on coping.

Finally, this study used a community sample as it was interested in how the majority of Tamils survivors of war cope in their country of origin and their host country. The researcher acknowledges that some Tamil individuals do seek or receive treatment from mental healthcare services and some do have diagnoses of mental health conditions. Although one obvious difference in coping would be the use of professional help, it would be interesting to see if there are other differences in coping between a clinical and community sample.

Clinical and Policy Implications

The results from the current study have a number of important clinical and policy implications which will now be highlighted and may be relevant to other war-affected populations. Many Tamils in the UK have lived through prolonged periods of war and political conflict. During such times, they have witnessed and been victims of assassinations, bomb attacks, and sexual and physical violence. Many have experienced forced displacement, and food and water shortages. Whilst some survivors of war are able to immigrate, others are forced to seek refuge in other countries. Limited research suggests that Tamils rarely seek professional help and are under-represented in mental health services in the UK (Loewenthal et al., 2012).

Professional help. The current study suggests that this community seem to utilise a wide variety of individual, social and spiritual coping strategies to manage their experiences and do not consider health interventions necessary or appropriate. Reasons for limited up-take of services include language barriers; health professionals' limited understanding of the culture and historical context and mistrust in services (Beiser et al., 2013, Dein & Sembhi, 2001). Limited uptake may also be due to the pluralistic nature of help-seeking in the Tamil community based on the illness beliefs and values. Pluralistic help-seeking may have important clinical implications because it is the most preferred approach amongst Tamil survivors of war (Samarasinghe, 2002). Given that war has consequences at a mass level, interventions tailored to the individual may be both culturally and resource inappropriate (Tribe, 2007).

The current study argues that mental health professionals must acknowledge that individuals exposed to war and conflict will not necessarily develop mental health problems and that there is a danger of pathologising such individuals. The study suggests that many Tamils, in

the UK adopt strategies which enhance their resilience and functioning without the need for professional intervention. Many studies have in fact reported that a vast majority of refugees resettled in western countries do not develop mental health disorders classified as 'serious' (Fazel, Wheeler & Danesh, 2005). Powerful cultural and social mechanisms can enhance coping despite experiences of trauma, and religious practice and involvement in the community have been shown to be effective coping mechanisms (Ungar, 2008).

A holistic approach. Mental health professionals need to develop a better understanding of the contexts that war-affected populations have lived within which many BME communities have highlighted (Dein & Sembhi, 2001). Professionals also have a responsibility to consider how mental health and wellbeing may be enhanced through intrapersonal and interpersonal coping resources. This is likely to involve health professionals working collaboratively with religious, community and voluntary organisations to develop and deliver holistic mental health and wellbeing promotion strategies. This may also involve providing appropriate training and education to mental health professionals and those working in community organisations. It is likely that such an approach will also reduce the need for crisis interventions in individuals from war-affected populations who do experience mental health problems.

Psycho-social support. This study suggests that Tamils value social support during times of crisis, take collective responsibility for their wellbeing and accumulate shared resources. For many Tamils in the UK, empowering Tamils in Sri Lanka has helped them to find meaning in their lives. In western communities the emphasis following trauma is on personal growth and recovery (Linley & Joseph, 2003) providing a rationale for individual psychological therapy. In the Tamil community, coping and resilience occurs at a group level. This presents a challenge for services developing and delivering interventions aimed at promoting psychological wellbeing in war-affected communities in the UK. It seems that, replenishing and increasing resources at a group-level may enhance coping capacity and reduce psychological distress rather than therapeutic interventions targeted at individuals. This may be best achieved through social support and membership to community organisations (Gurbiye, 2011a). Current therapeutic support offered to refugees and asylum seekers includes psycho-social groups which strengthen individual's coping skills through peer support and experiential learning (Refugee Council, 2016).

Bearing this in mind, this study recommends that community interventions should focus on increasing the social capital within the Tamil community and other war-affected populations in the UK. There are different types of social capital and two forms have been identified; bonding and bridging capital (Putnam, 1995) which is of particular relevance here. Bonding capital occurs within communities and bridging capital occurs between communities. The current study suggests that helping the Tamil community to increase social capital within their community is extremely important in promoting resilience and recovery. This may be through membership to community organisations and involvement in social and religio-cultural events. However, the study also suggests that increasing bridging capital is also important. Improving relationships between communities can aid the acculturation process for immigrants, refugees and asylum seekers and reduce issues such as racism and discrimination which many individuals face in their host country.

Tamils seem to prefer emotional and social support at a group level. This adds to literature which has suggested that relief, rehabilitation and development programmes in Sri Lanka may want to consider group interventions and multi-level approaches (Somasundaram, 2007). The study suggests it is important to consider the value of community support groups and group programmes when targeting individuals from collectivist cultures. Such interventions may have higher levels of uptake than ones purely focussed on the individual. This study also highlights the value of peer-support based on shared experience, shown to be valuable in a wide range of settings. The Expert Patient Programme (EPP) is an example of such peer-led support in which those who provide support have personal experience of long-term conditions (Petch, 2008). The emphasis in EPP is on self-directed support which may be appropriate for this client group.

This research found that shared experiences facilitated meaning making amongst survivors of war. Narrative approaches such as ‘Tree of Life’ work (Ncube, 2006) have been successfully undertaken with asylum seeker and refugee populations who have experienced loss and trauma and this approach is currently used by some services in the UK to help survivors of war re-author their lives (Refugee Council, 2016). This approach could be highly relevant to Tamils and other war-affected populations. Some have suggested that collective narrative practices enable people to share stories about their lives and to create stories which are meaningful in their present and future. It allows individuals to focus on their skills and resources and within group settings can be an extremely powerful tool.

Intra-personal coping. The current study also highlights the need for services to achieve a balance between the individualistic demands of western cultures and the interdependence of South Asian cultures (Durvasula & Mylvaganam, 1994). This study suggests that Sri Lankan Tamils are not wholly collectivistic and do utilise individual coping strategies. The study provides evidence of the use of cognitive strategies such as avoidance of rumination and, guided imagery. However many Tamils utilise non-psychological mental strategies to cope with distress including positive self-talk and forgetting. This study acknowledges that whilst psychological interventions can have cultural limitations, (Kagan et al., 2011) some coping strategies particularly the cognitive strategies can be taught, and should be incorporated into public health policies and psychosocial intervention programmes. Individuals could be taught specific coping skills such problem-solving, emotion regulation, avoidance of rumination and goal development but may prefer to do this in a group setting.

Religion. For many Tamils, religion is considered an important coping strategy in dealing with distress and adversity. In many South Asian cultures such as Tamil culture, the use of self-help through prayer and ritual is promoted (Dein & Sembhi, 2001). The current study corroborates previous findings and suggests that community interventions need to address the spiritual and religious needs of BME communities. Spiritual beliefs have been shown to play a positive role in mental health and suicide prevention and promote coping and recovery (Coghlan & Ali, 2009; Mohr & Huguelet, 2004).

Education and employment. This study also highlights education and work as important protective factors in Tamil mental health. For many Tamils, their personal struggles increased their desire to contribute to their host country through education and the workforce. Many Tamils immigrants and refugees in the UK, make positive contributions to society. Although some may have to rely on government support, this is not the case for the majority. Many Tamils who have claimed asylum in the UK are now in full time employment. Research has suggested that the Tamil population are characterised as 'super immigrants' as they are integrated into the labour market, do not rely on social welfare and maintain high levels of education (Lie, 2004; Østby, 2002). The current study suggests it is important to acknowledge the fact that immigrants and refugees have multiple identities and that society may tend to focus on their immigrant identity rather than other identities. This is in part due to the media which tends to portray individuals negatively. In the current climate, where the UK has seen an influx of refugees in recent months and restrictions have been

placed on immigration, it is important to consider the detrimental consequences of such actions. Refugees in particular are often viewed as strain on the economy and this research demonstrates that immigrants and refugees come to the UK with a number of skills and resources and take an active role in contributing to both their host country and country of origin. The study supports the argument for the economic value of cultural diversity (George, Lalani, Mason, Rolfe & Bondibene, 2012).

The recommendations detailed above may also be applicable to other countries supporting war-affected BME individuals who either immigrate or seek asylum. They may be particularly relevant to western countries where cultural beliefs about distress and coping may be markedly different to those within BME communities.

Conclusions

The current study makes recommendations in line with the community psychology approach (Orford, 1992) which considers the importance of the wider social context in which Tamil people live as well as emphasises interpersonal and collective relations. There is a need to enhance collective resources within this war-affected community in order to improve psychological well-being. The study recommends that this population may benefit from preventative rather than treatment-based approaches aimed at maximising current service provision and enhancing existing resources. Preventative approaches should encourage self-help, build on existing strengths and utilise support from non-professionals within this community. Interventions targeted at specific war-affected communities seem the most appropriate and feasible and can also be a cost-saving strategy.

The study suggests it could be beneficial for professionals to work closely with community organisations and support service provision for Tamils within them. Such services currently meet the cultural and social needs of Tamils which seem vital to their wellbeing and there may be scope to address psychological needs within these services too. It is also important to provide training for community members and leaders so that they are better equipped at supporting their own community. Furthermore, professionals need to find appropriate methods of raising awareness of local and national support organisations as many individuals are not likely to visit health professionals through which services may be promoted. Given the current migrant crisis and with particular consideration to Syrian refugees, for war-

affected populations, knowing where and how to access support is vital. The challenge is developing community interventions which are integrated and holistic. What may prevent this is the focus on treatment-based interventions for individuals to which a large proportion of resources are directed to.

Dissemination

The researcher will offer to provide a summary of the research findings to all participants who took part in the study. The current study will also be considered for peer-reviewed scientific journals.

References

Ahmed, K., Mohan, R.A., & Bhugra, D. (2007). Self-harm in South Asian women: a literature review informed approach to assessment and formulation. *American Journal of Psychotherapy*, *61*, 71-81.

Ali, S., Dearman, S.P., & McWilliam, C. (2007). Are Asians at greater risk of compulsory psychiatric admission than Caucasians in the acute general adult setting? *Medicine, Science and the Law*, *47*, 311-314.

Almoshmosh, N. (2016). The role of war trauma survivors in managing their own mental conditions, Syria civil war as an example. *Avicenna Journal of Medicine, 6*(2), 54-59.

American Anthropological Association. (1998). *American Anthropological Association Statement on 'Race'*. Retrieved from http://www.aaanet.org/stmts/racepp.htm

Amirkhan, J.H. (1990). A factor analytically derived measure of coping: the coping strategy indicator. *Journal of Personality and Social Psychology*, *59*, 1066-1074.

Anand, A.S., & Cochrane, R. (2005). The Mental Health Status of South Asian Women in Britain: A Review of the UK Literature. *Psychology and Developing Societies*, *17*(2), 195-214.

Anderson, J., Moeschberger, M., Chen, M. S., Jr., Kunn, P., Wewers, M. E., & Guthrie, R. (1993). An acculturation scale for Southeast Asians. *Social Psychiatry and Psychiatric Epidemiology*, *28*(3), 134–141.

Aragona, M., Rovetta, E., Pucci, D., Spoto, J., & Villa, A. M. (2012). Somatization in a primary care service for immigrants. *Ethnicity & Health*, *17*(5), 477-491.

Aspinall, P. J. (2002). Collective Terminology to Describe the Minority Ethnic Population: The Persistence of Confusion and Ambiguity in Usage. *Sociology, 36* (4), 803–816.

Balls Organista, P., Organista, K. C., & Kurasaki, K. (2003). The relationship between acculturation and ethnic minority mental health. In K. M. Chun, P. Balls Organista & G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 139–161). Washington, DC: American Psychological Association.

Basoglu, M., Livanou, M., Crnobaric, C., Franciskovic, T., Suljic, E., … Duric, D. (2005). Psychiatric and cognitive effects of war in former Yugoslavia: association of lack of redress for trauma and posttraumatic stress reactions. *JAMA, 294*, 580-90. doi:10.1001/jama.294.5.580

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*, 233–245. doi: 10.1111/j.0020-7985.2003.00268.x

Beliappa, J. (1991). *Illness or Distress: Alternative Models of Mental Health.* Newcastle: Confederation of Indian Organisations (UK).

Bernard, H.R., & Ryan, G.W. (2010). *Analyzing qualitative data: Systematic approaches*. Los Angeles: Sage

Berry, J.W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, *29*, 697–712.

Bhaskar, R. (1978). *A Realist Theory of Science*. Hassocks: Harvester Press.

Bhugra, D. & Bhui, K. (2001). *Cross-cultural psychiatry: A practical guide*. London: Arnold.

Bhugra, D., Bhui, K., Desai, M., Singh, J., & Baldwin, D. (1999a). The Asian Cultural Identity Schedule: an investigation of culture and deliberate self-harm. *International Journal of Methods in Psychiatric Research, 8* (4), 212-218.

Bhugra, D., Corridan, B., Rudge, S., Leff, J., & Mallett, R. (1999b). Early manifestations, personality traits and pathways into care for Asian and white first-onset cases of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology, 34*, 595-599.

Bhugra, D., & Desai, M. (2002). Attempted suicide in South Asian women. *Advances in Psychiatric Treatment, 8*, 418-423.

Bhugra, D., Lippett, R., & Cole, E. (1999c). Pathways into care: an explanation of the factors that may affect minority ethnic groups. In D. Bhugra and V. Bahl (Eds.), *Ethnicity: An agenda for mental health* (Chapter 4). London: Gaskell.

Bhui, K. (1999). Common mental disorders among people with origins in or immigrant from India and Pakistan. *International Review of Psychiatry*, *11*, 136-144.

Bhui, K. (2013). *Public mental health and inequalities.* In K. Bhui (Ed.), *Elements of Culture and Mental Health: Critical Questions for Clinicians (*1st ed., pp.73-75). RCPsych Publications: London.

Bhui, K., Bhugra, D., Goldberg, D., Dunn, G., & Desai, M. (2001). 'Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner.' *Psychological Medicine, 31*, 815-825.

Bhui, K., Bhugra, D., Goldberg, D., Sauer, J., & Tylee, A. (2004). Assessing the Prevalence of Depression in Punjabi and English Primary Care Attenders: The Role of Culture, Physical Illness and Somatic Symptoms, *Transcultural Psychiatry*, *41* (3), 307-322.

Bhui, K., Chandran, M., & Sathyamoorthy, G. (2002). Mental health assessment and South Asian men. *International Review of Psychiatry*, *14*, 52-59.

Bhui, K., King, M., Dein, S., & O'Connor, W. (2008). Ethnicity and religious coping with mental distress. *Journal of Mental Health, 17*, 141-151.

Bhushan, B., & Kumar, J.S. (2012). A Study of Posttraumatic stress and growth in Tsunami relief volunteers. *Journal of Loss and Trauma*, *17*(2), 113-124.

Bracken. P., Giller, J., & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social Science and Medicine, 40,* 1073-1082.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.

Braun, V., & Clarke, V. (2012). Thematic Analysis. In H. Cooper (Ed.), *APA Handbook of research methods in Psychology Volume 2*. (pp. 57-71). Washington DC: Magination (American Psychological Association).

