

**“A SINKING HEART”: BELIEFS OF DISTRESS IN THE PUNJABI
COMMUNITY**

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A thesis submitted in partial fulfillment of the requirements of the
University of East London for the Doctoral Degree in Clinical
Psychology

May 2016

“When the mind is cleaned with the jewel of spiritual wisdom, it does not become dirty again.”

- Guru Granth Sahib Ji

ABSTRACT

As the challenge of providing culturally appropriate care in the NHS becomes more apparent there is more research being invested into looking at the relationship between mental health and culture. Due to migration numbers, there is particular growing interest in the mental health of South Asians who significantly underutilise mental health services. There are several known barriers to access including stigma and shame, fear of breaching confidentiality, and perceiving Western services as being culturally incompetent. The term 'South Asian' is often used to refer to individuals who originate from countries of the Indian subcontinent: India, Pakistan, Sri Lanka, Bangladesh, Nepal, Maldives, and Bhutan. Current literature assumes that all needs of the South Asian community are the same. Hence this term is problematic; used to represent a range of beliefs, practices, religions, and cultures.

This study focused specifically on the Punjabi Sikh community in the UK and sought to explore beliefs about psychological wellbeing and an understanding of mental health issues. Eight Punjabi Sikh members of the community were interviewed; participants were a non-clinical population and had not accessed mental health services prior to this research. A thematic analysis was conducted and three themes were identified; 'We are Warriors!', 'The Importance of Family Expectations', and 'Understanding Mental Health Issues'.

Findings suggested that the Punjabi Sikh community may not perceive mental health services as being relevant to them as they believe they do not suffer from 'ill mental health'. Psychological wellbeing was believed to be an integral part of a Punjabi Sikh lifestyle that Punjabi people already practise. This community is also likely to be strongly influenced by their Sikh history and believe they are capable of managing hardships without the input of external services. The research concludes with some methodological considerations and implications for clinical practice.

ACKNOWLEDGMENTS

Firstly, I would like to thank those who participated in this study, I am grateful to you all for giving me your time and sharing your experiences with me. I hope your stories will help in increasing awareness of mental health issues in the Punjabi community.

A big thank you to Dr Claire Higgins for all your guidance, encouragement, and support. Your enthusiasm for my research kept me going until the end!

I would like to dedicate this thesis to my Granddad who unfortunately did not get to see me complete this course. A big thank you to my family and friends for supporting me throughout the doctorate, I could not have completed this journey without your faith and words of encouragement, a special thank you to my sister Sandeep who helped me endlessly.

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CHAPTER ONE: INTRODUCTION

This chapter begins by defining a number of terms used throughout the study; this will help orientate the reader to the language being used. A description outlining some of the issues faced by Black and Minority Ethnic (BME) communities when accessing mental health services are then explored. Before examining the particular barriers faced by the South Asian population, the researcher presents an overview of the cultural beliefs and values held specifically by the Punjabi Sikh community, with a closer look at the Sikh religion and theories of acculturation. Following this the researcher considers both Western and alternative understandings of mental health issues. The chapter concludes with the rationale and aims of the current study and highlights the need to provide culturally sensitive practice to the Punjabi Sikh community.

1.1. Terminology

'Race' is a social construct used to define a group of individuals who share distinct physical characteristics (Owens & King, 1999). However, the term 'race' becomes problematic when certain social groups are treated as superior and have access to power and resources that are not available to other groups (Department of Health & Human Services, 1999). 'Ethnicity' refers to a common heritage shared by a particular group (Zenner, 1996) and gives people a sense of belonging (Fernando, 1991). 'Culture' is "the shared history, practices, beliefs, and values of a racial, regional, and religious group of people" (D'Ardenne & Mahtani, 1999). The term is viewed as dynamic and used to describe differences between groups of people. The researcher later deconstructs the concept of culture, which is influenced by language and context, and may not represent a shared set of values and beliefs.

In the UK, the term 'BME' is used to describe people of non-white descent (Institute of Race Relations, 2015). This term can be used to refer to White *minorities* too, however for the purpose of this research the term will refer to the

definition from Race Relations. The term 'Western' commonly refers to people from the United Kingdom, United States of America, Australia, New Zealand, and Europe. The term implies people of Western culture are the dominant White majority and is often portrayed as the ideal when compared to other cultures (Patel, Bennett, Dennis, Dosanjh, Miller, Mahtani, & Nadirshaw, 2000, p. 33).

'Mental health' can be described as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively...and is able to make a contribution to her or his community" (World Health Organisation, WHO, 2014). 'Mental illness' on the other hand refers to different clinical presentations characterised by "a combination of abnormal thoughts, perceptions, emotions, behaviour, and relationships with others" (WHO, 2015). Most research takes this position and is aligned with the medical model of illness. The researcher challenges this medical view and believes psychiatric diagnoses should be abandoned and that clinicians should work with presenting 'symptoms' within the context of the individual (see the work of Bentall, 2006). "Psychological Wellbeing is usually conceptualised as some combination of the affective states such as happiness and functioning with optimum effectiveness in individual and social life" (Deci & Ryan, 2008). The authors that coined this term are Canadian and the researcher acknowledges 'psychological wellbeing' may be constructed differently in different contexts. The researcher adopted this broad term hoping to encapsulate a range of cultures without being reductive.

1.2. BME and Healthcare

In the UK, a range of research findings in healthcare settings indicate that people from BME communities encounter disadvantages and discrimination when seeking the healthcare that they are entitled to (Mir, Nocon, Ahmad, & Jones, 2001; Alexander, 1999; Butt & Mirza, 1996). According to the Office of National Statistics (ONS) (2012), BME groups comprise 15.8% of the total UK population, and are more likely to be unemployed and live in under-developed geographical areas. As

a result, they are often under-represented and discriminated against in healthcare (Daker-White, Beattie, & Means, 2002; Social Exclusion Unit, 2000).

'Inside Outside: Improving Mental Health Services for BME Communities in England' (National Institute for Mental Health in England, 2003) reported those from BME communities are more likely to suffer poorer health and face greater difficulties when accessing healthcare. The consequence of discrimination on the health of minority groups has been well documented (Johnson 1993; Karseras & Hopkins 1987). Evidence demonstrates that this has arisen for a number of reasons including; poor socio-economic status, language barriers, and discrimination (Rahman, Palmer, Kenway, & Howarth, 2000). Even after overcoming the barriers to access, they are more likely to experience poorer treatment outcomes and negative experiences from healthcare professionals (National Institute for Mental Health in England, 2003).

In the past, policy makers and service providers have taken the 'colour-blind' approach that assumed BME service users could be integrated into existing healthcare service provisions. Since then it has been acknowledged that the NHS need to be aware of the diverse needs of BME communities and provide a more culturally sensitive approach (Commission for Race Equality, 1997). The Acheson report (1998) reiterates that "equality was a founding principle of the NHS and is central to Government policy". Within mental health services specifically, there are initiatives to promote race equality; the Department of Health (DoH) (1999, 2005) implemented the 'National Service Framework' and 'Delivering Race Equality' to challenge the inequalities people experience. This framework indicates that all services must address the diverse needs of all ethnic groups. The NHS has a professional and ethical duty to provide equitable healthcare "irrespective of gender, race, disability, age, sexual orientation, religion, or beliefs" (NHS Constitution for England, 2009). Thus, as well as upholding a professional responsibility, clinical psychologists working in the NHS are required to follow procedures and protocols in line with UK legislation (Equality Act, 2010).

1.2.2. BME Population in the UK

The BME population in the UK is diverse and ever-changing. The 2011 Census¹ found that 14% of the population of England and Wales belongs to a BME group; South Asian was the largest BME subgroup with 1.4 million people (2.5%). Those who consider themselves as White British has decreased in size from 91.3% in 2001 to 86% in 2011 despite being the dominant ethnic group. This can be partly attributed to the ageing population of White British which is estimated to have more over 60s than under 16s (Greene & Kirton, 2009). However, the predominant driver of this population change may be due to the increase in international migration in recent years (Census: 'Ethnic group, local authorities in the United Kingdom', 2011). It is important to note that there could be numerous reasons for this, such as historic, commonwealth ties, legislative changes, personal, economic, and cultural events. It could also be related to international politics, events, and conflicts (2011 Census Analysis: Ethnicity and Religion of the Non-UK Born Population in England and Wales, 2015). International migration has also had an impact on the number of births in the UK over recent years. In 2006, 21% of births in the UK were to mothers born outside the UK. The largest groups of mothers born outside the UK were those born in Pakistan, India, and Bangladesh, who together accounted for 5% of all births in the UK in 2006 (Dormon 2014; Tromans, Natamba, & Jefferies, 2009).

The 2011 Census also revealed that those who identify with a 'White Other' category have increased from 58,000 to 570,000 between 2001 and 2011. This data included a high number of Polish-born people reflecting the large impact that the expansion of the EU in 2004 has had upon demographics in the UK. In addition to migration numbers, those with a dual-heritage are the fastest growing ethnic group in the UK and numbered 1.25 million in the 2011 Census. It has been estimated that by 2020 there will be 1.4 million people in the UK that are of dual heritage (Census: 'Ethnic group, local authorities in the United Kingdom', 2011).

¹ At the point of research this was most recent Census carried out

1.3. Punjabi Sikhs: A Cultural and Historical View

1.3.1. Punjabi Sikhs: The Origins

The Punjabi community originates from the Punjab; a region spread over Northern India and Eastern Pakistan. The Punjab, known as the 'land of five rivers', is made up of two Persian words; *Panj* meaning five and *Aab* meaning water. The predominant religion practiced by this community is Sikhism; a religion founded by Guru Nanak Dev Ji in 1499 AD (Grewal, 1990). He aspired to create a casteless society where all individuals were believed to be the children of God and were therefore equal (Singh, 1987).

The term 'Guru' means Teacher and Guru Nanak's most important message was 'Human Rights for all'. Guru Nanak was followed by nine consecutive Gurus. The second, Guru Angad Dev Ji, advocated the concept of voluntary service and helping those in need (*sewa*)². The third, Guru Amar Das Ji, created community kitchens, (*langar*), that were open to all without prejudice. This allowed everyone to sit together and eat food prepared in the communal kitchens promoting equality and bringing humility. The fourth, Guru Ram Das Ji, continued the traditions of his predecessors and established the township of Ramdasapur, today named the holy city of Amritsar. It is considered the principle city and headquarters of Sikhism today. The fifth, Guru Arjun Dev Ji, highlighted the concept of tolerance and martyrdom. This Guru ultimately achieved martyrdom himself when he was tortured to death in the river Ravi by the Mughal Emperor Jahangir. The sixth, Guru Hargobind Ji, is remembered for initiating a military tradition within the religion to resist Islamic persecution and protect the freedom of religion. The seventh, Guru Har Rai Ji, considered the "gentle Guru" often healed animals spreading the notion that all living things bore a soul. The eighth, Guru Harkrishan, was the youngest Guru aged just five years old. His untimely passing came as a result of contracting smallpox after helping others during a smallpox epidemic in

² Selfless service performed without any expectation of result or award for performing it. It is an important aspect of Sikhism to dedicate time into providing a service to others

Delhi. The ninth, Guru Tegh Bahadur Ji, sacrificed his life to save the Hindu religion from persecution by the Mughal Emperor Aurangzeb. He taught Sikhs that helping the less fortunate may sometimes come at the cost of their own lives. The tenth, Guru Gobind Singh Ji, introduced many of the customs that Sikhs practise today. In 1699 AD during the annual harvest celebration of Baisakhi 'The Khalsa' (The Pure Ones) was created; this represented five baptised Sikhs who gave their allegiance to continue the teachings of the Gurus (Singh, 1987).

During the Basakhi celebration Guru Gobind Singh had addressed the congregation and urged the Sikhs to take a pledge to lead a pure life as taught by the other nine Gurus. As he drew his sword he asked for a volunteer who was willing to sacrifice his head. No one answered his first call until the third invitation, when a person called Daya Ram came forward and offered his head to the Guru. Guru Gobind Singh took the volunteer inside a tent, and emerged shortly, with blood dripping from his sword. He then demanded another head. One more volunteer came forward, and entered the tent with him. The Guru again emerged with blood on his sword. This happened three more times. Then the five volunteers came out of the tent unharmed. These five, who were willing to sacrifice their lives for their Guru, became known as the 'the five beloved ones'. The word Khalsa translates as 'sovereign' and the five that were brave enough to put themselves forward as a sacrifice were considered to have the will and strength to fight oppression.

It was at this ceremony, Guru Gobind Singh also announced there was no difference between the Guru and his disciplines abolishing all existing social divisions as was fundamental in the teachings of Guru Nanak. In creating The Khalsa, Guru Gobind Singh was considered to have transformed the Sikh faith into a warrior community. Giving the name 'Singh' to all males and 'Kaur' to all females to be used after their first name, he created a sense of unity and strength among the Sikhs, and encouraged Sikhs to defend their religion.

Guru Gobind Singh was only nine when he became the Tenth Sikh Guru. He was considered a great warrior and a spiritual leader. He had spent most of his time fighting against the oppression and destruction committed by unjust forces in Punjab. He fought for righteousness and sacrificed his all for human liberty and equality. In 1708, Guru Gobind Singh declared that the Holy Scriptures in the Guru Granth Sahib Ji was to be his successor. All Sikhs were to regard these scriptures as the eternal and supreme Guru.

1.3.2. Punjabi Sikh Spirituality

Spirituality is thought to inform the daily life of Punjabi Sikhs. It is not considered a form of worship to please God, but to reinforce a positive attitude toward the self and others to make life more enjoyable (Bhamra, 2015). There are strong beliefs about the concept of 'happiness' coming from within and not from external sources; for instance, being rich is not considered to be a root to happiness and in the same vein being poor does not equate to unhappiness. Spirituality is considered important in the recovery process for many who have illnesses. If one's attitude towards their illness is positive, they can live a richer life and change the trajectory of that illness. If one adopts a negative attitude, then the said illness may intensify. Spirituality provides comfort, strength, and prevents people from feeling alone (Ibid).

1.3.3. The UK's Punjabi Sikh Diaspora

Though originating from India, Punjabi Sikhs have settled in many countries around the world; namely UK, US, Canada, and parts of Europe and Africa (Ember, Ember, & Skoggard, 2005). The Sikh diaspora is reported to have begun after the fall of the Sikh Kingdom in 1849 which led to the annexation of the last Emperor, Maharajah Duleep Singh. After being exiled from India by the British Raj aged just 15, Maharajah Duleep Singh became the first Punjabi Sikh settler in the UK (Singh, 2011).

As reported in the 'British Sikh Report' (BSR) (2013), there have been a number of waves of Punjabi Sikhs migrating to the UK. The first wave began migrating from the Punjab in 1911; having annexed the Sikh Kingdom, the British Raj began recruiting many Punjabi Sikhs in the British Indian Army. As a result, there was already an established Punjabi Sikh presence in many parts of the UK at the start of the First World War (Singh, 2011). The most significant wave of migration was reported after World War II, during which time the very definition of 'home' was eradicated by the Partition of India in 1947, which forced the majority of the Punjabi Sikh community to abandon their homes in the newly-formed Pakistan and establish a new home in India Punjab. This mass migration impacted India greatly, leading to a country wide recession and the further deracination of many Punjabi Sikhs (Chatterji, 2007). The rapid economic growth in the 1950's increased employment opportunities and a shortage of labour workers throughout the UK enticed many young male Sikhs to migrate and work in manual and skilled labour. Many came with the intention to send money back to their families still residing in Punjab in hope to survive the stagnated economy (Myrvold, 2011). Working to maintain the welfare of their families came at a high cost, with migrants cutting off families to stay longer than intended with the aim of earning more money to send home. This contradiction between their families and family welfare brought about another surge in migration where Sikh women would travel to join their husbands (Ballard, 1972). Most were reported to have settled in Southall, West London, where many took advantage of the jobs offers at Woolfe's Rubber Company, and Nestle foods (Gillespie, 2001).

Other reported movements of the Sikh community included from Africa, where the increased pressure from East Africa to be independent and 'Africanised' at the expense of their non-native residents forced Punjabi Sikhs to leave their established vocations and settle elsewhere (British Sikh Report (BSR), 2013; Singh & Tatla, 2006). With the existing connection to the British Indian Army and therefore the British Empire, this community migrated to the UK with feelings of having lost their ties to India and lack of 'anchor' to a country (BSR, 2013). Since

migration Punjabi Sikhs have struggled with the idea of having no homeland and perhaps this is why they are considered the 'premier migrants of South Asia' (Singh & Tatla, 2006).

The complex issue of Punjabi Sikh families migrating to the UK was explored further by Bhachu (1985), where his findings revealed that Punjabi Sikhs had found it easier to integrate in the UK due to their lack of ties to India. Furthermore, the BSR (2013) found that 95% of Punjabi Sikhs were proud of their 'Britishness' and preferred the term 'British Sikh' in reference to their identity. It also found that 91.5% of Punjabi Sikhs spoke English fluently. This supports earlier findings by ICM research (2007) which interviewed 500 British South Asians. Amongst the sample there were only 39 Punjabis however 77% of them reported feeling "completely British". This is also consistent with the 2011 UK census revealing that only 1% of Punjabis describe themselves as 'British Asian' with 70% self-identifying as 'British' or 'British Sikh'.

Today, there is reported to be 420,000 Punjabi Sikhs living in the UK; of which 240,000 are British born (Census, 2011), with the majority residing in Slough, Hounslow, and Ealing (ONS, 2011). The vast majority of British Punjabi Sikhs go on to achieving further education with only 1% listing an apprenticeship as their highest level of education (BSR, 2016). 60% of this population are in full time employment, 6% are employed part time, with a further 15% self-employed, and only 4% are unemployed with 1% of the Punjabi Sikh community claiming benefits (BSR, 2014). Their migrant employment may be rooted in manufacturing, textile, and service sectors such as Heathrow Airport in West London, but the community today boasts professionals in Law, Business, Politics, Medicine, and Academia. Punjabi Sikhs have also become better represented in sports, music, and art industries (BSR, 2016), such as the cricketer Monty Panesar and popular TV chef Tony Singh who notably appears on BBC's Saturday Kitchen.

Statistics reveal that 87% of British Punjabi Sikh households are home owners, 49% own more than one property, 47% live in multi-generational households, and 34% of households have an income of over £80,000 per annum (BSR, 2014). It has been widely reported that Punjabi Sikhs are considered a key part of the UK community and promote values that encourage integration into society and helping others where possible, for example Punjabi Sikhs donate approximately £125 million to charity each year and spend over 65 million hours on voluntary activities (BSR, 2013; BSR, 2016).

1.4. Acculturation and Assimilation

Migration is a process of social change where individuals leave one geographical area for permanent residency in another. Typically, they transfer their knowledge and expressions of distress with them and when settled, their identity is likely to change (Bhugra, 2004). This process of cultural and psychological change is called acculturation and is the result following exposure to multiple cultures (David, Berry, & John, 2010). This term typically applies to minority cultural groups but is not exclusive to them (Bhugra, Bhui, Desai, Singh, & Baldwin, 1999). For Punjabi Sikhs, migration was mainly driven by political turmoil and economic crisis and various research sources suggest that the community have found it easier to integrate into a British community and feel a limited connection with their Indian roots (BSR, 2013; ICM Research, 2007; Bhachu, 1985).

Berry (1997) outlined a model that categorises acculturation strategies into two dimensions. The first is concerned with the retention or rejection of one's inherent cultural identity and the second with the adoption or rejection of the new host culture. Berry (1997) proposed four strategies that arise from this; 'assimilation', 'separation', 'integration', and 'marginalisation'. 'Assimilation' occurs when individuals wish to reject their inherent cultural identity and accept their new host culture. When individuals wish to retain their cultural heritage and reject their host culture this is called 'separation'. This strategy is often reinforced when individuals migrate to geographical areas that are highly populated with similar ethnic minority

groups. When individuals are interested in maintaining their inherent cultural practices but are also open to accepting new practices in their host culture, this is known as 'integration'. Given that Punjabi Sikhs have adapted to their new host culture so well that they wish to be referred to as 'British Sikh' it could be suggested that Punjabi Sikhs have adopted this strategy following migration to the UK. Berry (2005) later reported that those who pursue this strategy experience less distress and achieve "better adaptations". Finally, there are some individuals who have little interest in retaining their cultural heritage, (which may not always be a choice) and little interest in their host culture, this is referred to as 'marginalisation' (Berry, 1997).

Although Berry's (1997) model is helpful in conceptualising some of the change-processes that people go through following migration, it takes a very linear approach to explaining such a very complex and multifaceted process. Ontologically, Berry has firmly asserted his roots in realism (Berry & Sam, 1997), positing an 'objective and knowable reality' (Williams & Arrigo, 2006). To adopt a universalist perspective proposing all psychological processes that operate during acculturation, are the same for all cultural groups is careless and denies the historical, political, and socio-economic realities facing migrants when they leave their homelands, and fails to explain experiences that differ.

Bourhis, Moïse, Perreault, and Senécal 's (1997) Interactive Acculturation Model attempted to emphasise the role of the dominant cultural group, arguing that minority ethnic acculturation strategies are interlinked with the acculturation orientations of the majority group as they ultimately hold the power. They suggested 'marginalisation' is more likely to occur when the dominant group rejects an individual's 'home identity', not because the individual themselves rejects it. There have also been other studies suggesting acculturation strategies can differ between private and public domains, for example individuals may privately reject the values of the host culture but could be seen as adapting well and demonstrate the adoption of new cultural practices in a public arena (Judit, Vijver, & Fons, 2004). This study was conducted in Turkey and Holland and

cannot be generalised to the Punjabi Sikh community but demonstrates the complexities involved in acculturation and identity.

Bhatia's (2002) dialogical model of acculturation on the other hand demonstrates the complexity of acculturation by drawing on the assumptions of social constructionism; representing a critical, dynamic, and holistic approach. Bhatia (2002) argues that acculturation and identity are both dynamic, and those from minority ethnic groups often create multiple forms of the 'self', depending on the context they find themselves in. Such individuals therefore experience "a dialogical process that involves a constant moving back and forth between incompatible cultural positions...feeling simultaneously assimilated, separated, and marginalised" (Bhatia 2002).

Prior to the work of Berry (1997) and Bhatia (2002), Stopes-Roe and Cochrane (1987) investigated the complicated process of assimilation and suggested there are three important factors to consider; cultural, structural, and identificational. Assimilation refers to the way minority ethnic groups adjust to the cultural practices and beliefs of the majority group. This concept considers the different rates and different extents to which people adjust. It is a process that depends on the motivations of both sides, i.e. the host community has a responsibility in how they choose to receive and welcome migrants. Stopes-Roe and Cochrane (1987) also acknowledged that adjustment to a new culture is affected by the circumstances surrounding the migration and the strength of one's 'home identity'. Examining British South Asians, they found generational, gender, and ethnicity differences in how assimilated an individual from a minority ethnic group felt with the majority. For example, Hindus were likely to feel assimilated than Muslims and Sikhs. Robinson's (2009) findings also reflected that Punjabi Sikhs were more likely to adopt an integrated identity than other South Asian subgroups. Such research also challenges the assumption of heterogeneity amongst the South Asian population and emphasises the need to examine subgroups independently (Johnson & Nadirshaw, 1993).

As well as discrimination, exclusion, and hate crime affecting acculturation, it was previously reported that individual's cultural changes were dependent on their 'cultural awareness' and 'ethnic loyalty' (Keefe & Padilla, 1987; Padilla, 1980). This suggests that there may be generational differences in how cultural changes are adopted. The acquisition of alternative customs presented in the host community may be a way to avoid rejection and alienation, and promote acceptance. Perhaps this is why Punjabi Sikhs have found it easier to break ties with their homeland and 'integrate' more into a 'British' community. Bhachu (1985) described this community as being caught up in a "no-man's cultural desert". Perhaps following Partition Punjabi Sikhs felt no 'ethnic loyalty' from their neighbours, so worked hard to feel a sense of belonging elsewhere. It has also been documented that one's cultural identification may derive from how strongly one identifies with a particular group (Jamal & Chapman, 2000). Perhaps the Punjabi Sikh community self-identify more as British because they see the British values and practices as being more aligned to their own.

1.5. Western Mental Health and Alternative Approaches

1.5.1. Western Mental Health

In the UK, a quarter of the population experiences a mental health issue every year, with the most common difficulties being 'mixed anxiety' and 'depression'. Women are more likely to receive treatment than men whilst almost 10% of children are diagnosed with a mental health difficulty. With more of an ageing population, 'depression' is affecting one in five older adults. Studies show that British men are three times more likely to commit suicide than British women, and self-harm statistics reveal higher rates in the UK compared to other countries in Europe (Vos, Xiong, Visser, Jasielec, Hassenstab, Grant, Carins, Morris, Holtzman, & Fagan, 2013; McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009).

