

# Walking Corpse Syndrome: A trauma-related idiom of distress amongst Sri Lankan Tamils

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## Abstract

This article introduces Walking Corpse Syndrome, a common idiom of distress in Tamil Sri Lanka that is characterized by a variety of cognitive difficulties, feelings that an individual is functioning reflexively or impulsively, and acute attacks of dissociation that are accompanied with the sensation of empty-headedness. Walking Corpse Syndrome demonstrates some overlap with Western nosology, although it appears to be its own unique illness category, most likely of Ayurvedic provenance. The article comprises two studies. One is a secondary interview analysis of community members that aimed to identify the key symptoms of Walking Corpse Syndrome, allowing us to determine the local ethnopsychology of the syndrome and to elicit illustrative vignettes. The other study is a survey of Sri Lankan Tamil psychiatrists that aimed to investigate their understanding and experience of the disorder. This article outlines how, in certain cultural contexts, such syndromes emphasise the loss of attentional capacity and forgetfulness; it highlights the importance of “thinking a lot” as an idiom across cultures; and it details the many ways that Walking Corpse Syndrome is a key idiom of distress to assess in order to give adequate mental healthcare to Sri Lankan Tamil populations.

## Keywords

Cultural syndromes, idioms of distress, Sri Lankan Tamil, thinking a lot, trauma

## Introduction

Different cultures and communities exhibit and explain mental health symptoms in different ways, and it is important for clinicians to be aware of relevant contextual information that stems from a patient’s culture, race, ethnicity, religion, or geographical place of origin. “Idioms of distress” refer to the particular ways in which members of a given sociocultural group convey emotional and psychological distress (Nichter, 1981). Idioms of distress can correspond to culturally-specific syndromes, and also to psychological or somatic complaints and acting-out behaviours.

Idioms of distress play a significant role in cross-cultural mental healthcare. In research, studying idioms of distress helps to ensure that local psychological categories are acknowledged, that locally salient symptoms that fall outside of official psychiatric classification are addressed, and that the nature of the phenomenon under investigation is not skewed or otherwise misinterpreted (Kleinman, 1977). Idioms of distress also play an important role in clinical practice,

e.g., in identifying points of entry for intervention or building rapport (Hinton & Lewis-Fernandez, 2010). In the following, we outline the ways in which idioms of distress can be clinically useful (for a review, see: Hinton & Lewis-Fernandez, 2010; Hinton et al., 2019).

Idioms of distress often point to factors that contribute to mental health problems (e.g., trauma exposure) or general life stressors (e.g., interpersonal distress, concerns about personal safety). For example, in many cultures, interpersonal conflict is considered to be a well-defined cause of certain cultural syndromes;

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among Trinidadian patients, for instance, an episode of *tabanka* often indicates a dispute involving the family (Kirmayer, 1989), as does *dhat syndrome* amongst patients from India (Chhabra, Bhatia, & Gupta, 2003).

Idioms of distress can help clinicians assess the presence of different types of psychopathology. For example, Lewis-Fernandez and colleagues (2009) found that *ataque de nervois* among Caribbean Latinos is associated with panic disorder, major depression, dissociative disorder, generalized anxiety disorder, and several other DSM categories. Similarly, a study by Hinton and colleagues (2002) among Cambodian refugees found that attacks of *khyâl* are highly correlated with PTSD and panic attacks (Hinton et al. 2002). Similar connections have also been drawn between idioms of distress and destructive behaviours, such as substance abuse, episodes of violent anger, and suicide attempts (Guarnaccia, Lewis-Fernandez, & Rivera Marano, 2003).

Identification of idioms of distress can facilitate the development of a therapeutic alliance between the patient and the clinician. Indeed, non-Western patients often consider the idiom of distress to be their most salient problem; if the clinician does not ask about this complaint and does not specially address this idiom, the patient can feel misunderstood. This, in turn, can fracture the therapeutic alliance, and with it, the efficacy of the intervention. Conversely, if a clinician is able to clearly communicate to the patient that the proposed treatment will address the idiom of distress, relieve the cause of their suffering, and increase their resilience, treatment adherence and therapeutic success are far more likely (Singh, 1985; Hinton & Lewis-Fernandez, 2010). The current article investigates an idiom of distress among traumatized Sri Lankan Tamils.

After Sri Lanka gained independence from Great Britain in 1948, dormant tensions between the Sinhalese majority and the Tamil minority became increasingly overt. The result was a devastating 26-year civil war (1983–2009) between the Sri Lankan Security Forces (SLF) and the Liberation Tigers of Tamil Eelam (LTTE), whose mission was to create their own Sri Lankan Tamil state, or Eelam, in the North and East of the country.

The war was marked by indiscriminate shelling, countless large-scale massacres, and widespread displacement of civilian populations. Throughout the war period, there were also ongoing abductions, disappearances, torture, and extrajudicial killings of Tamil civilians by the SLF, LTTE and various paramilitary groups. Official death tolls have not been calculated, but hundreds of thousands of Tamil civilians are believed to have died, including between 40,000 and

60,000 in the final months alone (Panel of Experts on Accountability in Sri Lanka, 2011).

One of the major consequences of the Sri Lankan civil war has been the internal and external displacement of people. The war resulted in four major waves of Tamil refugee migration: 1984, 1999, 2006, and when the war ended in 2009. Currently, the Sri Lankan Tamil diaspora abroad is estimated to be around one million, or one quarter of the entire Sri Lankan Tamil population (International Crisis Group, 2010). Significant Sri Lankan Tamil refugee populations can be found around the world, including India, the United Kingdom, Germany, Switzerland, Denmark, and the United States. Sources estimate that there are currently between 200,000 and 300,000 Tamil people living in Canada, making it the largest Sri Lankan Tamil population outside of South Asia (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015).