Braun, V., & Clarke, V. (2013). *Successful qualitative research: a practical guide for beginners.* London: Sage

British Psychological Society. (2009). *Code of Ethics and Conduct*. Leicester: BPS.

British Red Cross. (2016) *Refugee facts and figures.* Retrieved from http://www.redcross.org.uk/What-we-do/Refugee-support/Refugee-facts-and-figures

Bronfenbrenner, U. (1979). *The Ecology of human development: experiments by nature and design.* Cambridge: Harvard University Press.

Burnett, A., & Peel, M. (2001). Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. *British Medical Journal, 322*, 544-547.

Burr, V. (2003). *Social constructionism.* London: Routledge.

Burr, J., & Chapman, T. (1998). Some reflections on cultural and social considerations in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 5,* 431-437.

Cannon, W. (1932). *Wisdom of the Body*. United States: W.W. Norton & Company.

Centre for outcomes research and effectiveness; CORE. (2011). *Competence frameworks.* Retrieved from http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. Indian Journal of Psychiatry, 55(2), 299–309. doi.org/10.4103/0019-5545.105555

Chard, R.R., & Gaberson, K.B. (2001). Achieving rigour in qualitative research studies. AORN Journal, 74, 674.

Chew-Graham, C., Bashir, C., Chantler, K., Burman, E., & Batsleer, J. (2002) South Asian women, psychological distress and self-harm: lessons for primary care trusts. *Health & Social Care in the Community*, *10*(5), 339-347.

Chokkanathan, S. (2009). Resources, stressors and psychological distress among older adults in Chennai. *Social Science & Medicine*, *68,* 243-250.

Cochrane, R., & Stopes-Roe, M. (1977). Psychological and social adjustment of Asian immigrants to Britain: A community survey. *Social Psychiatry, 12,* 195-207.

Cochrane, R., & Stopes-Roe, M. (1977). Psychological symptom levels in Indian immigrants to England- A comparison with native English. *Psychological Medicine, 11,* 319-332.

Coghlan, C., & Ali, I. (2009). Suicide. In C. Cook, A. Powell & A. Sims (Eds.), *Spirituality and Psychiatry* (pp. 61-80). RCPsych Publications: London.

Coleman, J.S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94,* 95-120.

Critical Appraisal Skills Programme; CASP (2014). *CASP Qualitative Tool.* Retrieved from http://www.casp-uk.net/

Cromby, J., & Nightingale, D.J. (1999). What's wrong with social constructionism? In D.J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice*. Buckingham: Open University Press.

D'Alessio, V., & Ghazi, P. (1993). Asian women in suicide epidemic. *The Observer*, 6.

Dein, S., & Sembhi, S. (2001). The use of traditional healing in South Asian psychiatric patients in the UK: Interactions between professional and folk psychiatries. *Transcultural Psychiatry*, *38*(2), 243–257.

Department of Health (2005). *Delivering Race Equality: A Framework for Action*. London: Department of Health.

Department of Health (2009). *Improving Access to Psychological Therapies: Black and Minority Ethnic (BME) Positive Practice Guide.* London: Department of Health.

Department of Health (2014). *Wellbeing: Why it matters to health policy*. Retrieved from https://www.gov.uk/government/publications/wellbeing-and-health-policy

Dhillon, K., & Ubhi, M. (2003). Acculturation and ethnic identity in marginal immigrant South Asian men in Britain: a psychotherapeutic perspective. *Counselling & Psychotherapy Research*, *3*(1), 42-48.

Dissanayake, S. (2008). *UK Tamils polarised but powerful.* Retrieved from http://news.bbc.co.uk/1/hi/uk/7742134.stm

Durvasula, R., & Mylvaganam, G. (1994). Mental Health of Asian Indians: Relevant issues and community implications. *Journal of Community Psychology*, *22*(2), 97-108.

Express Scribe Transcription [Computer software]. Retrieved from http://www.nch.com.au/scribe/

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of Serious Mental Disorder in 7000 Refugees Resettled in Western Countries: A Systematic Review. *Lancet, 365* (9467), 1309-1314.

Fazil, Q., & Cochrane, R. (2003). The prevalence of depression in Pakistani women living in the West Midlands. *Pakistani Journal of Women's Studies: Alam-e-Nizwan, 10*(1), 21–30.

Fernando, G.A. (2003, August). *Psychophysiological, psychological, and psychosocial impact of torture on survivors.* Paper presented at the 11th annual meeting of the American Psychological Association, Toronto, Canada.

Fernando, G. A. (2005). Finding meaning after the Tsunami disaster: Recovery and resilience in Sri Lanka. *Traumatic Stress Points, 19*(1), 1- 12.

Fernando, G.A. (2012). Bloodied but unbowed: Resilience examined in a South Asian community. *American Journal of Orthopsychiatry*, *82*(3), 367-375.

Fernando, S. (1991). *Mental health, race & culture*. London: The Macmillan Press Ltd.

Fugard, A.J.B., & Potts, H.W.W. (2015). Supporting thinking on sample sizes for thematic analyses: A quantitative tool. *International Journal of Social Research Methodology*, *18* (6), 669-684. doi: 10.1080/13645579.2015.1005453

George, A., Lalani, M., Mason, G., Rolfe, H., & Bondibene, C.R. (2012) Skilled immigration and strategically important skills in the UK economy: Final report to the Migration Advisory Committee (MAC). Retrieved from National Institute of Economic and Social Research: http://www.niesr.ac.uk/sites/default/files/publications/290212_151752_0.pdf

Gerritsen, A.A.M., Bramsen, I., Deville, W., van Willigen, L.H.M., Hovens, J.E., & van der Ploeg, H.M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, *41*, 18-26.

Giacomini, M.K., & Cook, D.J. (2000) Users' Guides to the Medical Literature: XXIII. Qualitative Research in Health Care. Are the results of the study valid? *Journal of the American Medical Association, 284*, 357-362.

Gil, A. G., Wagner, E. F., & Vega, W. A. (2000). Acculturation, familism and alcohol use among Latino adolescent males: Longitudinal relations. *Journal of Community Psychology, 28,* 443–458.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared with social factors in exile. *The British Journal of Psychiatry, 172,* 90-94.

Green, B.L. (1994). Psychosocial Research in Traumatic Stress: An Update. *Journal of Trauma Stress, 7,* 341-362.

Greenhalgh, T. (1997a). How to read a paper: Getting your bearings (deciding what the paper is about). *British Medical Journal, 315*, 243-246.

Greenhalgh, T. (1997b). How to read a paper: Assessing the methodological quality of published papers. *British Medical Journal, 315,* 305-308.

Gregg, J., & Saha, S. (2006). Losing culture on the way to competence: the use and misuse of culture in medical education. *Academic Medicine*, *81*, 542-547.

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Gupta, V.B. (2010). Impact of culture on healthcare seeking behaviour of Asian Indians. *Journal of Cultural Diversity*, *17* (1), 13-19.

Guribye, E. (2011a). 'No God and no Norway': Collective resource loss among members of the Tamil NGO's in Norway during and after the last phase of the civil war in Sri Lanka. *International Journal Of Mental Health Systems, 5*:18. doi:10.1186/1752-4458-5-18

Guribye, E. (2011b). Sacrifice as coping: a case study of the cultural-political framing of traumatic experiences among Eelam Tamils in Norway. *Journal of Refugee Studies, 24* (2), 377-389.

Guribye, E., Sandal, G. M., & Oppedal, B. (2011). Communal proactive coping strategies among Tamil refugees in Norway: A case study in a naturalistic setting. *International Journal Of Mental Health Systems*, 5:9. doi: 10.1186/1752-4458-5-9

Hardgrove, A. (2009). Liberian Refugee Families in Ghana: The Implications of Family Demands and Capabilities for Return to Liberia. *Journal of Refugee Studies, 22*(4), 483-501. doi:10.1093/jrs/fep029

Harper, D. (2011). Choosing a qualitative research method. In D. Harper & A.R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 83-98). Chichester, UK: Wiley-Blackwell.

Hener, T., Weller, A., & Shor, R. (1997). Stages of acculturation as reflected by depression reduction in immigrant nursing students. *International Journal of Social Psychiatry*, *43*(4), 247–256.

Henwood, K., & Pidgeon, N. (1992). Qualitative research and psychological theorizing. *British Journal of Psychiatry, 83*, 97-111.

Horsburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing, 12*, 307-312.

International Centre for Ethnic Studies. (2016) *Ethnic Conflict of Sri Lanka: Time Line – From Independence to 1999*. Retrieved from http://ices.lk/sl_database/ethnic_conflict/time_line.shtml

Jacob, K.S., Bhugra, D., Lloyd, K.R., & Mann, A.H. (1998). 'Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK.' *Journal of the Royal Society of Medicine, 91,* 66-71.

Jacobson, N.S., Martell, C.R., & Dimidijan, S. (2001). Behavioural activation treatment for depression: returning to contextual roots. *Clinical Psychology: Science and Practice, 8,* 255-270.

Jobanputra, R., & Furnham, A. (2005). British Gujarati Indian immigrants' and British Caucasians' beliefs about health and illness. *International Journal of Social Psychiatry*, *51,* 356–364.

Joffe, H. (2011). Thematic Analysis. In D. Harper & A.R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209-223). Chichester, UK: Wiley.

Johnson, M.R.D. (2003). Ethnic diversity in social context. In J. Kai (Ed.), *Ethnicity, health and primary care*. (Chapter 1). Oxford: Oxford University Press.

Johnson, R., & Waterfield J. (2004). Making words count: the value of qualitative research. *Physiotherapy Research International, 9*(3), 121-131.

Kagan, C., Burton, M., Duckett, P., Lawthom, R., & Siddiquee, A. (2011). *Critical Community Psychology*. Chichester: Wiley & Sons.

Kai, J. and Bhopal, R. (2003). Ethnic diversity in health and disease. In J. Kai (Ed.), *Ethnicity, health and primary care*. (Chapter 2). Oxford: Oxford University Press.

Kail, R. V., & Cavanaugh, J. C. (2010). *The Study of Human Development. Human Development: A Life-span View* (5th ed.), Belmont, CA: Wadsworth Cengage Learning.

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

Karmi, G. (1992). Refugee health. *British Medical Journal, 305,* 205-206.

Kemp, A., Green, B.L., Horowitz, C., & Rawlings E.I. (1995). Incidence and correlates of PTSD in battered women: shelter and community samples. *Journal of Interpersonal Violence, 10,* 43-55.

Kim, B. S. K., & Abreu, J. M. (2001). Acculturation measurement: Theory, current instruments, and future directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C.M. Alexander (Eds.), *Handbook of multicultural counselling* (2nd ed., pp. 394–424). Thousand Oaks, CA: Sage.

Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review, 21*(3), 287-298.

Koneru, V. K., & Weisman de Mamani, A. G. (2006). Acculturation, ethnicity, and symptoms of schizophrenia. *Interamerican Journal of Psychology, 40,* 355–362.

Krishna, R., Maithreyi, R., & Surapaneni, K. M. (2010). Research Bias: A Review for Medical Students, Journal *of Clinical and Diagnostic Research, 4,* 2320-2324.

Landy, D. (1977). *Culture, disease and healing: Studies in medical anthropology*. New York: Macmillan.

Laugani, P. D. (2007). *Understanding cross-cultural psychology.* Beverly Hills, CA: Sage Publications.

Lawrence, P. (2000). Violence, Suffering, Amman: The Work of Oracles in Sri Lanka's Eastern War Zone In V. Das & A. Kleinman (Eds.), *Violence and Subjectivity*. Berkeley: University of California Press.

Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer

Lee, E.S. (1966). A Theory of Migration. *Demography, 3*(1), 47-57.

Levenson, R., & Coker, N. (1999). *The health of refugees: A guide for GP's*. London: Kings Fund.

Lewis, G., Pelosi, A. J., Araya, R., & Dunn, G. (1992). Measuring psychiatric disorder in the community: A standardized assessment for use by lay interviewers. *Psychological Medicine, 22*, 465–486.

Liamputtong, P. (2007) *Researching the vulnerable: A guide to sensitive research methods.* London: Sage.

Lie, B. (2004). *Fakta om ti innvandrergrupper I Norge (facts about ten immigrant groups in Norway).* Oslo: Statistics Norway.

Liebling, H., Winter, D., Ruratotoye, B., Slegh, H., and Brown, R. (2014) 'Resilience in the face of adversity: Case studies in Sierra Leone and Eastern Congo'. *Clinical Psychology Forum, 258*, 61-65.

Lin, N., Suyemoto, K., & Kiang, P. (2009). Education as catalyst for intergenerational refugee family communication about war and trauma. *Communication Disorders Quarterly, 30*(4), 195-207.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Linley, P.A., & Joseph, S. (2003). Trauma and personal growth. *The Psychologist, 16* (3), 135.

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012). Reducing the barriers to accessing psychological therapies for Bengali, Urdu, Tamil and Somali communities in the UK: some implications for training, policy and practice, British *Journal of Guidance and Counselling*, *40*(1), 43-66.

Loring, M., & Powell, B. (1988). Gender, race and DSM-III: a study of the objectivity of psychiatric diagnostic behaviour. *Journal of Health and Social Behaviour, 29,* 1-22.

Lowe, F. (2008). Colonial Object Relations: Going Underground Black-White Relationships. *British Journal of Psychotherapy, 24* (1), 20-33.

Madill, A. (2007). Survey of British Psychological Society Qualitative Methods in Psychology Section Members 2006. *British Psychological Society Qualitative Methods in Psychology Section Newsletter, 3,* 9-14.

Madhill, A., Jordon, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91,* 1-20.

Mamtani, R., & Mamtani, R. (2005). Ayurveda and yoga in cardiovascular diseases. *Cardiology in Review, 13,*155-162.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *British Medical Journal, 320*, 50-52.

MAXQDA (version 12) [Computer Software]. Berlin, Germany: VERBI Software GmbH.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage.

Meyer, A., Wagner, B., & Dutton, M. (2010). The relationship between battered women's causal attributions for violence and coping efforts. *Journal of Interpersonal Violence, 25*(5), 900-918.

Miller, M., Yang, M., Hui, K., Choi, N., & Lim R. (2011). Acculturation, enculturation, and Asian American college students' mental health and attitudes toward seeking professional psychological help. *Journal of Counseling Psychology*, *58*(3):346-357.

Minsky, S., Vega, W., Miskimen, T., Gara, M., & Escobar, J. (2003). Diagnostic patterns in Latino, African American and European American psychiatric patients. *Archives of General Psychiatry, 60*, 637-644.

Mitchell, M.D., Hargrove, G.L., Collins, M.H., Thompson, M.P., Reddick, T.L., & Kaslow, N.J. (2006). Coping variables that mediate the relationship between intimate partner violence and mental health outcomes among low-income African American women. *Journal of Clinical Psychology. 62*(12), 1503-1520.

Mitchem, J.D. (2012). Survivor Guilt. In K.B. Penuel & M. Statler (Eds.), Encyclopaedia of Disaster Relief. London: Sage

Mohr, S., & Huguelet, P. (2004). The relationship between schizophrenia and religion and its implications for care. *Swiss Medical Weekly, 134*, 369-376.