In high income and developed countries, such as the UK and US, mental health services tend to be dominated by psychiatry which typically revolve around a biological approach to understanding emotional disturbances and behaviours considered to deviate from societal norms. Various medications have been developed for common mental health difficulties, such as 'depression' and 'schizophrenia', despite the limited evidence for these being caused by biological factors (Nestler, Barrot, & DiLeone, 2002; Stahl, 2000). Wyatt and Midkiff (2006) also assert there is little evidence to support the biological processes in mental illness but despite this, psychiatry continues to have a powerful impact on how mental health difficulties are understood and treated. On the contrary, clinical psychology attempts to understand such difficulties in the context of environmental and social circumstances, offering alternative coping strategies to medication. Often psychologists will draw upon various modalities to inform their work depending on the clinical presentation of their service users and service provision. For example, mental health problems may be understood in the context of a disrupted attachment, cognitive biases, learned behaviour, or trauma.

In the UK, mental health continues to be largely conceptualised in Western and individualistic terms. Psychology has traditionally been Eurocentric in nature derivative of a White middle class value system (Naidoo, 1996). It is criticised for being culturally incompetent; lacking in cross cultural relevance and for not recognising the impact of social inequalities (Patel, 2003). 'Western psychology' also faces the potential danger of locating the causes of psychological distress in the individual (Patel & Fatimilehin, 2002).

1.5.2. Alternative Approaches to Mental Health

Western mental health care has become the foundation of healthcare globally; this is largely due to the Western asylum-psychiatry that was imposed during colonialism in non-Western countries (Fernando, 2014). It has been further argued that developing mental health care in this way has diverted attention from difficult social inequalities that mandate political and economic solutions in the non-West

(Fernando, 2014), and that perhaps psychiatry has colluded with those who have benefitted from the status quo which in turn defuses political challenges and reframes mental health problems being caused by individuals (Kirmayer, 2006). It has also often assumed that the diagnostic manuals developed and utilised in the West are impartial scientific instruments. However, the Diagnostic and Statistical Manual (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD-10) are not impartial credentials; they make a range of assumptions which reflect a Western biomedical model and suggest such explanations are representative of different cultural groups (Tribe, 2014). Mental health diagnoses such as 'schizophrenia', 'bipolar', and 'depression' are reported worldwide and *can* present similar symptoms in individuals across a number of continents (Weissman, Broadhead, Olfson, Sheehan, Hoven, Conolly, Fireman, Farber, Blacklow, Higgins, & Leon, 1998). However, there is a particular challenge when it comes to diagnosis, as such conditions vary across race, ethnicity, and culture. 'Idioms of Distress' are ways in which different cultures express, experience, and cope with feelings of distress (Kirmayer & Young, 1998). For example, in Africa distress sometimes takes the form of worms in the head or ants crawling under the skin (American Psychiatric Association, APA, 1994), whereas some South Asian groups are more likely to express "cardiopulmonary and vestibular symptoms, such as dizziness, vertigo, and blurred vision" (Hsu & Folstein, 1997). *Latah* is a condition from South East Asia affecting the Malay race in which sufferers exhibit abnormal behaviours resulting from shock (Prince & Tcheng-Laroche, 1987). Moreover, Latino participants often view psychiatric diagnoses as "potentially very socially damaging", preferring to describe their psychological distress as *nervios* (which refers to one's nerves) (Carpenter-Song, Chu, Drake, Ritsema, Smith, and Alverson, 2010). The researcher acknowledges the limitations of such examples; while they demonstrate the way different cultures perceive and express psychological distress, it is important to note these ideas have been generalised to wide and diverse continents.

When reviewing ethno-cultural beliefs about mental health, Abdullah and Brown (2011) identified a wide range of cultural beliefs in relation to mental illness. Malik (2000) interviewed 60 adult males and 60 adult females who had either migrated from Pakistan to the UK or were of Pakistani origin and born in the UK. The study focused on how participants identified the experience of distress, the causes of distress, and possible ways of alleviating it. The findings suggested that distress was constructed relationally; either between people or in response to situations as opposed to the 'problem' being located in the individual (Ibid). Malik (2000) also highlighted South Asians are more likely to report somatic symptoms which are not appraised to biomedical explanations. Literature therefore suggests there are cultural variations in the context and interpretation of symptoms related to psychological distress (Anand & Cochrane, 2005; Karasz, 2005).

Rathod, Pradhan, and Pinninti (2016) looked into non-Western explanations around the psychiatric diagnosis 'psychosis' in the UK and found they were strongly appraised to religious and spiritual understandings. Some of these experiences were evaluated as being positive as they allowed individuals to transcend beyond their limitations and achieve higher accomplishments. Similarly, Jacob, Bhugra, Lloyd, and Mann (1998) looked at 'common mental disorders' and explanatory models amongst Indian women living in the UK. They found participants when expressing any psychological difficulties such as 'low mood' they were more likely to refer to physical symptoms they were feeling.

To an extent the ICD-10 does acknowledge that there are exceptions to assuming the universality of psychiatric diagnosis (WHO, 1992), so the question remains why are services still not meeting the cultural needs of their users? More research is continuing to report that understandings of the 'mind' and 'madness' have developed differently in non-Western cultures and are often influenced by political and economic contexts (Fernando, 2014). Yet the tendency for Western psychiatry to construct distress as the symptomology of 'neurological disorders' rather than a response to the socio-political conditions of global capitalism and social

inequalities (Fernando, 2014) may leave non-Western cultures with unmet psychological and emotional needs.

As many service users, particularly of a BME background, reject psychiatric interpretations of their experiences and seek to understand their experiences within their own contexts (National Survivor User Network, 2014), there is emphasis on developing culturally-sensitive services. Such services should be cautious of the application of universal theories of distress and consider thoughtful integration of the vast cultural variations that exist into assessment and interventions. This would mean services are being more responsive to the individuals presenting. For example, Tucker, Marsiske, Rice, Jones, and Herman's (2011) 'Patient-Centred Culturally Sensitive Health Care' model states that in order to provide culturally-sensitive healthcare, the following characteristics should be considered: (a) clinicians should emphasise respect for the culture of patients and enable them to feel comfortable to talk about it; (b) the relationship should be seen as a partnership; and (c) the patient should feel empowered to disclose cultural understandings of their health and care should be based on the culture of the patient and not the clinician's. (See also Formative Model; Tucker, Herman, Ferdinand, Beato, & Cooper, 2007). In the context of the current study, in order to do this effectively, there is the need to first understand how Punjabi Sikhs construct psychological wellbeing and mental health problems and the beliefs they hold about treatment and help-seeking.

1.6. Literature Review

This subsection of the chapter focuses on the limited research carried out on Punjabi Sikhs and their views of mental health. Subsequent to this, it summarises the current literature amongst the South Asian population, exploring their beliefs of mental health, relationship to help, and barriers to accessing services.

1.6.1. Search Strategy

To conduct the literature search for this study, the following electronic databases were searched; EBSCO PsychInfo, PsychArticles, CINAHL, Scopus, and Science

Direct, for the period 1980 to 2015 inclusive. The search began with a specific focus on 'Punjabi Sikh', however the search results identified minimal articles related to this term. The researcher therefore amended their search strategy to include 'South Asians'; this produced more results but then included broader research which was not explicitly related to this topic. In order to maximise the search results, the researcher utilised Google Scholar and grey literature including unpublished work, to include any other relevant articles not captured by the above databases.

1.6.2. Inclusion and Exclusion Criteria

Studies investigating an understanding and awareness of mental health difficulties within the Punjabi Sikh community were prioritised in the search, however due to the paucity of research carried out on this population, mental health issues within the South Asian community as a whole were also included in this review. Due to this limited research, international as well as UK research was included but searches were restricted to those written in English only. Both qualitative and quantitative peer reviewed literature ranging from 1980 to 2015 was incorporated. Studies that included other ethnic groups and did not focus solely on a South Asian population were also reviewed. Studies recruiting "Asian" participants without clarifying who fell under this generic term were excluded as this term can often refer to individuals from China, Japan, Vietnam, and Korea.

The literature search identified 230 articles. Titles and citation abstracts were then reviewed to exclude irrelevant papers and remove duplicate studies. The researcher focused on the following information; study aims, methodology, participant sample, and data analysis to condense the literature and include the most relevant articles only. A total of 36 articles were reviewed. See appendix A for further detail on the searches conducted. Now the researcher presents a narrative account of the literature identified.

1.6.3. Cultural Perspectives on Mental Health

Culture is a social construct which may have different individual and societal meanings, depending on the context in which it is applied (Cooper, Beach, Johnson, & Inui, 2005). The dialectical fluidity of terms such as 'culture' and 'race' makes them problematic concepts often used interchangeably in literature. The researcher therefore acknowledges that culture is a problematic term. There is a tendency to view culture as a fixed entity which can be described and understood, as opposed to thinking about culture as a perpetual movement, in which it is re-defined as it moves through different phases (Fenton & Sadiq-Sangster, 1996). The researcher uses terms such as 'Western culture' and 'Punjabi culture' critically and does not imply the superiority of one culture over another within the context of this research.

Theoretically looking at Ancient culture, there were four main cultural avenues that were commonly noted: Indian, Egyptian, Roman, and Chinese. Across all four cultures the phenomenon of mental health has been observed in a similar way; the idea of the supernatural influence on the human mind and a close relationship between the body and the mind. In India, the human mind and its functioning, consciousness, and dynamics of human behaviour have been an area of exploration for centuries (Gautam & Jain, 2010). Gautam and Jain (2010) note a number of studies relating to cultural factors influencing the presentation of illness, beliefs on psychopathology, and stigma.

Attitudes towards those who experience mental illness can vary across individuals, families, ethnicities, cultures, and countries. Kulhara and Chakrabarti (2001) looked globally into the role of culture on those with a diagnosis of 'schizophrenia' and observed that although there are some experiences that present globally, there are significant cultural differences in treatment outcomes. These outcomes appear to be 'better' in cultures that are considered to be developing rather than the dominant Western culture. Explanations for this finding are difficult to ascertain but Kulhara and Chakrabarti (2001) assumed that social and environmental

culturally-determined processes such as support networks, experiences of migration, and how emotions were expressed and talked about in the family home, were partly responsible.

Culture was found to be a significant predictor in how people conceptualise their distress (Loewenthal, Mohamed, Mukhopadhyay, Ganesh, & Thomas, 2012; Sheikh & Furnham, 2012). The impact of culture and context were highlighted across the entire help-seeking pathway, from identifying problems to diagnosis, and selecting interventions (Cochrane & Hussain, 2002). This may be due to linguistic, religious, and social variations from the clinicians providing care. In addition, it appears that the pervasiveness of psychological distress varies amongst different cultural backgrounds, due to an interaction of biological, psychological, and social factors. Therefore, it is important that service provision validates and understands cultural differences to ensure appropriate care and treatment is provided (Bhugra & Osborne, 2006).

Western concepts however have a tendency to be individualist and Eurocentric and do not always take cultural context into account (Patel, 2003). Patel (2003) further argues that Western psychology privileges a view of the self as “an individual, separate, autonomous, and independent being”. Locating the problem within the individual may not always be appropriate, especially when some cultures are likely to hold collectivistic values (Weatherhead & Daiches, 2010).

1.6.4. Culture-Bound Syndromes

‘Culture-Bound Syndrome’ is a term used to describe the uniqueness of some symptoms in specific cultures (Sumathipala, Siribaddana, & Bhugra, 2004). For example, a number of Latino women from the Caribbean, display ‘*ataque de nervios*’; a condition that involves screaming uncontrollably, episodes of crying, trembling, and verbal or physical aggression. On occasion fainting or seizure-like episodes and suicidal ideation have been reported (Jackson, 2006). A culture-bound syndrome from Japan is ‘*taijin kyofusho*’ whereby sufferers become

extremely distressed or embarrassed of themselves and fear displeasing others with their bodily functions (Kiriike, 2003). In India, '*Dhat Syndrome*' is a condition whereby nocturnal emissions from the body lead to the sufferer experiencing severe anxiety, often associated with sexual impotence. The individual typically exhibits various somatic, psychological, and sexual symptoms believing they are passing semen ('*dhat*') through their urine (Chhabra, Bhatia, & Gupta, 2008). A number of other Culture-Bound Syndromes are highlighted in the DSM-V (APA, 2013). In the past, attempts have been made to fit these syndromes into Western diagnoses and treatment. In order to work with individuals who display symptoms of a Culture-Bound Syndrome, research needs to be invested into examining how different cultural, social, and biological contexts interact to shape people's experiences of distress and how they construct meaning.

This term has been previously critiqued by Hughes (1998) who stated that by viewing particular 'symptoms' belonging exclusively to a specific culture runs the risk of clinicians distorting any overlaps between the same condition across different cultures. In addition to this, globalisation is changing the traditional boundaries of cultures around the world; urbanisation and the influence of media are changing how distress is experienced and expressed in cultures (Bhugra & Mastrogianni, 2003) therefore the term Culture-Bound Syndromes should be applied critically.

1.7. Research on Punjabi Sikhs

1.7.1. Sikhism and Mental Health

There are some distinctive features of the Sikh religion that encourage psychological wellbeing (Nayar, 2004). Sikhism does not believe that psychological difficulties are caused by spirit possession or desecration of any religious principles. Nor does it stipulate that treatment can be sought through supernatural powers or rituals. It was in fact reported that the third Guru made hospitals to treat the sick, where the fifth and eighth Gurus helped treat patients

with leprosy and smallpox respectively. Sikhism is a relatively young religion which means some of its teachings are considered fairly progressive as far as religious beliefs are concerned. In regards to mental health, the Guru Granth Sahib contains texts that describe everyday emotions such as sadness, happiness, and anger, as well as describing more serious mental health issues; 'symptoms' that could represent Western conditions such as 'psychosis' and 'depression' (Kalra, Bhui, & Bhugra, 2013). Some of the symptoms of 'depression' are expressed through the use of metaphors. 'Depressed' individuals are said to suffer in sadness and agony and are compared to feeling like "maggots in manure" (Guru Granth Sahib, 1993, p. 125). There is also a reference made to losing interest in previously enjoyed activities (p. 179), loss of sexual interest, and self-neglect (p. 225). The text cites an 'afflicted mind' may harbour negative thoughts (p. 222-3), a loss of sleep and change in appetite (p. 306-16). These 'symptoms' are very much aligned with a traditional Western view of mental illness in particular 'depression'.

Sikhs believe that the primary cause of illness is rooted in the mind. They believe the mind is a non-stop thinker and can create thought patterns that are 'evil'. It is these thoughts that are considered to be the cause of 'disease'. The mind is known to function on two main levels; the conscious and the unconscious. However, Sikhs believe there is another level called the 'super conscious' which can only be accessed through meditation, and is considered to bring one peace of mind and gain control of these 'evil' thoughts (Guru Granth Sahib, 1993).

In regards to 'depression' the text also asserts that peace and tranquility can help restore the mind back to a balanced state. It mentions the importance of acknowledging 'depression' and treating it in time (p. 1279). The text equates meditating on God's name to medicine stating it relieves the mind of its suffering (p. 259-14; p. 675-6). The Guru Granth Sahib also suggests meditation as having a therapeutic effect. Through meditation and listening to spiritual teachers, followers are said to live a life of eternal bliss. For the long-term management of 'depression', the text recommends remembering and praising the Lord (p. 1421)

and dedicating oneself to selfless service of others (p. 110) which enables one to attain happiness (p. 21). When God's name is chanted day and night (p. 896) it serves as a protective and therapeutic measure for emotional distress (p. 23) (Guru Granth Sahib, 1993).

Although Punjabi Sikhs share many beliefs and practises with the broader South Asian community, religiously they are a separate entity and Sikhism itself is not a known barrier for accessing services (Gill, 2010). Unlike other South Asian religions Sikhism does not state that psychological difficulties are caused by evil eye³ or spirit possession. They do not believe that it is a punishment from God for their sins or that there is a need to perform rituals to please God by reciting Holy Scriptures (Singh, 2000). In regards to the current study, given that Sikhism actively promotes psychological wellbeing, it may mean that the participants already have coping strategies put in place which protects them from experiencing mental health problems. It may also mean participants are more forthcoming in discussions regarding mental health as Sikhism appears to normalise psychological and emotional distress, suggesting there may be a strong link between religion and mental health for this community.

1.7.2. The Mental Health of Punjabi Sikhs

Existing evidence indicates that Punjabi people are more likely to be diagnosed as having a 'clinical disorder' than other ethnic groups (Bhui et al., 2001). In the UK 'depression' was found to be more common in Punjabi people than White people (Bhui et al., 2004) and Punjabis are more likely to be diagnosed as having more somatic symptoms than other South Asian subgroups (Bhui et al., 2004; Fenton & Sadiq-Sangster, 1996; Krause, Rosser, Khiani, & Lotay, 1990).

Most researchers agree that Western classifications of distress are not always directly translatable in non-Western cultures (Bhugra, 1996; Manson, 1995). For example, the word 'depression' is absent from many languages (Manson, 1995); it

³ A malevolent glare superstitiously believed to cause harm

is seldom used in others; (Hamdi, Yousreya, & Abou-Saleh, 1997) or constructed entirely differently (Lee, 1998; Abusah, 1993). Although the Guru Granth Sahib describes how 'depression' may manifest (Kalra, Bhui, & Bhugra, 2013), the Punjabi language has no literal translation for 'depression' (Krause, 1989). When Krause (1989) looked at the concept of 'depression' specifically within the Punjabi community, it was noted that the term 'sinking heart' was used to describe psychological distress experienced by Punjabi residents in Bedford. The meaning of this expression was uncovered as being closely tied to feelings about absent family members. Similar observations were made in Fenton and Sadiq-Sangster's (1996) study using Punjabi women in Bristol. 'Sinking heart' describes the physical sensations that are experienced in the heart. These symptoms are thought to be caused by "excessive heat, exhaustion, worry and/or social failure" (Krause, 1989). Research conducted in the Punjab found that women were more likely to present with this phenomenon (Bhugra, Baldwin, & Desai, 1997). Complaints of 'heat' were once again identified with all participants making links between bodily and emotional states. This finding has been replicated in the UK; Punjabi participants in a focus group setting recognised the word 'depression', but preferred to use phrases such as 'weight on my heart/mind' to describe a low mood state (Bhugra et al., 1997). Participants also used terms such as 'gas' and 'heat' to describe symptoms of distress, which are consistent with traditional Ayurvedic models used in India, despite not being very common in the UK. The Punjabi model of 'sinking heart' proposes a culturally sensitive explanation of distress. It is based on cultural ideas of the self and combines the body and mind. Krause (1989) concluded that the Punjabi model resembled the Western model of stress but was similar in form only and not content. The study did not outline any specific interventions for a 'sinking heart' but offers a culture-bound explanation of somatic symptoms. It highlights the importance of language when constructing experience, and that Western concepts will not have the same meanings in non-Western languages. Thus far, there has been no research to develop or challenge this phenomenon.

In fact, there is generally very little research that has been carried out on the Punjabi Sikh community. Whilst it has been indicated that this may be the case because Punjabi Sikh people are less likely to report medical and psychological difficulties to healthcare professionals, preferring to utilise alternative methods of coping such as yoga (Cave & Norris, 2012), the researcher asserts from personal experience that there may be a strong narrative around help-seeking behaviours and not wanting to expose vulnerability. The researcher also believes that following daily Sikh practices is likely to serve as a protective factor, reducing access to services and hospital admissions. The small number of Punjabi Sikhs in clinical settings may imply to clinicians that research is not required into this community, especially given that healthcare professionals are more likely to somatise the symptoms of this community (Bhui et al., 2004; Fenton & Sadiq-Sangster, 1996; Krause et al., 1990).

1.8. South Asian Research

The term 'South Asian' refers to individuals whose ethnicity originates from countries of the Indian subcontinent: India, Pakistan, Sri Lanka, Bangladesh, Nepal, Maldives, and Bhutan (Bhui, 2002). In the UK, the South Asian population is a growing population and has significantly increased from 3.9% in 2001, to 5.3% in 2011. It is predominantly comprised of Bangladeshis, Pakistanis, and Indians (ONS, 2012). Although the South Asian ethnic category is reported to be younger than the majority population in the UK (ONS, 2003), those who immigrated to the UK between 1950 and 1970 looking for work are now an ageing population. The number of elders from ethnic groups aged 50 and over is predicted to increase from 2.4 million in 2016 to 3.8 million by 2026 (Older BME People and Financial Inclusion Report, 2016).

Due to the limited research carried out on Punjabi Sikhs, the following studies have been included because they have identified using Punjabi Sikhs as part of their sample.

1.8.1. Religion and Ethnicity

As well as culture, religion and ethnicity have been identified as important factors in mental health. Cinnirella and Loewenthal (1999) explored the religious and ethnic group influences on 52 females. They used the following religious groups; White Christian, Pakistani Muslim, Indian Hindu, Orthodox Jewish, and Afro-Caribbean Christian and found several differences between the groups. The Afro-Caribbean Christian and Pakistani Muslim groups had perceived prayer as being a particularly effective coping strategy in times of distress. In addition, both groups had expressed more concerns about community stigma and had associated this with further 'mental ill health'. White Christian and Jewish groups had reported a fear of being misunderstood by healthcare professionals that were not of the same religious background. The results supported recent recommendations for ethnic-specific mental healthcare and reinforce more research be carried out on the link between religion and mental health. This study did not use Punjabi Sikhs as part of their sample but the study was included as it demonstrates the differences between religious groups and supports the view of the researcher that South Asian subgroups should be examined independently.

The South Asian view of therapy may differ from the Western view. Morjaria and Orford (2002) found that South Asians were more likely to reconnect with their religious values during the process of therapy. In East London, the South Asian community appraised illness and misfortune to a belief in *jinn*s (spirits). These beliefs also partially determined how individuals sought help and what coping strategies they utilised (Anand & Cochrane, 2005). Some South Asian communities believe services are unequipped to provide them with culturally appropriate care (Raghavan & Waseem, 2007; McGrother, Bhaumik, Thorp, Watson, & Taub, 2002), thus are more likely to respond to such difficulties by seeking alternative treatment, which often involves consulting folk and religious healers (Dein, Alexander, & Napier, 2008).

Religious variations in the perception of 'depression' and responses to it are widespread amongst South Asians (Lavender, Khondoker, & Jones, 2006; Hussain & Cochrane, 2003). For some individuals, seeking professional help conflicted with their religious beliefs of distress, for example, demonic possession, evil eye, and black magic (Khalifa, Mullick, Nahar, & Walker, 2013; Malik, 2000). Physical and mental illnesses are often considered God's will or karma, and are associated with a philosophical and passive attitude, thus people often turn to spiritual or cultural sources of support (Pirani, Papadopoulos, & Foster, 2008; Faulkner & Layzell, 2000; Greenwood, Hussain, Burns, & Rapheal, 2000). Given that most symptoms of mental illness in this community are considered spiritual, religious, or medical tribulations, therapy may be viewed as a problem-solving tool and not relevant (Rastogi & Wieling, 2003).

Recommendations of the above studies included more service provision around ethnic specific interventions and more work exploring the link between religion and beliefs around mental health. Mainstream mental health in the current NHS context is dominated by the medical model in its positioning, training, and application. This provides limited concern of the mental health issues of other ethnic groups (Naidoo, 1996). Mental health professionals who are heavily influenced by the dominance of Western explanations and interventions often operate from the assumption that their clinical practice can be applied to all populations. A better understanding of the role religion and ethnicity play in mental health issues is important in the development of more accessible and appropriate service provision for minority ethnic communities (Fulford & Woodbridge, 2007).

There are a number of factors that have been identified as contributing to the underutilisation of mental health services by South Asians. The following are reported to be the most influential and may be relevant to the Punjabi Sikh community too.

1.8.2. Stigma

Stigma has been identified as a key barrier to accessing services (Loya, Reddy, & Hinshaw, 2010; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). In South Asia where many cultures value “conformity to norms, emotional self-control, and family recognition through achievement” (Abdullah & Brown, 2011), mental health difficulties are stigmatised in the community. There is a resilient cultural stigma around psychological distress within this ethnic community. Gary (2005) coined the term “double stigma” and refers to belonging to an oppressed group (in this case a minority ethnic group) with the additional stigma of mental illness. Increased levels of stigma are notorious for resulting in the denial of mental illness amongst this population (Gilbert, Gilbert, & Sanghera, 2004; Gureje, Simon, Ustan, & Goldberg, 1997) and reluctance to access services (Bradby, Varyani, Oglethorpe, Raine, White, and Helen, 2007; Karasz, 2005; Fikree & Pasha, 2004). Time for Change (2010) found that shame and fear of the community deterred South Asian participants from disclosing mental health issues. Participants discussed how the community seldom addressed any problems and are encouraged to maintain secrecy around any mental health needs. Participants feared such information being uncovered to the wider community would “contaminate” or “tarnish” everyone associated with the individual in question. It is worth noting that findings were not broken down into different subgroups; results were presented as if the South Asian community as a whole are equally affected by such issues. This assumes that the South Asian community is a homogenous group and overlooks the uniqueness of each community that falls under this term.