While conducting a qualitative study examining the psychosocial effect of war-trauma and daily stress among Sri Lankan Tamil refugee men in Toronto, Canada (Affleck, Thamocharampillai, Jeyakumar & Whitley, 2018), a unique pattern of mind-related complaints came to the fore as a common expression of distress. Participants described their minds as being extremely “flaccid” (*thuvanda*), extremely “slack” (*thalarantha*), extremely “weak” (*nalantha*), extremely “sluggish” (*mantha*), and “numb” (*marantha*). For conceptual purposes, we labelled this pattern of complaints “floppy mind”, and initially believed it to be its own illness category. However, after further consideration, which included consultations with colleagues in Sri Lanka, we determined that the complaint pattern that we termed floppy mind was in fact a symptom set within a larger local disorder called *nabaippinam*, which translates into English as “walking corpse”: a term known to both lay people and mental health workers in Sri Lanka (Somasundaram, 2010).

The present article comprises two studies. One is based on interviews with Tamils in the community with Walking Corpse Syndrome that aimed to identify the key symptoms, to elicit the local ethnopsychology of the disorder, and to obtain illustrative vignettes. The other study is with Tamil psychiatrists living and working in the war affected regions of Sri Lanka that aimed to investigate their views and experiences of the disorder.

## Study I: Participant views of Walking Corpse Syndrome

### Methods

We performed a secondary analysis (Heaton, 1998, 2008) of interviews collected as part of a larger study

that was designed to better understand the relationship between masculinity and mental health in Sri Lankan Tamil refugee men (Affleck et al., 2018). In this original study, in-depth interviews were conducted with 33 Tamil refugee men that were originally from the North and East of Sri Lanka, and had resettled in Toronto, Canada. Participants' age ranged from 20 to 60, and time spent in Canada ranged from 3 to 27 years. Interviews were conducted in Tamil and then translated into English by the second author (UT), a psychiatrist from the war-affected region of Sri Lanka who is fluent in both Tamil and English and was temporarily based in Toronto. Participants were recruited from the community using a snowball sampling method and were interviewed at the office of an NGO that served the Canadian Tamil community. Before data collection for the original study began, a local advisory board, consisting of community representatives, members of an elders' organization, and Tamil-speaking mental health professionals, culturally validated the interview schedule, following the model of Flaherty and colleagues (1988). The interview schedule included questions such as "How did your war experiences impact you?" and "Tell me about your life in Canada". Ethics approval was granted by the Institutional REB of the Douglas Mental Health University Institute, Montreal Canada.

We used thematic analysis (Braun & Clarke, 2006, 2013). First, the authors read and reread the interviews multiple times to familiarize themselves with the data. Next, descriptions matching the pattern of distress that we labelled Walking Corpse Syndrome were identified. Such descriptions were found in 29 of the 33 original study interviews. Initial codes were then generated, which focused upon participants' understandings of the symptoms, causes, and treatment of the disorder. Lastly, conditional themes were created and then refined through constant comparison of the interview data.

## Results

Participants' accounts of Walking Corpse Syndrome were naturally organized into four syndrome dimensions: experiential components, explanatory model, impact on daily functioning, and coping strategies. These syndrome dimensions are outlined below. Following this discussion, three illustrative vignettes are presented. This approach follows Langer's (2016) *Research Vignette* model of results presentation, with these illustrative vignettes contextualizing participants' experience of the syndrome dimensions. The demographic characteristics of our participants are listed in Table 1.

**Table 1:** Basic demographic characteristics of Study One.

	N	%
<b>Age</b>		
20–29	3	9.1
30–39	8	24.2
40–49	11	33.3
50+	8	24.2
<b>Marital status</b>		
Married	23	70.0
Engaged or living together	2	6.1
Unmarried	5	15.2
<b>Employment</b>		
Labourer/factory/retail	14	42.4
Cook/restaurant	3	9.1
Unemployed	13	39.3
<b>Time spent in Canada</b>		
3–5 years	10	30.3
5–10 years	17	51.5
10+ years	6	18.2

## Syndrome dimensions

**Experiential components.** Participants described both an acute and chronic state. Acute episodes or "attacks" occurred in which their mind would suddenly become overwhelmed to the point where it would stop working completely. Participants used terms such as "freezing" (*uraitthal*), "numbing" (*maraththal*) and "becoming fully paralyzed" (*seyal ilappu*) to explain what happened to their minds during this process. Such attacks were characterized by the loss of all situational awareness and self-awareness, with intense sensations of "blank mindedness" (*mana verumai*) or "empty head-ness" (*thalai verumai*), in which an individual feels their head is filled with only white space. As one participant explained:

Frequently my mind freezes totally and stops functioning. Inside my head there is only blankness. I have no idea where I am or what I am doing, not comprehending or perceiving what is happening around me. I become physically stuck in the place where I develop the change and I cannot move.

These attacks could last anywhere from minutes to several hours, and participants could not recall the thoughts or actions that immediately preceded or took place during these episodes.

The chronic state is marked by slowed thinking, poor concentration, memory loss, acute absentmindedness, and the inability to organize thoughts. As one participant explained:

My mind functions slowly and superficially. I cannot even recall my phone number. I forget within a few

minutes what I did and where. My concentration is poor. I am unable to coordinate my thoughts or actions. These problems impair my involvement with all tasks and functions.