Myers, F., McCollam, A., & Woodhouse, A. (2005). *Equal minds: Addressing mental health inequalities in Scotland*. Edinburgh, Scotland: Scottish Executive.

National Institute for Health and Care Excellence. (2006). *Post-traumatic Stress Disorder (PTSD): The management of PTSD in Adults and Children in Primary and Secondary Care*. Retrieved from https://www.nice.org.uk/guidance/cg26

Nazroo, J.Y. (1997). *Ethnicity and mental health: Findings from a national community survey*. London: Policy Studies Institute.

Ncube, N. (2006). The Tree of Life Project: Using narrative ideas in work with vulnerable children in South Africa. *The International Journal of Narrative Therapy and Community Work, 1,* 3-16.

Nguyen, L., & Peterson, C. (1993). Depressive symptoms among Vietnamese- American college students. *Journal of Social Psychology*, *133*, 65–71.

Nuttman-Shwartz, O., & Dekel, R. (2009). Ways of coping and sense of belonging in the face of a continuous threat. Journal Of Traumatic Stress, 22(6), 667-670. doi:10.1002/jts.20463

Office for National Statistics. (2011). *National Census 2011*. Retrieved from https://www.ons.gov.uk/census/2011census

Office for National Statistics. (2010). *Measuring Subjective Wellbeing in the UK.* London: The Office for National Statistics.

Orford, J. (1992). *Community Psychology: Theory and Practice.* Chichester: Wiley and Sons Ltd.

Østby, L. (2002). *The Demographic Characteristics of Immigrant Populations in Norway*. Oslo: Statistics Norway (Reports 2002/22).

Paulhus, D.L. (1991). Measurement and control of response biases. In J.P. Robinson, P.R. Shaver & L.S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes*. (pp. 17-59). San Diego, CA: Academic Press.

Peace Pledge Union. (2015). *An end to War.* Retrieved from http://www.ppu.org.uk/war/endtowar.html

Peace Pledge Union. (2015). *War and Armed Conflict.* Retrieved from http://www.ppu.org.uk/

Petch, A. (2008). The Expert Patients' Programme. *Community Care*, 32-33.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), Doing qualitative research in psychology (pp. 245-273). Hove, UK: Psychology Press.

Policy Exchange (2015). *A Portrait of Modern Britain.* Retrieved from http://www.policyexchange.org.uk/publications/category/item/a-portrait-of-modern-britain

Prigerson, H.G., Shear, M.K, & Jacobs, S.C. (2000). Grief and its relation to posttraumatic stress disorder. In D. Nutt, J.R. Davidson & J. Zohar. (Eds.), *Posttraumatic stress disorders: Diagnosis, management and treatment.* (pp. 163-177). New York: Martin Dunitz Publishers.

Putnam, R.D. (1995). Bowling alone: America's declining social capital. *Journal of Democracy*, *6*, 65-78.

Qureshi, A. (2013). *On the role of culture and difference in evaluation, assessment and diagnosis.* In K. Bhui (Ed.), *Elements of Culture and Mental Health: Critical Questions for Clinicians (*1st Ed., pp.31-35). RCPsych Publications: London.

Qureshi, A., Collazos, F., Ramos, M., & Casas, M. (2008). Cultural competency training in Psychiatry. *European Psychiatry, 23* (suppl. 1) 49-58.

Race on the Agenda: ROTA (2013). *Mapping the mental health support needs of Tamil people in West London.* ROTA: London.

Rai, D., Skapinakis, P., Wiles, N., Lewis, G., & Araya, R. (2010). Common mental disorders, subthreshold symptoms and disability: longitudinal study. *British Journal of Psychiatry*, *197* (5), 411-412.

Rajkumar, A., Premkumar, T., & Tharyan P. (2008). Coping with the Asian tsunami: perspectives from Tamil Nadu, India on the determinants of resilience in the face of adversity. *Social Science & Medicine, 67*(5): 844-853.

Rao, A.V. (1992). Parasuicide and suicide: Some psychological considerations. *Indian Journal of Social Psychiatry, 8*, 4-7.

Rappaport, J. (1977). *Community psychology: Values, Research and Action.* New York: Holt, Rinehart and Winston.

Refugee Council. (2016). *What we do: Therapeutic services*. Retrieved from http://www.refugeecouncil.org.uk/what_we_do/therapeutic_casework/

Reuters. (2006). *Sri Lankan Conflict*. Retrieved from www.alertnet.org/thenews/newsdesk/L22409028.htm

Ritchie, J., & Spencer, L. (1994). Qualitative Data Analysis for Applied Policy Research. In A. Bryman & R. Burgess (Eds.), *Analysing Qualitative Data* (pp. 173-194). London: Routledge.

Rodriguez-Reimann, D. I., Nicassio, P., Reimann, J., Gallegos, P. I., & Olmedo, E. L. (2004). Acculturation and health beliefs of Mexican Americans regarding tuberculosis prevention. *Journal of Immigrant Health*, *6*, 51–62.

Royal College of Psychiatrists (2010). *No health without public mental health: The case for action*. London: Royal College of Psychiatrists.

Rubin, H.J, & Rubin, I.S. (1995). Qualitative interviewing: The art of hearing data. Thousand Oaks, CA: Sage.

Russell, S., Subramanian, B., & Russell, P.S. (2012). Psychopathology, Traumatic Life Events and Coping skills among Patients attending a primary-care adolescent clinic. The Indian Journal of Pediatrics, *79*(1), 52-59.

Sabaratnam, T.M. (2012). *Sri Lankan Tamil Struggle.* USA: Tamil Sangam.

Sainsbury Centre for Mental Health (2006). *The Costs of Race Inequality. Policy Paper 6.* London: Sainsbury Centre for Mental Health.

Sainsbury Centre for Mental Health (2007) *Mental Health at Work: Developing the Business Case Policy Paper 8*. London Sainsbury Centre for Mental Health.

Salant, T., & Lauderdale, D. S. (2003). Measuring culture: A critical review of acculturation and health in Asian immigrant populations. *Social Science & Medicine*, *57*, 71–90.

Samarasinghe, G. (2002). *Counselling vs. Community-Based Approaches*. Paper presented at National Conference on Mental Health, Sahanaya, Colombo.

Sandelowski, M. (1994). Notes on qualitative methods: the use of quotes in qualitative research. *Research in Nursing and Health*, *17*, 479-482.

Save The Children. (2006). *Rebuilding in Sri Lanka.* Retrieved from http://www.savethechildren.org.uk/scuk/jsp/microsites/tsunami/country.jsp?group=countryupdatesandsection=srilanka

Seagal, Z.V., Williams, J.M., & Teasdale, J.D. (2002). *Mindfulness-based cognitive therapy for depression: a new approach to prevent relapse*. New York: Guilford Press.

Seligman, M. E. P. (1972). Learned helplessness. *Annual Review of Medicine, 23* (1), 407–412.

Seligman, M. E. P. (1975). *Helplessness: On Depression, Development, and Death*. San Francisco: W. H. Freeman.

Shea, M., & Yeh, C.J. (2008). Asian American students' cultural values, stigma, and related self-construal: Correlates of attitudes toward professional help seeking. *Journal of Mental Health Counselling*, *30*, 157–172.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry/Psychiatric Epidemiology*, *35*, 326-334.

Shon, S.P., & Ja, D.Y. (1982). Asian families. In M. McGoldrick, J.K. Pierce, & J. Giordano (Eds.), *Ethnicity and family therapy*. New York: Guilford Press.

Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998). Trauma exposure, post-migration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica, 97*(3), 175-181.

Simon, S. (1996). *Gender in Translation: Cultural Identity and the Politics of Transmission*. London: Routledge.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A Smith (Ed.), Qualitative Psychology: A practical guide to research methods (pp. 51-80). London: Sage Publications.

Somasundaram, D. (2007). Collective trauma in northern Sri Lanka: a qualitative psychosocial-ecological study. *International Journal of Mental Health Systems, 1*(5) doi: 10.1186/1752-4458-1-5

Somasundaram, D. (2010). Collective Trauma in the Vanni- a qualitative inquiry into the mental health of the internally displaced due to the Civil war in Sri Lanka. *International Journal of Mental Health Systems*, *4*, 22-31.

Somasundaram, D. & Sivayokan S. (1994). War trauma in a civilian population. *British Journal of Psychiatry*, *165*(4), 524-527.

Somasundaram, D. & Sivayokan S. (2005). *Mental Health in the Tamil Community*. Jaffna: Shanthiham.

Sossou, M., Craig, C., Ogren, H., & Schnak, M. (2008). A qualitative study of resilience factors of Bosnian refugee women resettled in the southern United States. *Journal Of Ethnic & Cultural Diversity In Social Work, 17*(4), 365-385.

Sousa, C. A. (2013). Political violence, health, and coping among Palestinian women in the West Bank. American Journal Of Orthopsychiatry, 83(4), 505-519. doi:10.1111/ajop.12048

Stainton Rogers, W. (2011). Social Psychology (2nd ed.). Maidenhead, UK: Open University Press.

Stige, S., & Sveaass, N. (2010). Living in exile when disaster strikes at home. *Torture: Quarterly Journal On Rehabilitation Of Torture Victims And Prevention Of Torture*, *20*(2), 76-91.

Stopes-Roe, M., & Cochrane, R. (1987) The process of assimilation in Asians in Britain. *International Journal of Comparative Sociology*, *28*, 43–55.

Summerfield, D. (1995). Assisting survivors of war and atrocity: notes on "psycho-social" issues for NGO workers. *Development in Practice, 5,* 352-356.

Summerfield, D. (1998). *The social experience of war and some issues for the humanitarian field.* In P.J. Bracken and C. Petty (Eds.), Rethinking the Trauma of War (1st ed., pp. 9-37). Free Association Books: London.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war affected areas. *Social Science and Medicine, 48*, 1449-1462.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal, 322*, 95-98.

Summerfield, D. (2002). Commentary on Tribe, R. 'Mental Health of Refugees and Asylum-seekers'. *Advances in Psychiatric Treatment, 8,* 247.

Swami, V., Arteche, A., Chamorro-Premuzic, T., Maakip, I., Stanistreet, D., & Furnham, A. (2009). Lay perceptions of current and future health, the causes of illness, and the nature of recovery: Explaining health and illness in Malaysia. *British Journal of Health Psychology*, *14*, 519–540.

Tebes, J.K. (2005). Community science, philosophy of science, and the practice of research. *American Journal of Community Psychology, 35,* 213-230.

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research, 4*(2), 161-178.

Tichy, L.L., Becker, J.V., & Sisco, M.M. (2009). The downside of patriarchal benevolence: Ambivalence in addressing domestic violence and socio-economic considerations for women of Tamil Nadu, India. *Journal of Family Violence, 24*, 547-558. doi:10.1007/s10896-009-9253-4

Tribe, R. (2007). Health Pluralism: A more appropriate alternative to western models of therapy in the context of the civil conflict and natural disaster in Sri Lanka. *Journal of Refugee Studies, 20*(1), 21-36.

Tribe, R. (2013). *Is trauma-focussed therapy helpful for survivors of war and conflict?* In K. Bhui (Ed.), *Elements of Culture and Mental Health: Critical Questions for Clinicians (*1st ed., pp.1-6). London: RCPsych Publications.

Tumarkin, M. (2005). *Traumascapes*. Melbourne: Melbourne University Press.

Turner, S., & Gorst-Unsworth, C. (1990). Psychological sequelae of torture. A descriptive model. British Journal of Psychiatry, *157*, 475-480.

Ungar, M. (2008). Resilience across Cultures. *British Journal of Social Work 38*(2), 218-235.

United Nations High Commissioner for Refugees. (2003). *Sri Lanka* Retrieved from http://www.unhcr.ch/cgi-bin/texis/vtx/statistics

United Nations High Commissioner for Refugees. (2011a). *UNHCR Global Trends 2010.* Retrieved from http://www.unhcr.org/4dfa11499.html

United Nations High Commissioner for Refugees. (2011b). *The UK and Asylum.* Retrieved from http://www.unhcr.org.uk/about-us/the-uk-and-asylum.html

United Nations High Commission for Refugees. (2015). *Facts and figures about refugees.* Retrieved from http://www.unhcr.org.uk/about-us/key-facts-and-figures.html

van Os, J., Linscott, R.J., Myin-Germeys, I., Delespaul, P., & Krabbendam, L. (2009). A systematic review and meta-analysis of the psychosis continuum: evidence for a psychosis proneness-persistence-impairment model of psychotic disorder. *Psychological medicine, 39,* 179-195.

Wadley, S.S. (1980). The paradoxical powers of Tamil women. In S. Wadley (Ed.), *The powers of Tamil Women* (pp. 153-170). New Delhi: Manohar.

Weerackody, C., & Fernando, S. (2011). *Reflections on Mental and Well-Being: Learning from Communities affected by Conflict, Dislocation and Natural Disaster in Sri Lanka.* Colombo: People's Rural Development Association (PRDA).

Weisman, A. G., Lopez, S. R., Ventura, J., Nuechterlein, K. H., Goldstein, M. J., & Hwang, S. (2000). A comparison of psychiatric symptoms between Anglo-American and Mexican-American patients with schizophrenia. *Schizophrenia Bulletin, 26,* 817–824.

West, J.C., Herbeck, D.M., Bell, C.C., Colquitt, W.L., Duffy, F.F., Fitek, D.J., Rae, D., Stipec, M.R., Snowden, L., Zarin, D.A., & Narrow, W.E. (2006). Race/ethnicity among psychiatric patients: variations in diagnostic and clinical characteristics reported by practicing clinicians. *Focus, 4,* 48-56.

Williams, P.E., Turpin, G., & Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK: a review of the literature. *Clinical Psychology and Psychotherapy*, *13*(5), 324-338.

Willig, C. (2001). Introducing qualitative research in psychology: Adventures in theory and method. Buckingham: Open University Press.

Willig, C. (2012). Perspective on the epistemological bases for qualitative research. In H. Cooper (Ed.), *APA Handbook of research methods in Psychology Volume 1.* (pp. 1-17). Washington DC: Magination (American Psychological Association)

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities access to mental healthcare. *International Journal of Mental Health Nursing, 14,* 88–95

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15,* 215-228.

Yardley, L. (2008) Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed, pp.235-251). London: Sage.

Yehuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry, 152,* 1705-1713.

Zhou, X., Peng, P., Zhu, X., Yao, S., Dere, J., Chentsova-Dutton, Y.E., & Ryder, A. (2016) From culture to symptom: Testing a structural model of "Chinese somatization". *Transcultural Psychiatry, 53,* 3-23.

Zhou, X., Min, S., Sun, J., Kim, S. J., Ahn, J., Peng, Y., Noh, S., & Ryder, A. G. (2015). Extending a structural model of somatization to South Koreans: Cultural values, somatization tendency, and the presentation of depressive symptoms. *Journal Of Affective Disorders, 176,* 151-154. doi:10.1016/j.jad.2015.01.040

Zwi, A. and Ugalde, A. (1989). Towards an epidemiology of potential violence in the Third World. *Social Science and Medicine, 28,* 633-642.