Increased levels of stigma are notorious for resulting in the denial of mental illness amongst this population (Gilbert, Gilbert, & Sanghera, 2004; Gureje, Simon, Ustan, & Goldberg, 1997). The somatisation hypothesis suggests those from ‘traditional’ South Asian communities are more likely to seek support for psychological distress through physical health services (Kawanishi, 1992). For example, there is a large body of evidence suggesting ‘depressed’ South Asian women present to services with gynaecological symptoms. This is because they

perceive the somatic expression of their emotional distress as needing to access such a service. Healthcare professionals in return continue to see these women also perceiving their difficulties as being medical (Patel, Pednekar, Weiss, Rodrigues, Barros, & Nayak, 2005; Patel, & Oomman, 1999).

1.8.3. Low Referral Rates

Husain, Creed, and Tomenson (1997) reported that GPs had a tendency to overlook the psychological problems of South Asian patients, and that diagnosis and treatment was often attributed to somatic symptoms. They investigated 44 South Asian women diagnosed with 'depression' in Manchester. All but five had 'depressive' symptoms that had lasted over a year, yet 'depression' was noted by the GP in only one case. Husain et al. (1997) highlighted this was a preliminary study as there was a small sample of GPs used and recommend more research should be carried out in this area. They suggested the findings were related to the high somatisation of psychological and emotional distress in this population, which may have led to GPs to misdiagnose 'depression' for a medical illness. Another study in the UK that focused on South Asian women with a diagnosis of 'depression' rated on the General Health Questionnaire (GHQ), discovered 50% of them had all withheld their psychological difficulties from their GP. These GPs had been unable to recognise any symptoms of 'depression' neglecting their psychological needs (Jacob, Bhugra, & Lloyd, 1998).

In East London, South Asians were found to be prescribed lower dosages of antidepressants where there were greater numbers of South Asian residents. Reasons for this are difficult to ascertain but may be due to differences in explanatory models and less reliance in biomedical strategies (Hull, Cornwell & Harvey, 2001; Cornwell, 1998). Hull, Aquino, and Cotter (2005) later inferred that successful drug treatment of 'depressed' South Asians may be less likely than for White patients.

1.8.4. Help-Seeking Behaviour

An extensive evidence base highlights distinct patterns of help-seeking behaviour amongst BME populations (Kim & Omizo, 2003; Leong, Wagner, & Tata, 1995); who underutilise psychological services, present in crisis situations with more severe symptoms, and are more likely to terminate therapy once in treatment (Abe-Kim et al., 2007; Kim, Ng, & Ahn, 2005; Chen, Sullivan, Lu & Shibusawa, 2003; see 'Circles of Fear' Keating, Robertson, Francis, & McCulloch, 2002; Leong & Lau, 2001; Li & Browne, 2000; Sue, 1999; Cheung & Snowden, 1990).

Across South Asia, there are insufficient mental health resources available to meet the needs of the population. Mental health services that are available are often hospital-based in inner city boroughs meaning that 80-90% of populations have no access to treatment (Britannica Mental Health Review, 2007). In most cases, mainstream society rejects people accessing mental health services invalidating their difficulties. People labelled as 'mentally ill' fall victim to discrimination and violence, facing stigma and social exclusion. The absence of mental health policy means that mental healthcare often gets neglected violating the human rights of those considered vulnerable (Ibid). Instead of being offered support they are isolated from society (WHO, 2001). If this is the context of many South Asians perhaps it is not surprising that even when they migrant to the UK they are not interested in accessing services.

An investigation of psychological distress in South Asian women in the UK by Chew-Graham et al. (2002) revealed that mental health services were only accessed at point of crisis. This 'delayed help-seeking' behaviour in South Asian women was also mirrored in a Canadian study (Ahmad, Driver, McNally, & Stewart, 2009). While there is an array of complex explanations for this delay, in both studies the women unanimously highlighted the importance of enforced silence in their culture in regards to psychological wellbeing.

Other research indicates South Asians are stereotyped as a 'Model Minority' and are held to high standards of social success and personal morality (Mahmud, 2001). Given this 'Model Minority' status, strong family and moral values, and a heavy emphasis on educational success, South Asians living in Western countries have distinctive acculturation pressures that can lead to emotional issues but face barriers to treatment. Being considered a 'Model Minority' may lead to the denial of emotional and psychological difficulties in both mental health professionals and the South Asian community themselves, which in turn results in very low rates of access to services.

1.8.5. Does This Community Need Access?

In South Asia, suicide is one of the top three causes of death for people aged between 15 and 24, 35% of suicide cases are related to mental health difficulties, over 60% are deemed preventable, and the number of people who commit suicide is higher than those who die due to road accidents, terrorism, and HIV/Aids (WHO, 2001). The UK now contains a large number of South Asians who are second or third generation of their descendants and are particularly prone to 'depression' and suicidality (Ahmad et al., 2004). It is difficult to ascertain the reasons for this population being at high risk of suicide but it may be linked to reasons related to immigration and acculturation (McKenzie, Serfaty, and Crawford, 2003). A number of studies have supported this idea of cultural conflicts in the family and found that they can lead to attempted suicide or engaging with self-harming behaviours (Husain, Waheed, & Husain, 2006; Hicks & Bhugra, 2003). Much earlier findings by Kingsbury (1994) revealed that family relationships were responsible for a majority of suicide attempts and for those diagnosed with 'depression'.

Interestingly South Asian suicides and those who attempt suicide are less likely to be diagnosed with psychiatric illness or 'personality disorder'. Hunt, McKenzie, and Serfaty (2003) found that the most common diagnosis for South Asians was 'affective disorder' which was hypothesised as being linked to high suicide rates. Suicide rates for this population in the UK may however be even higher; it is

difficult to ascertain the exact number because ethnicity is not always recorded on death certificates (McKenzie, Bhui, Nanchahal, & Blizard, 2008).

1.9. Limitations of Literature Review

This review highlighted that cultural conceptualisations about mental health are complex and multifaceted. Religious and medical philosophies co-exist and beliefs are influenced by powerful societal and cultural narratives. Information regarding access to services in the Punjabi community appears to be limited and research is often collated under the broad term 'South Asian'. Only some studies were explicit about the inclusion of Punjabi Sikhs in their samples (Soorkia et al., 2011; Anand & Cochrane, 2005; Sheikh & Furnham, 2000; Sembhi & Dein, 1998). There are also no studies to date which have exclusively explored a Punjabi perspective of psychological wellbeing. While this may be the case due to the smaller number of Punjabis in comparison to other South Asian subgroups worldwide, it is interesting how little research has been considered on the Punjabi community.

In regards to literature on South Asians, Ineichen (2012) suggested there is a need to separate the population by country of origin (those born in the UK vs South Asian continents). This is in light of issues such as immigration and acculturation and the impact they have on the mental health of South Asians. Most of the research fails to differentiate between the South Asian subgroups, despite reported differences in religious customs and traditions, socio-economic status, levels of education, and family structure. This has significant implications for the findings as they cannot be generalised to all South Asians. Given that at times the specific cultural and religious differences were disregarded, we cannot assume South Asians are a homogenous group. Furthermore, there was little exploration into the researchers' own ethnicities, which may have had an impact on both data collection and analysis.

1.10. Rationale for Current Research

Evidence indicates that there is an underrepresentation of Punjabi Sikhs, accessing mental health services (Goodman, Patel, & Leon, 2008; Bhui et al., 2003) with many reporting low service user satisfaction which has failed to improve over time (Bhui & Bhugra, 2002). Legal frameworks have increased the emphasis on healthcare organisations to acclimatise their services to ensure equitable access. This includes recognising the need to provide culturally appropriate services (Equality Act, 2010). The 'Delivering Race Equality in Mental Healthcare' publication also stressed the importance of meeting the needs of all ethnic groups when providing healthcare (DoH, 2005). However, despite proposing a five-year action plan which focused on reducing the social inequalities faced by BME populations, providing culturally competent care continues to be an issue for healthcare commissioners in the UK.

This research proposes to explore the beliefs of psychological wellbeing held specifically by the Punjabi community. In this context the term 'Punjabi' will refer to those whose ethnic heritage originates from India and follow the Sikh religion. Using qualitative methodology, this study will explore how these beliefs impact on help-seeking behaviour and shape relationship to help. There are only a small number of studies that have focussed on specific questions around personal constructions of psychological wellbeing amongst the South Asian population in the UK (Fenton & Sadiq-Sangster, 1996) but none specifically on the Punjabi Sikh community. Further to this, there is limited research in the UK regarding culturally appropriate interventions specifically for the Punjabi Sikh community.

Most of the current literature and interventions offered assumes that all needs of the South Asian community are the same. It is well documented that there is vast ethnic, cultural, and religious differences amongst the communities that fall under the umbrella term 'South Asian' (Greenwood et al., 2000). Despite the overarching similarities in culture, South Asians do not all practise the same religion or speak

the same language. Each subgroup has differing migration narratives, political contexts, and socio-economic circumstances (Nazroo, 1997). Hines et al. (1992) noted the importance of recognising the differences between ethnic subgroups and integrating the differences into clinical practice. Similarly, when Loewenthal et al. (2012) investigated Bengali, Urdu, Tamil, and Somali communities accessing 'Improving Access to Psychological Therapies' (IAPT), analysis suggested communities varied in how they conceptualised mental health issues and how they accessed help when issues arose. For example, all members of the Urdu focus group struggled with the concept of anxiety stating there is no direct translation available in the Urdu language, whereas the Somali group spoke about anxiety as a "fleeting situational discomfort that passes away" describing it as a physical and emotional experience. For the Tamil participants the study reported a lack of knowledge of anxiety (Ibid). When looking at the psychological needs and help-seeking behaviours of British South Asians, Soorkia, Snelgar, and Swami (2011) also found differences between the groups represented under this label. Hence the term 'South Asian' is problematic; it is used interchangeably to represent various ethnic groups who self-identify with each other through common descent from the Indian subcontinent, but retain quite unique identities.

The researcher therefore asserts that the inclusion of Punjabis under the label South Asian is unhelpful and reductionist. Limited research indicates when compared to other ethnic groups, Punjabis with 'common mental disorders' are more often assessed as having 'clinical disorders' and 'physical and somatic disorders' (Bhui et al., 2001). Krause (1989) earlier found that although Punjabi immigrants tend to somatise their psychological distress, they were able to articulate it in using Western psychological language. Barriers to accessing mental health services for this population were identified as a limited understanding of the concept of mental health and awareness of available services. Although the Punjabi Sikh community shares *some* similar values with the broader South Asian community, there are some distinctive features of the Sikh religion that differ in regards to traditions and customs (Nayar, 2004). Sikhism was not identified as

being a barrier to seeking services. Some research suggests it may even encourage those who need psychological support to be more open to accessing services, with values condemning superstitious beliefs and evil eye (Gill, 2010). Currently the evidence indicates that Punjabi people are more likely to identify with a British culture, their Sikh values condemn beliefs commonly held by other South Asian subgroups, and they are encouraged to actively take care of their psychological wellbeing. In light of this, the researcher proposes that there is a need to understand what beliefs about mental health are held in the Punjabi Sikh community, distinctly from other subgroups within the South Asian community.

1.10.1. Aims

This study aims to explore how mental health issues are talked about within the Punjabi Sikh community. The researcher hopes to gain a better insight into how the Punjabi community in the UK perceives psychological wellbeing, explore help-seeking behaviour, and outline practical solutions to increase their access to mental health services if this is needed.

1.10.2. Research Questions

- How does the Punjabi community in the UK understand psychological wellbeing?
- What awareness is there of mental health issues?

CHAPTER TWO: METHODOLOGY

This chapter begins by outlining the epistemological position and rationale for adopting a qualitative approach for this study. An explanation of the research design, recruitment, participant sample, and data collection will follow. The researcher will attend to any ethical issues and present the process of analysis, followed by an outline of their own position within this research.

2.1. Epistemology

Epistemology, or the 'theory of knowledge', is the study of knowledge and justified belief (Barker, Pistrang, & Elliot, 2002). In research epistemology determines the assumptions held about the world and how knowledge is gained; therefore, it is necessary to clarify an epistemological position (Winter, 2013). In line with Braun and Clarke (2006), the researcher recognises that they have made active decisions with regards to how to approach this study and respond to the data collected. These decisions have been guided by the subjective experiences of the researcher and will inevitably impact the knowledge produced.

This study adopts a critical realist stance which can be positioned between a realist approach where reality can be directly observed, and a social constructionist approach where knowledge is a social reality and value laden dependent on individual interpretation (Harper, 2012). This stance assumes there to be an objective reality but posits that knowledge is constructed through people's interpretations of the world and this is influenced by one's own beliefs, expectations, and cultural contexts (Finlay, 2006). Although it recognises that an independent reality exists, it also acknowledges one cannot achieve direct contact with this reality (Willig, 2008).

As well as establishing an epistemological position in research, it is also important to state an ontological position. Ontology relates to fundamental questions about

'reality' (Nightingale & Cromby, 1999). The researcher retains an ontological realism assuming that there is a world that exists independently of one's perceptions, whilst also subscribing to a form of relativism believing one's understanding of this 'reality' is constructed from one's own perspective (Ibid). This position is reinforced by the assumption that an individual's 'reality' exists, it is material and has 'real' effects on 'real' physical bodies. This 'reality' however is inherently subjective and context bound.

The relevance of such positions on the current study is that the researcher asserts that psychological wellbeing and mental health problems exist independently outside of the participants' realities. However, the researcher believes that there will be multiple accounts for the same phenomena resulting from different perspectives (Willing, 2008). This position is suited to exploring how the Punjabi community understands psychological wellbeing, mental health problems, and help-seeking, as it allows the researcher to acknowledge that there are socially constructed cultural discourses that may influence these understandings. The study did not aim to investigate how 'true' or 'false' these accounts were, instead it focussed on obtaining rich descriptions about psychological wellbeing and mental health problems. From this position, the researcher also acknowledges that their own perception of the world and contribution of knowledge plays an important role in data collection (Parker, 1997), and that meanings are constructed between the participants and the researcher (Willig, 2012).

2.2. Methodology

This study aimed to explore the beliefs of psychological wellbeing held specifically by the Punjabi Sikh community. Using qualitative methodology, this study explored how these beliefs impact on help-seeking behaviour and shape relationship to help.

Qualitative researchers are interested in “how people make sense of the world and how they experience events” (Willig, 2008). Qualitative research methods focus on discovering and understanding the experiences of participants (Willig, 2008) rather than analysing lists of numeric data like quantitative research (Smith, 2008). Given that qualitative researchers are concerned with experience; it was decided that this research method was better suited to explore how psychological wellbeing is talked about in the Punjabi community. Oakley (2000) also states that such methods are often advocated for research with less powerful groups, in this case a minority ethnic group.

2.2.1. Method

This study adopts a Thematic Analysis (TA) which identifies emerging patterns and themes across a data set (Braun & Clarke, 2012). It is described as the “most systematic and transparent form of qualitative analysis, because it holds the prevalence of themes to be important without sacrificing the depth of analysis” (Joffe, 2012).

2.2.2. Rationale for Thematic Analysis

When considering what analysis was most suited for this qualitative research, Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GT) were also explored. These approaches all seek to understand the everyday reality of participants and share a common goal to ascertain themes across a data set (Braun & Clarke, 2006). Given their classic epistemological stance in social constructionism, discourse and narrative analyses were excluded as they are not concerned with the ‘underlying reality’ of a participant, but rather the way participants construct their social worlds through language (Silverman, 2001).

IPA focuses on the lived experiences of individuals and the meanings they give to these experiences, related to a specific phenomenon (Smith & Osborn, 2008). IPA focuses on the unique characteristics of participants as well as patterns of meaning across the data set. The combination of psychological, interpretative

(hermeneutics), and idiographic components makes this approach distinctive to others (Smith, 2007).

GT is an inductive methodology involving the construction of theory through the analysis of data (Faggiolani, 2011). GT differs from the traditional model of research as it allows the researcher to gather ideas about the data once collected as opposed to applying a pre-existing theory or hypothesis before data collection (Allan, 2003).

All three approaches allow the emergence of patterns to be collected from the data. However, the research was not intended to capture first-person accounts of experience or maintain an idiographic focus as practised in IPA (Larkin, Watts, & Clifton, 2006), nor was it intended to develop a new theory as demonstrated in GT. Instead, the researcher adopted the theoretically independent TA as it permitted a more flexible and accessible approach to data analysis.

TA can be conducted using an inductive (data-driven) or a deductive (theory-driven) approach. An inductive approach facilitates the generation of themes independent to existing theory and knowledge, whilst a deductive approach maps out themes onto previously conceived theoretical concepts and hypotheses (Braun & Clarke, 2006). An inductive approach is usually recommended as most appropriate for exploratory research. However, it was suggested that as the researcher is Punjabi Sikh and was already familiar with some of the literature surrounding this topic, it was unlikely they could avoid the influence of previous knowledge during the analytical process (Braun & Clarke, 2012). Therefore, a dual deductive-inductive approach was considered to be the most appropriate in allowing the generation of new ideas (Joffe, 2012). From this position, whilst welcoming new concepts, existing ideas about the Punjabi community and psychological wellbeing have inevitably informed data analysis.

In addition, TA was analysed at both semantic and latent levels. At a semantic level themes were explicit and taken at 'face value', the researcher did not look beyond the content of what the participants had said. Latent themes however were implicit and attempted to "identify underlying ideas, assumptions, and conceptualisations" (Braun & Clarke, 2006). As well as acknowledging the way individuals made meaning of their experiences, TA characterised by critical realism acknowledged the impact of the broader social context (Braun and Clarke, 2006).

2.3. Research Design

A qualitative research design was adopted for this study. Smith, Flowers and Larkin (2009) stated for professional doctorates, between four and ten participants are sufficient as "it is important not to see the higher numbers as being indicative of 'better work'". Smith and Eatough (2006) also argued that a larger sample size can lead to a superficial qualitative analysis. Data saturation is believed to occur when the recruitment of new participants does not lead to new information being obtained (Guest, Bunce, & Johnson, 2006). The researcher therefore aimed to recruit a minimum of six people.

2.3.1. Data Collection

The researcher chose to employ a data collection method that encouraged participants to express themselves as openly as possible. Focus groups can hold many advantages; they are valuable in setting context and in some cases can reduce anxieties and potential pressures on participants that one-to-one interactions can produce. However, it was considered better to conduct individual interviews especially when the known barriers to this community are stigma and reluctance to share personal information (Loya et al., 2010; Wynaden et al., 2005). Verbal interview data is widely used in TA and is usually collected via semi-structured interviews containing five to seven discussion topics (Wilkinson, Joffe, & Yardley, 2004).

2.3.2. Pilot Interview

A pilot interview is considered useful in assessing the suitability of the research design and interview questions (Turner, 2010). Before the pilot interview was conducted University of East London (UEL) approval was obtained. This interview was conducted to ensure the interview schedule was appropriate for the intended population. Additionally, it served as a good reflective exercise for the researcher to measure how much influence their own experiences and assumptions about the Punjabi community had on the questions asked.

The pilot participant was fully informed of the research study, participant anonymity, and confidentiality. They were also debriefed and offered the opportunity to be signposted to organisations that provide additional support in the event that they became distressed. The pilot interview was conducted with a British Punjabi female who had no personal contact with mental health services. The interview was then transcribed verbatim and discussed with the Director of Studies (DoS). Feedback was provided regarding the interview schedule and interviewing style. As the interview was carried out for the researcher's development only, all data collected was destroyed. The researcher recorded the process in a reflective diary which highlighted a tendency to ask leading questions based on their own experiences (see appendix B for an excerpt). Therefore, the researcher re-evaluated their approach and implemented a new interviewing technique; asking open questions and maintaining a position of curiosity.

2.3.3. Ethical Issues

2.3.3.1. *Ethical Approval*

Ethical approval was granted by UEL Ethics Committee (see appendices C-F). NHS approval was not required as the research involved a non-clinical population. This research was not thought to pose any major ethical issues as participation was voluntary and it did not involve the use of any treatment. The most important ethical concerns were ensuring that participants gave informed consent and that the confidentiality of data was protected. It should be noted however that during

one interview the participant became tearful and distressed when talking about the loss of a loved one. The interview was terminated as the researcher consoled the participant. After talking about the loss, the participant insisted they wished to continue with the interview. The researcher emphasised that they were able to stop the interview again at any time and if necessary they could abandon the interview altogether. Details of bereavement services in the area were offered but the participant declined.

2.3.3.2. Informed Consent

An information sheet was given to all potential participants and a consent form was completed prior to any data being collected (see appendices G & J). All participants were informed that they had the right to withdraw from the research at any given point. Demographic data was also collected (see appendix I for questionnaire). The researcher reassured all participants that their data would be protected.

2.3.3.3. Confidentiality

Anonymity was ensured by assigning participants with codes. All consent forms and codes were kept in a locked cabinet. They were stored separately from any other identifiable data, for example demographic details. The researcher transcribed all data collected. Any identifiable information was anonymised including all quotations used. It was made clear prior to any data collection that only the researcher, DoS, and examiners would have access to the transcripts.

2.3.4. Participants

2.3.4.1. Exclusion Criteria

As the research involved a non-clinical population, all service users were excluded. Punjabi people that were not of a Sikh religious heritage were also excluded, as were those under the age of 18.

2.3.4.2. Recruitment

The researcher had the advantage of being a part of the community they were investigating; family, community centres, and religious places of worship allowed increased access to this population. Participants were recruited via opportunity and referral sampling techniques (see appendices J & K for recruitment poster⁴). The researcher focussed on recruiting from geographical areas that have a large number of Punjabi inhabitants, for example Southall in West London. The researcher's own background was found to promote participation from this community. Those who expressed an interest in participating were provided with an information sheet. This presented an overview of the study and outlined contact details for further queries regarding participation.

2.3.5. Procedure

Following initial contact, the researcher explained to potential participants the purpose of the study and gave them an opportunity to ask any questions. A convenient time and venue was agreed and participants were given the option of being interviewed either in their homes or a private room in a community centre. Potential participants were then given an information pack containing a letter with a confirmed appointment, an information sheet, and a consent form. Before each interview began, informed consent was obtained and participants were reminded they were free to withdraw from the study at any given time without reason. The researcher, fluent in both English and Punjabi, offered a choice to the participants as to which language they preferred the interview to be conducted in. All eight participants occasionally used Punjabi terms but predominately spoke English.

Basic demographic information was collected (see Table 1). A semi-structured interview schedule with broad topic areas was used as a prompt to talk about mental health and psychological wellbeing. The interviews lasted between 60 and 90 minutes and started with the broad question "What is your understanding of

⁴ The researcher used the term 'stress' in the recruitment posters to avoid using medical or psychological terminology. The poster was utilised to generate interest but the researcher explained what was meant by the term 'stress' on approach

psychological wellbeing?”. If participants required a prompt, a definition by Deci and Ryan (2008) was given (see p. 2). This then led to an exploration of mental health issues, relationship to help, help-seeking behaviours, and barriers to accessing services. All interviews were audio-recorded and transcribed verbatim.

2.3.5.1. *Materials*

A digital recorder was used. All participants were informed the interviews would be audio recorded prior to any data being collected.

2.3.5.2. *Semi-Structured Interview Schedule*

The researcher wanted themes to emerge and evolve organically. Therefore, instead of set prescriptive questions the researcher devised an interview schedule to guide participants (see appendix L). This enabled a more participant-led interview which aimed to limit researcher bias.

2.3.6. Sample

A sample totalling 8 adult males and females of Punjabi origin were interviewed for this research. All were of a Sikh religious heritage.

Table 1 *Sample Characteristics*

Pseudonym	Age	Gender	Highest Ed Level	Occupation	Marital Status	Dependents	Recruitment Source	Country of Origin
Jasmin	28	F	Masters	Consultant	Single	0	Snowball	UK
Suman	70	F	Masters	Retired	Widow	3	Temple	India
Simran	42	F	PGCE	Teacher	Married	1	Snowball	UK
Tejinder	44	M	PGCE	Teacher	Married	1	Snowball	India
Amarjit	51	M	GCSE's	Carpenter	Married	2	Temple	India
Kiran	28	F	Masters	Council	Single	0	Snowball	UK
Amar	39	M	Post Grad	Solicitor	Single	0	Snowball	UK
Gurpreet	31	M	Post Grad	Optician	Single	0	Snowball	UK

2.4. Data Analysis

2.4.1. Transcription

All audio recordings were transcribed verbatim by the researcher. The transcription process is regarded as “a key phase of data analysis within interpretative qualitative methodology” (Bird, 2005), as it is recognised that meanings are created from the data. There are a range of conventions for transforming verbal texts into written texts (Lapadat & Lindsay, 1999; Edwards & Lampert, 1993); for this study Parker’s (2005) transcription convention was used (see appendix M). All personal details of the participants were removed and anonymised. Once completed, each transcript was re-read to ensure accuracy. The researcher also made hand-written notes which helped with the process of creating meaning (Braun & Clarke, 2006).

2.5. The Process of Thematic Analysis

Braun and Clarke’s (2006) six phase approach to TA was followed. As with all qualitative research, the assumptions and contexts of the researcher was considered to play a key role in the process of analysis (Willig, 2008).