These cognitive symptoms were often accompanied with feelings of emotional numbness, an overheated somatic state, and the persistent feeling that the mind was operating impulsively or that it was outside of the individual's conscious control; that is, participants felt that their minds were operating enough to fulfil basic functions, such as moving their bodies, but they were not conscious of their actions or thoughts. Participants spoke of themselves as "zombies" (*vetrudal*) and explained how they were "living like dead people" (*pinam maathiri vaalthal*) to convey their lack of cognitive and emotional depth and the feeling that their minds were working impulsively.

**Explanatory model.** According to participants, Walking Corpse Syndrome is caused by trauma, worry, and what could be described as "thinking a lot", namely, by unwanted thoughts, such as worries and recollections of trauma repeatedly coming to mind. These dysphoric cognitions work to overwhelm, exhaust, and eventually paralyze the mind. As one participant described:

My mind is always flooded with worries, sorrows, grief, memories and angry thoughts. I do not feel any energy in my mind. My mind is exhausted. I do not have the energy even to think. My capacity to think has been shrunken. My mind functions very slowly. It is shallow and has no depth.

Participants understood this chronic state as one of partial mind-paralysis, marked by slowed thinking, poor concentration, and memory loss. The metaphors that patients used to describe this chronic state reflected their understanding that their minds had become partially paralyzed or disabled. For example, participants compared their minds to "ragdolls" (*uruthikulaintha*) or "bodies without bones" (*sathaippindam*), which when required to stand, simply flop back down upon the ground. As one participant explained: "My mind is not functional. It cannot stand up. I try to erect my mind but it remains floppy on the ground." Acute episodes or "attacks" were understood to be states of full paralysis, where the mind would suddenly become overwhelmed to the point where it would stop working completely. The metaphors that participants used to describe these attacks, such as "freezing" (*urai-thal*), "numbing" (*maraththal*), and "becoming fully paralyzed" (*seyal ilappu*) reflected this developmental process.

**Impact on daily functioning.** Participants outlined a variety of ways in which their lives were negatively impacted by Walking Corpse Syndrome. One main difficulty surrounded conversations. Participants described how they would often get their thoughts and words mixed up or lose track of what had been said previously. As one participant explained: "I cannot comprehend what others speak to me. When someone talks to me I cannot understand what has been said. Words are registered patchily and therefore I cannot remember what has been spoken to me." These difficulties interfered with participants' ability to meet people and relate to others, including family members.

Difficultly navigating the social space was another common complaint. As a result of absentmindedness, participants would often walk in the wrong direction, get on wrong subway or bus, or fail to observe traffic signals. As one man explained: "My mind has been flaccid for a long time. I constantly get lost. I cannot follow maps and travel by subway. Often I fail to observe traffic signals and go across the roads when the walking signal does not blink."

A number of participants described how they would often leave the house on an errand, only to forget where they were going and have to come home. As a result of these challenges, participants struggled with issues of social isolation. In fact, several had become shut-ins, confining themselves to their apartments and only going out when it was absolutely necessary. Feelings of alienation and isolation were common. As one participant explained: "I feel alone in the middle of the ocean."

Symptoms could also impact employment. Participants described how they would regularly arrive unprepared for work or late as a result of getting lost. The inability to focus and organize their thoughts could affect their performance. As one young man who had recently lost his job explained:

I could not complete targets, even small ones. I hurried to act or to complete targets without organizing things and understanding why, when, and how to act. I got to the point where I would become tensed, fidgety and stressed whenever I was asked to do anything.

Walking Corpse Syndrome also impacted participants' ability to relax. Poor concentration and forgetfulness interfered with activities that they had previously found enjoyable. One participant explained how reading had become impossible,

I do not remember or am not aware of what I read. Then I have to go back to the sentence where I lost my attention and re-read passages again. But within a

couple of sentences I again lose my awareness/attention. This is a major problem for me. This was not the case in the past.

Similar difficulties arose when participants tried to watch movies or television programs. Often, they would lose focus or forget what had happened earlier in the storyline. However, it was not the loss of these activities per se that the participants found the most difficult. Rather, it was the lack of respite from their condition that these activities would normally have provided. As one young man explained:

There is no escape. I try listening to music, I try to sit and watch television or movies, I try to read, but I can't concentrate, and I can't remember anything. I get lost in the story. I attempt to escape my mind but I cannot. Nothing works.

The suffering associated with Walking Corpse Syndrome can be profound. In the interviews, it was commonly associated with mental health problems, including depression, social isolation, and anxiety. It was also linked to suicidal thoughts. As one man described:

My mind has shrunken. It is always in a weak and flaccid state. I cannot work. I cannot lead my wife and children. I fail at everything I do. Surely the agony of death is less severe than the sufferings that I persistently experience.

**Coping strategies.** Participants outlined a broad range of self-treatment strategies for Walking Corpse Syndrome. Many used calming exercises, such as yoga and meditation, to help reduce the stress and anxiety that they associated with their symptoms. Others associated Walking Corpse Syndrome with an overheated somatic state and attempted to lower their body temperature, often through cold baths and cold head presses. As one participant explained: "I take many cold baths to cope with my [cognitive] difficulties, often several times a day. I am always too hot." Participants also used alcohol and tobacco to calm their minds and cope with the various life stresses associated with their disorder. While they worked in the short term, many felt that these substances ultimately increased their body temperature. As one man explained: "I didn't drink or smoke before the war, but now I do heavily. These habits help me to relax, but they are not good for me. They contribute to the heat in my body."