Appendices

Appendix A: Literature Review Study Details

Study	Design	Sample characteristics	Sample Type	Sample Size	Outcome Measures	Analysis	Results	Main Findings	Limitations
Beiser, Simich, & Pandalangat, 2003	Quantitative Used probabilistic sampling in Tamil households in Toronto Canada n=1600 selected	Predominantly Hindu, relatively young, and, well-educated Slightly more men than women	Community	n=1110	Survey questionnaire asking about post-migration stressors, psychological resources, social resources and modules from International Diagnostic Interview	Descriptive statistics	Barriers to professional help-seeking: language problems, logistics (travelling to appointments), mistrust in healthcare systems, lack of understanding of cultural and background, and more likely to seek help for physical symptoms vs. psychological Coping strategies: 30% rituals 15.3% traditional herbal remedies 9.3% religious stones/bracelets 5.5% astrologer <1% Psychiatrist or mental health practitioner	Barriers to help-seeking including language, fear of mistreatment, and illness beliefs lead to alternative coping mechanisms Refugee mental health promotion may be met through education, increasing cultural competence, and community interventions Health promotion policies/programmes have not kept up with mental health research looking at refugee and immigrant populations	A majority of participants in the study were Hindu which may influence socio-cultural values Other aspects of the study sample were homogeneous (socioeconomic status and age group)
Bhushan & Kumar, 2012	Quantitative	Individuals from NGO's in Tamil Nadu	Community	25 female relief volunteers 20-45 years old	Demographic information Counterfactual thinking approach Post-traumatic growth inventory Impact of event scale Proactive coping inventory (PCI) Dissociative experiences scale	Correlational analyses And MANOVA	Proactive coping positively correlated with relating to others, new possibilities, personal strength, spiritual change, appreciation of life and total post-traumatic growth score Proactive coping equals taking charge, finding new challenges, visualising dreams, finding a way around obstacles, problem solving	Proactive coping had implications for PTG Proactive coping affected one's ability to relate to others as well as searching for new possibilities and spiritual change.	Small sample size limits transferability/generalisability Lack of control group however hard to find a suitable comparison group Tracing relief volunteers for follow- up difficult task, many dropped out A few key variables (such as personality) could not be incorporated in the study PCI only measured proactive coping instead of full range of strategies
Fernando, 2012	Qualitative 6 Focus Groups to elicit ideas about resilience	Men and women Ethnicity: Sinhala, Tamil and Muslim Wide range of locations Age range: 21-62 years	Community	n=43 (n=27 women)	N/A	Grounded Theory Schema Analysis	Coping in Tamils: Close family relationships and friendships Sharing problems Psychosocial gratitude Having children/ having many children Working for the sake of children and parental duties Children living without fear Receiving aid from family, community and NGO's Talking &, laughing Avoidance of rumination and letting things go Mental strength Strength of will Religious beliefs /practices	Some components of resilience can be taught; thus they can be the focus of interventions and public health policies Findings challenge idea that Sri Lankans are wholly collectivistic Future research could examine how collectivistic or individualistic Sri Lankans truly are, and in which domains. This information may enhance psychosocial intervention programs	Small sample size makes results difficult to generalise Focus groups represented diverse ethnic groups rather than specific Lack of Triangulation Men and women in focus groups limited discussion of specific issues In groups, people may have felt uncomfortable discussing particular issues Perceived status differences may have limited discussion Lack of discussion to themes specific to developmental stages/age groups

Study	Design	Sample characteristics	Sample Type	Sample Size	Outcome Measures	Analysis	Results	Main Findings	Limitations
Guribye, 2011a	Qualitative Ethnographic field work and observation of pro-LTTE Tamil NGO's Attendance at demonstrations, meetings and in-depth conversations Use of key informants	Individuals from NGO's	Community	14 men 6 women Snowball sampling for further informants	N/A	The analytical process was a continuous pendulum between theoretical (re)assessment and empirical observation The general approach was grounded theory	Impact: refugees experienced a radical breakdown of collective coping resources in exile during the last phases of the civil war in their country of origin Social support, employment, and membership in organisations are important resources Open support for LTTE amongst sample	Replenishing diminished resources may enhance the coping capacity within the community and reduce psychological distress	Findings may not be valid to individuals who do not support the same political orientation Correlations between resource loss and mental health problems among the participants have not been systematically investigated A randomized controlled study could have provided more detailed knowledge about relationships between crisis, resources and individual mental health
Gurbiye, 2011b	Qualitative Participant observation in two Tamil voluntary organisations Fieldwork including participation in activities at the centre (passive observer and active participant)	Participants supported LTTE abroad Male and female Approximately 40 years old	Community	Not specified	N/A	Narrative analysis	Narratives were cultural-political and related to heroes and martyrs Tamils living in other countries experienced guilt and obligation towards their homeland Reconceptualisation of the meaning of sacrifice in exile Encouraged children to do well in school and in higher education in order to access more resources which could benefit the Tamil community both in exile and in the homeland Spent less time with families and more time involved in community Used rituals such as Annai Poopathy Remembrance Day and Great Heroes Day to remind them of their obligation	Many narratives around the importance of personal sacrifice for the Tamil cause Personal struggles lead to social commitment, collective well-being and promotion of positive social engagement allowing them to cope with their experiences A coping strategy embedded in collective experience is belief that tragedy can strengthen communities Many sacrificed family and leisure time to prioritise NGO work	Most participants openly supported LTTE and so findings may not be representative of wider Tamil population

Study	Design	Sample characteristics	Sample Type	Sample Size	Outcome Measures	Analysis	Results	Main Findings	Limitations
Guribye, Sandal & Oppedal, 2011	Qualitative Ethnographic field work over 2 years Case study Activities at resource and counselling centre and participant observation	Tamil refugees living in Norway	Community	Not specified	N/A	The analytical process was a continuous pendulum between theoretical (re)assessment and empirical observation Grounded theory	Forming common goals: on one hand wanting to integrate into host society and on other hand encouraging children to maintain Tamil identity Desire to improve social conditions for Tamils in Sri Lanka Supporting the LTTE Experiences influenced desired future life trajectory Resource accumulation: Many Tamils invested time and effort into voluntary work for the benefit of the Tamil community Participation in education and work force in host country in order to integrate into host country Important to value self-reliance and demand as little from welfare system as possible	Communal proactive coping strategies adopted; collective responsibility and shared resource accumulation for future and well-being Long term aspirations related to situation in homeland and in exile Increased co-operation towards desired outcomes The study shows that proactive coping efforts occur in a dynamic social setting which may force people to use their accumulated proactive coping resources in reactive coping efforts Hardship strengthened desire to integrate into host country and participate in education and workforce	Lack of consideration of interplay between individual and collective coping strategies What are the payoffs of collective efforts versus individual efforts? Little consideration of the interplay between individual and collective belief systems and competencies Results cannot be generalised/transferable to participants outside of these organisations who have mutual aspirations and share resources The Tamil community had not concluded their on-going coping efforts at time of study
Kanagaratnam, Mason, Hyman, Manuel, Berman & Toner, 2012	Qualitative Interviews in focus groups	Victims of intimate partner violence	Community	63 Tamil women living in Toronto from Tamil Nadu, India	N/A	Analysed using feminist theory Thematic analysis with discourse analysis applied to certain concepts	Emotion-focussed/passive coping: Self-blaming Relying on faith Diverting the mind Normalising abuse Endurance Being strategic Problem-focussed coping: Gaining more independence Getting separated Getting treatment for spouse Getting outside/professional help	Women showed a marked preference for "passive" modes of coping rather than "active" modes Coping strategies fell along a continuum of emotion-focussed to problem-focussed coping, with an emphasis on emotion-focused coping	Social desirability as the participants may have been reluctant to be open about attitudes towards IPV and professional help, in fear of rejection from the other participants A majority of participants in this study were Hindu which may influence socio-cultural values Other aspects of the study sample were homogeneous: all of the midlife women being married and all of the young women being enrolled in University. This affects transferability despite authors stating this reflects Tamil community The non-random selection of participants that limit generalization of findings Future studies should aspire for more variation in study sample

Study	Design	Sample characteristics	Sample Type	Sample Size	Outcome Measures	Analysis	Results	Main Findings	Limitations
Rajkumar, Premkumar & Tharyan 2008	Qualitative Cross-sectional (9 months post-trauma) 6 Focus Groups	Men and women in Tamil Nadu, India exposed to Tsunami	Community	10-15 participants per focus group	N/A	Framework Approach Thematic Analysis	Participants expressed distress in broader terms than available in traditional categorical psychiatric symptoms and constructs Changes observed in attitudes towards life, their world-view, plans and ambitions regarding the careers of their children Individual coping: Individuals collectivise personal sorrow and view themselves as part of larger traumatised society. Had meagre expectations about their lives Community coping: More united community following disaster Reduced communal conflicts Increased social gatherings Increased alcohol consumption and domestic violence Being thankful to elders Religious: Being thankful to God Requiems, rituals and religious practices Change in spiritual attitudes following traumatic event	Survivors valued their unique individual, social and spiritual coping strategies over formal mental health services. Role of professional mental health services rarely recognised The results confirm that this community tended to adopt a collective response to massive trauma to enhance resilience Coping mechanisms exist at individual and community levels that enhance resilience in the face of adversity and enable normal functioning in the majority of those affected, without requiring professional intervention	Small sample size Convenience sampling Focus group means that more vocal individuals given more of a platform Lack of multiple coding between researchers
Russell, Subramanian & Russell 2012	Quantitative Cross-sectional	Adolescents with and without psychopathology attending a drop in clinical	Clinical and community	n=100	Child behaviour checklist, Life event scale, Codding ton's life event scale, Impact of Event scale, Modified Jalowiec coping scale	Parametric X^2 T tests Mann Whitney U	Significant difference in total coping score between psychopathology vs. no psychopathology Strong association between coping style and psychopathology. Certain types of coping are associated more with psychopathology	Overall coping style emotion focussed (optimistic and emotive) and problem focussed (confontativie and supportant) methods used less frequently Emotion focussed used more in those with psychopathology Females used more emotion focussed coping	Sample size relatively small making it difficult to generalise findings Participants were from an adolescent clinic and may not reflect true prevalence, traumatic life events or coping styles seen in general population Data obtained through self-report and subject to bias Cross-sectional nature of study means difficult to infer causality

Study	Design	Sample characteristics	Sample Type	Sample Size	Outcome Measures	Analysis	Results	Main Findings	Limitations
Somasundaram, 2007	Qualitative Ecological Participatory observation Interviews Focus groups Case studies	Men and women Northern Sri Lanka	Community	Not specified	N/A	Not specified	Impact: Loss and separation Change in family dynamics Change in child rearing Social withdrawal and reduced school performance PTSD and other psychiatric disorders Somatic complaints and *Perumuchu* (Deep sighing breathing signifying worries and emotional burdens) Passivity Community 'silenced' Mistrust in government Coping: Indigenous coping-rituals and ceremonies Relaxation techniques Mantras and meditation Family cohesion and interdependence Community became passive and silent Group support More dependent on international aid	Fundamental changes in the functioning of the family and the community following war and natural disaster At family level there was a significant change in family dynamics and changes in significant relationships. At community level: lack of trust among community members, and communities tended to be more dependent, passive, silent, without leadership, mistrustful, and suspicious Coping strategies implemented at the time: Family support Psychosocial interventions Structured play and activity for children Rehabilitation programmes	The case for collective trauma and coping described not validated The outcome of the community interventions not collected in a systemic way
Somasundaram, 2010	Qualitative Participatory observation Interviews Focus groups Case studies Open-ended questionnaire	Men and women in Vanni, Northern Sri Lanka who experienced internal displacement as a result of war	Community	Not specified	N/A	Not specified	Impact: Inequity, discrimination Helplessness Coping: Withdrawal Isolation Silence Suspicion Benumbing Cultural practices Rituals Problem solving Escape Suicide Alcoholism Sexual negligence Dependence on support from government/army Allegiance to the LTTE	What emerged from the narratives was the collective nature of trauma Families and communities which gained equilibrium experienced positive changes in individuals Boundary between individual and outside became blurred : when talking about personal agony, impact on family/community was considered Long term psychosocial interventions may help 'heal' families and communities. Interventions for recovery should be holistic and integrated	

Study	Design	Sample characteristics	Sample Type	Sample Size	Outcome Measures	Analysis	Results	Main Findings	Limitations
Tichy, Becker & Sisco, 2009	Quantitative	Victims of domestic violence	Community	64 women from Tamil Nadu , India Urban and rural areas 18-56 years	Demographics Relationship values misperceptions scale Revised Conflict tactics scale Post-traumatic stress diagnostic scale	Correlational analyses MANOVA	Status negatively related to help-seeking-treatment or counselling Indian women unlikely to label abusive experiences as such Women of higher socioeconomic status less likely to have accurate perception of domestic violence Experience of psychological abuse is more strongly associated with post-traumatic stress than physical abuse	Women with higher SES less likely to have accurate perception of abuse or report domestic violence Women with more realistic conceptions more likely to seek help These findings have significant implications for public health strategies	Sampling conservative and results may not be transferable Social desirability may have affected responses Since the research related to this population is largely undeveloped, the instruments utilized were not previously normed on this population A portion of domestic violence victims were not able to voice their experiences, these victims are those who have lost their lives in the face of domestic abuse or those who were incapable of coming forward
Tribe, 2007	Qualitative Participant observation Texts and relevant materials were reviewed Discussions held with colleagues Thirty five semi-structured interviews conducted	Individuals from all ethnic groups	Community	Not specified	N/A	Not specified	Ayurvedic medicine is practised widely, particularly in the rural areas, and many people may receive allopathic and ayurvedic medicine concurrently The use of cultural and religious rituals and traditions in dealing with emotional difficulties is also widely practised, particularly in rural and war torn parts of the country Mediums, astrologers and religious leaders within the community are also consulted for problems or difficulties encountered in life Although religious and cultural practices might not commonly be associated with ‘treatment’, they can provide a healing function	Western medicine, traditional medicine, the use of rituals and the skills of healers are frequently interwoven in the Sri Lankan context It appears to be the preferred choice of survivors of the Sri Lankan conflict situation for dealing with psychological distress	Data collected from a diverse ethnic groups making it difficult to draw conclusions about specific groups

Appendix B: Recruitment Advertisement

University of Essex

Sri Lankan Tamil Men and Women Wanted

Do you have direct experience of living through the Civil war and political conflict in Sri Lanka?

Do you access a Tamil community organisation?

Are you currently living in the UK?

Would you be willing to talk about your experiences privately & confidentially?

As part of my research for a Doctorate in Clinical Psychology at the University of Essex, I am interested in talking to adults of Sri Lankan Tamil origin who have experience of living through the Civil war in Sri Lanka. I would like to meet with you to talk about your experiences. Our discussions will be confidential and people who take part in the study will remain anonymous. Interviews will take approximately 60 minutes.