Phase One: Familiarising Oneself with the Data

During the first phase it is recommended that transcripts are read a number of times to allow for data familiarisation. The researcher immersed herself in the data and analysed each transcript independently, searching for meanings and possible patterns. In addition to this, hand-written notes were kept which helped to generate ideas for potential codes (see appendix N for an excerpt of a transcript).

Phase Two: Generating Initial Codes

Following individual analysis of each transcript, data was systematically coded and organised into meaningful groups (Tuckett, 2005). Coding was dependent on whether themes were semantic or latent and used a dual inductive-deductive

approach. Extracts of text were collated in a separate word document; some extracts were categorised under more than one code and any discrepancies in the data were also coded. Codes were classified into groups to enable the researcher to identify any potential themes and patterns. Appendix O outlines a list of identified codes.

Phase Three: Searching for Themes

After the data was coded and collated, potential themes were generated from the grouped codes. The themes were then classified to help identify overarching themes; mind-maps were used to aid this process. The researcher used this process to think about the relationship between codes, themes, and different levels of themes.

Phase Four: Reviewing Themes

This phase involves two levels of reviewing and refining themes:

Level One: This level involved the researcher reviewing the coded data extracts and considered any patterns that appeared to be forming. The consistency of the themes was verified against the data extracts to ensure each theme was supported by coherent and relevant data. Ambiguous themes were collapsed into overarching themes and some overarching themes were divided into sub-themes until a “thematic map” was formulated (Braun & Clarke, 2006).

Level Two: This level aimed to assess the validity of individual themes in relation to the whole data set. The process involved the researcher re-reading the data to identify potential themes that were overlooked. The initial thematic map was also re-worked and a final map was created which represented the final themes and sub-themes (see appendices P-R). When the development of themes was considered to have reached saturation point, the researcher stopped reviewing the data.

Phase Five: Defining and Naming Themes

Following the last refinements of the thematic map, the final themes were defined. Each individual theme was analysed and reviewed to ensure it described the information clearly.

Braun and Clarke's (2006) 15-point checklist of criteria for a good thematic analysis was used following the analysis (see appendix S).

2.6. Reliability and Validity

Cresswell (1998) stated 'verification' was key in addressing issues of reliability and validity in qualitative research. He proposed eight procedures to evaluate the quality of research and believed at least two should be employed.

The researcher kept a reflective diary to record personal reflections throughout the research process. This diary highlighted implicit thoughts which may have influenced the data and ensured the researcher was attuned to their own values and assumptions. This had been considered particularly important due to the researcher's personal connection with the research. Data verification procedures of peer review were also adopted to help clarify researcher bias; the researcher was involved in a research group with other trainees, who met at various points of the research process. Further to this, two participants were invited to review the themes generated to ensure the reliability of the findings, "this is the most critical technique for establishing criteria" (Chamberlain, 1999)

2.7. Researcher Reflexivity

Reflexivity in general is considered good practice when conducting good qualitative research (Harper, 2012). As qualitative research is associated with interpretation and meaning, it is important to attend to the position of the researcher and their influence on the co-construction of the findings. This is because all qualitative methods are subjective in nature and the assumptions and

values of the researcher inevitably are an underlying threat to the accuracy of research outcomes (Willig, 2001), therefore it is impossible for a researcher to remain detached from their research study (Willig, 2008).

Given that the researcher had a personal connection to the topic area, she anticipated that her own experiences may influence the findings. In order to track the researcher's thoughts and feelings, a reflective diary was kept throughout the research process (see appendices T & U for an example). This process was also imperative during research meetings with the DoS to reflect on any assumptions with an objective party.

The researcher was concerned that her personal experiences would stop her maintaining a position of curiosity and would lead her to make more assumptions than if she was working with an unfamiliar cultural group. She was also aware that her actual presence in the interviews may be a barrier for some participants and that they may not feel comfortable talking openly about mental health given the generic stigma that has been found to surround this topic. In addition, the researcher's personal experiences may have shaped her ideas about mental health issues and how it is talked about in the community; therefore, the researcher felt all data collection and analysis needed to be looked at through a critical lens. Data verification procedures of peer review and triangulation were adopted to help clarify researcher bias and allow for richer descriptions.

2.7.1. Researcher's Position

I would identify myself as a 31-year-old British Punjabi woman of middle class background. By profession, I am a Trainee Clinical Psychologist. As I approach the end of my clinical doctorate, I find myself desperately clinging on to the 'trainee' part. It is the part of my professional identity that I am not quite ready to lose. To my friends and colleagues I am Sukhi. To my family I am Jinny.

As a British-born Punjabi Sikh, I have always considered my multiple and conflicting cultural identities to be very complex. I grew up on a street where my

family were the only 'ethnic minority'. I grew up in a house where, as well as my parents and younger sister, my nuclear family included my paternal grandad, aunt, uncle, and two cousins; I assumed this set up was 'normal'. I was surrounded by lots of people and I loved having a full house to come home to. My parents had both migrated to the UK when they were teenagers. In hindsight, I would say my family were 'traditional'; they maintained most Punjabi customs and we celebrated religious holidays. Sometimes my mum would take me to the *Gurdwara*⁵ and tell me stories about Sikhism. I thought they were very interesting but I often wondered why no one talked about these at school.

At school no one could pronounce my full name so I shortened it to 'Sukhi'. I was only one of four children in my year group who was not White. I only really paid attention to this at the age of 7 when someone had pointed out my different skin colour. I did not understand why I was not the same as my peers and I was angry at my family for not giving me a heads up about my difference! In the evenings after school I was looked after by my childminder. She was English and I enjoyed going to her house because she made me chips and fish fingers for dinner, just like what my school friends ate at home. I used to tell them what I had eaten the next morning to show them that I was just like them.

I started asking more questions about 'being brown' and my family told me more about my heritage. There seemed to be a lot of pride around being a Sikh. "Our people are strong" my grandad would say, "We have to always be ready to stand up for ourselves". I remained on mental standby not knowing exactly what I was supposed to be standing up for or to. Growing up I started to realise that all my extended family lived in areas heavily populated with Punjabi Sikhs. Visiting them was a culture-shock for me, "there are so many Punjabis here!" I would say. I did not like Indian music or watch Bollywood films, much to the dismay of my relatives. They would tease me and say I was different to them. They would call me a 'coconut'; the implication being that from the inside I was White, however this would confuse me as my school friends did not see my inside as being White.

⁵ ⁵ Sikh Holy Place of Worship

My mum started to send me to classes at the *Gurdwara* every Sunday. I am still not clear today about what had motivated this sudden decision. I noticed my younger sister did not have to attend. At 'Punjabi school' I was taught how to read and write Punjabi and how to be a 'good Sikh girl'. I remember asking the teacher why I had to be a good Sikh girl when I had not asked how to be one. She had made no attempts to hide her disappointment and told me to think about how the Gurus had died in order for me to be living the life I am today.

At the age of 13 I (what my mum calls it) "rebelled" and said I no longer wanted to attend these classes. My announcement was met with more disappointment and it seemed I had failed in my task to be a 'good Sikh girl'. As an adolescent in the eyes of my grandad I deviated more and more away from my 'Punjabi' side, as I desperately tried to fit in with my White peer group. I had wanted to eliminate my difference and blend in at school. I did not want to be 'that Asian family' anymore.

My interest in this research was motivated by personal experiences of living with an uncle diagnosed with a 'mental health problem'. As a child, he had seemed fine to me, and I would spend time with him and never had any reason to believe he was any different to me, or any other family member. In fact, I thought he was one of the nice ones. I had heard the label "paranoid schizophrenia" thrown around the house in reference to him. No one had explained to me what this meant, just to approach him with caution because he may not always want to talk to me. I was confused, he always wanted to talk to me, and he always played with me, even when I was being silly. He was kind. "He's just very paranoid" my family would say but I had also heard the way extended family members and neighbours talked about him – why wouldn't he be "paranoid"?

Other than medication, my uncle had not accessed any other support from mental health services. At the time I did not even know there were such services available. Even though I felt we were a close family unit, we had never had open conversations about his difficulties and if the subject ever came up in conversation then my curiosity was immediately dismissed. I was asked why I was so fixated on my uncle's difficulties and why I was so intent on making him feel bad. It appeared

as my intentions were misunderstood. My grandad especially had no tolerance or sympathy for my uncle's difficulties; he would encourage him to find a job, provide for his family, keep active, and all would be well. He would refer to this idea of being 'Punjabi'. "What does this mean"? I would ask him, like it was a shield against anything bad. According to my family, being a Punjabi Sikh means we must be strong, we must work hard, put our best foot forward, and front it out when life gets us down. We must control our emotions and hide vulnerability. I have since reflected on this and perhaps this strong determination stems from the aftermath of the British colonialism of India and the Partition. We are after all the descendants of very strong leaders that resisted oppression so we could live peacefully and proudly today.

It was only after moving out for University that I appreciated being a Punjabi Sikh, and when I became proud of my heritage. I was suddenly surrounded by a range of cultures and ethnicities and no one tried to force into one box. I started to think it was ok to be informed by different cultural scripts and I allowed myself the fluidity to move between different narratives and identities. One day I created my own box...on ethnicity questionnaires, I stopped ticking 'British Indian' and started ticking 'other' referring to myself specifically as a 'British Punjabi'. I then wanted Punjabi Sikhs on the map.

We are a group that are easy to miss because 'we get on with it' and its only now I understand it was not shame that drove my family to stay quiet about my uncle's diagnosis. It just did not matter; it was not a story they wanted to perpetuate because they believed he was still capable of living a good quality of life and achieving anything he wanted. This problem saturated story was mine, not his. Whilst I may be criticised for this romanticised view of Punjabis, this narrative has stayed with me throughout my career. It makes me question my own relationship to help and how this informs my clinical work and how it will inevitably impact this piece of research. With this in mind I will endeavour to remain reflexive throughout the study and not impose my own experiences onto the data.

CHAPTER THREE: RESULTS

This chapter outlines the findings of this study in relation to the research questions. The themes generated from the analysis are presented below in Table 2. From the data, initial codes were clustered into three main themes and eight subthemes.⁶ Individual themes are discussed using extracts of data to support each theme. Further analysis of the data in relation to existing literature is discussed in the following chapter.

Table 2

Theme	Subtheme
1. "We are Warriors!"	1a. Sikh History & Punjabi Narrative
	1b. "We already have Psychological Wellbeing"
2. The Importance of Family Expectations	2a. Looking After Each Other
	2b. Being Independent & Successful
	2c. Information Sharing is a Family Privilege
3. Understanding Mental Health Issues	3a. Perceptions of Service Users
	3b. What Help is Available?
	3c. Learning from the Media

3.1. "We are Warriors!"

This was the most salient and recurrent theme across the interviews. This theme is comprised of two subthemes; the first encapsulates a powerful narrative derivative from Sikh history. Participants referred to themselves as needing to be 'Warriors' to get to where they are today. They all referred to the several attempts of Sikh genocide but this information was captured after the interviews had been terminated so unfortunately specific quotes cannot be included in the text. When participants talked about Sikhism they considered the religion to be more than a just a relationship with God. Even those who stated they were not particularly religious (i.e. complying with practice such as regular attendance to the *Gurdwara*, or prayer) felt that having a Sikh heritage contributed to a vast part of their identity.

The second subtheme 'We already have Psychological Wellbeing' describes a strong belief held by all participants that they were equipped with the skills

⁶ These themes were also consistent with themes identified in the pilot interview

required to protect themselves against ‘ill mental health’. There were reports of already knowing how to maintain psychological wellbeing through guidance from parents at an early age. A belief of respect in religion and spiritual traditions was fundamental in the participants’ upbringing. This occurred through prayer, meditation, visits to the *Gurdwara*, and the celebration of religious holidays.

3.1.1. Sikh History and Punjabi Narrative

Sikhism has a turbulent history where followers have needed to fight for their faith and traditions. Most Punjabi Sikhs share strong ethno-religious ties; many countries such as the UK recognise Sikhism as a designated ethnicity on their census, arguing that Sikhs self-identify as an ethnicity and believe that they are more than just a religion. Even those who do not consider themselves to be practising Sikhs, spoke about how significant the impact of Sikh history was on forming their current identities. All participants made reference to the metaphor of being a fighter and needing to resist the oppression Punjabi people were once subjected to nearly 400 years ago⁷. The narrative was very powerful and all participants revealed how they embodied the idea of needing to be a fighter:

“Sikh people left India and they were all strong, Sikh people are all like yeeaaahh... [gestures with her arm to signify strength] and I keep using that word strong but you know like tough. We’re all really tough and maybe from back in the day we had to fight for our religion so that’s something that has fed through all the generations” (Jasmin: 142-145)

Jasmin reported during childhood that whenever she was having a bad day, her mother often referred to the idea of her needing to be a fighter. Tejinder recalled his mother encouraging him with a similar idea after revealing that someone at his school had made a racist remark to him. This idea became important in Tejinder’s upbringing as his mother consistently referred to it. When he was feeling low and

⁷ Sikhism was considered a resistance movement against Islamic persecution

lacking motivation in life, Tejinder's mother would remind him of his religious heritage:

"You guys are the children of a great leader Guru Gobind Singh Ji" [tenth Sikh Guru] (64-65)

All participants were in agreement that the idea of being a fighter and standing up against oppression had led to them feeling very proud to be Punjabi. All participants spoke passionately about needing to be strong in times of adversity. Participants spoke about the importance of keeping focus and determination on their goals despite any difficulties encountered. The idea of strength seemed to be a powerful narrative passed down through generations:

"I think at the end of the day whatever's going to happen is going to happen. You just have to deal with things. I think you'll just have to build up strength yourself to try and tackle that issue. Obviously inform your family about it. Maybe I would keep it to myself for a little bit just to figure out what it is, what I'm having to deal with" (Kiran: 489-494)

When asked where that narrative came from, participants stated it had been embedded into their upbringing and their mothers had advocated resilience as an important way to live:

"I think it might be cultural thing where you're expected to deal with it. I think it comes from my mum because she was a very strong willed person. I think she's always had to endure so much so I think that it sort of runs through the family" (Kiran: 496-498)

"Since childhood I've always had to deal with my own problems and challenges. I always feel like I can do it. With my mum's upbringing and

teaching, I feel that you've just got to deal with what's been thrown at you"
(Tejinder: 245-247)

Resilience and fortitude kept difficult emotions under control even when life felt overwhelming. When talking about the loss of one of his closest friends, Amar said he had made the decision to manage his grief alone:

"I just deal with stuff myself. I'm the kind of the person that doesn't worry people about my problems. I'm quite strong so it's got to be quite a lot. I mean I've always got a lot going on. But it's a matter of don't worry, I've dealt with everything" (Amar: 253-257)

Amar chose not to express his true feelings about this bereavement as he did not want to upset his parents. Similar judgements about appearing vulnerable and wanting to avoid upsetting family members were further expressed by Jasmin:

"When my grandmother was really ill, I was really trying to be strong and be there for my dad 'cause you sort of put on a front. I think its cause you gotta be perfect, well not perfect but you can't be seen to have a problem"
(Jasmin: 35-38)

Being emotionally and mentally strong meant adapting well to things like stress, trauma, adversity, or tragedy. Participants spoke about resilience being a quality that they were born with:

Amarjit: *"They don't want to go [to services]. We are Punjabi and we can manage. What I can say. When you think about big warriors that come from Punjab"*

Int: *"Warriors?"*

Amarjit: *"Warriors yeah"*

Int: *"So what is a Punjabi warrior?"*

Amarjit: *"They are strong. You are from Punjab and that is in your blood"*

Int: *"And do you feel like you have to be a warrior?"*

Amarjit: *"I can say a warrior for everyday life" (346-352)*

This idea of being a Punjabi Warrior was strongly linked to the Sikh religion. For the participants Sikhism was more than a religion; it had become an identity used as inspiration to face difficulties. The Sikh history had led all participants into developing identities that they deemed as being almost indestructible:

"I don't know why, maybe it's the values of being Punjabi like strong and we're proud, and you know we're pretty strong hard people actually"
(Jasmin: 139-140)

"When we talk about own Sikh history, we get warmth from it. We learn all those stories and that gives them more vigour" (Suman: 526-531)

To develop resilience, participants believed it was important to focus on building particular skills such as learning to manage strong feelings and solving problems efficiently. They believed they may not always be able to control what life threw at them, but that they always had a choice about how to respond to the event. Again, this inner strength was talked about as being innate in the Punjabi community:

"One should be strong isn't it? You have to be. Strength is within you. But you have to find it and use it" (Suman: 599-600)

"We don't show weakness in our faith...the culture of Sikhism, it's really strong and they're like lions" [makes roaring sound] (Kiran: 148-151)

The participants were so wedded to the concept of being warriors, they believed they did not need to accept help from others. Especially if they were able to manage a setback themselves without needing to involve others:

“I don’t think I approach anyone to deal with trouble. I think again it’s childhood experiences. When you’re thrown in at a young age and you have to deal with it. It’s a make or break scenario, I just deal with it myself. But I think if I was real desperate and there was no one around then I probably would [ask someone for help]” (Tejinder: 232-238)

This quote captures the unwillingness reflected in all eight participants to ask for help. There was a consistent belief that one should be able to manage their own problems and not seek support from others. Family and friends were spoken about as being a contingency, but it was strongly favoured to deal with misfortunes by oneself. Many participants identified the Punjabi community as being very proud and talked about this being a potential barrier to seeking help as it was seen as going against the grain of one’s history and looking weak:

“We are very proud people. We don’t want others to know our problems. I don’t need anyone else’s help. I can do it myself” (Simran: 388-391)

“It’s a very proud culture...it becomes like a competition as to who does better” (Gurpreet: 331-335)

“I literally feel if I had to walk into my doctors tomorrow and say “I’m depressed, I can’t take this no more” for me that would be a big sign of, that would be just me giving up. Possibly weakness. Just not being able to cope. A sign of giving up on control as well” (Amar: 404-411)

“It’s seen as a weak sign. Being a bit mental in the head” (Tejinder: 134)

When Suman was asked whether she would have considered accessing psychological services after the loss of her husband and daughter she simply stated:

“Oh no, I thought I must pull my socks up” (Suman: 207)

She stated this narrative had been entrenched into her from an early age and that the narrative had continued to dominate her life whenever she faced any challenges. Suman said this ‘Punjabi narrative’ had protected her and stopped her “losing my mind” after the death of her husband and daughter. She talked at great length about using the Sikh history to remind herself that she had come from a community that radiated resilience and to “give up would be an insult to my people”.

3.1.2. “We already have Psychological Wellbeing”

All participants talked about the concept of psychological wellbeing as being ingrained into them from an early age. Participants referred to ideas around self-acceptance, personal growth, and autonomy. They talked about achieving psychological wellbeing through living an active and balanced life, which included working hard and taking time out to enjoy life and go on holiday, etc.:

“Happy soul means you have balance. I think it [psychological wellbeing] is the balance between working and domestic life. Keeping busy...so going out with friends. Sometimes we went to India on some holidays” (Suman: 173-176)

“If you’re going to spend all day indoors and not go out regularly...you’ll literally start banging your head against the wall. You get stuck in this kind of rut. There’s no surprise that’s what they’re going to start feeling. They need some help from the doctor” (Amar: 433-440)

All participants felt it was a priority for everyone to maintain psychological wellbeing:

“I’ve always known since young that mental health is one of the most important assets you can have” (Amar: 561-562)

“It’s all about thought process and how you manage your thought processes. Yeah I think it’s important” (Gurpreet: 20-21)

“Stress overall affects your mental wellbeing” (Tejinder: 185)

When asked where these ideas had come from, the participants reported that psychological wellbeing had been taught to them by their parents from an early age. Ideas about maintaining a sense of inner peace was strongly embedded in the spirituality of Sikhism but were not talked about using the same Western terminology:

“They don’t realise they are teaching mental wellbeing...positive state of mind. It’s just not using that terminology...it may not be spoken about directly because they don’t have the knowledge to speak about it directly. They don’t call it mental health or make sure you have positive mental health. But I think it is something that is strongly emphasised, especially further back down the tradition” (Gurpreet: 135-146)

Participants were strongly influenced by the spirituality promoted by Sikhism to help them preserve their psychological wellbeing. All participants believed they could control their own happiness and “train” their minds via prayer and meditation to be at peace:

“My father in-law gave me a book called the Sukhmani Sahib, [chapter in Holy book] I didn’t know the value of that at that time. I kept it but only read

that book when my daughter died. That really gave me peace of mind and understood those meanings. Then I was so thankful to my father in-law who gave me that book. Sukh means comfort, Mani means diamond. Diamond of comforts. I read that book and I really thought ‘good gracious’” (Suman: 96-105)

“If you are spiritually strong, it will make you mentally strong” (Gurpreet: 35)

Participants had spoken about psychological wellbeing as a concept that could be achieved if one worked hard enough to obtain it. Participants had referred to psychological wellbeing as being a lifestyle choice for one to proactively make:

“It’s doing what you wana do. In the sense that you know what’s gona make you happy, you know what’s right and wrong for you” (Kiran: 16-17)

“I do a lot of prayers. I’m quite spiritual. I think I mentally relax by reading mainly spiritual type of books. I have a very strong spiritual belief. Through my prayers and through positive actions and service, I find that helps me a lot” (Tejinder: 237-239)

“Just go and pray, go meditate in God’s name...it’s so Zen Sikhism, it’s like very Buddhist. Go to the temple, you pray, you’re in your own space” (Jasmin: 148-149)

The participants expressed strong beliefs about Sikhs having psychological wellbeing. It was interpreted by the researcher that the participants believed they had achieved a sense of mastery and were not in need of acquiring new skills:

“I don’t think the majority of Sikh people are mentally sick” (Kiran: 488)

“...a strict work ethic and stronger family ties, means we do not suffer with mental health problems and it is not something the community has to be concerned about” (Suman: 499-502)

When asked to elaborate on such a firm belief, all participants stated that their Sikh practises could be used as a deterrent for such problems. This reinforced the belief that Punjabi people did not need to access services or utilise Western methods of coping with distress.

In addition to Sikhism promoting psychological wellbeing, the religion instructs that all humans are equal and should all be valued in the same way. Furthermore, Sikhism does not believe in superstitions and rejects all rituals and routine practises such as fasting and pilgrimage. As a result, many participants considered it to be a progressive religion that accepts mental health problems:

“From a Sikh perspective it’s [mental health problems] totally accepted. I think any perception that it’s not accepted is from South Asian cultural perspective” (Tejinder: 421-422)

“Sikhism is a very progressive religion. From a Sikh perspective it’s [mental health problems] totally accepted. It’s described in the Guru Granth Sahib Ji. The Punjabi community are seen as more accepting” (Gurpreet: 393-421)

3.2. The Importance of Family Expectations

Family was another strong theme across the interviews; participants believed it was a given that families should support each other through times of misfortune. This theme is comprised of three subthemes; ‘Looking After Each Other’ refers to a deeply embedded belief passed down through generations that an individual problem is a problem concerning the whole family. ‘Being Successful and

Independent' refers to the pressures of working hard to accomplish goals set by the family and wanting to make them proud, as individual success is also seen as collective success. There was also a strong message about needing to be independent and 'get on' with life even when experiencing hardship. Participants talked about this pressure being a part of 'normal' Punjabi life. Family was therefore paradoxically regarded as both a source of support and source of stress. Finally, the subtheme 'Information Sharing is a Family Privilege' captures the simple belief that the participants' personal lives are their own business and they have the right to keep that information private. This was an interesting finding as most literature on South Asians suggests all subgroups are affected by issues of stigma and shame around mental health. It would appear that this sample were not affected by such issues and took a pragmatic approach to their problems preferring to keep them private.

It is common in the Punjabi community for multiple generations of a family to live in the same household. This traditional family unit has survived even after migration to the UK. All participants described living with extended families and complying with some traditional family roles. Participants talked about wanting to be respectful and consider the feelings and thoughts of their family members before making any decisions, as they all valued individual sacrifice for the benefit of their family. Family roles were clearly defined by the community, for example, amongst Punjabi families the primary role of children was to bring honour and success. While this theme may be perceived as a contradiction to the previous theme, participants spoke about both themes being important to their psychological wellbeing. No participant had expressed any conflict about having to be both independent and lean on family members when necessary. In fact, participants were encouraged to be independent and prioritise the development of their resilience, and then return to the family where this collective 'warrior' identity was strengthened.