### Vignettes of Walking Corpse Syndrome

**Vignette 1. Thavam.** 62-year-old Thavam has a complex trauma history. As a member of Sri Lanka's Tamil minority, he suffered through the horrors of the long and drawn-out Sri Lankan civil conflict. During the war, Thavam's home and business were repeatedly destroyed and he and his family were displaced on multiple occasions, often for months at a time. Two of his daughters died during separate periods of intense government shelling. Like many civilian men, Thavam was detained and heavily tortured by the Sri Lankan Security Forces. This torture left him permanently physically and sexually disabled. After a year in an internment camp in Sri Lanka, Thavam made his way to Canada as a refugee. There, he experienced a number of resettlement stressors, including acculturation difficulties, mental health problems, and unemployment. He is highly worried that he will not be able to provide for his wife and surviving daughter. He also carries profound feelings of guilt and shame that, as a father, he was not able to protect his two daughters who died during the war.

Since arriving in Canada, Thavam has noticed that his mind has become increasingly "flaccid" (*thalarvu*) and "weak" (*nalivu*). He has difficulty remembering details, gets confused easily, and has difficulty concentrating. As he describes, his thinking is "superficial" (*aalamillaatha*) and "shallow" (*soorntha*), and he feels as though he is "acting impulsively" (*saduthiyaana unthuthalin meethu seyathpaduthal*) without any cognitive or emotional depth. Recently, Thavam gave up riding his bicycle, as he found he would often fail to observe the rules of the road and was increasingly getting into trouble with motorists and pedestrians. It was also common for him to start out on an errand and then forget where he was going. He has also noticed some somatic changes, namely, an increase in body temperature. He describes himself as perpetually overheated. The flaccidity and weakness of his mind have impacted his identity, as they have affected his ability to help and support his family. This is particularly devastating because he prided himself on his ability to care for his family. He worries about their wellbeing and is ashamed of his shortcomings.

Periodically, Thavam experiences acute episodes where, as he describes, his mind becomes "frozen" (*urathal*). During these times, he loses all situational awareness, cannot form thoughts, and cannot find or organize his words to speak. As he describes it, his head feels "completely empty" (*muluverumai*). Thavam attributes both these general cognitive difficulties and acute episodes to the prolonged psychological trauma that he experienced during the war and to his worries about his family.

Thavam tries to meditate and do yoga to calm his body, but intrusive memories and worries make this difficult. His most helpful coping strategy involves long cold baths, which he takes up to three or four times a day. These baths help to reduce stress and lower his body temperature. Despite these efforts, Thavam feels that his condition is becoming steadily worse. If it does not get better, he fears that he will eventually lose his cognitive capacity altogether and end up completely debilitated.

**Vignette 2.** Bernard. 41-year-old Bernard has had trouble maintaining employment. His most recent job was as a line cook at a breakfast restaurant. However, as had been the case with his previous jobs, after only a few months, his employment was terminated. Bernard is married with three children and constantly worries that he will not be able to provide for his family. He is deeply ashamed and feels as though he is continually failing in his role as man.

Since arriving in Canada four years earlier, Bernard's cognitive capacity has been steadily declining. He cannot remember details, such as dates or telephone numbers, he has trouble remembering if he has completed tasks, and he has great trouble following directions. His concentration has also declined dramatically. He cannot focus on tasks for more than a few seconds and abandons them without awareness.

Bernard blames his disorder for his recent loss of employment. He was constantly mixing up orders and making mistakes. On several occasions, he arrived at work having forgotten to shave, shower, or brush his teeth. He also has trouble following conversations and often forgets what had been said earlier. These difficulties have made it impossible for him to join in the camaraderie of the workplace, and he often has felt alienated. On his way to work, he also commonly becomes disoriented, getting on the wrong bus or taking the subway in the wrong direction. On such occasions, he would either show up to work very late, or simply go home out of embarrassment. When his boss questioned him about his absence, he would claim that he was physically unwell.

Like other Sri Lankan Tamils, Bernard experienced multiple intense traumas during the war. His two younger brothers were forcefully recruited into battle by the LTTE and were subsequently killed. On multiple occasions, Bernard and his family were caught in intense periods of shelling between the SLF and the LTTE, in which they witnessed unspeakable traumas. At the end of the war, they were detained for eight months in an internally displaced camp in Sri Lanka, where Bernard was tortured. Several months after the war ended, he also found out that his wife and one of his daughters had been sexually abused by the guards at the camp.

Bernard feels responsible for his wife and daughter's sexual assault. He feels as though he failed in his obligation as husband and father to protect them. He also feels intense guilt about leaving family members behind in Sri Lanka. Following tradition in Sri Lankan Tamil culture, as the oldest surviving son, Bernard is responsible for his elderly parents and sisters. He worries constantly about their wellbeing and safety in Sri Lanka. Bernard attributes his disorder to worries and guilt and to the traumas that he experienced during the war. As he describes it, worries and memories of past traumas have "exhausted" (*thuurnthupoathal*) his mind.

Bernard is aware of his limitations and is deeply concerned about them, but he does not know how to cope with his condition, which he feels is becoming worse. Over the past several years, he has developed a drinking habit and has become a heavy smoker. He is aware that these behaviours are problematic: they are addictive and make him short-tempered. They also increase his body temperature, which he believes makes his cognitive symptoms worse. Despite this, he doesn't feel that he can stop; they are the only things that control his worries, anxiety, and intrusive memories from the war.