To find out more, or if you are interested in taking part in this research please contact **Angeline Dharmaindra at:**
asdhar@essex.ac.uk or by telephone on [redacted]

Appendix C: Participant Information Sheet

University of Essex

Information Sheet

Research Study exploring methods of coping used by Sri Lankan Tamils to manage their experiences of war and political conflict

What is this research about?
This study aims to look at how Tamil people living in the UK coped with their experiences of civil war and political conflict in Sri Lanka.

What is the aim of the research?
There is very little research on how Sri Lankan Tamils have coped with their distressing experiences and through your participation we hope to learn more from you. I hope that this study can help professionals develop a better understanding of how the Tamil community deal with their difficult experiences. Through the research we may start to understand how professionals can support the Tamil community and help them to cope.

Confidentiality and privacy
Your name will not be included on any of the information for the study. The information you provide for the study will be stored in a secure location or on a computer which only the research will have access to. Only the person who interviews you will have access to any identifiable information. Information which may be of benefit to the Tamil community may be shared with organisations and findings from the research may be published but your anonymity will be protected. Information may also be shared with research supervisors (see below) but your anonymity will be protected in this case.

What you tell me will remain confidential unless something you tell me makes me worried about your safety or the safety of others. In this instance, I would have to talk to my supervisor and inform the organisation through which you heard about the study.

Ethical approval
The University of Essex Ethics Committee will approve this research project. The ethics committee consider whether this research could be harmful to people and whether taking part is safe. By gaining approval, we are ensuring that the research you take part in is safe and in your best interests.

Who is conducting the research?
My name is Angeline Dharmaindra and I am a Trainee Clinical Psychologist at the University of Essex. I am of Sri Lankan Tamil origin. The research I am doing is part of my Doctorate in Clinical Psychology and I have a special interest in the mental health needs of ethnic minority groups, particularly the Tamil community. I will be supervised by [redacted] and [redacted] at the University of Essex who you are able to contact should you wish to discuss the study further or have any questions about me. My supervisor's contact details are: [redacted] and [redacted]

Results of the study
The general findings from the study will be shared with those who took part when the study is finished. The findings may also be presented to colleagues and health professionals and it is hoped that the findings from the research will be published.

Withdrawing from the research
If you wish to withdraw from the study at any point you can contact me and your data will be destroyed.

Talking about your experiences of the war may be upsetting and it is important that you access support if necessary from the organisation through which you heard about the study.

Researcher's contact details:

Email: [redacted]
Telephone: [redacted]

Appendix D: Participant Screening Questionnaire

University of Essex

Initial Questionnaire

The information provided below will remain confidential and will only be used to ensure you are eligible to take part in the research study.

If you have any difficulties in completing this questionnaire please contact me to discuss this on:

1. What is your ethnic origin?

2. Which ethnic group best describes you?

Tamil ☐

Singhalese ☐

Mixed (please specify)……

Other (please specify)…….

3. How old are you?

4. When did you leave Sri Lanka?

5. How long have you lived in the UK?

6. Were you directly exposed to the war and political conflict in Sri Lanka?

7. Do any of the following apply to you?

I have been seen by Mental Health Services in Sri Lanka or the UK ☐

I have been diagnosed with a mental health condition in Sri Lanka or the UK ☐

I have worked in mental health services in Sri Lanka or the UK ☐

8. Are you able to understand and communicate in English?

Appendix E: Consent and Confidentiality Form

University of Essex

Consent and Confidentiality Form

Title of Project: An exploratory study of coping strategies used in the aftermath of the Sri Lankan Civil war: Evidence from a Sri Lankan Tamil community sample living in the UK

Name of Researcher: Angeline Dharmaindra

Please tick each box to indicate you have read, understood and agree to each point:

☐ I consent to take part in the above named study.

☐ I have had the opportunity to consider the information and ask questions which have been addressed appropriately.

☐ I understand that this study is **confidential** and that **only** the person who interviews me will have access to any identifiable information. At no point will my identity be revealed to a third party.

☐ I understand that my interview(s) will be audio recorded and will be accessible to the researcher and if necessary the researcher's supervisor/examiners.

☐ I understand that I may stop the recording at any time without giving reason, and that I may require the recording to be deleted at any time without giving any reason.

☐ I understand that the information I provide will be stored in a secure location or on a computer file which **only** the researcher will have access to.

☐ I understand that the audio recording will be transcribed and I consent to extracts being published providing my anonymity is assured.

☐ I understand that I can withdraw from the study at any point and that if I do so my data will be destroyed.

☐ I understand that I may become distressed through talking about my experiences of the war.

☐ I understand that if the researcher is concerned about me, they may encourage me to contact a member of the organisation through which I heard about the study in order to get appropriate support.

☐ I also understand that if the researcher has concerns about my safety or the safety of others they will inform the research team and the organisation through which I heard about the study.

Name: ……..

Signed…… **Date**……..

Address: ……..

…….

…….

……..

Mobile telephone number:

Home telephone number:

Please mark as CONFIDENTIAL and return to:

Angeline Dharmaindra

[redacted]

If you wish to discuss this further please call on: [redacted] or email on [redacted]

Appendix F: University Ethics Amendment Application and Approval Letter

Ethics Approval: Amendment Request

Name: Angeline Dharmaindra

Date: 6/10/15

Re: Ethics Approval Application ref. 14023

Description of Amendment:

I would like to make two amendments to the above ethics application

1) To widen the age range for recruitment from 18-65 years to 18+. Older adults who wish to participate will be reviewed on a case by case basis.
2) To extend recruitment from the Tamil Community Centre in Hounslow to other voluntary, community and religious organisations accessed by the Tamil community across London. Some have already been identified and included in the original proposal.

Reason for Amendment:

1) Although I initially stated in the proposal 18-65 reflects adult working age, this research is interested in the improvement and development of community interventions and not just mainstream services which is age dependant. Furthermore, the researcher feels this may exclude participants who are willing to participate and can provide valuable research data but fall short of this age restriction.
2) The researcher is recruiting from a hidden population and to date recruitment has been a slow process. Since ethical approval in June, 1 interview has been undertaken. This has been due to the fact that many Tamil individuals with experience of war and trauma may utilise the TCC infrequently or utilise other support services (or none). Furthermore as mentioned the researcher intends to use snow ball sampling and it will not be possible to ensure that further participants are associated with a specific organisation. Excluding such individuals will have a significant impact on recruitment. Recruiting from a wider geographical location may therefore also increase recruitment. The researcher is providing participants with signposting information and intends to undertake a full de-brief following interviews and feels this is adequate support for participants.

(For office use only)

The amendment has been approved ☑

The amendment has not been approved ☐

Resubmission required ☐

Signature: [redacted]

Name (in block capitals): [redacted]

Department: G - HHS

Date: 12/10/2015

Appendix G: Interview Schedule

Interview Schedule for Interview exploring methods of coping used to manage experiences of war and political conflict in Sri Lanka

My name is Angeline Dharmaindra and I am a Sri Lankan Tamil who was born in the UK. I am a trainee clinical psychologist and as part of my job I am very interested in how people experience distress but also manage and live with difficult experiences. I have invited you along today so that I can ask you some questions about your experiences of the Civil war and how you have coped. I am interested in your personal experiences and would really like to learn from them.

Explain to the interviewee how they were selected.
Emphasise confidentiality and anonymity- real details will not be used
Seek permission to tape the interview and make notes
Explain risk protocol and breaking confidentiality if risk issues emerge

Provide an opportunity for the interviewee to ask questions.

I would like to start of my asking you a few general questions about yourself:

1. Record the gender of the participant:

□Male
□Female

2. How old are you?

3. Are you married? Single? Or in a relationship?
Probe client to find out whether they are in a relationship, cohabiting or have been in a previous relationship and how long this was for.

4. Do you have any children? How many? Girls or boys? What are their ages?

5. Did you go to school in Sri-Lanka? Did you gain any qualifications there or later on?

6. Are you working at the moment? Did you used to work? What did you do?

7. Do you identify with a particular religion or religious or spiritual group?

8. How long did you live in Sri Lanka for?

9. When do you come to the UK?

10. Have you lived in any other country prior to coming to the UK?

Ask for dates and locations. Explain this is for interview purposes only and this will not be shared with government services.

I would like to know more about your experiences of the war and what it was like for you. In order to consider some of the next questions, please try to think back to the time when you lived in Sri Lanka and recall some of the difficult experiences you faced.

11. Why don't you start by briefly telling me about your experiences of the war and political conflict in Sri Lanka? This is not the focus of the interview but it would be helpful to know about.
Ask about siblings, family and friends if relevant

12. Did you ever spend any time in war/refugee camps? What was it like for you?

13. I started off in earlier interviews thinking about the idea of coping but have found others have used other words such as managing or surviving. What word do you tend to use? Can you describe the ways in which you tried to manage the difficult experiences you had?
How did you deal with it? What did you do?

14. Did you find ways to cope with others? *Explore cultural and religious practices if relevant*

15. In what way? If relevant, explore methods of coping with family, community and if relevant wider community. Ask about siblings, parents, extended family and friends

16. Do you think the ways in which you have learnt to cope/manage have been influenced by living in the UK or by British views and values?

17. Do you think the war has changed your understanding of distress? Pain, sadness, suffering

18. Have you got anything you would like to add? Any final thoughts.

Turn off audio

Thank interviewee for taking part in the interview and explain what will happen to the data collected

Debrief and provide contact details for participant should they require additional support as well as information on relevant services. Revisit difficult sections and acknowledge how frightening/difficult this must have been. I noticed when we talked about……..you got very upset……this must have been extremely frightening/hard for you

Do you know of anyone else who attends this centre/service who would like to take part in this study? Give information leaflet and advert

If participant is distressed advise them to contact the organisation through which they heard about the study. Discuss breaking confidentiality if risk issues emerge

Appendix H: University Ethics Application and Approval Letter

University of Essex

School of Health and Human Sciences

[redacted]

[redacted]

11 June 2015

Miss Angeline Dharmaindra

[redacted]

Dear Angeline,

Re: Ethical Approval Application (Ref. 14023)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the Research Director.

Kind regards,

[redacted]

[redacted]
Ethics Administrator
Health and Human Sciences

cc. [redacted] Supervisor
[redacted] Supervisor
[redacted] REO

50 years

Contains recycled material

Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc.) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:

   An exploratory study of coping strategies used in the aftermath of the Sri Lankan civil war: Evidence from a Sri Lankan Tamil community sample living in the UK

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title. Do you object to the title of your project being published? Yes ☐ / No ☒

3. This Project is: ☐ Staff Research Project ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Angeline Dharmaindra	Clinical Psychology (Health and Human Sciences)
[redacted] and [redacted]	Clinical Psychology (School of Health and Human Sciences)

5.	**Proposed start date**: April 2015
6.	**Probable duration**: Project likely to end in April 2016 (exact date to be confirmed)

7. Will this project be externally funded? Yes ☐ / No ☒

If Yes,

8.	What is the source of the funding?
	N/A

9. If external approval for this research has been given, then only this cover sheet needs to be submitted

External ethics approval obtained (attach evidence of approval) Yes ☐/ No ☒

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): .....

Name(s) in block capitals: ....ANGELINE DHARMAINDRA.....

Date: 31/3/15.....

Supervisor's recommendation (Student Projects only):

I have read and approved both the research proposal and this application.

Supervisor's signature:..... .....

Outcome:

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC ☑

This application is referred to the FEC because it does not fall under Annex B ☐

This application is referred to the FEC because it requires independent scrutiny ☐

Signature(s): .....

Name(s) in block capitals: .....

Department: .....S.H.H.S.....

Date: .....4/6/2015.....

The application has been approved by the FEC ☐

The application has not been approved by the FEC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): .....

Name(s) in block capitals: .....

Faculty: .....

Details of the Project

1. **Brief outline of project** (This should include the purpose or objectives of the research, brief justification, and a summary of methods. It should be approx. 150 words in everyday language that is free from jargon).

Many Sri Lankan Tamils have been exposed to prolonged experiences of war and political conflict yet there is a lack of research relating to the mental health needs of people from the Sri Lankan Tamil community. Furthermore, little is known about how this community copes with distress at an individual, family or community level. The current research aims to explore the ways in which Sri Lankan Tamils living in the UK have coped with their experiences of war and conflict in Sri Lanka. Given the difficulty in accessing research participants from this ethnic group, snow-ball sampling will be used to recruit individuals from a variety of third sector organisations. A qualitative design will be used to focus on the highly personal experiences of the people participating and the meaning of their unique experiences. Semi-structured interviews will be undertaken with participants to explore the experiences of living through war and the coping behaviours adopted to deal with distressing experiences. The researcher intends to use thematic analysis in order to identify salient themes within the research data.

Participant Details

2. Will the research involve human participants? (indicate as appropriate)

Yes ☒ No ☐

3. Who are they and how will they be recruited? (If any recruiting materials are to be used, e.g. advertisement or letter of invitation, please provide copies).

The participants for the study will be Sri Lankan Tamils currently living in the UK with experience of living in Sri Lanka during the civil war. Participants must have had direct experiences of living through war and political conflict. Participants will be of adult working age and able to communicate in English. Please see proposal for full inclusion and exclusion criteria.

Participants will be recruited from voluntary, charity and religious organisations. A key organisation has been identified however other organisations may be involved at a later date if there are issues with recruitment (an ethics amendment will be applied for in this case). An information sheet and recruitment advertisement will be provided (see appendix for copies). It is anticipated that snowball sampling will be needed in order to recruit participants for the study however subsequent participants will have to be linked to an organisation which provides advice and support (see section 4 below). Participants can contact the researcher directly and the researcher plans to use a separate phone for research purposes, which will have a personal recording for potential participants. Individuals can contact the researcher to gain additional information for the study, to

volunteer to participate and to request a de-brief or support following participation in the study. Telephone number to be confirmed.
Will participants be paid or reimbursed? No

4. Could participants be considered:

(a) to be vulnerable (e.g. children, mentally-ill)? Yes ☒/ No ☐

(b) to feel obliged to take part in the research? Yes ☒/ No ☐

If the answer to either of these is yes, please explain how the participants could be considered vulnerable and why vulnerable participants are necessary for the research.

Participants may be considered vulnerable because their experience of war and political conflict may have exposed them to distressing events. Individuals will be recruited from voluntary, charity and religious organisations. These organisations currently provide community support and signposting for Tamil individuals and they can continue to be accessed during the research. Furthermore some organisations have links with local mental health services and help individuals to access appropriate support. If the researcher is concerned about a research participant they can advise the participant to contact the organisation they were recruited from or if necessary be supported to do so. The researcher will be using a community sample for the current study and those actively under the care of mental health services will not be approached to take part in the study. See section 8 below for further details.

Information will also be provided to research participants on a number of organisations which can provide information, advice and support to individuals from the Tamil community should they require it at any time during or after the research. Participants will also be given the opportunity of a de-brief following the interview (see proposal for further details). They will also be given the contact details of the researcher should they require support during the research process.

Informed Consent

5. Will the participant's consent be obtained for involvement in the research orally or in writing? (If in writing, please attach an example of written consent for approval):

Yes ☒ No ☐

How will consent be obtained and recorded? If consent is not possible, explain why.