3.2.1. Looking After Each Other

Family played a key role in the lives of the participants; all eight described their family as having a big impact on their psychological wellbeing. The family was seen by participants as the main source of support. Strong intergenerational expectations about 'duty' and 'entitlement' were often expressed. Participants were unanimous in their convictions that caring for people with problems was the family's responsibility:

"I think the Punjabi culture is quite good towards your family...Quite serving towards families and responsibilities to each other. Some of my family, they help me...every week I phone his [her late husband's] sister" (Suman: 193-199)

"Actually it's frowned upon if you don't talk to your family about your problems because it's perceived as not being connected to the family" (Gurpreet: 303-304)

"I'm lucky 'cause I have a network of people around me. I got my mum, my dad, I got my best friend and stuff. I don't have siblings so I speak to my cousins and they're brilliant" (Jasmin: 27-29)

"If they're in the family, you can't really leave them alone. Whatever the situation is, you've got to face it. If any close family is doing weird things, you need to calm them down and talk to them" (Amarjit: 213-216)

Participants agreed there was no shame in other communities accessing help from mental health services, but they were not deemed a necessity amongst this sample. The same reluctance was expressed towards the possibility of utilising physical healthcare services such as the local GP or hospital care. When asked about the possibility of accessing services as well as turning to family members,

participants reported they felt as though approaching services was a betrayal to loved ones:

“I wouldn’t look at going to a mental health service...I would turn to friends and family” (Gurpreet: 296-301)

Even when prompted to think about accessing services hypothetically, all participants said they would only access a service if they were forced to.

Amarjit described when his sister was starting to become unwell, she was perceived as doing “weird things” by his family. Some of these behaviours they referred to were her lack of appetite and withdrawal from engaging with activities she had previously found enjoyable. He hypothesised that her low mood was a result of parental stress and pressure. Even when the ‘problem’ was located as being within the family, approaching external help was still not viewed as a desirable option by Amarjit. Other participants took a similar stance and expressed a preference to keep their problems within the family and close friendship groups.

Only one participant worried about being a burden on services:

“There are other people who need the service more than I do. They may be more deserving of the service than someone who feels a bit down for the day” (Amar: 425-427)

When asked more about this, Amar felt that he was equipped with enough support around him and suggested services were difficult to access as it was. He felt that he did not warrant “draining” under-resourced services which he felt were irrelevant to him in the first place.

3.2.2. Being Successful and Independent

Amongst the participants there was a strong sense of wanting to make the family proud, as achievements reflected well on family members. There was a feeling of obligation that one should listen to their family, given the struggles previous generations have had to endure in order to make a better life for the upcoming generations:

“Sikh people are a hard working generation. Always going forward” (Suman: 514-516)

“They encourage us children to do very well in our education...most of my cousins have been pushed to do well. My dad is forcing my brother to get a good job and finish his education off” (Kiran: 514-519)

“What parents don’t understand is that, sometimes the kids aren’t going to be that bright or a genius, you’ve got to do everything right. As an individual you might feel that pressure...my parents wanted me to do something a bit more academic” (Kiran: 111-116)

“There’s that perception of representing your parents” (Gurpreet: 560)

Gurpreet went onto discuss how accessing mental health services would not only make the person needing support look weak, but also associated family members. Disclosing problems was thought to tarnish the family reputation which could impede the future for family members. Deviating from family expectations also caused too much stress and participants preferred to feel connected to their families. Participants also talked about how important it was to project an image of success to the wider Punjabi community:

“Our culture has a lot of expectation put on us. You gotta do the right thing, at the right time...like buy a house, settle down, have children. That is

achievement in Punjabis eyes. If you're not married by thirty or whatever, it's like oh god there's something wrong with her" (Jasmin: 213-220)

Not conforming to these norms challenged the reputation of the person and their immediate family, this maintained the need to keep problems a secret. Members of the community considered to be successful were highly praised and valued. This created pressure on people to continue to conform and avoid the disclosure of mental health problems, as it was a definitive way to negate one's success.

There was a collective expectation that individuals should learn from their elders:

"The hope is that you learn and you pass on what you've learnt...I think that's been the key to, sort of the, the way we are really" (Gurpreet: 114-121)

"My mum is quite strong willed...she had to leave India, her family were there and then come here and get married. That's made me gain a lot of confidence...I think that's where I get my strengths from" (Kiran: 502-509)

"It's probably because their parents told them to work hard and become somebody...with good morals and respect for other people and work hard and earn an honest living...that's what they're trying to portray to their children and to us" (Simran: 528-531)

Despite the need to learn from elders and look after each other, there was also the expectation that one should also be fiercely independent in their journey to be successful, especially when it comes to managing problems. Independence was a narrative that had been encouraged in the lives of all participants from an early age:

“When I was fourteen, fifteen my parents started pushing me to get a job...to become independent and learn the value of money and work”
(Kiran: 72-73)

“Since childhood I’ve always had to deal with my own problems and challenges. I always feel that I can do it. With my mum’s upbringing and teaching I feel that you’ve just got to deal with what’s been thrown at you”
(Amarjit: 245-247)

3.2.3. Information Sharing is a Family Privilege

Participants were concerned about keeping personal information concealed from members of the community, not due to fears of being stigmatised but because information was considered to be private and privileged. When asked about the stigma and shame of mental health problems, participants were not overly concerned about this; they restricted personal information to close family members because as far as they were concerned no one else needed to know:

“Only to the people that need to know, I think. But not to everyone in the society, no. But if the people needed to know like your family, your friends, yes that’s fine” (Simran: 339-440)

“I think he’ll [her brother in relation to their mother’s death] talk when he needs to talk. He’s quite a closed person and likes to keep everything to himself. I don’t think he’d discuss his feelings with just anyone, he keeps his cards close to his chest” (Kiran: 351-354)

Some participants had expressed a curiosity about mental health issues but had suppressed the temptation to ask others about it, due to concerns around causing offence and feeling it was not their place to ask:

“It’s something I would love to ask but I don’t wana offend anyone, I don’t feel like I’m in the right position in the family to ask...It’s ‘cause they haven’t spoken about it, and you don’t wana offend them” (Jasmin: 191-197)

Jasmin was concerned about being perceived as prying or being intrusive about other people’s personal information and it had stopped her asking about other people’s experiences. Similarly, despite learning that one of his closest friends had been admitted into a mental health unit Amar believed his friend was entitled to privacy and therefore refrained from asking any details:

“You kind of expect a bit of privacy in a way as well. A lot of the time it’s just something personal” (Amar: 235-236)

Amar thought it was difficult enough to access a service, without the additional pressure of telling others:

“It probably takes quite a lot of strength to seek the help anyway. So you don’t want to go around and have to tell everyone what you’re doing and why you’re doing it for” (Amar: 663-665)

3.3. Understanding Mental Health Issues

This theme looks at how the participants talked about mental health issues and what beliefs they hold about people who access mental health services. This theme is comprised of three subthemes; ‘Perceptions of Service Users’, ‘What Help is Available?’, and ‘Learning from the Media’. When talking about their understandings of mental health issues, participants talked about these as primarily being Western problems and strongly asserted the notion that the Punjabi community were unlikely to suffer from ‘ill mental health’. Participants reported that they were not aware of what mental health services in the UK offered as treatments and assumed medication to be the main intervention available. They

were open to the idea of learning more about services and service users, and used the media to inform them of such matters. The knowledge that they feel they had gained from the media about mental health was thought to be adequate and they had rated this as a good learning source. In regards to their personal opinions about how mental health problems affected them, all eight participants expressed feeling exempt from experiencing such problems described by Western healthcare professionals, stating they had existing skills to overcome these:

“We [Punjabi people] don’t believe in that [mental health] you know? But when it comes to this country then I know I can believe that depression is big problem...there’s a lot of stress here. In India, maybe I was young at the time but nobody cares about tomorrow” (Amarjit: 106-112)

3.3.1. Perception of Service Users

There were three participants whom, prior to the research, had direct contact with service users. When participants were asked about people who access services, participants referred to ideas that could be perceived as being stereotypical when describing some of the difficulties service users may present with:

“They’re talking to themselves...doing weird things” (Tejinder: 14-16)

“People just breaking stuff and just doing un-normal things” (Amarjit: 28)

“My understanding of schizophrenia is...there’s bipolar as well isn’t it? That’s a different branch of schizophrenia. One minute you’re ok, the next you’re not” (Jasmin: 182-185)

Participants commonly used the word ‘normal’ to describe behaviour that was considered more desirable in society:

“People don’t wana be mentally unwell...You would not be normal. There’s something wrong with you” (Amar: 607-608)

“I guess and you don’t want to be treated differently...you just want to be normal in society like everybody else” (Simran: 343-344)

It was observed that participants had the tendency to pathologise behaviour that they perceived to deviate from their cultural norms:

“We’re thinking she’s got a double personality sort of thing, but she’s never been diagnosed with anything...but there must be something wrong with her because you don’t do what she does” (Simran: 235-238)

“There’s a guy at work who I think is sort of borderline autistic. But nobody knows if he’s actually got a condition...the way he acts is very strange” (Kiran: 452-454)

When talking about her father who has a diagnosis of Dementia, Simran referred to the way he would be perceived in society if they found out:

“I think people will think that he’s a bit mental” (Simran: 201)

When asked to elaborate on the term ‘mental’, Simran used her sister-in-law as an example whom she believes to have mental health problems based on her behaviour:

“She’ll blow up...and start swearing for no reason” (Simran: 232-233)

When Simran was asked how she had made sense of her father’s diagnosis she described there was “something wrong with his brain” and this had been something he could not have controlled for.

Participants reported there was reluctance in the Punjabi community to talk about issues that made them appear vulnerable, so often people kept any difficulties they had to themselves. Even when someone in the wider family was considered to be experiencing a mental health issue, participants stated that they would not approach the person to ask more about it. Despite feeling compassionate towards such individuals, participants insisted that they found it easier to avoid asking and admitted to making assumptions about the person's experiences instead:

"She had a breakdown and no one's spoken about it or what happened with her. She comes to events but she can't deal with loads of people and she's not all there" (Jasmin: 117-119)

When referring to those who may be suffering with mental health issues, some participants used language that may be perceived as being pejorative and negative:

"The person's a bit cracked, cracked up in the head" (Tejinder: 121)

"She's a bit mental... She's bit of a nutter" (Simran: 227-228)

Some participants reflected that they had unintentionally adopted their parents' views of service users and felt they made judgments towards them fearing they were unpredictable and dangerous:

"If you go too close to them they might hurt you. But you don't want to put yourself in that situation where they can hurt you or something" (Amarjit: 53-202)

"It's really like crappy to be mentally ill. It's seen as not very nice" (Jasmin: 250-251)

Amarjit recalled that as a young child he was advised by his parents to keep his distance from people that they perceived to behave 'oddly'. When asked about the idea of being 'odd', Amarjit stated it that encompassed all behaviour that digressed from his cultural norms. He went onto add that given his age and lack of interest at the time in pursuing the matter, he had not pressed the issue or questioned what his parents had meant. Amarjit added that his views changed after immigrating to the UK twenty years later.

One participant in particular commented on the way mental health problems were perceived in India when he lived there:

"Mental health is seen as a weakness. If you've got it, can you just keep it to yourself? Otherwise it might spread like a flu" (Tejinder: 280-281)

Tejinder reported this was not his personal viewpoint and went on to talk about the differences between the wider South Asian culture and the more specific Punjabi culture. He reported that the two cultures were different and although there were some similarities around family values, etc, he believed his Punjabi culture to be more accepting and liberal of mental health problems. Jasmin shared this view regarding South Asian culture:

"That's just the culture...conservative culture where you got to be right and proper and you gotta be honourable. Because everyone has to behave correct and proper" (Jasmin: 50-53)

It would appear that there are conflicting cultural and religious scripts on mental health problems, and views on this topic are perhaps dependent on which script has the most influence on a person. Another participant explicitly made the distinction that Sikhism as a religion did not always fit into the wider South Asian culture:

“The application of Sikhism into the wider culture is not direct” (Gurpreet: 421-423)

Other participants had also alluded to feeling like ‘outsiders’ amongst other South Asians. This supports existing research about Sikh Punjabis feeling limited connections to India. In regards to India, Amar also spoke about the stigma that existed around mental health. He reported people there worried about the impact on a whole family if one person were to have mental health problems:

“People might have their views and it might change. Maybe they’ll try to less contact you. Even somebody from your family has got that illness. Other people might try to keep away from you as well” (Amar: 242-243)

Amar made it clear that these were not his personal views but like previous participants talked about this wider ‘South Asian culture’.

Amarjit voiced similar frustrations about the South Asian community as a whole being judgmental but stated that he himself was not concerned about what other South Asian subgroups thought of him:

“If you tell them [South Asians outside of the Punjabi community] they will take the mick out of you. I think if it doesn’t concern them, why would I worry? I think wellbeing is more important than those things...than what other people think” (Amarjit: 235-240)

Amarjit’s strong stance on not caring what the wider society thinks of him, and wanting to take a stand could be related to the Punjabi narrative of being leaders and not giving into oppressive ideas. Given the lack of ties Punjabi people are reported to feel towards South Asia, the participants appeared to be saying they did not care to fit into a culture they felt rejected them following the Partition of India.

In regards to the aetiology of mental health problems, all participants spoke about the cultural ideas that exist in India about such problems being attributed to religious or spiritual explanations. For example, ideas around 'ill mental health' occurring due to evil spirits or transgressions committed in a past life. The sample however reported that they did not believe any of those explanations to be accurate and instead prescribed biological causes as the root of mental health problems:

"I thought there was something wrong from inside their head. That's why they were behaving like that and they need medical help" (Tejinder: 44-45)

"...from maybe a genetic perspective or physically in the brain" (Gurpreet: 234)

As well as the belief that mental health problems were a biomedical entity and caused by an organic malfunctioning of the brain, participants talked about mental health as something one could control by maintaining the correct diet. They suggested that it was one's own personal responsibility to ensure they preserved their psychological functioning through eating well:

"There may be an abnormality or a defect, not just the brain, but in your body, there may be a genuine defect. Maybe low on iron or a certain iron, vitamin or whatever which would cause mental instability" (Gurpreet: 235-237)

"...let's say, from weakness in your body. The weakness is if you don't have the right balance for the diet" (Amarjit: 164-172)

In addition to this, participants also spoke about environmental stressors as triggering mental health problems, stating they believed that life events evoking trauma and sadness in people could affect people's psychological wellbeing:

“I think the person might be bit disturbed from the family...I think maybe extra stress from family issues” (Amarjit: 180-181)

“I think what causes it could be a range really, it could be financial issues, family struggles, work struggles...” (Tejinder: 176-177)

“My mum passed away last year so...that’s been a lot of pressure on me and my family as a whole...emotional stress” (Kiran: 124-126)

After the loss of Kiran’s mother, her family had started a dialogue about the impact of bereavement on them both individually and as a whole, where psychological wellbeing was discussed as important to look after.

3.3.2. What Help is Available?

This subtheme captures the participants’ own admission that they tend to lack knowledge of local services, reporting they do not need to recruit external help. There was even reluctance expressed towards the possibility of utilising healthcare services such as the local GP and hospital care for physical health concerns. This is perhaps not surprising, given that the participants believe they are warriors and do not need help of any kind. With regards to mental health services, all eight participants reported that they did not know what support was available for people who were struggling with any mental health issues. They had relied on the media to inform them of such services and when asked they reported that they held limited knowledge about what psychologists did. Six participants expressed concern about losing respect in the community after accessing such services.

All participants spoke about perceiving a mental health diagnosis as being negative and were concerned about being put into a box and being given a lifelong label:

“You’re being put into a box and a label...“I’m a patient”” (Amar: 752-753)

“It’s just seen as a negative thing. It’s seen as a big disability if someone’s like mental” (Tejinder: 119-120)

“I don’t think we did tell many people...They [his parents] just stayed quiet. They didn’t want to tell anybody. Because she needed to get married” (Amarjit: 502-509)

“It might have a big impact later on their lives with their job, or marriage, and so on” (Gurpreet: 136-137)

Within the Punjabi community where arranged marriages are common, mental health diagnoses were considered a grave threat to marriage prospects, both for the person experiencing mental health problems and for relatives through association. ‘Mental ill health’ was believed to be terminal, which raised many anxieties about mental health problems in the context of marriage proposals.

Some participants raised suspicions about services, and feared they were not places of support where people can receive some respite:

“You get more sick if you into hospital. It’s more depressing going into hospital. I’ve never trusted them” (Suman: 434-634)

Suman revealed that she had developed these fears after hearing from others about their negative experiences of hospitals and healthcare professionals. Other participants expressed similar feelings of mistrust towards services:

“Sometimes if they don’t get back to you then you’re think they don’t really care. It’s a job to them. You’re just another person. Another statistic. It depends on the professional. Whether they carry on with you or they have

too many patients and they're too busy to see you, kind of thing" (Simran: 358-361)

Suman reported a preference for disclosing problems to her own community in a different setting, as opposed to mental health professionals in hospitals. She had proudly reported that the Punjabi people in her area had started to utilise Punjabi community centres as an outlet to talk about problems and share information about mental health. She had also stated that the environment felt safer and that she was not concerned about talking to members of her own community:

"They have started talking about it, there are Punjabi community centres" (Suman: 547-551)

Despite reporting a biological component to the causes of mental health problems, participants were suspicious about the use of medication as a treatment and doubted it would be of any benefit. All participants were concerned about medication being offered as the first line of treatment too readily:

"It just seems like it was being dolled out regularly. Everyone just walks into a doctor's office "I don't feel well", "I know what it is. I got depression. Doc, I'm not happy" and then bang they get their prescriptions" (Amar: 164-169)

Amar saw medication as an easy way to dismiss someone without getting to the root cause of the problem. He was concerned about medication being prescribed as a treatment and was very sceptical about taking it. For him it presented as a significant barrier to accessing services:

"That would be quite a big thing for me...That would be quite serious to be taking anti-depressants. I don't like taking medication as it is...I see the side effects" (Amar: 457-467)

When asked about medication, most participants did not like the idea of taking medication:

“There’s always a reluctance of being medicated in the first place, so actually I would rather avoid having medication. There’s reluctance in the Punjabi community for any prospect of being medicated” (Gurpreet: 434-453)

The researcher interprets this as perhaps invalidating the warrior stance and ideas around being strong and beliefs about maintaining an inner peace through meditation. Further to suspicions around medication there was limited knowledge regarding other types of treatments available in the NHS, with two participants enquiring whether extreme treatments such as Electro-Convulsive Therapy (ECT) are still being used:

“The only one I know is the electric shock really. Do people do this?”
(Suman: 638)

When Amarjit disclosed that his sister had sought some treatment for low mood in India when they were younger, he could not recall what treatment she had received and despite the emphasis on spirit possession causing such issues for people at the time, he still assumed his sister had been given ECT:

“We took her to the doctor and they referred her to a...special hospital. They must have done some electric shocks on her” (Amarjit: 459-460)

Aside from medication and ECT participants did not know what treatments were offered to people presenting to mental health services. All participants had been surprised to hear about the existence of talking therapies. When the researcher described some of the coping strategies used to manage difficult emotions, in

Cognitive Behavioural Therapy (CBT) for example, all participants stated this was not something the Punjabi community needed support with.

3.3.3. Learning from the Media

Participants all reported that they found Western media very useful and all trusted it as a good source of education for such topics, and had not challenged the accuracy of its portrayal. There was substantial reliance on media representations to form perceptions about people with mental health problems. Participants referenced popular TV shows and films as being influential to adding to their knowledge base about mental health:

“...it’s media as well and seeing it in films and understanding psychological illnesses” (Amar: 583-584)

“I saw this film...He was playing this role of a mentally disturbed person in the hospital...His girlfriend used to ask him “come home, come home”. At the end, those mentally ill people, when they got disturbed they hit him, on the floor, his glasses are torn. At the end, I don’t really know what happened but he walked out with his girlfriend. It does affect you. Even watching the film, it does affect you” (Suman: 314-319)

Here, Suman also reflected on her own affect after watching the film, and the inability to tolerate the distress of others worrying about the impact on her own psychological wellbeing. Other participants also praised the media as a helpful avenue for increasing awareness about mental health, especially in the Punjabi community:

“It’s [mental health] so out there now...‘Still Alice’, I dunno if you’ve seen it. It’s a wicked film ‘cause it’s so real, and I come across someone who has some form of dementia...And she still had all the social skills, everything, you would never think she’s got a problem...I really enjoyed that movie and

it was very sad, but it was a great way to understand...and I really believe that people need to be a bit more educated on it” (Jasmin: 254-267)

“My first real knowledge of anti-depressants was from watching ‘The Sopranos’” (Amar: 154)

Amar also went onto to make the distinction between Western and Indian media, reflecting on how Indian films can have a negative impact on such topics:

“If you watch Hindi films and stuff my mum and dad are watching, if there is ever a film with someone who is, got some kind of mental difficulty...they’re the butt of the jokes” (Amar: 628-631)

CHAPTER FOUR: DISCUSSION

This chapter begins with a summary of the analysis in relation to the research questions and relevant literature. The researcher then considers the wider implications of the findings for the clinical practice of psychologists working with the Punjabi community, highlighting some recommendations for future research. The chapter concludes with a critical review of the methodological limitations and a reflective account considering the research process.

4.1. Research Questions

- How does the Punjabi community in the UK understand psychological wellbeing?
- What awareness is there of mental health issues?

4.2. Discussion of Themes

4.2.1. "We are Warriors!"

The strongest theme that was identified in this study was the idea of being a 'Punjabi Warrior'; an identity that was embedded into the participants from an early age which promoted strength and resilience, as well as humility, and fairness and equality. Messages about being strong and confronting problems 'head on' was the foundation for this identity and was built on the survival of the Punjabi Sikh community following the many historical attempts of genocide by India and Pakistan. Participants reflected on their childhoods and being strongly encouraged by their parents to think of themselves as the children of Guru Gobind Singh, who was renowned as being a 'Punjabi Warrior'. All participants were proud to be considered warriors and referred to the survival of their ancestors as being the most powerful inspiration during any hardship (Singh, 1987). Being descendants of a strong leader and believing one's genes carry warrior status was strongly linked to the participants' perception of Sikhism. Even with a 42-year age difference

between the youngest and oldest participant, and given the generational differences, issues around acculturation, and different life stressors, the 'warrior' narrative ran deeply through all eight participants.

Participants reported that the key principles of Sikhism were at the root of their wellbeing. When talking about psychological wellbeing on the whole, participants stressed that the key to one's happiness was through leading a simple life guided by simple principles, and living by necessity rather than greed. The participants spoke of developing a skill set that allowed them to manage difficult emotions more efficiently, for example reflecting on their feelings in diaries, being mindful, and staying active to induce a positive mood state. These strategies mirrored techniques practiced in mainstream models such as CBT (Beck, 2011), indicating that they were already practising some of the skills promoted by some mainstream psychological services. It was noted that there was a substantial emphasis on the preservation of psychological wellbeing, highlighting a preference to prevent rather than cure.

It appears from the research that the Sikh world view regarding mental health encompasses a holistic framework to healing where the mind, mood, and body are interrelated (Singh, 1993). When faced with an obstacle all three domains are impacted. All participants reported that they combined religious and spiritual elements of Sikhism into their daily routines and felt that this reinforced a stable balance in health by attaining a sense of inner peace. The mind, mood, and body were thought to be interlinked and that it was one's choice and responsibility to nurture all three elements. Ideas around spirituality and meditation to find peace were prominent, especially as coping strategies through times of hardship. Participants reported regularly utilising meditation as a way of coping with stress or negative feelings. The idea of centering oneself by taking a step back and connecting with the universe sounded similar to ideas from mindfulness (Kabat-Zinn, 1994). All participants reported that living a life of purity and believing all creatures to be of value helped them maintain a sense of inner peace.

An extensive evidence base indicates positive associations between religion and mental health (Koenig, King, & Carson, 2012). Sembhi and Dein (1998) provided strong empirical evidence for the integration of religious values with Western therapies. Sandhu (2005) presented the Sikh Life-Stress Model as “an existential approach or philosophy premised on the assumption that human beings are motivated by the ego’s desire to fulfil four core human needs; security (*surakhia*), love (*prem*), respect (*izzat*), and freedom (*azaadi*)”. The model states that these four core human needs are connected and can be pursued concurrently. Security is the need to feel safe referring to the emotional, physiological, and material aspects of life; Love involves the need to form relationships and intimacy with others; Respect is the need to be treated with dignity and recognition of one’s self-worth; Freedom involves feeling liberated to pursue ambitions and dreams. There is emphasis on these four needs to be pursued via collective ego, involving one’s family and the wider community. For Punjabi Sikh elders, it is the cultural norm to fulfil the four human needs at a group level, but the younger generation of Punjabi Sikh are likely to pursue these needs at an individual level (Nayar, 2004). This model directly conflicts with Maslow’s hierarchy of needs (1943) where lower needs are required to be fulfilled before higher needs. The Sikh Life-Stress model is well established in Canada and has been helpful in conceptualising the unique religious and spiritual needs of the Punjabi Sikh community (Sandhu, 2005), but given the findings of this study it appears that it could be relevant to Punjabi Sikhs in the UK and could inform clinical practice here.