**Vignette 3.** Sivam. Sivam is a 38-year-old father of two who owned a transportation business in the north of Sri Lanka. During the war, Sivam was detained and heavily tortured on two different occasions by the SLF. Out of fear for his life, he was forced to leave his wife and children and flee the country. He travelled first to India, and eventually ended up as a refugee in Canada.

Sivam suffers from flashbacks and nightmares that stem from his torture experience. However, his central mental health complaint surrounds what he describes as "sluggishness" (*mantha*) or "numbness" (*maraththa*) of the mind. His memory and concentration have declined, and as a result, he has trouble following conversations. He often forgets what has been said and finds that he repeats himself. He also has difficulty organizing words and topics in sentences, and often he mixes up his words. Before the war, Sivam enjoyed reading. However, when he tries to read now, he cannot focus. He ends up reading the same sentence over and over without awareness and gets lost in the plot. The same thing happens when he tries to watch movies. As a result of his condition, Sivam does not work. He spends his days mindlessly watching daytime television. Sivam has also become socially isolated. He has no friends and mostly remains in his apartment, leaving only for essentials. When he does go shopping, it tends to be late at night, when there is less risk of running into someone he knows.

Sivam also experiences what he describes as “attacks” where his mind becomes “frozen” (*uraithal*). He describes how, during these times, his mind feels completely blank, filled only with white space. His most recent attack came on a trip to the grocery store. Seemingly out of nowhere, he lost awareness of where and who he was. He could not form any thoughts. He sat on the sidewalk with his bicycle for several hours before he could reorient himself and make his way back home. Sivam finds these attacks terrifying and is highly anxious about the next time one will happen.

Sivam attributes both his general condition and acute episodes to the traumas that he experienced in Sri Lanka and to his anxiety over the family he left behind. He constantly worries about his family’s safety and wellbeing, particularly that of his wife and children.

Sivam has considered going to a mental health professional, but fears that he will not be able to form the thoughts and sentences that would be necessary to convey his feelings and ideas to a therapist. He is also terrified that discussing the trauma that he experienced in Sri Lanka will itself prompt an acute attack. Sivam practices yoga and meditation in an attempt to calm his mind. He also applies cold head compresses, which he makes out of tea towels soaked in cold water. These head wraps help to lower his high body temperature, which he feels is connected to both his general state of mind and to his acute attacks.

## Study II: Tamil psychiatrists’ view of Walking Corpse Syndrome

### Methods

The second study involved an open-ended interview questionnaire that was electronically administered (via email) to six Tamil psychiatrists residing in the North of Sri Lanka who lived and practiced during the war and post-war periods with populations affected by the war. Interview questions pertained to beliefs about the existence, parameters, causes, vulnerabilities, symptoms, and expected remedies of Walking Corpse Syndrome. Questions included: “What are the terms that Tamil people use to describe this symptom pattern?”, “Who typically develops *nabaippinam*?” and “How do you treat *nabaippinam*?” Ethics approval for this study was obtained from the University of Jaffna, Sri Lanka. This study used purposive sampling method. Participants were recruited by the second author (UT) a psychiatrist who works in the North of Sri Lanka. Analysis used the method of Braun & Clarke (2013) and followed the same steps as Study I, outlined above.

### Results

The psychiatrists’ accounts of Walking Corpse Syndrome were organized into five symptom dimensions: syndrome characteristics, explanatory model, epidemiological profile, relation to DSM disorders, and treatment. These symptom dimensions are outlined below.

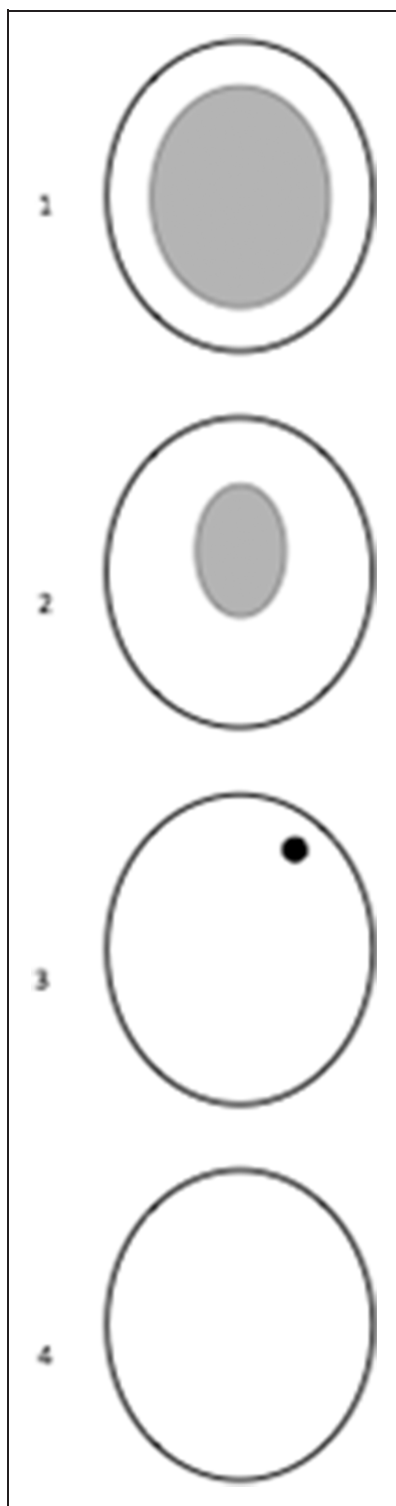
#### Syndrome dimensions

**Syndrome characteristics.** According to the psychiatrists who were interviewed, Walking Corpse Syndrome (*nabaippinam*) is a common disorder that is often found amongst those who survived the conflict. It consists of both an acute and chronic state. The chronic state is characterized by cognitive confusion and decline, with a pattern of symptoms that resembles those of early onset dementia. Behavioural changes, such as diminished self-care, social isolation, and increased agitation, and disagreeableness are also commonly observed.