Consent to take part in the study will be sought through the completion of a consent form before the participant is involved in the research interview. Only once this is completed will participants be interviewed.

Please attach a participant information sheet where appropriate.

Confidentiality / Anonymity

6. If the research generates personal data, describe the arrangements for maintaining anonymity and confidentiality or the reasons for not doing so.

Given that this research will generate a large volume of personal data, individuals who agree to participate will be assigned a unique identity code which will remain with them throughout the research process. The names and other person identifiable data corresponding to the codes will be stored separately from the data which only the lead researcher will have access to.

Data Access, Storage and Security

7. Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project. Please provide details of those who will have access to the data.

In order to maintain the security of any personal data collected, each individual will be assigned a unique identity code which will be linked to their interview data. Only the lead researcher will have access to information which links the participants' names to their identity codes. This information will be separated from the study data and will be stored on a secure computer in a password protected file. Raw data and recording devices will remain the responsibility of the chief investigator and will be stored in a locked filing cabinet. Any data stored electronically will be password protected.

It is a requirement of the Data Protection Act 1998 to ensure individuals are aware of how information about them will be managed. Please tick the box to confirm that participants will be informed of the data access, storage and security arrangements described above. If relevant, it is appropriate for this to be done via the participant information sheet ☒

Further guidance about the collection of personal data for research purposes and compliance with the Data Protection Act can be accessed at the following weblink. Please tick the box to confirm that you have read this guidance (http://www.essex.ac.uk/records_management/policies/data_protection_and_research.aspx) ☒

Risk and Risk Management

8. Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

Yes ☒ No ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:
Given there are some psychological risks to participants associated with this project, the researcher will do the following in order to ensure these risks are minimised. Participants may become distressed when talking about their experiences of coping. The researcher must ensure participants are aware of their rights to withdraw from the study or stop the interview if it becomes too distressing. Individuals will be recruited from voluntary, charity and religious organisations which already provide community support for Tamil individuals and many of which have links

to local health services. Individuals will be advised and supported to contact these organisations if the researcher feels this is necessary. All participants will be offered a full de-brief immediately following the interview and provided with the researcher's contact details should they require a de-brief or support at a later date.

Where serious concerns are raised, participants will be advised that the research team will have to be informed. They will also be informed that the organisation they were recruited through will have to be contacted. Issues of risk or safeguarding will be discussed immediately with the research supervisor and the risk protocol outlined by the North East Partnership Foundation Trust will be followed.

The researcher will also provide each participant with information on Tamil organisations they can contact at any time during or after the research and direct participants to particular organisations if appropriate.

9. Are there any potential risks to researchers as a consequence of undertaking this proposal that are greater than those encountered in normal day-to-day life?

Yes ☒ No ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:
The researcher will be interviewing participants on their experiences of war and coping. During interviews it is likely that the interviewer will be exposed to information of a distressing nature and witness participants becoming distressed as a result of talking about their experiences. The researcher will use supervision regularly to debrief and reflect on interactions with participants and the content of interviews. The researcher will be collecting data in the field which may involve lone working. The lone working policy will be followed and researcher will carefully consider time and location when conducting interviews. Where possible interviews will be undertaken within community settings during office hours and with other staff in the building.

10. Will the research involve individuals below the age of 18 or individuals of 18 years and over with a limited capacity to give informed consent?

Yes ☐ No ☒

If Yes, a criminal records disclosure (CRB check) within the last three years is required.

Please provide details of the "clear disclosure":

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:

11. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty and/or University Ethics Committees

N/A

Appendix I: Support and Signposting Resources

Citizens Advice Bureau

https://www.citizensadvice.org.uk/

Provide free, independent, confidential and impartial advice to everyone on their rights and responsibilities.

Refugee Council

Gredley House,
1-11 Broadway
Stratford
E15 4BQ

020 7346 6700

Advice on immigration and nationality, welfare rights, health, housing. Counselling and therapeutic support and signposting to support services. Also run English classes.

MIND

15-19 Broadway
Stratford
London
E15 4BQ

020 8519 2122
mind.org.uk

Mental health charity which provides information and support.

Tamil Community Centre

10 School Road
Hounslow
Middlesex
TW3 1QZ

tccentre@googlemail.com
020 8570 7750
07947 816 273

To advise the community on health and wellbeing through social, education, leisure and dance activity. To assist the Tamil community who are suffering from financial hardship, sickness and distress by providing advice, information and welfare. Provides language classes, mother and toddler groups and community activities.

South London Tamil Welfare Group

36 High Street,
Colliers Wood
London
SW19 2AB
Tel: 020 8542 3285

Email: admin@sltwg.org.uk

Provide support predominantly for Tamil refugees and other community members by offering advice and services relating to their Immigration, welfare benefits, housing, education, health, domestic violence, family learning, employment and training needs.

Tamil Sangham

369 High Street North
Manor Park
London
E12 6PG

0208 471 7672
admin@ltsuk.org

Organise classes and training, youth activities and Tamilion festivals. Provide social, welfare and advisory services and to promote social integration through training classes and cultural and leisure activities.

Mind4Tamils

020 3383 6650
0845 527 7155

To promote emotional health, and the relief of distress, through the provision of group work, workshops and community-activities.

Downham Tamil Association

135 Boundfield Road
Catford
London
SE6 1PE

07983396261
07985798710
0208695118

Has a supplementary school which provides instruction in the Tamil language, Indian Instrumental music (Miruthangam), Indian dance (Bharathanatyam), and cultural tradition. They also offer English and Maths lessons following National Curriculum guidelines and learning in schools. As well as academic activities, the Association hosts a cricket club for under sixteens and celebrate Tamil and Western cultural festivals.

Tamil Community and Youth Centre

52 Cliffview Road
Lewisham
London

Language and arts for the Tamil community

Croydon Tamil Community Centre

Thornton Road
Thornton Heath
Surrey
CR7 6BD

0208 665 0444

London Sivan Kovil

4a Clarendon Rise
Lewisham
London
SE13 5ES

If you are distressed at any point following the interview please contact:

- **The organisation through which you heard about this study**

Appendix J: Extracts from Lone Working Policy

9.3 **Home Visits**

9.3.1 ***Prior to Arranging a Home Visit***

- Decide whether there are any factors that suggest an accompanied visit or whether it would be more prudent to meet the service user at the office or at a neutral location where assistance is more readily available.
- Ensure an itinerary is left with team office, giving details of whom and where the visits are and anticipated time of return.

9.3.2 ***On Arrival at the Home***

- If the interviewee appears aggressive or enraged from the outset, do not enter the premises.
- If the interviewee has an animal which appears aggressive, do not proceed with the interview until the owner has removed the animal. The presence of animals can raise anxieties or created distractions whether the effect is felt by the employee or the service user. If the animal cannot be moved into another room, the employee and service user should move. Even if the employee feels confident about animals, it is wise for the animal to be moved.

9.3.3 ***The Interview***

If the service user shows signs of violent or offensive behaviour or intoxication from illicit substances or alcohol, explain that this behaviour is not tolerated. Withdrawal from such a difficult situation is not a sign of weakness and should always be acted upon.

10 **FRAMEWORK FOR RISK ASSESSMENT FOR LONE WORKING**

10.1 Risk Assessment is a key element in the successful management of health and safety procedures within the workplace.

Risk Assessment is there to identify what risks we are willing to tolerate, what controls are in place and are these controls effective

10.2 The role of managers is crucial to risk assessment as they will be aware of the hazards inherent in the workplace and be able to measure the outcomes

of the workplace procedures.

10.3 What follows is a checklist which can be used to carry out a Risk Assessment in a systematic way which will enable the setting of priorities and allocation of resources. It is suggested that a risk rating for each factor of low, medium or high be set and an action plan developed. See Appendix A of the Risk Management Strategy.

11 GENERAL POINTS

11.1 Information

11.1.1
- It is essential that critical information relating to past incidents of violence or assessment of future risk – is clearly documented in Trust Clinical database and is available to all practitioners and clinicians.
- All incidents of violence or near misses should be documented using the IR1/Datix process as well as a clear account on Trust Clinical database and the risk assessment of the service user updated accordingly.

11.2 Workplace – The Building

11.2.1
- Action to be taken to improve the safety of the building with regard to risk of violence?
- Areas/rooms where people feel particularly vulnerable – identify why? eg Do fire doors reduce people's hearing in an emergency?

11.3 Reception and Admission Facilities

11.3.1
- Risk of violence to reception staff?
- Risk of violence to other service users?
- Risk of violence to staff as they enter or leave the building?
- Is reception area welcoming and pleasant and what may need to be done to improve it?
- Existence of potential weapons, eg furniture?
- Procedures for minimising waiting times and informing visitors of reasons for delay?
- Provision of toys, books, plants?
- Procedures for employees to advise each other of anticipated risk related to a specific person and time?
- Procedures for supplying extra staff to the scene of a violent incident and what their role should be?

11.4 Interviewing Facilities

11.4.1
- Friendly and relaxed atmosphere in the area used for interviewing and other formal discussions with service users?

- Identification of particular room for use with people who have a history of violent behaviour?
- Allocation of responsibility to ensure absence of potential weapons in all interviewing facilities?
- Arrangements for escape should an incident occur?
- Arrangements for activating the alarm?
- Identification of people who will respond to the alarm and their role?

11.5 **Living and Activity Areas**

11.5.1
- Friendly and relaxed atmosphere?
- Identification of risks specific to the particular service users?
- Backup arrangements?

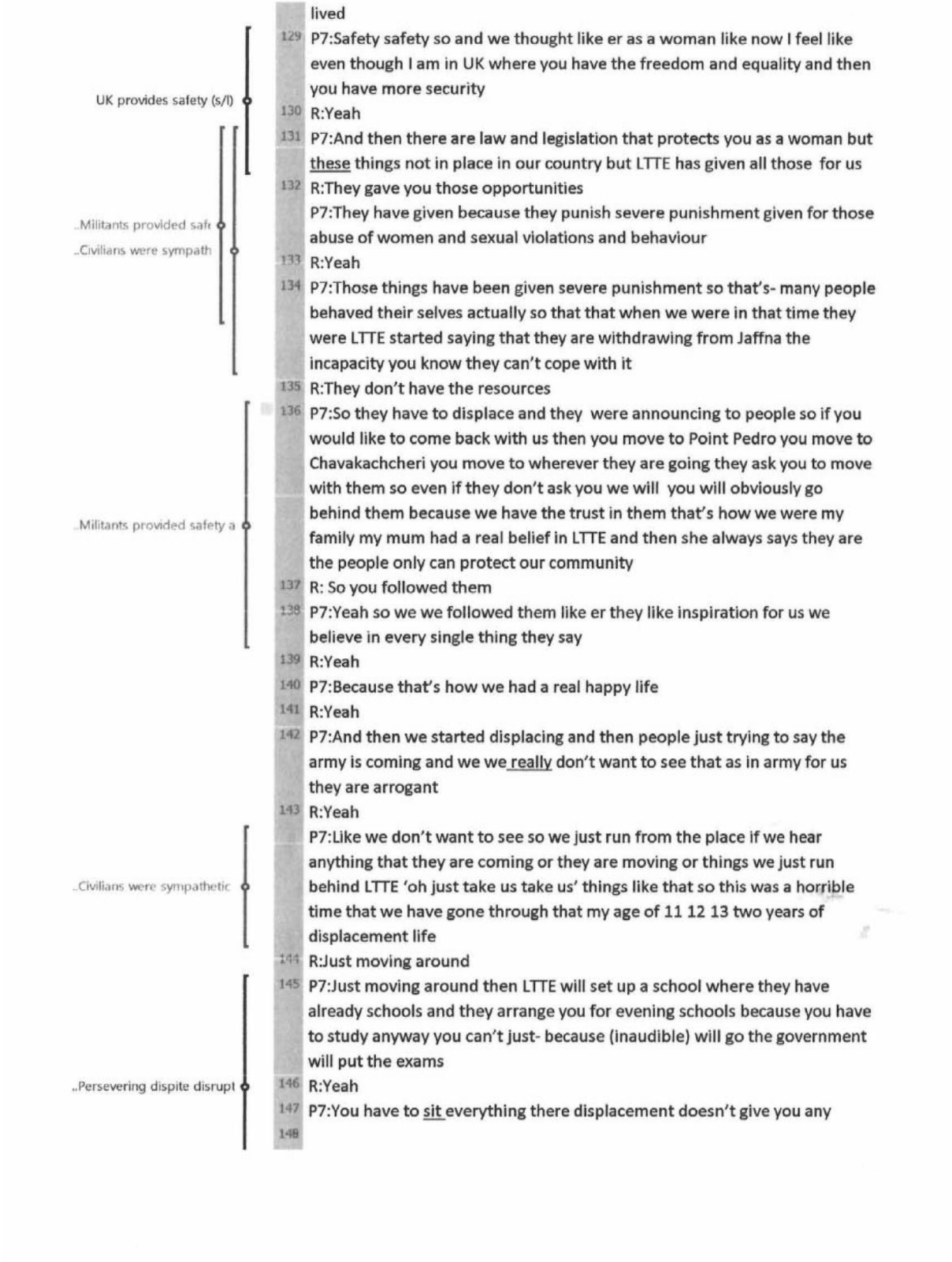
11.6 **Working Arrangements**

11.6.1
- Circumstances, times staff feel vulnerable in the building?
- Procedures for staff to record their movements away from the workplace (eg home visits) and be in contact with their manager?
- Procedures for accompanied visits or interviews, or use of alternative/neutral venues?
- No high risk visits or interviews should be scheduled at the end of the day unless contingency arrangements and back up as be identified and can be maintained.