All participants had referred to the widespread civil and political unrest, and massacre in the North Indian state of Punjab in 1984. According to Human Rights organisations, Indian security forces and police had tortured, executed, and illegally cremated more than 10,000 Punjabi Sikhs (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). When political crises and economic instability lead to migration and individuals leave one geographical area for permanent settlement in another, there is a strong possibility that aspects of that individual’s cultural and ethnic identity will change (Bhugra, 2003). This was not apparent in this study

where the history and identity had accompanied the participants and become a dominant narrative in their lives. All participants reflected they felt no ties to India which appeared to unite Punjabi Sikhs together and reinforced the 'warrior' identity. Identity appears to be particularly important to the Punjabi Sikh community. When Simich, Maiter, and Ochocka (2009) investigated the underlying psychosocial processes that promote psychological wellbeing in migrant populations, they studied five ethnolinguistic groups (Mandarin-speaking Chinese, Polish, Punjabi Sikh, Somali, and Spanish-speaking Latin American) in Canada. One of the incidental findings that arose from this research was the importance of religion and identity to the Punjabi Sikh participants. The study was carried out in Canada, and although the findings cannot be generalised to a UK population, it highlights the importance of identity to Punjabi Sikhs and how closely it is linked to ideas around their psychological wellbeing.

Some participants expressed that psychological services should collaborate with faith leaders to help communities raise awareness of mental health problems. Some further contemplated whether religious and spiritual ideas could somehow be incorporated into mainstream interventions. The general consensus across all the participants concluded that Sikhism is more a way of life as opposed to a religion and that more people should practice some of the principles to retain a sense of wellbeing. Singh (2008) supported this idea and suggested that there is great scope for its use in various modalities and clinical populations. The integration of spirituality has previously lead people to receive culturally attuned treatment programs and has demonstrated high rates of recovery (Azhar & Varma, 2000; Fallot, 1998; Razali, Hasanah, Aminah, & Subramaniam, 1998).

Parkes and Gilbert (2010) looked at the mental health needs of the Sikh community in Birmingham, and reported that many service users stressed that their spiritual beliefs formed an important part of their daily living and were key to their recovery. They concluded that it is essential for services to work in collaboration with communities and integrate religious and spiritual beliefs as

required. Those who practiced Sikhism were found to have a better sense of 'self' (Froggett, 2001) and a stronger internal locus of control (Bhugra, 2003). The need to integrate traditional views into therapy was also highlighted by Vontress and Epp (2000), who reported 80% of the world's population utilised traditional faith healers in times of distress. It was considered therefore important and useful that Western therapists take into account the cultural backgrounds of their service users (McCormick, 1998). Nayar (2004) also stressed that the Punjabi community's mental health needs can be attended to by encompassing traditional Sikh values into the therapeutic context.

The 'warrior' identity had led current participants to believe that they were able to overcome any emotional and psychological distress by themselves as they actively sought to protect and preserve their psychological wellbeing every day. When asked about the prospect of accessing mental health services, participants insisted this was not a necessity for the Punjabi community. If participants did however wish to share the burden of any problems, they asserted that their family members were their equivalent to psychological services, thus highlighting loyalty not only to an inherent cultural script but their family members. This was motivated by a strong conviction that one should be able to manage their own problems during challenging times even if it meant suppressing one's emotional responses and adapting positively to stress and trauma. This supports research carried out on psychological wellbeing by Deci, Ryan, Gagné, Leone, Usunov, and Kornazheva (2001). Their Self-Determination Theory assumes that basic psychological needs are universal and innate. According to the theory, feelings of autonomy, competence, and resilience must be satisfied on an ongoing basis for people to function and develop in an optimum way. This appeared to be the case with the current participants who all nurtured their psychological wellbeing on a daily basis and described feelings of ownership of it. This may in part help explain the low rates of Punjabi people in mental health services.

4.2.2. The Importance of Family Expectations

This theme highlights the importance of family and how their role can either help or hinder one's psychological wellbeing. On first glance, this theme appears to be in direct opposition to the concept of being a 'Punjabi Warrior' however, the participants did not express any internal conflict around this apparent contradiction. They appeared to have negotiated these two ideas and allowed them to co-exist; this shows the complexity around being a 'warrior' and suggests that even 'warriors' need support at times. Punjabi Sikhs tend to have strong family networks; the family is regarded as an integral part of their lives and tend to be very close knit (Singh, 2009). All participants identified their family as being their first point of contact when needing support. Participants stressed that the family unit was duty bound to take care of one another and provide help when necessary. However, with this support comes an expectation to adhere to strict family rules. For this reason, most participants reflected that their parents had been explicit about their expectations of them, forcing their own aspirations to become secondary to their parents.

Unlike in Western society, the term 'family' in the Punjabi Sikh culture can be extended to include; those who feel a strong sense of responsibility to another by virtue of close relationship (even if living apart); those who may not be blood related but share a common ancestry; and those whom a person builds a relationship with through marriage (Singh, 2009). Participants believed that the 'extended family' would often care for an individual with a mental health problem before seeking psychological services; this finding is consistent with Chadda (2001) who found that 90% of people experiencing chronic mental health problems lived with their families and did not access external support. Other literature found that family is regarded as the most important structure in caring for vulnerable members (Cooper et al., 2005; Conrad & Pacquiao, 2005; Commander et al., 2004; Husain, 2004), including those with mental health problems (Lawrence, Banerjee, Bhugra, Sangha, Turner & Murray, 2006).

All participants reinforced the view that the whole is greater than the sum of its parts, and placed a great value on the wellbeing of the whole group, even if it was at the expense of the individual's own happiness. The cultural values of Punjabi communities emphasise a collectivist orientation, advocating that issues remain within the family and be managed privately (Singh, 2009). This could suggest that disclosing personal problems to anyone deemed an outsider is a breach of loyalty. The acknowledgment of external help may be kept at bay to avoid making family members feel like they have failed each other. British Sikh Punjabi families insist on caring for family members with mental health problems and the idea of an extended family makes the burden feel lower (Lloyd, Singh, Merrit, Shetty, Singh, & Burns, 2013).

Whenever help is sought, family members often feel compelled to accompany the individual in need to all clinical appointments. Although this can assist with rapport building and initial anxieties, individuals may feel they are unable to disclose the full extent of their problems. For the clinicians working with such families, there may also be issues surrounding confidentiality (Singh, 2009). In addition to the emphasis on the role of the family, there were strong messages about needing to be independent and successful in one's own right. The participants had stated that they were encouraged by their parents from an early age to be independent and be able to support themselves when necessary. It was observed that in the current sample all but one participant had a post-graduate education. The need to be successful and high-achieving appears to be important to this community with previous research supporting this finding (BSR, 2016). Focusing on one's personal growth, ideas around self-determination, and feeling that one is able to achieve whatever they put their mind to may be linked to the 'warrior' narrative (Deci et al. 2001).

Finally, participants had briefly talked about there being a culture of stigma, shame, and secrecy surrounding mental health problems in the wider South Asian community and the implications on marriage (Bradby, Varyani, Oglethorpe, Raine,

White, & Helen, 2007; Ng, 1997). Although they considered the impact of accessing mental health services on their future prospects including marriage, the participants reported that their reluctance to talk about problems to anyone external to the family was mainly motivated more by the perception that their information was private and there was little need to make this public knowledge. This finding may come as a surprise given the vast amount of research that claims stigma and shame is a key barrier to access for this community (Bradby et al., 2007; Vogel, Wester, & Larson, 2007; Das & Kemp, 1997).

4.2.3. Understanding Mental Health Issues

All participants felt that they had an understanding of the concept of psychological wellbeing; some did not use this term per se but felt that the idea of maintaining psychological wellbeing was an ordinary part of daily Sikh life. Many participants referred to the idea of happiness as being a tangible concept one could control, and believed it was their personal responsibility to actively preserve it. Participants spoke about being equipped with preventative strategies that protected them against mental health problems. Several participants had referred to mental health problems as being primarily a 'Western problem'.

All participants had reflected on the way mental health is conceptualised in India but all reported that they themselves did not subscribe to the idea that spirits or evil eye cause such problems. Participants in this study attributed the causes of mental health problems as being dietary related or abnormalities in the brain. They also identified some potential triggers of mental health problems that are typically aligned with Western explanations of mental health, for example bereavement or other stressful life events. This contradicts existing research that suggests the biosocial-medical model adopted by NHS services is in contrast to ethnic minority explanatory models of mental health (Loewenthal et al., 2012; Sheikh & Furnham, 2012; Dein, 2010).

It was observed that participants referred to mental health dichotomously using terms such as 'normal' and 'not normal' to describe human behaviour. Their idea of deviating from normality involved an individual acting outside of accepted cultural norms. There was also a difference in the way certain psychological difficulties were talked about in relation to others, for example, participants spoke more sympathetically about 'stress' and 'depression' compared to 'psychosis' and 'personality disorder'. This may be because participants have been exposed to the former difficulties more. It may also be because terms such as 'personality disorder' and 'psychosis' do not have clear translations in other languages (Rathod et al., 2016). Existing research on the Punjabi community reveals the difficulties in translation and how distress amongst Punjabis tends to be described in physical sensations (Krause, 1989). All participants touched on the notion that severe and enduring mental health problems such as 'schizophrenia' were a Western issue, resulting in the belief that Punjabis do not suffer from such 'disorders'. Whilst most simply alluded to this idea, some participants explicitly stated that Punjabi people did not experience psychological distress in the same way as other communities. They felt better equipped to manage their problems and therefore felt immune to such problems. Participants continued to build on this narrative concluding that mental health problems were not something that affected the Punjabi community.

Most participants spoke about being curious about mental health diagnoses and the treatments available. However, they also expressed their reluctance to find out more as they thought it was not their place to ask and believed that talking about such matters could make the problem worse. Jorm, Korten, and Jacomb (1997) coined the term 'Mental Health Literacy' defining it as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". There are several aspects of Mental Health Literacy including; the ability to recognise different types of psychological distress, beliefs about risk factors, knowledge about interventions, and knowledge of the professional help available. All participants reported they did not have enough knowledge regarding mental health treatment and services. The three participants who had direct access to a

service user also expressed not knowing the scope of what psychological services offered. This could be interpreted as the sample thinking that there is not a need for them to know, given the fact that they believe they are 'warriors' and have their own strategies put in place to ensure they are protected against mental health problems.

Participants also reported relying on media to obtain information about mental health; it may be the case that they feel they have acquired all the knowledge they need. In the UK, research indicates that very little is known about the way in which people acquire knowledge and beliefs about mental health; 33% cited anecdotal evidence from others as an important source for information on mental health problems (Jorm, 2000; Hiller, Sandman, Ehlig, Weisbecker, Kepplinger, & Benkert, 1999; Wolff, Pathare & Craig, 1999). Participants had identified Western media as the sole medium of learning about mental health, which suggests that their attitudes about mental health may have been built on stereotypical ideologies. There were numerous references to Western media being a useful tool as education in this area. Participants also referred to popular UK and US television dramas depicting mental health problems as being important influences. Some participants commented on the negativity of mental health in Indian films where the behaviour of characters with mental health problems was exaggerated and dramatised; portraying them as volatile and violent. Media is a common mode of accessing information in the UK, with 32% of the general population citing it as their main source of information (Jorm, 2000). Media has the potential to de-stigmatise as well as to stigmatise (Philo, Henderson, & McCracken, 2010) and can be both helpful and hindering when it comes to accessing accurate information, especially on mental health (Byrne, 2003).

4.2.4. New Contributions to Literature

This study contributes a fresh approach to how specific aspects of the Punjabi Sikh culture influence the beliefs of psychological wellbeing, which has scarcely been studied in Psychology (Sandhu, 2005). There are currently no existing

studies that specifically focus on the beliefs of psychological wellbeing within this population, therefore this study provides a distinct insight into this community's experiences. The study also details why the Punjabi Sikh community refrains from accessing services and reveals a novel help-seeking narrative.

The 'warrior' stance was the strongest theme throughout the interviews, with all participants referring to the history of how Sikhism had survived through the turmoil it faced. It was by far the dominant theme as participants kept referring back to the idea of being a 'warrior' and it laid the foundation to the way participants managed their everyday hardships; it was their inherent identity and mapped their decision making. It highlighted the importance of inner strength and self-agency, despite the emphasis on a collectivist community, and irrespective of Western influence this message had been passed down through many generations. Bhugra (2004) stated that when individuals migrate they do not leave their beliefs or idioms of distress behind. This community appears to support this statement, as they have strongly held onto their identity as 'warriors' and Punjabi narratives around strength and resilience.

Religion was found to be significantly related to this 'warrior' identity. Participants believed their religion extended beyond being a relationship with God and instead represented a relationship to life. Participants had implemented daily spiritual practices into their lives encouraged by Sikhism and felt they had enough resources to manage any hardships. The participants described already utilising some of the coping strategies that most mainstream talking therapies promote. As this sample took a more active approach to preserving psychological wellbeing, and believed it was vital to do so, this is a community that may see mental health services as being redundant.

4.3. Implications and Recommendations

4.3.1. Implications for Clinical Practice

The current findings have implications for clinicians working with individuals from a Punjabi Sikh background. Firstly, given the unique and strongly embedded narrative about being a ‘warrior’ linked to the Sikh religion, the researcher proposes that there is a need to understand this community separately from the wider South Asian community. The current findings support that culture-specific elements of understanding psychological distress are not only overlooked from existing dominant causal models, but in every area of mental healthcare, for example from the methods used to determine distress to the interventions available. It has been proposed that a more diverse and culturally meaningful practice of assessment and intervention of distress is required in order to promote services that respond to the needs of individuals from different cultural backgrounds.

4.3.1.1. *‘Warrior Wellbeing’*

One potential way of working with the Punjabi Sikh community could be to embrace and utilise the idea of ‘warrior wellbeing’. Taking a community psychology approach, it would be helpful for clinical psychologists to firstly consult with faith leaders and community members to ascertain whether there is a need for psychological input to promote psychological wellbeing for local Punjabi Sikh communities. If this support is required and welcomed by the community, clinical psychologists should conduct further consultation to think about how such support would be most useful. One dilemma this current study has presented is that the participants stated there was no need for psychology in their community. It would seem psychological interventions have little to offer them as they are already exercising helpful coping strategies on a regular basis, some of which are used in mainstream therapies. In light of this, healthcare professionals may wish to consider helping faith leaders and community members draw on the strategies this community is already utilising. This could be achieved through the implementation

of ‘warrior wellbeing’ workshops in *Gurdwaras* and community settings focusing on having a peaceful mind. These would be open for anyone to attend who is interested in reconnecting, reinforcing, or repairing their ‘inner warrior’. Sessions could be guided by passages in the Guru Granth Sahib that discuss mental health and encourage inner peace. It may also be a space to discuss stories about the Gurus and Sikh history to strengthen the collective identity of this community. An identity which appears to inspire strength and resilience in Punjabi Sikhs equipping them with the necessary ‘armour’ to prevent them accessing mental health services. Holding these sessions in the local community with other community members may help normalise help-seeking and is aligned with their current Sikh practices making them the experts of their own wellbeing.

However, caution needs to be taken; this is a community that wants to have autonomy over their psychological wellbeing. This is also a community that has faced many attempts to be colonised. Therefore, clinical psychologists need to work in collaboration with community members and not position themselves as the experts. It may also be important to consider exploring the idea of being a ‘warrior’ and relationship to help. This may involve building on the ‘warrior’ metaphor further *with* the community to think about ways in helping ‘injured warriors’ and negotiating the challenges of being strong but also wanting to ask for help. On the other hand, the ‘warrior’ narrative may present as a challenge to those who do experience mental health problems and present to services for treatment. Clinicians need to think about what this means for people’s identities if they feel unable to live up to the ‘warrior’ narrative and rely on oneself for internal strength. In such work, clinicians may need to think about the development of alternative narratives to ensure Punjabi people are not denying themselves the right to access support.

4.3.3.2. Punjabi Sikhs that present to Services

It has been proposed that NHS services need to provide more diverse and culturally meaningful practices in order to respond to the needs of individuals from

different cultural backgrounds. The Race Relations (Amendment) Act (2000) places a duty on all public authorities to challenge discrimination in service delivery, so the responsibility is on the healthcare system to bridge their knowledge gap, challenge stereotypes, and respect the needs of those from all cultures. For the Punjabi Sikhs who do present to services, clinical psychologists need to ensure they demonstrate cultural competency during clinical contact. Clinical psychologists also need to include an assessment of family dynamics, learn about specific cultural norms, and understand the shame around seeking help (Shapiro, 2003).

Clinicians should employ a curious stance to understanding culture, especially as younger generations may be contending with conflicting identities and prioritising parental expectations over their own needs. In addition, clinicians need to consider wider cultural influences and be aware that Western models of individualism contrast with the role of the family (Inman & Tewari, in press; Durvasula & Mylvaganam, 1994). During assessment, the use of a genogram could aid understanding of one's immigration history, family structure, and relationships with extended family members (Lim & Nakamoto, 2008). 'Re-storying' cultural issues may help Punjabi service users understand generational differences in the family and the acculturation process, as well as multiple, perhaps conflicting, cultural identities. Whilst having strong family networks and looking after each other can be seen to conflict with the idea of internal self-reliance and a 'warrior' identity, the participants had managed to resolve this conflict. They talked about the importance of being independent and self-reliant but returning back to the family to look after each other when necessary. Promoting one's own psychological wellbeing felt vital to being able to there for others. The participants viewed this as strengthening the collective 'warrior' identity in the community. Therefore, in clinical work it may be necessary to engage family members in interventions. This should be considered on a case-by-case basis and may create ethical dilemmas for the clinician involved; who ultimately makes the decisions, the individual or the family? In this community it appears to be a complex combination. The person is

viewed as having autonomy but also as being intimately integrated with the family. The participants also highlighted the use of daily Sikh spiritual practices in their lives to ensure that they were free of distress and able to maintain a sense of inner peace. They all felt this protected them from becoming overwhelmed when faced with problems and felt the religion further inspired them to be resilient when confronting turbulence. This necessitates a holistic approach to ethical matters such as informed consent, issues around confidentiality, and one that includes the individual's personal context as well as the religious or spiritual dimension of their experience.

Clinical psychologists also have a role in providing consultation in order to provide education and promote information about mental health issues. Using a systemic framework and leadership skills, this role should be extended throughout the different levels of the healthcare system (Onyett, 2007). Clinical psychologists have a duty to provide supervision to the wider mental health team to reflect on their role in consciously or unconsciously perpetuating mental health stigma (Gilbert, 2001). If clinical psychologists did consult with faith leaders and community members as suggested above, they could disseminate their findings to other healthcare professionals working with the Punjabi Sikh community to safeguard 'cultural competence'. This may help professionals feel more confident when asking questions surrounding the topics of religion and culture.

The participants in this study all reported that they were not fully aware of what services were available for those experiencing mental health difficulties and expressed an interest in learning more. It would therefore seem that there is the need to enhance mental health literacy within this community. Clinical psychologists could achieve this by offering guidance and developing policies with media departments in mental health services. Given that the findings indicated that there was a substantial reliance on media to obtain information about mental health, it seems this would be a useful way to disseminate this information. Utilising mass media has indicated large scale change in reducing mental health

related stigma (Brinn, Carson, Esterman, Chang, & Smith, 2010; Bala, Strzeszynski, Cahill, 2008; Francis et al., 2002) and could play a useful role in shaping how mental health problems are perceived. This awareness may encourage contact from the large proportion of those who only enter mental health treatment at crisis points. The main messages from the media should focus on normalising help-seeking behaviours and promoting self-compassion. Thus if anyone from this community did wish to seek support perhaps this would encourage them.

Local Governments have been successful in the past in promoting awareness for physical health problems that particularly affect the Punjabi Sikh community, such as diabetes. This was initially denied by the community as being a problem for them (BSR, 2013). The role of social media has also been documented as promoting awareness about mental health problems and could provide a medium to share information and normalise 'unusual' experiences (Donovan, 2003). Such forums could be monitored by clinical psychologists, or other healthcare professionals, who in turn could disseminate psychology blogs highlighting what services are available.

4.3.2. Recommendations for Future Research

This study sought to examine the awareness of mental health issues within the Punjabi Sikh community in the UK; a group that for research purposes is often engulfed within the wider South Asian population. By employing a critical realist TA approach, it was assumed that the notion of psychological wellbeing existed within the Punjabi community. Future research could build on this by utilising a different design, specifically a social constructionist epistemological position to explore how the Punjabi community constructs distress. A discourse analysis may also be useful in observing naturally occurring language and analysing the semantics behind the language.

While South Asians share some historical and political circumstances, and cultural values, there is a degree of diversity within South Asian subgroups. In light of the current findings highlighting a novel 'warrior wellbeing' identity and not needing to rely on anyone outside the family for help, there is a need to conduct more culturally-specific research on other South Asian subgroups to observe additional within-group differences. Resilience and protective factors are often overlooked in mental health research on minority ethnic groups with barriers to accessing services taking priority. Given some of the protective factors identified in this study, it is perhaps safe to assume that other ethnic minority groups may hold their own beliefs about the preservation of their psychological wellbeing.

It is important however to recognise the limitations of this study; the themes were identified from this sample of eight Punjabi Sikh community members, therefore the researcher cannot assume that the 'warrior' narrative resonates with other community members. There is a need to conduct further research to investigate whether this identity is something that fits with the wider Punjabi Sikh community. If this narrative appears to run strongly through the community in general, clinical psychologists should strongly consider consulting with community members and faith leaders to co-construct appropriate campaigns that could help inform service development.

Another much needed area of investigation is to focus on the clinical population of Punjabi Sikh people that present to services before reaching crisis points and are engaging with psychological interventions. It would be useful to explore how much of this narrative is relevant to their identity, and whether they are incorporating daily spiritual Sikh teachings to promote psychological wellbeing. It is vital that clinicians approach this narrative with caution and explore whether the warrior narrative resonates with them and if so, consider how they have managed the conflict of being strong and asking for help. Further research could look to deconstruct this idea of being strong and whether it is a helpful rule for living or one that impedes help-seeking behaviour.

4.4. Critical Review: Evaluation of Current Research

This section aims to evaluate the quality of the current study by applying Yardley's (2011) criteria for assessing validity. Yardley identifies the following core principles; Sensitivity to Context, Commitment and Rigour, Coherence and Transparency, and Impact and Importance. These principles have been assessed to fit with the epistemological stance taken.

4.4.1. Sensitivity to Context

The Introduction Chapter provides an overview of the existing literature on the topic; the researcher demonstrated sensitivity to context by highlighting the socio-economic milieu in which the current study is situated in and identifying gaps in the literature. Given the interactional nature of data collection, the researcher considered the impact of also being Punjabi Sikh on the participants. The researcher demonstrated sensitivity to context by adopting a position of curiosity, displaying empathy when appropriate, and addressing any power dynamics that emerged which may have positioned the researcher as the expert. Sensitivity to context continued during the process of analysis, where making sense of the participants' experiences required "immersive and disciplined attention" (Yardley, 2011). Yardley advocates that this is the best example of sensitivity to context.

4.4.2. Commitment and Rigour

This was demonstrated through various means. Firstly, the researcher carried out a pilot interview to ensure the questions asked were appropriate. This was also an opportunity to assess the impact of the researcher's own status as a Punjabi Sikh on the participant. Given the researcher's own context and personal experience of the community, the researcher was mindful during the interviews not to assume any shared meanings. Even when participants spoke of common traditions and customs the researcher was personally familiar with, further clarification was sought to facilitate idiographic understanding. During analysis, time was dedicated to engage with the data set to ensure a thorough and systematic analysis, taking

into account the complexity of the data. Two participants were contacted to check the codes and themes generated, to validate the analytical process further. Codes and themes were discussed critically with peers who held knowledge of TA. Rigour was also achieved through regular supervision with the DoS, which not only allowed for discussion of some of the problematic aspects of TA (Salmon, 2003) but kept the researcher committed to the epistemological underpinnings of the research.

4.4.3. Coherence and Transparency

The researcher aimed to be transparent throughout the study by explicitly highlighting every aspect of the research design, data collection, and analysis. The researcher kept an 'audit trail' which included examples of initial codes and mind maps of how emergent themes across the transcripts developed to form overarching and sub themes. The researcher also included verbatim excerpts to allow the reader to make their own assessment of how grounded the themes were within the data. Furthermore, the researcher aimed to demonstrate reflexivity throughout; it was important to acknowledge the impact of any assumptions or personal experiences held by the researcher on the findings. To make these biases explicit, the researcher kept a reflexive journal throughout the study.

4.4.4. Impact and Importance

This study contributed useful knowledge of how the Punjabi Sikh community in the UK understands psychological wellbeing. Investigating this community in isolation has highlighted the distinct features of the Punjabi culture that are somewhat different to its counterparts under the South Asian umbrella. Focusing on the awareness of mental health issues within this community has offered the opportunity to inform the clinical practice of psychologists working with Punjabi Sikh people and helped make recommendations for future research.

4.5. Further Methodological Considerations

Although the study generally met the criteria proposed by Yardley (2011), it is necessary to consider further evaluation as there are inevitable limitations to any methodological approach used in research. Qualitative research is aimed at gaining a rich understanding of people's experiences and perspectives in the context of their social worlds (Braun & Clarke, 2006). It is however largely critiqued when compared to quantitative methods in relation to researcher bias, subsequent issues around validity, and the generalisation of small sample sizes (Willig, 2008).

The sample was self-selecting which means the findings may possibly be influenced by sampling bias. It could be argued that only participants who held a personal interest in this topic chose to participate, potentially resulting in a particular type of individual being recruited. Findings should therefore be considered in the context of those who participated.