Acute states are characterized by disassociation and “*manakkulappam*” – the abrupt loss of coordinated thinking or awareness of thought that manifests as an intense (and often terrifying) sensation that the head is completely blank or empty. According to the psychiatrists, such attacks are often accompanied with periods of excessive sweating and agitation and can last anywhere from an hour to a number of days. During such attacks, individuals can be seen to stare blankly or to repeatedly perform the same actions. Patients can also act aggressively or violently, but will have no recollection of doing so.

**Explanatory model.** According to the psychiatrists, Walking Corpse Syndrome results from prolonged exposure to war, excessive worries – which one psychiatrist unprompted referred to as “thinking too much” – and what is known as “traumatic guilt” (*manavadukku-travumarvu*), a concept that entered the Tamil lexicon during the war that refers to the specific feelings of shame and guilt that arise from the inability to adequately protect and provide for loved ones. In the explanatory model that was offered by psychiatrists, war-trauma, worry, and traumatic guilt work to effectively shrink the mind of the individual. One of the psychiatrists offered the diagram depicted in Figure 1 to illustrate this process.

Following this account, with prolonged trauma exposure, the normal mind (first image) becomes shrunken (second image). Eventually, the mind will narrow to the point where cognitive and emotional functions are lost, and only basic sensory and motor control remains (third image). This can lead to an individual’s feeling that they are functioning reflexively and



The developmental pattern of Walking Corpse Syndrome: Image 1 shows the normal mind. With trauma exposure the mind becomes smaller and smaller (Image 2 and 3), reducing cognitive, emotional and basic sensory functions. During an acute episode, the mind disappears completely and all functions are lost (Image 4).

impulsively, without awareness. During acute episodes – which, according to the psychiatrists, are brought about by “abrupt and extreme” periods of worry and stress (what could be called episodes of “thinking a lot”) – the mind disappears completely, and even basic motor functions are lost (fourth image). As the psychiatrist who sketched the explanatory diagram described, during acute episodes, “there is no mind, no thinking, no comprehension, no mind at all”.

**Epidemiological profile.** The psychiatrists explained how Walking Corpse Syndrome is most commonly found in men, particularly family men. In Sri Lankan Tamil society, traditional gender norms dictate that men are primarily responsible for the safety and wellbeing of the family and community. Hence, men tend to carry greater levels of worry – and higher levels of traumatic guilt in cases where their families were injured or killed in the war. However, Walking Corpse Syndrome can also be found in women, particularly women who are responsible for the wellbeing of young children.<sup>1</sup>

**Relation to DSM disorders.** Although Walking Corpse Syndrome is commonly found alongside typical trauma-related disorders, including depression and PTSD, according to the psychiatrists, it is a distinct illness category that falls outside the official psychiatric classifications found in the DSM and ICD. As one psychiatrist explained, “*Nabaippinam* crosses many diagnostic boundaries. Clinically it does not fit with any one type of common mental disorder such as somatoform disorder, depressive disorder or anxiety disorder.”

The psychiatrists described how, unlike in the case of depression, an individual suffering from Walking Corpse Syndrome does not necessarily experience low mood or depressive thoughts. Likewise, although it is believed to be linked to intrusive memories, unlike PTSD, Walking Corpse Syndrome does not necessarily include symptoms of hyper-arousal or avoidance.

**Treatment.** The psychiatrists outlined a number of treatment options for Walking Corpse Syndrome. These included anti-anxiety medications (benzodiazepines), anti-depressants (fluoxetine, citalopram), cognitive behavioural therapy (CBT), calming exercises like meditation and yoga, and psychosocial education on the emotional and psychological effects of trauma, worry, and traumatic guilt (*manavadukku* *travunarvu*). Several psychiatrists also described their attempts to educate patients about the pressures associated with traditional masculine gender norms. However, each psychiatrist explained how these treatments were less effective for Walking Corpse Syndrome than for other common mental disorders such as anxiety, depression and PTSD. As one psychiatrist explained: “I treat these



patients for depression and PTSD with antidepressants, benzodiazepines, and CBT. However, their response to treatment is poor.” According to the psychiatrists, even when they are treated, individuals suffering from Walking Corpse Syndrome are more vulnerable to serious chronic illnesses, such as hypertension, carcinoma, renal failure, and cardiac complications. They are also much more likely to be involved in accidents. As a result, individuals suffering from Walking Corpse Syndrome tend to have high rates of physical disabilities and mortality in general. As one psychiatrist explained, “most of those suffering from *nabaippinam* here die prematurely”.

## Discussion

In this article, we have tried to show how Walking Corpse Syndrome acts as a key idiom of distress among Sri Lankan Tamil survivors of mass trauma. In idioms of distress, culturally validated elements ‘run together’ to form a relatively coherent whole that reflects beliefs about causes, vulnerabilities, symptoms, and expected remedies (Good, 1977, 1994). Thus, in order to properly understand an idiom of distress like Walking Corpse Syndrome, it is important to examine the salient metaphors and ideas about the functioning of the body and mind shared by members of the local culture (Good, 1977; Kirmayer, 1993).