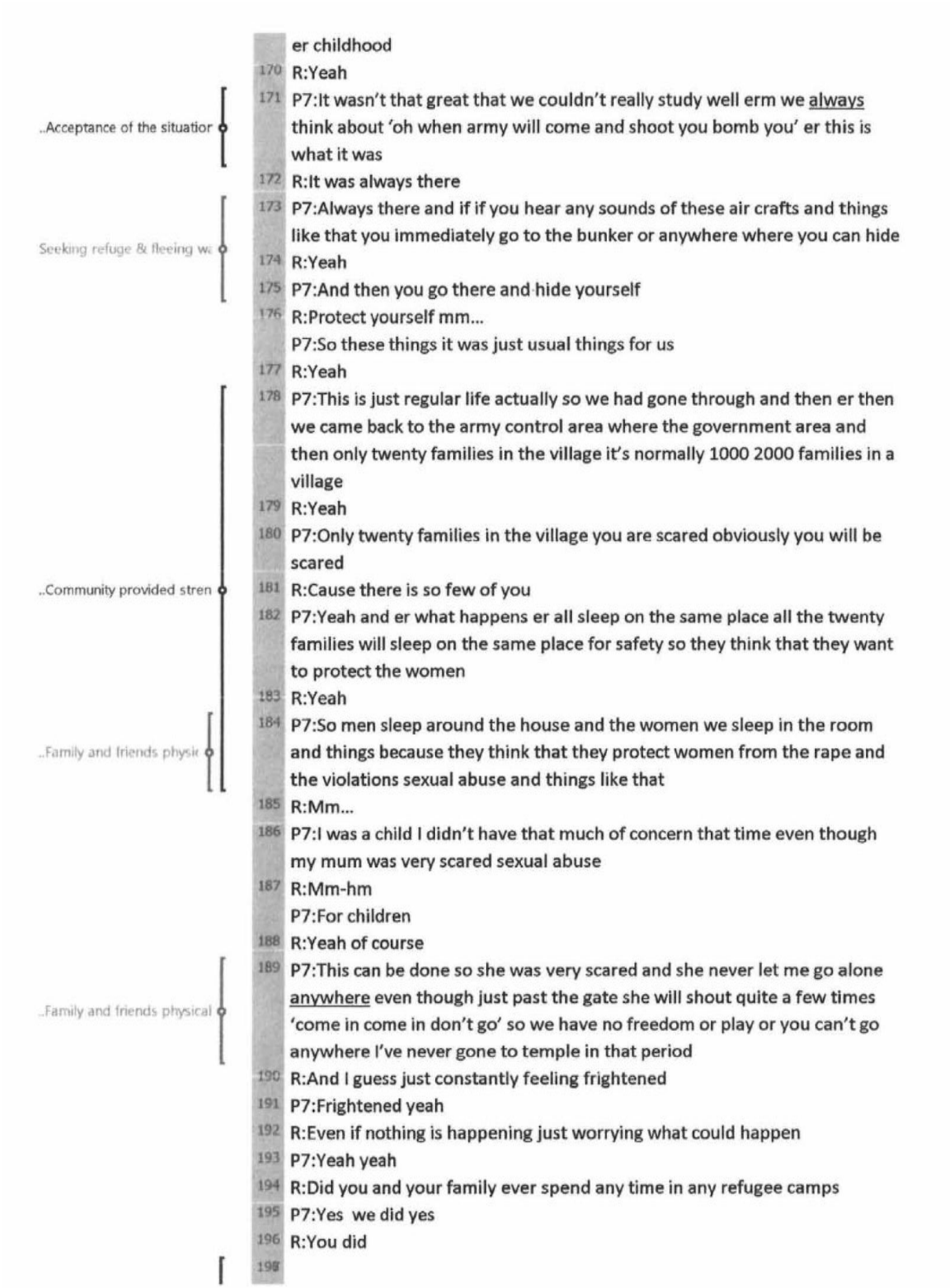
11.7 **Money and Valuables**

11.7.1
- Procedures for the handling of other people's money and valuables within the workplace?
- Medication and money storage?
- Identification of responsibility for safe handling and transport of money and valuables outside of the workplace?
- Procedures to minimise the necessity for staff to handle money and valuables at any time?

Appendix K: Sample of Coded Transcript



		situation bombing or- you have to study because you have exams you have to sit
	150	R:Sounds so stressful for a child to go through
..Its not easy to forget (s/l)	151	P7:It was when when when I was a child it was very stressful for us and I didn't realise that time when we have a peaceful life we think about that thing all these things we have gone through so that's how our life was there and then we moved to erm at last is the Killali that is the sea side area
	152	R:Mm...
	153	P7:Where LTTE given a path for people to move to go to Vanni from Killali that is the sea area where they just give you the boat service to just cross the sea and go to Vanni and settle down in Vanni many people had that chance to go to Vanni and settle down in Vanni but when we went to Killali that was a real disaster time with the army and (inaudible) and at that time we say er they bombing heavily that Killali so people dying I have seen many dying in front of me
	154	R:Oh gosh
		P7:Blood over the bodies and smog and it was horrible that I couldn't ever just forget those things like erm you know the heli they shoot from the gun from the heli that just come down and you can see
	155	R:The helicopters
..Acceptance of the situatior	156	P7: They shooting they shooting you can see the army man he is shooting so you see that and then it's coming in front of you or behind you and then you say 'oh I'm dead I'm dead' this is what we think
	157	R:You believe that you would die
	158	P7:Definitely yeah that's why we run and then we cry scream so things happened
	159	R:Yeah
	160	P7:That was the worst disaster that I had in my life and then we decided we can't erm... er cross the border because they just destroying people people just crying you see like thousands of people's bodies so you have to just cross them and go on the way so my mum and her siblings- few of them the few of them they crossed over the (inaudible) very few of them left
	161	R:Yeah
	162	P7:So me and my mum's three sisters and er other few relatives that were
Seeking refuge & fleeing we		left behind so we have to back to army's control otherwise you would have died
	163	R:Yes
	164	P7:Er so my mum was very scared to go back and then you know the rapes and things it would- anything can happen to you they can kill you and these things obviously where we didn't like to go back but you have to you know
	165	R:Yes
		P7:You have no choice either you have to die or go back
	166	R:Did anything like that happen to anyone you knew personally
	167	P7:Yes my family I got three cousins died on that place that we played together in
	168	



er childhood

170 R:Yeah

171 P7:It wasn't that great that we couldn't really study well erm we always think about 'oh when army will come and shoot you bomb you' er this is what it was

172 R:It was always there

173 P7:Always there and if if you hear any sounds of these air crafts and things like that you immediately go to the bunker or anywhere where you can hide

174 R:Yeah

175 P7:And then you go there and hide yourself

176 R:Protect yourself mm...

P7:So these things it was just usual things for us

177 R:Yeah

178 P7:This is just regular life actually so we had gone through and then er then we came back to the army control area where the government area and then only twenty families in the village it's normally 1000 2000 families in a village

179 R:Yeah

180 P7:Only twenty families in the village you are scared obviously you will be scared

181 R:Cause there is so few of you

182 P7:Yeah and er what happens er all sleep on the same place all the twenty families will sleep on the same place for safety so they think that they want to protect the women

183 R:Yeah

184 P7:So men sleep around the house and the women we sleep in the room and things because they think that they protect women from the rape and the violations sexual abuse and things like that

185 R:Mm...

186 P7:I was a child I didn't have that much of concern that time even though my mum was very scared sexual abuse

187 R:Mm-hm

P7:For children

188 R:Yeah of course

189 P7:This can be done so she was very scared and she never let me go alone anywhere even though just past the gate she will shout quite a few times 'come in come in don't go' so we have no freedom or play or you can't go anywhere I've never gone to temple in that period