In regards to recruitment the researcher did not experience any obstacles in obtaining participants; people had heard about the study through word-of-mouth and had been eager to participate. The study welcomed participants from all over the UK which would have provided an enhanced overview of experiences, however due to time and resources the researcher focused on recruiting from areas heavily populated with Punjabi Sikhs. As an unintentional result, all participants in this study were residents from the South East of England where the researcher also resides. Despite the recruitment of participants representing a range of experiences and contexts, it is important to acknowledge that they may not represent the beliefs of all Punjabi people living in the UK. Whilst all participants were British Punjabi Sikh, from a middle class background, and residents in the UK, there was a fair level of heterogeneity in participant characteristics. Some were born in the UK and others born in India. All participants had been living in the UK for the majority of their lives and considered the UK to be their home. The researcher also acknowledges that all but one participant is

educated to a post-graduate level and noted that this may have influenced the findings therefore results should be interpreted within the context of these participants. It could be argued however that this is actually representative of the Punjabi Sikh population as a vast majority tend to access higher education (see pg. 9).

Three participants made reference to the archaic caste (class) system used in India, which suggests it may be prominent for some Punjabi Sikh people living in the UK today, despite this contradicting one of the main principles of Sikhism; equality. Caste was an issue the researcher had not anticipated prior to the interviews but acknowledges may have impacted on some of the experiences and perspectives of participants. Despite these differences there was a large number of shared experiences across the participants, therefore the diversity in their characteristics did not reduce the representativeness of the data. Employing a TA within this research allowed the commonalities and differences across the data set to be summarised (Braun & Clarke, 2012).

The time and resources available for this study consequently limited the scope of the research. Although Guest et al. (2006) stated that there was no way of specifying the exact number of participants required within a research study, the researcher acknowledges a larger sample size may have provided more evidence for the themes identified. For such reasons, the findings cannot be generalised to all Punjabi people. Qualitative methods however do not thrive to achieve generalisation of findings; they focus on the development of understanding complex phenomena (Willig, 2008; Marshall, 1996). Using a sample size of eight was therefore deemed appropriate (Guest et al., 2006) in allowing a rich understanding of the beliefs and experiences around psychological wellbeing to emerge, in order to develop knowledge that could inform clinical practice and future research.

As this research adopted a critical realist position, inter-rater reliability may be considered a further methodological limitation in this study. All data collection and analysis was completed by the researcher alone. Multiple independent coders were considered inappropriate but codes and themes were discussed with the DoS. In addition, the researcher discussed codes and emergent themes with two participants; all participants had been given this opportunity but only two had expressed an interest in doing so. Williams and Morrow (2009) proposed that validation from participants ensures the integrity of data. The researcher also participated in a peer-led research forum which involved discussion of how grounded the themes appeared to be in the data. This ensured further credibility of the findings. By ensuring the analytical process was transparent and systematic, the researcher has attempted to provide reliability whilst remaining consistent with a critical realist position.

A relative strength of the research was the flexibility offered by the researcher regarding the times and locations of the interviews. The vast majority of participants opted to be interviewed in their homes as opposed to a private room in local community centres or temples. The researcher firmly asserts the notion that the familiarity of their surroundings allowed discussions to flow without interruptions or fear of judgement. Participants felt safe and spoke openly. It may also have minimised the power dynamics between researcher and participants.

Individual interviews offer a vast amount of information, however they have been criticised for not capturing naturally occurring interactions (Potter & Hepburn, 2005). Analysing everyday interactions may have increased assurance in findings, however given that the participants stated a tendency to hide behind bravado, individual interviews may have been the most effective way of obtaining information. The researcher asserts the same rationale for not adopting a focus group format.

Conducting a pilot interview helped the researcher to develop an interview style that was more neutral. The researcher used feedback from the pilot interviewee to develop the interview schedule and inform upcoming interviews. A strength of the current study was that the interview schedule was only used as a guide to prompt participants if necessary, therefore interviews were predominantly participant-led. In hindsight, the research design may have benefitted from initially consulting with the Punjabi Sikh community and co-creating the research together. In not doing so, means the researcher may have missed the opportunity to explore alternative areas in this topic that may be important to the community.

4.6. Reflexivity

Reflexivity recognises sensitivity to how prior assumptions or experiences may influence findings and vice versa. It is considered an important part of assessing rigour in research (Spencer & Ritchie, 2012). A reflective journal kept throughout the research process alerted the researcher to any potential influence on data collection and analysis.

Reflecting on the pilot interview I noticed three key areas that required development; firstly, I had unintentionally lead the discussion based on my personal knowledge of the community, secondly I had asked closed questions, and finally I had assumed shared meanings throughout. This permitted me to have more awareness of my interviewing style for subsequent interviews. The pilot interview served as a useful experience for me to reflect on my own skills as a researcher and reminded me I was there to collect information from participants regarding their knowledge, and not to seek validation for my own.

Prior to any data collection, I had anticipated that my own cultural background could be a potential barrier to allowing discussion to flow freely, however it transpired that my own ethnicity as a Punjabi Sikh actually promoted rich discussion as participants aligned themselves with a researcher that was “one of

them”. I then became concerned about my ability to remain in the role of a researcher and questioned how ‘Punjabi’ I was “allowed” to be. I realised during data collection that it was easy to compromise a position of curiosity; this was not only due to my own assumptions, but the participants themselves assumed a shared understanding. They frequently privileged me as having an automatic understanding of their experiences. I therefore paid particular attention to making my own assumptions explicit with a view to reduce researcher bias. Participants often looked perplexed when I asked for confirmation or elaboration and I found this feeling uncomfortable. I did not want to appear as though I had no knowledge of my own cultural traditions and customs, however I wanted to conduct a piece of research as ethically and reliably as possible. I often reflected on my desire to justify to my participants that I was indeed “Punjabi enough”.

I also reflected on my phrasing of certain questions; each interview began with a broad question to encourage an open discussion and not one influenced by my own agenda. Holding my pilot interview in mind, I attempted to ask open questions throughout. This was to ensure all ideas were introduced by the participants themselves. Despite this, I felt that I held the power as to which direction the interaction led to. It was me that followed up on certain responses, perhaps it was my own interest that motivated me to enquire more detail about a subject matter, and it was my choice to let go of statements that felt to digress from the topic.

I was also acutely sensitive to the fact my Punjabi Sikh background may have triggered some impression management from participants during the interviews. This was highlighted to me as a potential issue when some participants expanded on responses after the audio-recorder had been switched off, indicating that some topics felt too controversial for non-Sikhs to hear about. This made me realise the ways in which research can be influenced by wider contexts⁸. I felt my experience of therapeutic interviewing and positioning service users as experts by experience, enabled me to take a non-judgmental stance and attend to any potential power

⁸ At the point of conducting this research there was political unrest and anti-Sikh violence in the Punjab

dynamics during the interview process. I felt being in their homes alleviated this as I was on their territory.

Ritchie and Lewis (2003) considered the analysis process to be a dialogue between the researcher and the data. Given this, I was more reflective throughout the analytical process and used supervision to tend to my anxieties around getting the analysis “right”. By giving Punjabis’ a voice, a luxury I do not believe we have always had, I felt I had to do the analysis justice. There were times however when I questioned myself as to whether I had been interpreting the data in the context of my own experiences. I also reflected on the idea of being a “Punjabi Warrior” and whether this narrative was relevant to my own relationship to help, and if so how this impacted on my clinical work. Despite the controversial political occurrence at the time of analysis evoking a strong emotional response in myself, I endeavoured to be transparent about the analytical process presented, using a balance of excerpts which can hopefully be understood within context. Even with my keeping a journal of my biases and assumptions, I realised it can be very difficult for people to wholly separate their experiences from making sense of the world.

4.7. Conclusion

This study aimed to contribute to the limited understanding of mental health issues within the Punjabi Sikh community. Findings reveal that the issue of identity is paramount to Punjabi Sikhs; a community that has historically felt rejected and ostracised by other subgroups under the South Asian umbrella. The Punjabi Sikh community have been active in creating a place for themselves in the UK. They have created schools and *Gurdwaras* that, although are driven by their heritage, are open for all to attend and participate in. Drawing on their own history as inspiration and guidance, this is a community that has learned to adapt and manage distress. The ‘warrior’ narrative has been protective and has given this community a sense of belonging.

It would appear that an outward projection of emotional resilience, a relentless work ethic, and a strong drive to integrate, complicates how the Punjabi community manages problems and seeks support. It is possible that this community are unlikely to access services or acknowledge that they experience mental health problems, believing they already possess the necessary tools to maintain their psychological wellbeing. The Punjabi Sikh community are already employing coping strategies acquired from Eastern spiritual philosophies that are now being utilised as mainstream “therapy”. This idea challenges existing stereotypes about connecting with BME communities when perhaps psychology services should be asking what they could learn from the Punjabi Sikh community. A community that prides themselves on daily preservation of wellbeing; a concept which does not discriminate between the body and mind but instead looks after both holistically. Perhaps Western therapies need to adopt such an approach whilst also emphasising the need for preventative strategies against ‘ill mental health’, and having a strong inner narrative around coping. Such services may want to also consider collaborating with local faith leaders to promote community psychology approaches, if such interventions are required.

A culture celebrated for high adaptability and resilience does not want to allow itself to be psychologically vulnerable. A strong sense of internal self-reliance, the self-projection of resilience, and close familial connections, result in this community perhaps not needing mental health services. Thus making it difficult for healthcare professionals to reach out to this community. History has demonstrated to this community that no matter what misfortunes are presented they will manage without external help. It is a community whose resilience perhaps exceeds Western mental health services.

REFERENCES

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., Appel, H., Nicado, E., & Alegría, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. *American Journal of Public Health, 97*, 91-98.

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31*, 934-948.

Abusah, P. (1993). Multi-cultural influences in case management: Transcultural psychiatry. *Mental Health in Australia, 5*, 67-75.

Acheson, D. (1998). *Inequalities in health: Report of an independent inquiry*. London: HMSO.

Ahmad, F., Driver, N., McNally, M. J., & Stewart, D. E. (2009). "Why doesn't she seek help for partner abuse?" An exploratory study with South Asian immigrant women. *Social Science & Medicine, 69*, 613-622.

Ahmad, F., Riaz, S., Barata, P., & Stewart, D. E. (2004). Patriarchal Beliefs and Perceptions of Abuse among South Asian Immigrant Women. *Violence Against Women, 10*, 262-282.

Ahmed, S. M., & Lemkau, J. P. (2000). Cultural issues in the Primary Care of South Asians. *Journal of Immigrant Health, 2*, 89-96.

Alexander, Z. (1999). *The Department of Health: Study of Black, Asian and Ethnic Minority Issues*. London: Department of Health.

Allan, G. (2003). "A critique of using grounded theory as a research method". *Electronic Journal of Business Research Methods*, 2, 1-10.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington: American Psychiatric Press Inc.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington: American Psychiatric Press Inc.

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, 195-214.

Azhar, M. Z., & Varma, S. I. (2000). Mental Illness and its Treatment in an Islamic Society: Malaysia. In Ihsan Al-Issa (Ed.), *Al-Junun: Mental Illness in the Islamic World* (pp. 163-186). Connecticut: International Universities Press.

Bala, M., Strzeszynski, L., & Cahill, K. (2008). Mass media interventions for smoking cessation in adults. *The Cochrane Database Systematic Reviews*, 23.

Baldwin, C. (2005). Narrative, ethics and people with severe mental illness. *Australian and New Zealand Journal of Psychiatry*, 39, 1022-1029.

Ballard, R. (1990). Migration and kinship: The differential effect of marriage rules on the processes of Punjabi migration to Britain. In C. Clarke, C. Peach & S. Vertovek (Eds.), *South Asians Overseas* (chap.10, pp. 219-249). Cambridge: Cambridge University Press.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology*. Chichester: Wiley.

Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond* (2nd Ed.). New York: The Guilford Press.

Bebbington, P., Brugha, T., & Coid J. (2009). *Adult psychiatric morbidity in England 2007*. London: NHS Information Centre.

Bentall, R. (2006). Madness explained: Why we must reject the Kraepelinian paradigm and replace it with a 'complaint-orientated' approach to understanding mental illness, *Medical Hypotheses*, 66, 220-233.

Berry, J. W. (1997). Immigration, Acculturation and Adaptation. *Applied Psychology: An International Review*, 46, 5-68.

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

Berry, J.W., & Sam, D.L. (1997). Acculturation and adaptation. In J.W. Berry, M.H. Segall, & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology: Social behavior and applications* (Vol. 3, pp. 291–326). Boston: Allyn & Bacon.

Bhachu, P. (1985). *Twice Migrants: East African Sikh Settlers in Britain*. London: Tavistock.

Bhambra, R. (2015). *Sikhism and Spirituality*. Xlibris.

Bhatia, S. (2002). Acculturation, Dialogical Voices and the Construction of the Diasporic Self. *Theory Psychology*, 12, 55-77.

Bhattacharya, G., & Schoppelrey, S. L., (2004). Pre-immigration beliefs of life success, post immigration experiences, and acculturative stress: South Asian immigrants in the United States. *Journal of Immigrant Health*, 6, 83-92.

Bhugra, D. (1996). Depression across cultures. *Primary Care Psychiatry*, 2, 155-165.

Bhugra, D. (2003). Migration and Depression. *Acta Psychiatrica Scandinavica*, 108, 7-72.

Bhugra, D. (2004). Migration, distress and cultural identity. *British Medical Bulletin*, 69, 129-141.

Bhugra, D., Baldwin, D., & Desai, M. (1997). Focus group: Implications for primary and cross-cultural psychiatry. *Primary Care Psychiatry*, 3, 45-50.

Bhugra, D., Bhui, K., Desai, M., Singh, J., & Baldwin, D. (1999). The Asian Cultural Identity Schedule: An Investigation of Culture and Deliberate Self-harm. *International Journal of Methods in Psychiatric Research*, 8, 212-218.

Bhugra, D., Carta, M. G., Oumar, F. W., Moro, M. F., Moro, D., Preti, A., & Mereu, A. (2013). Trauma-and stress related disorders in the Tuareg refugees of a Camp in Burkina Faso. *Clinical Practice and Epidemiologic in Mental Health*, 9, 189-195.

Bhugra, D., & Osborne, T. (2006). Cultural assessment and management. *Psychiatry*, 5, 379-382.

Bhugra, D., & Mastrogianni, A. (2003). Globalisation and mental disorders: Overview with relation to depression. *The British Journal of Psychiatry*, 184, 10-20.

Bhui, K. (2002). *Racism and Mental Health: Prejudice and Suffering*. London: Jessica Kingsley Publishers.

Bhui, K., Abdi, A., Abdi, M., Pereira, S., Dualeh, M., Robertson, D., Sathyamoorthy, G., & Ismail, H. (2003). Traumatic events, migration

characteristics and psychiatric symptoms among Somali refugees: Primary communication. *Social Psychiatry and Psychiatric Epidemiology*, 38, 35-43.

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. (2002). Explanatory models for mental distress: Indications for clinical practice and research. *British Journal of Psychiatry*, 181, 6-7.

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, 307-322.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. Systemic review. *The British Journal of Psychiatry*, 182, 105-116.

Bird, C. M. (2005). How I Stopped Dreading and Learned to Love Transcription. *Qualitative Inquiry*, 11, 226-248.

Bourhis, R. Y., Moise, L. C., Perrault, S., & Senecal, S. (1997). Towards an interactive acculturation model: A social psychological approach. *International Journal of Psychology*, 6, 369-386.

Bradby, H., Varyani, M., Ogleshorpe, R., Raine, W., White, I., & Helen, M. (2007). British Asian families and the use of child and adolescent mental health services: A qualitative study of a hard to reach group. *Social Science & Medicine*, 65, 2413-2424.

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 Harris Cooper (Ed.), *The handbook of research methods in psychology*. (pp. 57- 71). Washington: American Psychological Association.

Brinn, M. P., Carson, K. V., Esterman, A. J., Chang, A. B., & Smith, B. J. (2010). Mass media interventions for preventing smoking in young people. *The Cochrane Database of Systematic Reviews*, 10.

Britannica Mental Health Review. (2007). *The Mental Health Act 2007: A review of its implementation*. Retrieved from http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf

British Sikh Report. (2013). *BSR 2013*. Retrieved from: <http://www.britishsikhreport.org/british-sikh-report/download-2013/>

British Sikh Report. (2014). *BSR 2014*. Retrieved from: <http://www.britishsikhreport.org/wp-content/uploads/2014/04/British-Sikh-Report-2014.pdf>

British Sikh Report. (2016). *BSR 2016*. Retrieved from: <http://www.britishsikhreport.org/wp-content/uploads/2016/03/British-Sikh-Report-2016.pdf>

Bruner, J. (1996). A narrative model of self-construction. *Annals of New York Academy of Sciences*, 17, 154-170.

Burr, J. (2002). Cultural stereotypes of women from South Asian communities: Mental health care professionals' explanations for patterns of suicide and depression. *Social Science & Medicine*, 55, 835-845.

Butt, J., & Mirza, K. (1996). *Social Care and Black Communities*. London: HMSO.

Byrne, P. (2003). Advances in Psychiatric Treatment. *Psychiatry and the Media*, 9, 135-142.

Carpenter-Song, E., Chu, E., Drake, R. E., Ritsema, M., Smith, B., & Alvenson, H. (2010). Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. *Transcultural Psychiatry*, 47, 224-251.

Carter, S., & Little, M. (2007). Justifying knowledge, justifying method, taking action: epistemologies, methodologies and methods in qualitative research. *Qualitative Health Research*, 17, 1316-1328.

Cave, D. and Norris, R. S. (2011). *Religion and the Body: Modern Science and the Construction of Religious Meaning*. Boston: Brill.

Census: Ethnic group, local authorities in the United Kingdom (2011). *Office for National Statistics*.

Chadda, R. K. (2001). Psychiatric patient in the community: Challenges and solutions. *Journal of Mental Health Behaviour*, 6, 7–15.

Chamberlain, K. (1999). Methodolatry and qualitative health research. *Journal of Health Psychology*, 5, 285-296.

Chatterji, J. (2007). *The Spoils of Partition: Bengal and India, 1947 – 1967*. Cambridge: Cambridge University Press.

Chaturvedi, S. K., & Bhugra, D. (2007). The concept of neurosis in a cross-cultural perspective. *Current Opinion Psychiatry*, 20, 47–51.

Chen, S., Sullivan, N. Y., Lu, Y. E., & Shibusawa, T. (2003). Asian Americans and mental health services: A study of utilization patterns in the 1990s. *Journal of Ethnic and Cultural Diversity in Social Work*, 12, 19-41.

Cheung, F. K., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal*, 26, 277-291.

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 and Social Care in the Community*, 10, 339-347.

Chhabra, V., Bhatia, M. S., & Gupta, R. (2008). Cultural Bound Syndromes in India. *Delhi Psychiatry Journal*, 11, 15-18.

Cinnirella, M., & Loewenthal, K. M. (1999). Beliefs about the efficacy of religious, medical and psychotherapeutic interventions for depression and schizophrenia among different cultural-religious groups in Great Britain. *Transcultural Psychiatry*, 36, 491-504.

Cochrane, R., & Hussain, F. A. (2003). Living with depression: coping strategies used by South Asian women living in the UK suffering from depression. *Mental Health Religion and Culture*, 6, 21–44.

Commander, M. J., Odell, S. M., Surtees, P. G., & Sashidharan, S. P. (2004). Care pathways for south Asian and white people with depressive and anxiety disorders in the community. *Social Psychiatry Epidemiology*, 39, 259-64.

Commission for Race Equality. (1997). *Commission for Racial Equality, Race, culture and community care: An agenda for action*. London: Chartered Institute of Housing, NHS Confederation.

Conrad, M. M., & Pacquiao, D. F. (2005). Manifestation, attribution, and coping with depression among Asian Indians from the perspectives of health care practitioners. *Journal of Transcultural Nursing*, 16, 32-40.

Cooper, L., Beach, M. C., Johnson, R. L., & Inui, T. S. (2005). Delving below the surface. Understanding how race and ethnicity influence relationships in health care. *Journal of General Internal Medicine*, 21, 21-27.

Cornwell, J. (1998). Do GPs prescribe antidepressants differently for South Asian patients? *Family Practice*, 15, 16–18.

Cresswell, J. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks: SAGE Publications, Inc.

D'Ardenne, P., & Mahtani, A. (1999). *Transcultural counselling in action* (2nd ed.). London: SAGE Publications, Inc.

Daker-White, G., Beattie A., & Means, R. (2002). *Serving the needs of marginalised groups in dementia care: younger people and minority ethnic groups – summary of key findings and conclusions*. Retrieved from:
<https://lemosandcrane.co.uk/resources/Dementia%20Voice%20-%20Serving%20the%20needs%20of%20marginalised%20groups%20in%20dementia%20care.pdf>

Das, A. K., & Kemp, S. F. (1997). Between two worlds: Counselling South Asian Americans. *Journal of Multicultural Counseling and Development*, 25, 23-33.

Dasgupta, S. D. (2002). *Defining community organizing. Organizing communities to challenge violence against women*. Minnesota: Praxis International.

David L., Berry J. W., & John, W. (2010). "Acculturation When Individuals and Groups of Different Cultural Backgrounds Meet". *Perspectives on Psychological Science*, 4, 472.

Deci, E. L., & Ryan, R. M. (2008). Facilitating optimal motivation and psychological well-being across life's domains. *Canadian Psychology*, 49, 14-23.

Deci, E. L., & Ryan, R. M. (2008). Hedonia, eudaimonia, and well-being: An introduction. *Journal of Happiness Studies*, 9, 1–11.

Deci, E. L., Ryan, R. M., Gagné, M., Leone, D. R., Usunov, J., & Kornazheva, B. P. (2001). Need satisfaction, motivation, and well-being in the work organizations of a former Eastern Bloc country. *Personality and Social Psychology Bulletin*, 27, 930-942.

Dein, S. (2010). *Religion, Spirituality, and Mental Health*. Retrieved from: <http://www.psychiatrictimes.com/articles/religion-spirituality-and-mental-health>

Dein, S., Alexander, M., & Napier, A. D. (2008). Psychiatry and contested notions of misfortune among East London Bangladeshis. *Transcultural Psychiatry*, 54, 31–55.

Department of Health. (1998). *Independent Inquiry into Inequalities in Health Report*. London: The Stationary Office.

Department of Health. (1999). *A National Service Framework for Mental Health*. London: Department of Health.

Department of Health. (2005). *Delivering Race Equality in Mental Health Care*. London: Department of Health.

Department of Health. (2009). *The Health and Personal Social Services Programmes*. London: Department of Health.

Department of Health. (2012). *The Health and Personal Social Services Programmes*. London: Department of Health.

Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General*. Maryland: Public Health Service.

Donovan, R. (2003). *Social marketing: Principles and practice*. IP Communications.

Dormon, O. (2014). "Childbearing of UK and non-UK born women living in the UK - 2011 Census data." ONS: London.

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

Eatough, V., & Smith, J. (2006). I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, 97, 483-498.

Edwards, J. A., & Lampert, M. D. (1993). *Talking Data: Transcription and coding in discourse research*. Hillsdale: Erlbaum.

Ember, M., Ember, C. R. & Skoggard, I. (2005). *Encyclopedia of Diasporas. Immigrant and Refugee Cultures Around the World. Volume 1: Overviews and Topics*. New York: Springer.

Equality Act. (2010). Table of Contents. Retrieved from:
<http://www.legislation.gov.uk/ukpga/2010/15/contents>

Faggiolani, C. (2011). "Perceived Identity: applying Grounded Theory in Libraries". *Journal of Law Information & Science*, 2, 1.

Fallot, R. D. (1998). *Spirituality and Religion in Recovery from Mental Illness: New directions for Mental Illness*. San Francisco: Jossey-Bass.

Farver, J. A., Narang, S. K., & Bhadha, B. R. (2002). East meets west: Ethnic identity, acculturation, and conflict in Asian Indian families. *Journal of Family Psychology*, 16, 338-350.

Faulkner, A., & Layzell, S. (2000). *Strategies for living: A report of user-led research into people's strategies for living with mental distress*. London: Mental Health Foundation.

Fenton, S., & Sadiq-Sangster, A. (1996). Culture, relativism and the expression of mental distress: South Asian women in Britain. *Sociology of Health and Illness*, 18, 66-85.

Fernando, S. (2014). Globalization of psychiatry – A barrier to mental health development. *International Review of Psychiatry*, 5, 551-557.

Fernando, S. (1991). *Mental Health, Race and Culture*. Basingstoke: Macmillan.