Walking Corpse Syndrome shares similarities with other trauma-related idioms of distress that have been identified in Tamil Sri Lanka. For instance, Somasundaram (2010) discusses *thihaiththupona*, a “dazed state” found amongst Tamil civilian populations after the war. Likewise, Sivoyokan (2011) identifies a number of head- or mind-related idioms that Tamil people use to express the psychic pain that results from psychological shock and trauma, including *thalaiviraikkuthu* or “numbing of the head”, *manamthuddikkuthu*, or “mind is jolting”, and *thalaichutrutu* or “head is rotating”.

Walking Corpse Syndrome shares similarities with other disorders that are commonly found in the aftermath of mass trauma, such as Survivor Syndrome found in survivors of Hiroshima (Lifton, 1967) and the Nazi concentration camps (Raphael, 1986). Indeed, in describing Survivor Syndrome in the aftermath of Hiroshima, Lifton (1967) uses similar metaphors as Walking Corpse Syndrome: “They seemed to live a half-life, as though they were ‘walking corpses’ or the living dead.” (Lifton, 1967: 92).

Walking Corpse Syndrome would seem to be an example of a syndrome of “thinking a lot”. This is a local idea of what happens when one thinks a lot, which may involve worry, trauma recall, or other dysphoric cognitions. Similarly, Cambodians believe that

“thinking a lot” results in mind disturbance, including a state of forgetfulness and poor attention to which they refer as “floating mind”. In this condition, a person ruminates on negative topics, such as worries, depressive themes (such as past failures), and traumatic events – to the point where their attentional focus is not strong enough to attend to the present moment and instead “floats” to various concerns and past traumas (Hinton et al., 2015).

Walking Corpse Syndrome also shares a number of key symptoms with “Brain Fog”, a debilitating stress-related syndrome found amongst high school and college age students from Nigeria. In this disorder, excessive worry and stress about academic achievement, results in difficulties concentrating, the inability to grasp or remember what has been read or spoken, feelings of vacancy in the head, and episodes of disassociation, in which individuals report becoming oblivious to their surroundings (Prince, 1960; Essien, Okafor, Okegbe, & Udofia, 2017).

Walking Corpse Syndrome can also be situated in the context of Tamil medical traditions. *Ayurveda* is a system of philosophy and medicine that has been used for thousands of years and remains widely practiced in India and Sri Lanka. Deeply embedded in the Hindu religion and culture of its origins, Ayurveda is both a reflection of that culture in areas of health and medicine and a determinant of beliefs and practices that affect many other facets of life, including diet, hygiene, and lifestyle (Weiss, 2003).

Like other systems of philosophy and medicine, Ayurveda has its own unique theory of the mind. In the classic Ayurvedic system, the mind has four distinct yet inter-dependent functions: *Indriyabhigraha*, the sensory and motor functions; *svasyanigraha*, control of these functions; *uha*, the ability to produce perception by combining the sensory organs, the motor functions, and the soul (*manas*); and *vicara*, the ability to interpret (deliberate, judge, discriminate) information gleaned from the first three functions (Obeyesekere, 1977).

Within the Ayurvedic system, there are three elements, which appear in the body as humours. Wind (*vayu*) is universal within the body, fire appears as bile (*pitta*), and water appears as phlegm (*kapha* or *slesman*). Health is maintained when the three humours are in harmonic balance, but when they are upset, they become *dosas*, or “troubles” within the body. When one of the humours is “angry” or excited, it increases in proportion to the other humours. Illness and disease result from these three humours being out of balance (Obeyesekere, 1977).

Like other diseases, mental illness (*ummada*) and impairments to mental functioning are believed to have physical causes. In classic Ayurveda, the mind (and the self) is located in the heart rather than the

brain. Following this conceptualization, the majority of mental illness (*ummada*) arises when the heart does not function efficiently, because the ducts (*sira*) and the channels (*dhamani*) that carry the humours (*dosas*) and vital elements (*dhatu*s) to that organ have failed to function satisfactorily. In this sense, as Obeyesekere (1977) explains, because mental illness is rooted in physicality, the majority of mental conditions are considered somatopsychic (i.e., psychological expressions of a somatic disorder) rather than psychosomatic (i.e., somatic expressions of a psychic disorder). The exception to this rule is the case of grief, anxiety, and psychological shock (trauma). Such experiences produce heat in the body, creating an excess of *pitta* (bile) in relation to the other humours. Thus, disorders that result from grief, shock, and anxiety are classified as *va-pit ummada* (madness caused by pitta) and/or *rat-pit ummada* (madness caused by blood and bile). According to the Ayurvedic explanatory model, these experiences have the effect of heating the body, which, in turn, forces bile and blood upwards towards the heart, affecting mental functioning (Weiss, 2003).

As in all other widespread systems of thought, beliefs within Ayurveda vary geographically and cross-culturally. In Sri Lanka, the *nilammaara* tradition combines classic Ayurveda with Sri Lanka's local religious traditions. Unlike classic Ayurveda, in the *nilammaara* tradition, the mind is located in the brain, rather than the heart.<sup>2</sup> Other than this re-location of the mind, however, the Ayurvedic explanatory model of mental health remains unchanged: mental illness is attributed to physical processes; only now, instead of affecting the heart, it affects the brain. Likewise, the experience of trauma (grief, anxiety, and emotional shock) heats the blood and bile, which then rise to the brain (as opposed to the heart), resulting in an increased body temperature and in mental illness (Obeyesekere, 1977).