190 R:And I guess just constantly feeling frightened

191 P7:Frightened yeah

192 R:Even if nothing is happening just worrying what could happen

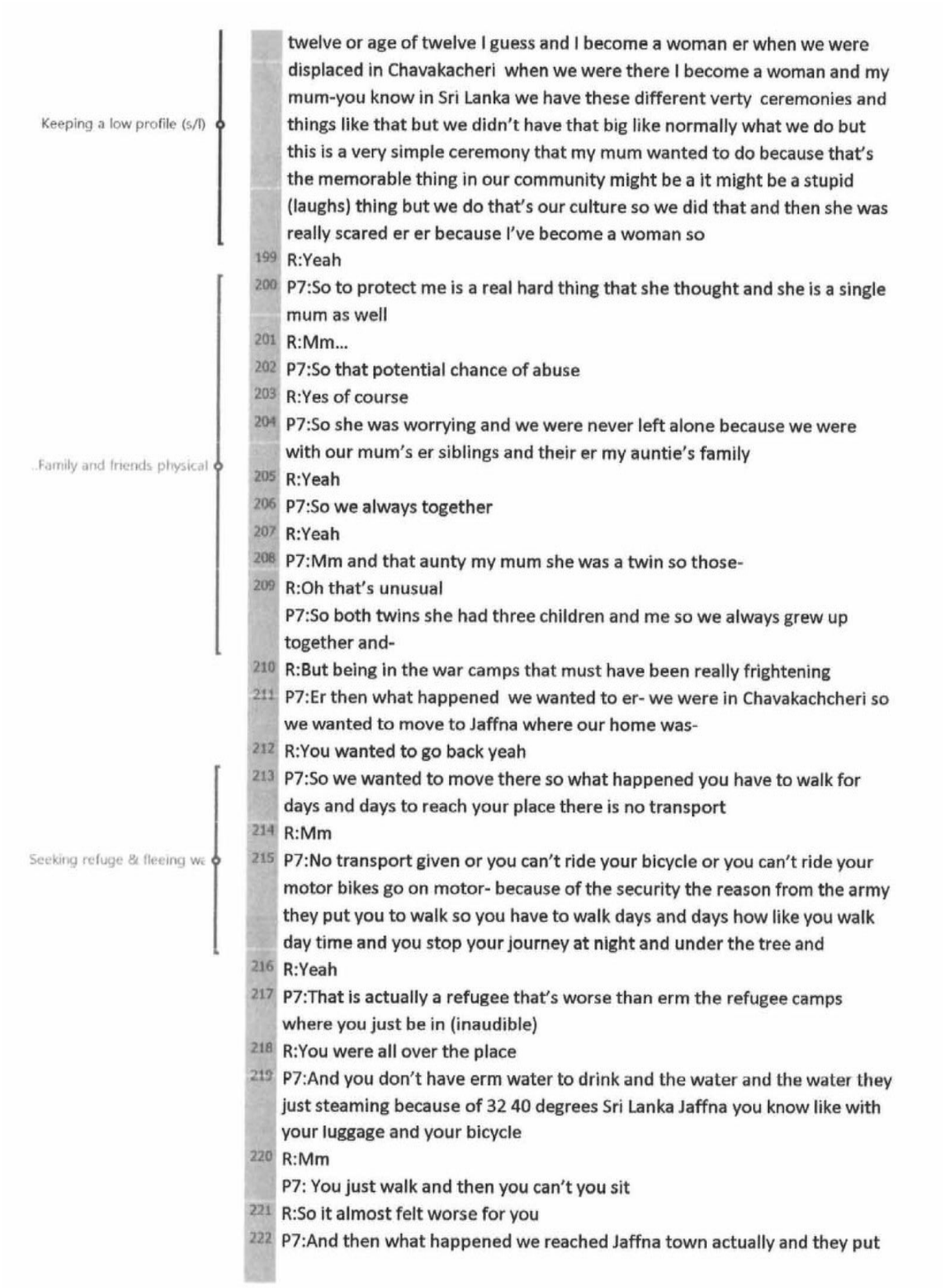
193 P7:Yeah yeah

194 R:Did you and your family ever spend any time in any refugee camps

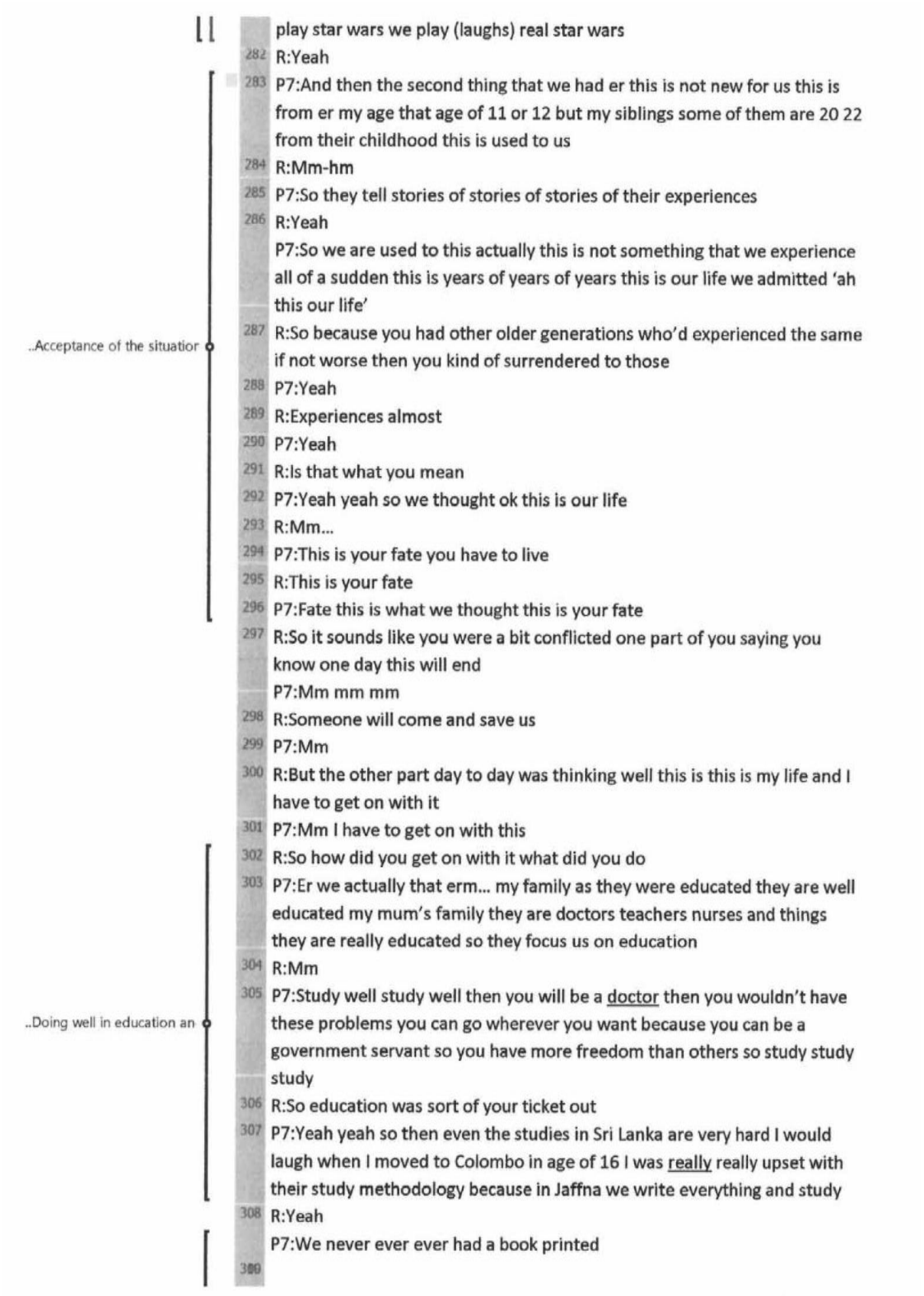
195 P7:Yes we did yes

196 R:You did

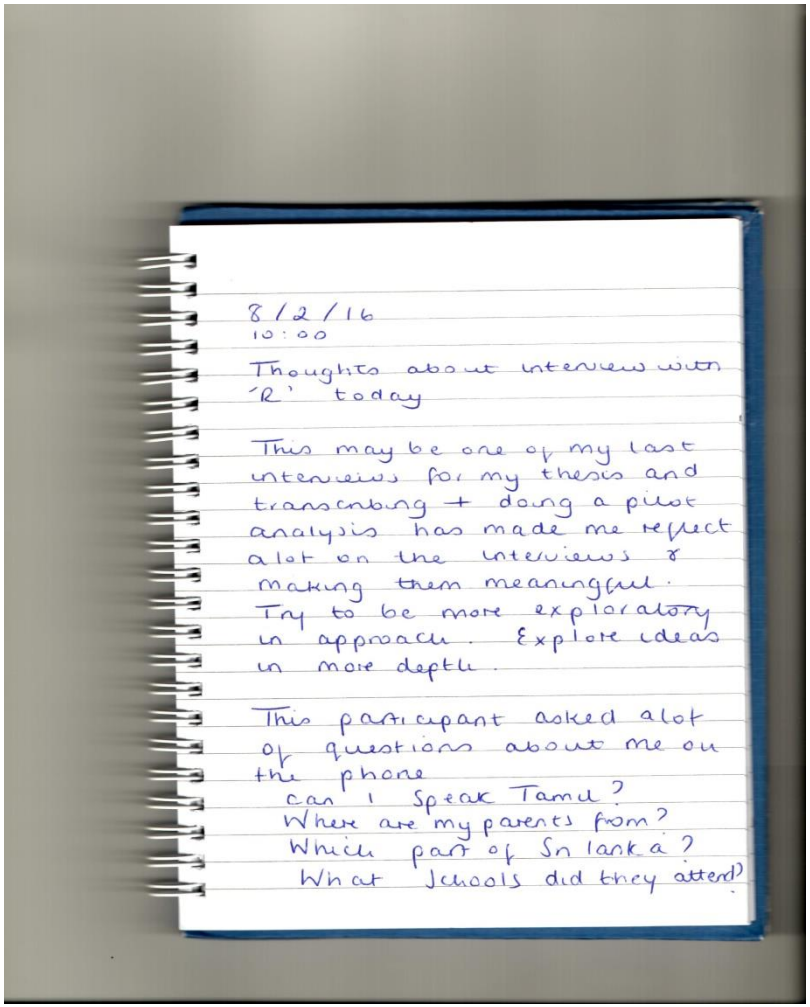
198


Keeping a low profile (s/l)
Family and friends physical
Seeking refuge & fleeing wa
twelve or age of twelve I guess and I become a woman er when we were displaced in Chavakacheri when we were there I become a woman and my mum-you know in Sri Lanka we have these different verty ceremonies and things like that but we didn't have that big like normally what we do but this is a very simple ceremony that my mum wanted to do because that's the memorable thing in our community might be a it might be a stupid (laughs) thing but we do that's our culture so we did that and then she was really scared er er because I've become a woman so
199 R:Yeah
200 P7:So to protect me is a real hard thing that she thought and she is a single mum as well
201 R:Mm...
202 P7:So that potential chance of abuse
203 R:Yes of course
204 P7:So she was worrying and we were never left alone because we were with our mum's er siblings and their er my auntie's family
205 R:Yeah
206 P7:So we always together
207 R:Yeah
208 P7:Mm and that aunty my mum she was a twin so those-
209 R:Oh that's unusual
P7:So both twins she had three children and me so we always grew up together and-
210 R:But being in the war camps that must have been really frightening
211 P7:Er then what happened we wanted to er- we were in Chavakachcheri so we wanted to move to Jaffna where our home was-
212 R:You wanted to go back yeah
213 P7:So we wanted to move there so what happened you have to walk for days and days to reach your place there is no transport
214 R:Mm
215 P7:No transport given or you can't ride your bicycle or you can't ride your motor bikes go on motor- because of the security the reason from the army they put you to walk so you have to walk days and days how like you walk day time and you stop your journey at night and under the tree and
216 R:Yeah
217 P7:That is actually a refugee that's worse than erm the refugee camps where you just be in (inaudible)
218 R:You were all over the place
219 P7:And you don't have erm water to drink and the water and the water they just steaming because of 32 40 degrees Sri Lanka Jaffna you know like with your luggage and your bicycle
220 R:Mm
P7: You just walk and then you can't you sit
221 R:So it almost felt worse for you
222 P7:And then what happened we reached Jaffna town actually and they put


252 P7:Mm
253 R:Or living with
P7:Mm mm
254 R:Erm what word do you tend to use
255 P7:Surviving
256 R:Survivng
257 P7:Mm
258 R:Mm er can you describe the ways in which you've tried to survive those difficult experiences you've had
..Coping alone in the absc
259 P7:Er... actually the thing is that you have to live you have your own life actually you have no parents we grew in in in our country we have a close relationship with parents and relatives
260 R:Yes
261 P7:Not like here
262 R:Your extended family
..Through experiences famil
263 P7:Yeah so it's like very close even though we are cousins we never feel like we are cousins we feel like we are siblings
264 R:That's right yes
P7:So that's how we are close so (.) even that hard times that we are going through and then ere r its its hard times tough time where you can't eat properly
265 R:Mm
266 P7:You have no water to get bath and er you you had a good life and then all of a sudden you and live in a classroom
267 R:Yeah
268 P7:Where you don't have any door to close so you have to stay with other people so its it's very difficult
269 R:Yeah
270 P7:But ultimate thing is like we had er hope that LTTE will save us soon
271 R:Mm
272 P7:So this is the first thing that as I'm a child I was thinking 'oh one day Prabhakaran mama will fight with them and then they rescue us'
273 R:So that was one way that you coped that hope that that the LTTE would come through
274 P7:Yeah they will definitely rescue us from this horrible situation this is the first thought that's always in my mind
275 R:Mm even as a child
P7:Even as a child so er we call them as mama's which they always protect us
..Civilians were sympathet
..Wanting revenge (I/s)
276 R:Yeah
277 P7:Like mama 'mama's will come and fight and kill these idiots and they will just rescue us' this is what we think
278 R:Yes
279 P7:And we thought I thought this is what- me and my siblings we just talk to each other we just play like we are LTTE and you are army and we shoot
280


play star wars we play (laughs) real star wars
282 R:Yeah
283 P7:And then the second thing that we had er this is not new for us this is from er my age that age of 11 or 12 but my siblings some of them are 20 22 from their childhood this is used to us
284 R:Mm-hm
285 P7:So they tell stories of stories of stories of their experiences
286 R:Yeah
P7:So we are used to this actually this is not something that we experience all of a sudden this is years of years of years this is our life we admitted 'ah this our life'
..Acceptance of the situatior
287 R:So because you had other older generations who'd experienced the same if not worse then you kind of surrendered to those
288 P7:Yeah
289 R:Experiences almost
290 P7:Yeah
291 R:Is that what you mean
292 P7:Yeah yeah so we thought ok this is our life
293 R:Mm...
294 P7:This is your fate you have to live
295 R:This is your fate
296 P7:Fate this is what we thought this is your fate
297 R:So it sounds like you were a bit conflicted one part of you saying you know one day this will end
P7:Mm mm mm
298 R:Someone will come and save us
299 P7:Mm
300 R:But the other part day to day was thinking well this is this is my life and I have to get on with it
301 P7:Mm I have to get on with this
302 R:So how did you get on with it what did you do
303 P7:Er we actually that erm... my family as they were educated they are well educated my mum's family they are doctors teachers nurses and things they are really educated so they focus us on education
304 R:Mm
..Doing well in education an
305 P7:Study well study well then you will be a doctor then you wouldn't have these problems you can go wherever you want because you can be a government servant so you have more freedom than others so study study study
306 R:So education was sort of your ticket out
307 P7:Yeah yeah so then even the studies in Sri Lanka are very hard I would laugh when I moved to Colombo in age of 16 I was really really upset with their study methodology because in Jaffna we write everything and study
308 R:Yeah
P7:We never ever ever had a book printed
309

Appendix L: Extracts from Reflective Journal

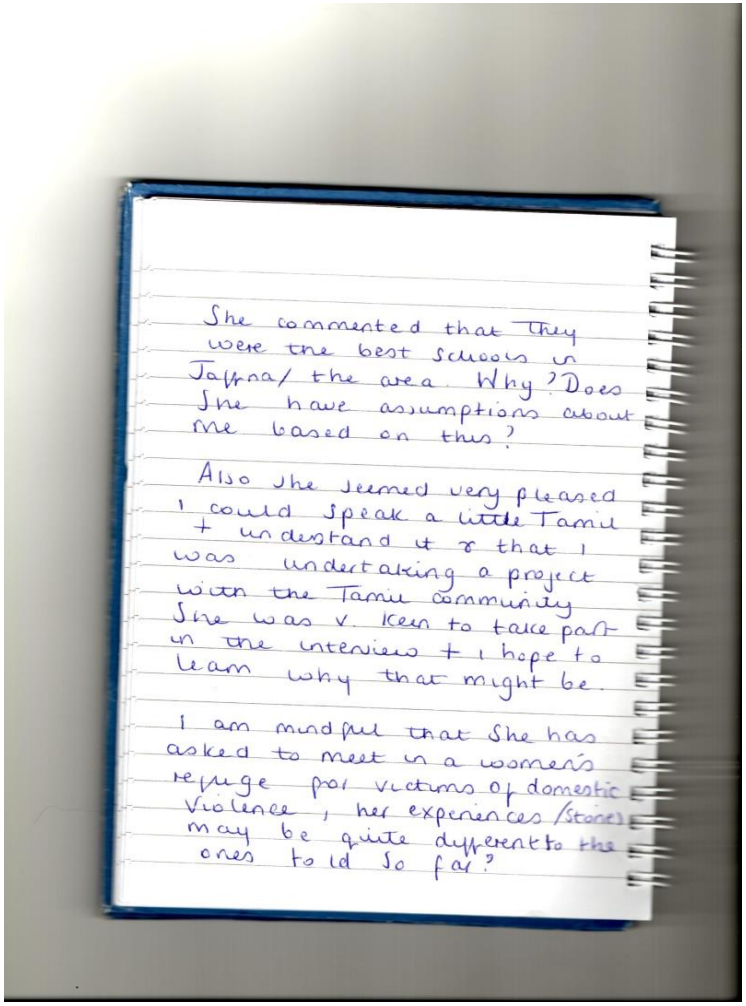


8/2/16
10:00

Thoughts about interview with 'R' today

This may be one of my last interviews for my thesis and transcribing + doing a pilot analysis has made me reflect alot on the interviews & making them meaningful. Try to be more exploratory in approach. Explore ideas in more depth.

This participant asked alot of questions about me on the phone
Can I speak Tamil?
Where are my parents from?
Which part of Sri lanka?
What schools did they attend?



She commented that they were the best schools in Jaffna/ the area. Why? Does she have assumptions about me based on this?

Also she seemed very pleased I could speak a little Tamil + understand it & that I was undertaking a project with the Tamil community. She was v. keen to take part in the interview + I hope to learn why that might be.

I am mindful that she has asked to meet in a women's refuge for victims of domestic violence, her experiences/stories may be quite different to the ones told so far?

This is the first time / interview in which Sexuality, Sexual violence + rape had been discussed

Some v. important themes also emerged around:

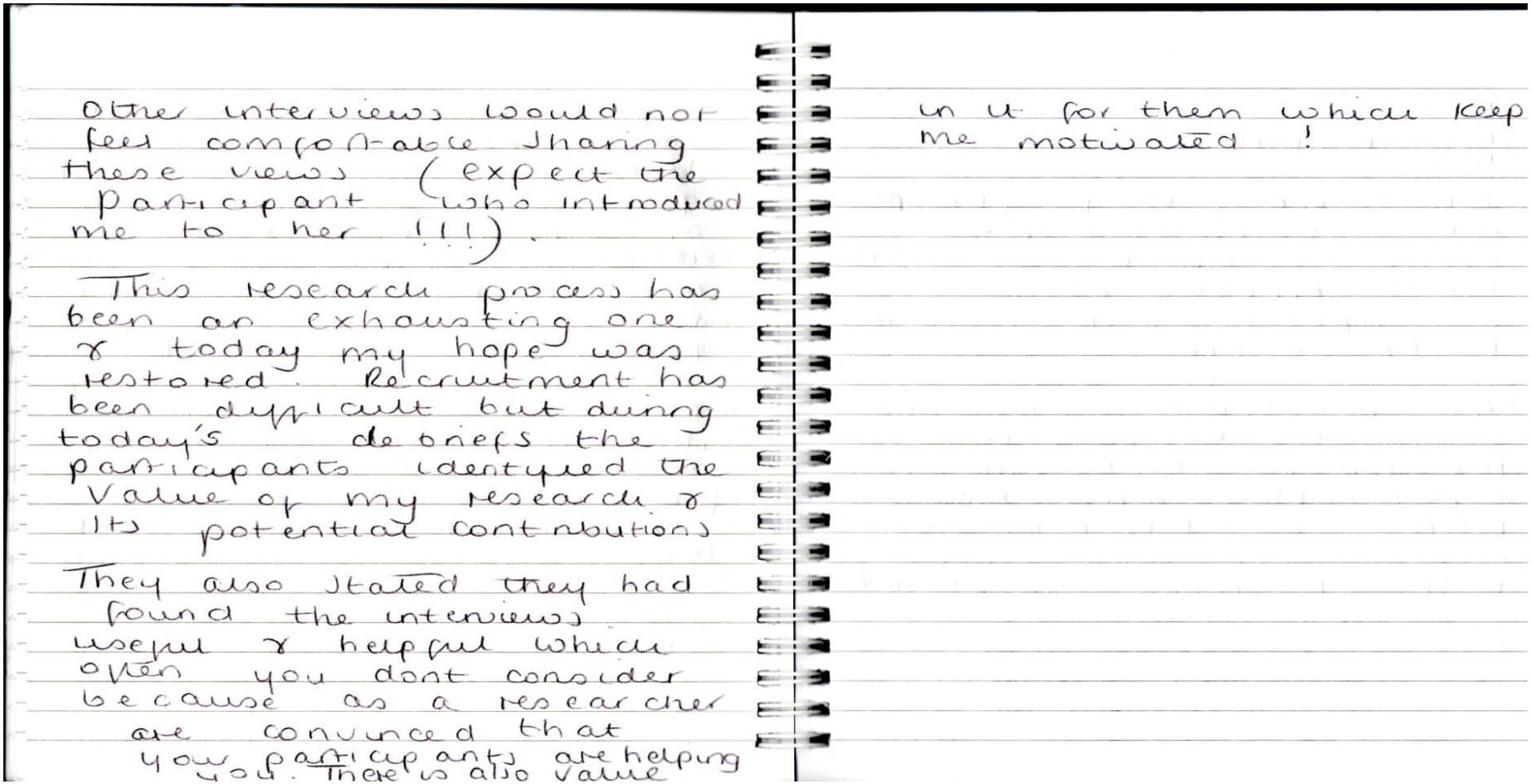
- revenge — and wanting to make things right
- using education to change your circumstances
- acceptance that this is part of life / bad karma

This lady was younger than me and I found myself being inspired by her self-determination

Our differences in terms of background, education & experiences did not seem so vastly different (except experience of war) or apparent as it had done in other interviews despite this still being the case!

↳ Why? Was she more acculturated, accepting of cultural differences. She was extremely articulate + highly educated and perhaps I found myself relating to her on an academic level?

I found her honesty + openess about revenge & love & respect for the Tigers moving as I had in the past felt perhaps



Other interviews would not feel comfortable sharing these views (expect the participant who introduced me to her !!!).

This research process has been an exhausting one & today my hope was restored. Recruitment has been difficult but during today's debriefs the participants identified the value of my research & its potential contributions.

They also stated they had found the interviews useful & helpful which often you dont consider because as a researcher are convinced that your participants are helping you. There is also value in it for them which keep me motivated !