In Ayurveda, mental illness (*ummada*) is recognized based on a number of premonitory symptoms, which include hypertension, long- and short-term memory loss, incorrect judgements due to anxiety, loss of cognitive function, and feelings of "emptiness of the head" (Venkataram, 2003; Fernando, 2010). To reach a diagnosis, an Ayurvedic practitioner will interpret symptoms in terms of the conception of mind and humoral theory of illness that was outlined above (Weiss, 2003). Ayurvedic treatments of psychological and psychosomatic/somatopsychic disorders reflect the Ayurvedic understanding of mind and illness, and include the calming of the mind, either through meditation and yoga (Venkataram, 2003), or via the use of herbs and tonics (Varier, 2004). In the case of trauma disorders (*va-pit ummada*), which result from the heating of bile and blood, additional measures are taken to

cool the body, either through foods, herbs and tonics, or through external stimuli (Obeyesekere, 1977).

Many elements of the Ayurvedic tradition can be seen in the accounts provided by the participants in Study I. The symptoms that were described by participants, such as cognitive difficulties, mindless mistakes, poor memory, and sensations of having an "empty" or "blank" head, correspond well to the Ayurvedic diagnostic criteria for mental illness. Likewise, participant's accounts of being "hot" and "over-heated", and the coping mechanisms that they detailed, such as yoga, meditation, and external cooling methods, correspond to the Ayurvedic explanatory model of how emotional or psychological shock (trauma) affect the body and the mind and with the Ayurvedic treatment approaches to trauma related disorders (*va-pit ummada* and *rat-pit ummada*).

The Ayurvedic conception of the mind can also be seen in participants' accounts of how they cannot register events or experiences, and how they act on "auto-pilot" superficially, without any emotional or cognitive depth or abilities. These symptoms reflect the Ayurvedic understanding of the mind, according to which the functions associated with the self, such as reasoning, deduction, and emotional engagement, are lost in Walking Corpse Syndrome, and only basic bodily functions, such as sensory and motor controls (*indriyabhigraha*), remain.

The Ayurvedic conception of mind can also be seen in the psychiatrists' accounts of Walking Corpse Syndrome outlined in Study II, specifically, in the explanatory model that they described. According to this model, trauma exposure and excessive worry shrinks the emotional and cognitive functions of the mind (*vicara*, *uha*, and *svasyanigraha*), leaving only the basic motor functions (*indriyabhigraha*). During the acute episode of Walking Corpse Syndrome, all four functions are lost.

## Limitations

The studies presented in this article have a number of limitations. For example, Study I used a secondary analysis approach, and the data that was analyzed was not specifically collected to address the existence or parameters of Walking Corpse Syndrome. As a result, it is likely that some variables that are important to the discussion may have been missed. This could have affected the interpretation of the data and ultimately the study's findings. However, we believe the risk to be minimal. The second author (UT) is a Sri Lankan Tamil psychiatrist with extensive experience working with war-affected Sri Lankan Tamil populations. He confirmed the team's interpretation of the data of Study I, as did our Sri Lankan Tamil colleagues

and the psychiatrists who were interviewed in the Study II.

Study II also had limitations. Due to logistical challenges associated with the Sri Lankan civil war, interviews could not be conducted in person. Rather, participants replied to the interview questions in writing. This likely resulted in a less nuanced dataset, because the researchers could not probe participant's responses to the same extent that they could in a face-to-face interview.

Lastly, neither study stratified for important factors such as age, sex, and caste, which could affect how Walking Corpse Syndrome is understood and experienced. To address these limitations, future research should undertake a more robust and systematic examination of Walking Corpse Syndrome, paying particular attention to the stratified experience within and between different sub-groups of the Sri Lankan Tamil population.

## Conclusion

In recent decades, Sri Lankan Tamils have been one of the most widely displaced populations in the world. Due to cultural differences and complex trauma histories, Sri Lankan Tamil patients can present a challenge to mental health workers in resettlement countries. This article has outlined Walking Corpse Syndrome, a common idiom of distress in Tamil Sri Lanka that is characterized by a variety of cognitive difficulties, feelings that an individual is functioning reflexively or impulsively, and acute attacks of dissociation that are accompanied with the sensation of empty-headedness and blank-mindedness. This syndrome does not correspond with official diagnostic categories outlined in the DSM and the ICD. By relying on these diagnostic manuals, mental health clinicians working with Sri Lankan Tamil populations may overlook key symptoms or otherwise skew the nature of patient's experience. Probing for Walking Corpse Syndrome and understanding the explanatory model that underpins this disorder can go a long way in improving the treatment experience and ultimately clinical outcomes of Sri Lankan Tamil patients. The current study further suggests that in certain cultural contexts, syndromes can focus on loss of attentional capacity and forgetfulness. It adds to the literature on the importance of "thinking a lot" as an idiom across cultures, and suggests the many ways that Walking Corpse Syndrome is a key experience-near idiom of distress to assess to give adequate care to Sri Lankan Tamil populations.

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## Notes

1. One psychiatrist outlined an important caveat: because of strictly defined gender roles within Tamil Sri Lankan society, frozen mind in men can have more urgent consequences for men than women, as it can affect the material wellbeing of the family. Likewise, due to gendered social structures that keep women indoors and men outdoors, men are more visible than women. For these reasons, families might be more willing to act in the face of social stigma and seek professional help for a male family member, and correspondingly be less likely to seek help for a female family member.
2. Bhela, one of Ayurveda's classic theorists, also located mental illness in the brain, not in the heart (Dasgupta, 1968: 340).

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