- Finlay, L. (2006). Mapping methodology. In: L. Finlay & C. Ballinger (Eds). *Qualitative research for allied health professionals: Challenging choices*. (pp. 9-29). Chichester, Sussex: John Wiley.
- Fikree, F. F., & Pasha, O. (2004). Role of gender in health disparity: The South Asian context. *BMJ*, 328, 823-826.
- Francis, C., Pirkis, J., Dunt, D., Blood, R., & Davis, C. (2002). *Improving mental health literacy: A review of the literature*. Melbourne: Centre for Health Program Evaluation.
- Froggett, L. (2001). From Rights to Recognition: Mental Health and Spiritual Healing among Older Pakistanis. *Psychoanalytic Studies*, 3, 177-186.
- Fulford, K. W. M., & Woodbridge, K. (2007). Values-based Practice: Help and healing within a shared theology of diversity. In Mary Coyte, Peter Gilbert, & Vicky Nicholls (Eds.), *Spirituality, Values and Mental Health* (pp. 49-50). London: Jessica Kingsley Publishers.
- Gary, F. A. (2005). Stigma: Barrier to Mental Health Care Among Ethnic Minorities. *Issues in Mental Health Nursing*, 26, 979-999.
- Gautam, S., & Jain, N. (2010). Indian culture and psychiatry. *Indian Journal of Psychiatry*, 52, 309–313.
- Gilbert, T. (2001). Reflective practice and clinical supervision: Meticulous rituals of the confessional. *Journal of Advanced Nursing*, 36, 199-205.
- Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and

service use in South Asian women living Derby. *Mental Health, Religion and Culture*, 7, 109-130.

Gill, I. (2010). *Punjabi Sikh Parents' Beliefs about Suicide and Suicide-Related Behaviours*. MA Thesis. USA: The University of British Columbia

Gillespie, M. (1995). *Television, Ethnicity and Cultural Change*. London: Routledge.

Goodman, A., Patel, V., & Leon, D. A. (2008). Child Mental Health Differences Amongst Ethnic Groups in Britain: A Systematic Review. *BMC Public Health*, 8, 1-11.

Greene, A-M. & Kirton, G. (2015). *Diversity Management in the UK: Organisational and Stakeholder Experiences*. London: Routledge.

Greenwood, N., Hussain, F., Burns, T., & Rapheal, F. (2000). Asian in-patient and carer views of mental health care. Asian views of mental health care. *Journal of Mental Health*, 9, 397-408.

Grewal, J. S. (1990). *The Sikhs of the Punjab*. Cambridge: Cambridge University Press.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18, 59-82.

Gupta, S. R. (1999). *Emerging voices: South Asian American women redefine self, family, and community*. Walnut Creek: AltaMira Press.

Gureje, O., Simon, G. E., Ustan, T. B., & Goldberg, D. P. (1997). Somatization in a

cross-cultural perspective: A World Health Organisation study in primary care. *American Journal of Psychiatry*, 154, 989-995.

Hackett, L., Hackett, R., & Taylor, D.C. (1991). Psychological Disturbance and its Associations in the Children of the Gujarati Community. *Journal of Child Psychology and Psychiatry*, 32, 851–856.

Halpern, D. (1993). Minorities and mental health. *Social Science & Medicine*, 36, 597-607.

Hamdi, E., Yousreya, A., & Abou-Saleh, M. T. (1997). Problems in validating endogenous depression in the Arab culture by contemporary diagnostic criteria. *Journal of Affective Disorders*, 44, 131-143.

Harper, D. (2007). Clinical Psychology. In Carla Willig & Wendy Stainton-Rogers, (Eds.), *The Sage Handbook of Qualitative Research Methods in Psychology*. London: SAGE Publications, Inc.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 83-97). Chichester: John Wiley & Sons, Ltd.

Hicks, M. H., & Bhugra, D. (2003). Perceived Causes of Suicide Attempts by U.K. South Asian Women. *American Journal of Orthopsychiatry*, 73, 455-462.

Hiller, A., Sandmann, J., Ehmig, S. C., Weisbecker, H., Kepplinger, H. M., & Benkert, O. (1999). The General Public's Cognitive and Emotional Perception of Mental Illnesses: An Alternative to Attitude-Research. In Jose Guimon, Werner Fischer & Norman Sartorius (Eds.), *The Image of Madness: The Public Facing Mental Illness and Psychiatric Treatment* (pp. 56-71). Basel: Karger.

Hines, P. M., Garcia-Petro, N., McGoldrick, M., Almeida, R., & Wetman, S. (1992). Intergenerational relationships across cultures. *Families in Society: The Journal of Contemporary Human Services*, 73, 323-338.

Hsu, L. K. G., & Folstein, M. F. (1997). Somatoform disorders in Caucasian and Chinese Americans. *Journal of Nervous and Mental Disease*, 185, 382-387.

Hughes, C. C. (1998). 'The Glossary of Culture Bound Syndromes in DSM-IV: A Critique', *Transcultural Psychiatry*, 35, 413.

Hull, S., Aquino, P., & Cotter, S. (2005). Explaining variation in antidepressant prescribing rates in east London: a cross sectional study. *Family Practice*, 1, 37-42

Hull, S. A., Cornwell, J., Harvey, C., Eldridge, S., & Bare, P. O. (2001). Prescribing rates for psychotropic medication amongst east London general practices: low rates where Asian populations are greatest. *Family Practice*, 18, 167-173.

Hunt, I. M., McKenzie, K., & Serfaty, M., (2003). Suicides in ethnic minorities within 12 months of contact with mental health services. *British Journal of Psychiatry*, 183, 155-60.

Hussain, J. (2010). Help or hindrance? South Asian women in the family firm. *Electronic Journal of Family Business Studies (EJFBS)*, 1, 4.

Husain, N., Creed, F., & Tomenson, B. (1997). Adverse social circumstances and depression among people of Pakistan origin in UK. *British Journal of Psychiatry*, 171, 434-438.

Husain, M. I., Waheed, W., & Husain, N. (2006). Self-harm in British South Asian women: psychosocial correlates and strategies for prevention. *Annals of General Psychiatry*, 5, 1-7.

ICM Research. (2007). Report retrieved from: <http://www.icmhsr.org>

Ineichen, B. (2012). Mental illness and suicide in British South Asian adults. *Mental Health Religion and Culture*, 15, 235-250.

Inman, A. G. (2006). South Asian women: Identities and conflicts. *Cultural Diversity & Ethnic Minority Psychology*, 12, 306-319.

Inman, A.G. & Tewari, N. (in press) *Culturally Diverse Mental Health: The Challenges of Research and Resistance*.

Institute of Race Relations. (2015). *Definitions*. Retrieved from: <http://www.irr.org.uk/research/statistics/definitions/>

Jackson, Y. (2006). *Encyclopedia of Multicultural Psychology*. London: SAGE Publications, Inc.

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

Jamal, A., & Chapman, M. (2000). Acculturation and inter-ethnic consumer perceptions: can you feel what we feel? *Journal of Marketing Management*, 16, 365–391.

Joffe, H. (2012). Thematic analysis. In David Harper & Andrew Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp.209-223). Chichester: John Wiley & Sons, Ltd.

Johnson, M. R. D. (1993). 'Equal Opportunities in Service Delivery: Responses to a changing population?'. In Waqar Ahmad (Ed.), *Race and Health in Contemporary Britain* (pp.183-198). Maidenhead: Open University Press.

Johnson, A. W., & Nadirshaw, Z. (1993). Good Practice in Transcultural Counselling: An Asian Perspective. *British Journal of Guidance & Counselling*, 21, 20-29.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177, 396-401.

Jorm, A. F., Korten, A. E., & Jacomb, P. A., (1997). 'Mental health literacy': A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166, 182 -186.

Judit, A., Vijver V., & Fons, J. R. (2004). "Domains and dimensions in acculturation: Implicit theories of Turkish–Dutch". *International Journal of Intercultural Relations*, 1, 19–35.

Jutlla, K. (2016). Cultural Norms About the Roles of Older People in Sikh Families: A Qualitative Study with the Sikh Community in Wolverhampton in the UK. *Indian Diaspora*, 720, 207-231.

Kabat-Zinn, J. (1994). Mindfulness Training as a Clinical Intervention: A *Conceptual Empirical Review*.

Kalra, G., Bhui, K., & Bhugra, D. (2013). Does Guru Granth Sahib describe depression? *Indian Journal of Psychiatry*, 55, 195-200.

Kakar, S. (1982). Indian medicine and psychiatry: cultural and theoretical perspectives on Ayurveda in his shamans, mystics and scholars. Boston: Beacon Press.

Karasz, A. (2005). Cultural Differences in Conceptual Models of Depression. *Social Science Medicine*, 60, 1625-1635.

Karseras, P., & Hopkins, E. (1987). *British Asians: Health in the Community*. Chichester: John Wiley & Sons.

Kawanishi, Y. (1992). Somatization of Asians: An Artifact of Western Medicalization? *Transcultural Psychiatric Research Review*, 29, 5-36.

Keating, F., Robertson, D., Francis, F., & McCulloch, A. (2002). Breaking the Circles of Fear: A review of the relationship between mental health services and African and Caribbean communities. London: The Sainsbury Centre for Mental Health.

Keefe, S., & Padilla, A. M. (1987). *Chicano ethnicity*. Albuquerque: University of New Mexico Press.

Khalifa, N., Mullick, M. S. I., Nahar, J. S., & Walker, D. (2013). Beliefs about Jinn, black magic and evil eye in Bangladesh: The effects of gender and level of education. *Mental Health, Religion & Culture*, 16, 719-729.

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects on client expectation for counselling success, client-counsellor worldview match, and client adherence to Asian and European American cultural values on counselling process with Asian Americans. *Journal of Counseling Psychology*, 52, 67-76.

Kim, B. S. K., & Omizo, M. M. (2003). Asian cultural values, attitudes towards seeking professional psychological help, and willingness to see a counselor. *The Counselling Psychologist*, 31, 343-361.

Kingsbury, S. (1994). The psychological and social characteristics of Asian

adolescent overdose. *Journal of Adolescence*, 17, 131–135.

Kiriike, N. (2003). Open Trial of Milnacipran for Taijin-Kyofusho in Japanese Patients with Social Anxiety Disorder. *International Journal of Psychiatry in Clinical Practice*, 7, pp. 107-112.

Kirmayer, L. J. (2006) 'Beyond the *New Cross-cultural Psychiatry*': Cultural Biology, Discursive Psychology and the Ironies of Globalisation' *Transcultural Psychiatry* 43(1): 126-144.

Kirmayer, L. J., & Young, A. (1998). Culture and somatization: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, 60, 420-430.

Koenig, H., King, D., & Carson, V. (2012). *Handbook of religion and health* (2nd Ed.). New York: Oxford University Press.

Krause, I-B. (1989). Sinking Heart: A Punjabi Communication of Distress. *Social Science & Medicine*, 29, 563-575.

Krause, I-B., Rosser, R. M., Khiani, M. L., & Lotay, N. S. (1990). Psychiatric morbidity among Punjabi medical patients in England measured by General Health Questionnaire. *Psychological Medicine*, 20, 711-719.

Kulhara, P., & Chakrabarti, S. (2001). Culture and schizophrenia and other psychotic disorders. *Psychiatry Clinical North America*, 24, 449–64.

Kumar V. (2004). Poisoning deaths in married women. *Journal of Clinical Forensic Medicine*, 1, 2–5.

Lapadat, J. C., & Lindsay, A. C. (1999). Transcription in research and practice: From standardisation of technique to interpretive positionings. *Qualitative Inquiry*, 5, 64–86.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.

Lavender, H., Khondoker, A. H., & Jones, R. (2006). Understanding depression: an interview study of Yoruba, Bangladeshi and white British people. *Family Practice*, 23, 651–658.

Lawrence, V., Murray, J., Banerjee, S., Turner, S., Sangha, K., & Bhugra, D. (2006). Coping with depression in later life: A qualitative study of help-seeking in three ethnic groups. *Psychological Medicine*, 36, 1375-1383.

Lee, S. (1998). Estranged bodies, simulated harmony and misplaced cultures: neurasthenia Chinese society. *Psychosomatic Medicine*, 60, 448-457.

Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, 3, 201-214.

Leong, F. T. L., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help-seeking attitudes. In Joseph Ponterotto, J. Manuel Casas, Lisa Suzuki, & Charlene M. Alexander (Eds.), *Handbook of multicultural counseling*. (pp. 415-438). London: SAGE Publications, Inc.

Li, H. Z., & Browne, A. J. (2000). "Defining mental illness and accessing mental health services: perspectives of Asian Canadians." *Canadian Journal of Community Mental Health*, 19, 143-159.

Lloyd, H., Singh, P., Meritt, R., Shetty, A., Singh, S., & Burns, T. (2013). Larger families associated with low burden. Source of parental burden in a UK sample of first generation North Indian Punjabi Sikhs and their white British counterparts. *International Journal of Social Psychiatry*, 59, 147-156.

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 & Counselling*, 40, 43-66.

Loya, F., Reddy, R., & Hinshaw, S. P. (2010). Mental Illness Stigma as a Mediator of Differences in Caucasian and South Asian College Students' Attitudes Toward Psychological Counseling. *Journal of Counseling Psychology*, 57, 484-490.

Luper, S. (2004). "Epistemic Relativism". *Philosophical Issues*, 14, 271–295.

Lyons, E., & Coyle, A. (2007). *Analysing Qualitative Data in Psychology*. London: SAGE Publications, Ltd.

Mahmud, T. (2001). Genealogy of a state-engineered "model minority" "not quite / not White" South Asian Americans. *Denver University Law*, 78, 657-686.

Malik, R. (2000). Culture and emotions: Depression among Pakistanis. In Corinne Squire (Ed.), *Culture in psychology*. New York: Routledge.

Manson, S. M. (1995). Culture and major depression. Current challenges in the diagnosis of mood disorders. *Psychiatric Clinics of North America*, 18, 487-501.

Marks, D. F. and Yardley, L. (2004). *Research Methods for Clinical and Health Psychology*. London: SAGE Publications, Ltd.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50, 370-396.

McCormick, R. M. (1998). Ethical considerations in First Nations counselling and research. *Canadian Journal of Counselling*, 32, 284-297.

McGrother, C. W., Bhaumik, S., Thorp, C. F., Watson, J. M., & Taub, N. A. (2002). Prevalence, morbidity and service need among South Asian and white adults with intellectual disability in Leicestershire, UK. *Journal of Intellectual Disability Research*, 46, 299-309.

McKenzie, K., Bhui, K., Nanchahal, K., & Blizard, B. (2008). Suicide rates in people of South Asian origin in England and Wales 1993–2003. *British Journal of Psychiatry*, 193, 406–409.

McKenzie, K., Serfaty, M., & Crawford, M. (2003). Suicide in ethnic minority groups. *British Journal of Psychiatry*, 183, 100–101.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey*. The Health and Social Care Information Centre: Social Care Statistics.

Merrill, J., & Owens, J. (1986). Ethnic differences in self-poisoning: A comparison of Asian and white groups. *British Journal of Psychiatry*, 145, 708–712.

Mir, G., Nocon, A., Ahmad, W., & Jones, L. (2001). *Learning Difficulties and Ethnicity, Report to the Department of Health*. Retrieved from:
<https://lemosandcrane.co.uk/resources/DoH%20-%20Learning%20difficulties%20and%20ethnicity.pdf>

Morjaria, A., & Orford, J. (2002). The role of religion and spirituality in recovery from drink problems: A qualitative study of Alcoholics Anonymous members and South Asian men. *Addiction Research & Theory*, 10, 225-256.

Myrvold, K. & Jacobsen, K. A. (2011). *Sikhs in Europe: Migration, Identities and Representations*. London: Routledge.

Naidoo, A. V. (1996). Challenging the hegemony of Eurocentric psychology. *Journal of Community and Health Sciences*, 2, 9-16.

National Institute for Mental Health in England. (2003). *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*.

Leeds: Department of Health. Retrieved from:

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084558

National Survivor User Network. (2014). Mental Healthwatch handbook. Improving mental health you're your community. Retrieved from:

<http://www.nsun.org.uk/assets/downloadableFiles/mentalhealthwatchhandbookv1april20142.pdf>

Nayar, K. E. (2004). *The Sikh Diaspora in Vancouver: Three Generations Amid Tradition, Modernity, and Multiculturalism*. Toronto: University of Toronto Press.

Nazroo, J. Y. (1997). *The Health of Britain's Ethnic Minorities: Findings from a National Survey*. London: Policy Studies Institute.

Nestler, E. J., Barrot, M., & DiLeone, R.J. (2002). Neurobiology of depression. *Neuron*, 34, 13–25.

NHS Constitution for England. (2009). *The NHS Constitution: The NHS belongs to us all*. Retrieved from:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093442.pdf

Nieuwsma, J. A., Pepper, C. M., Maack, D. J., Birgenheir, D. G. (2011). Indigenous perspectives on depression in rural regions of India and the United States. *Transcultural Psychiatry*, 48, 539-568.

Ng, C. H. (1997). The Stigma of Mental Illness in Asian Cultures. *Australian & New Zealand Journal of Psychiatry*, 31, 382-390.

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. McGraw-Hill International.

Oakley, A. (2000). *Experiments in Knowing: Gender and Method in the Social Sciences*. Cambridge: Polity Press.

Odell, S. M., Surtees, P. G., Wainwright, N. W., Commander, M. J., & Sashidharan, S. P. (1997). Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner-city health district. *British Journal of Psychiatry*, 171, 537-541.

Office for National Statistics. (2003). *Ethnic group statistics: A guide for the collection and classification of ethnicity data*. London: Office for National Statistics.

Office for National Statistics. (2012). Ethnicity and National Identity in England and Wales: 2011. Retrieved from:

<http://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11>

Office for National Statistics. (2015). 2011 Census Analysis: Ethnicity and Religion of the Non-UK Born Population in England and Wales. Retrieved from: http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171776_407038.pdf

Older BME People and Financial Inclusion Report. (2016). *The future ageing of the ethnic minority population of England and Wales*. London: Centre for Policy on Ageing.

Onyett, S. (2007). *Working psychologically in teams*. Leicester: The British Psychological Society.

Owens, K., & King, M. C. (1999). Genomic views of human history, *Science*, 286, 451–453.

Padilla, A. M. (1980). The role of cultural awareness and ethnic loyalty in acculturation. Boulder, CO: Westview.

Parekh, B. (1997). South Asians in Britain. *History Today*, 47, pp. 65-68.

Parker, I. (1997). Discursive psychology. In Dennis Fox, Isaac Prilleltensky & Stephanie Autsin (Eds.), *Critical Psychology: An Introduction*. (pp. 284- 298). London: London: SAGE Publications, Ltd.

Parker, I. (2005). *Qualitative psychology: Introducing radical research*. Berkshire: Open University Press.

Parkes, M., & Gilbert, P. (2010). Gods and gurdwaras: The Spiritual Care Programme at the Birmingham and Solihull Mental Health Foundation NHS Trust. *Mental Health Religion and Culture*, 13, 569-583.

Patel, N. (2003). Clinical psychology: reinforcing inequalities or facilitating empowerment? *The International Journal of Human Rights*, 7, 16-39.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Miller, A., Mahtani, A., & Nadirshaw, Z. (2000). *Clinical Psychology, 'Race' & Culture: A Training Manual*. Chichester: Blackwell.

Patel, N. & Fatimilehin, I. (2002). 'Racism and mental health' in Newness, C., Holmes, G. and Dunn, C. (Eds) *This is Madness: A critical look at psychiatry and the future of mental health services*, Ross-on-Wye: PCC Books.

Patel, V., & Oomman, N. (1999). Mental health matters too: Gynaecological symptoms and depression in South Asia. *Reproductive Health Matters*, 7, 30-38.

Patel, V., Pednekar, S., Weiss, H., Rodrigues, M., Barros, P., Nayak, B., Tanksale, V., West, B., Nevrekar, P., Kirkwood, B. R., & Mabey, D. (2005). Why do women complain of vaginal discharge? A population survey of infections and psychosocial risk factors in a South Asian community. *International Journal of Epidemiology*, 34, 853-862.

Philo, G., Henderson, L., & McCracken. (2010). *Making Drama out of a Crisis: Authentic Portrayals of Mental Illness in TV Drama*. Retrieved from:
http://oxleas.nhs.uk/site-media/cms-downloads/shift_tv_research_summary.pdf

Pirani, F. M., Papadopoulos, I., Foster, J., & Leavey, G. (2008). "I will accept whatever is meant for us. I wait for that – day and night": The search for healing a Muslim shrine in Pakistan. *Mental Health, Religion & Culture*, 11, 375-386.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, 2, 38-55.

Prince, R., & Tchong-Laroche, F. (1987). Culture-bound syndromes and international disease classifications. *Culture, Medicine and Psychiatry*, 11, 3-20.

Rack, P. (1982). *Race, Culture and Mental Disorder*. London: Tavistock.

Raghavan, R., & Waseem, F. (2007). Services for young people with learning disability and mental health needs from South Asian Community. *Advances in Mental Health and Learning Disabilities*, 1, 27-31.

Randhawa, G., & Stein, S. (2007). An exploratory study examining attitudes toward mental health and mental health services among young South Asians in the United Kingdom. *Journal of Muslim Mental Health*, 2, 21-37.

Rasmussen, A., Rosenfeld, B., Reeves, K., & Keller, A. S. (2007). The Subjective Experience of Trauma and Subsequent PTSD in a Sample of Undocumented Immigrants. *The Journal of Nervous and Mental Disease*, 195, 137-143.

Rahman, M., Palmar, G., Kenway, P., & Howarth, C. (2000). *Monitoring Poverty and Social Exclusion*. York: Joseph Rowntree Foundation.

Rastogi, P., Khushalani, S., Dhawan, S., Goga, J., Hemanth, N., Kosi, R., Sharma, R. K., Black, B. S., Jayaram, G., & Rao, V. (2014). Understanding clinician perception of common presentations in South Asians seeking mental health treatment and determining barriers and facilitators to treatment. *Asian Journal of Psychiatry*, 7, 15-21.

Rastogi, M., & Wieling, E. (2003). Voices of marriage and family therapists of color: An exploratory survey. *Journal of Feminist Family Therapy*, 15, 1-20.

Rathod, S., Pradhan, B. & Pinninti, N. (2016). *Brief Interventions for Psychosis: A Clinical Compendium*. Southampton: Springer.

Razali, S. M., Hasanah, C. I., Aminah, K., & Subramaniam, M. (1998). Religious-sociocultural psychotherapy in patients with anxiety and depression. *Australia & New Zealand Journal of Psychiatry*, 32, 867-872.

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. London: Sage.

Roberts, G. A. (2000). Narrative and severe mental illness: what place do stories have in an evidence-based world? *Advances in Psychiatric Treatment*, 6, 432–441.

Robinson, L. (2009). Cultural Identity and Acculturation Preferences Among South Asian Adolescents in Britain: An Exploratory Study. *Children & Society*, 23, 442–454.

Salmon, P. (2003). How do we recognise good research? *The Psychologist*, 16, 24-27.

Sandhu, J. S. (2005). A Sikh perspective on life-stress: Implications for counselling. *Canadian Journal of Counselling*, 35, 35-46.

Sembhi, S., & Dein, S. (1998). The use of traditional Asian healers by Asian psychiatric patients in the UK: A pilot study. *Mental Health, Religion and Culture*, 1, 127-134.

Shapiro, D. (2003). The tortured, not the torturers, are ashamed. *Social Research*, 4, 1131–1148.

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

Sheikh, S., & Furnham, A. (2012). The relationship between somatic expression, psychological distress and GP consultation in two cultural groups. *Counselling Psychology Quarterly*, 25, 389-402.

Silverman, D. (2001). *Interpreting Qualitative Data, Methods for Analyzing Talk, Text and Interaction*. (2nd ed.). London: SAGE Publication, Inc.

Simich, L., Maiter, S. & Ochocka, J. (2009). From social liminality to cultural negotiation: Transformative processes in immigrant mental wellbeing. *Anthropology & Medicine*, 16, 253-266.

Singh, G. (1993). *Sri Guru Granth Sahib [English Version]*. New Delhi: World Book Center.

Singh, G., & Tatla, D.S. (2006). *Sikhs in Britain: The Making of a Community*. London: Zed Books.

Singh, K. (2000). How does stigma present itself in different cultural communities? Mental disorder and stigma in the South Asian community. *Visions: BC's Mental Health and Addictions Journal*, 9, 9-10.

Singh, H. (2009). *Caring for a Sikh Patient*: Nectar Publishing.

Singh, K. (2008). The Sikh spiritual model of counseling. *Spirituality and Health International*, 9, 32-43.

Singh, N. G. K. (2011). *Sikhism: An Introduction*. London: I. B. Tauris & Co Ltd.

Singh, P. (2007). The History of Sikh Gurus. Lotus Books. pp. 128–147.

Singh, T. (1987). *How to Raise a Child of God*. Los Angeles: Life Action Press.

Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies On Health and Well-Being*, 2, 3-11.

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

Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In Jonathan Smith (Ed.), *Qualitative psychology: A practical guide to methods*. (2nd eds). London: SAGE Publication, Inc.

Social Exclusion Unit. (2000). *Policy Action Team Report 12: Young people*. London: The Stationery Office.

Soni, R. V., & Balarajan, R. (1992). Suicide among immigrants from the Indian subcontinent. *British Journal of Psychiatry*, 156, 46–50.

Spencer, L., & Ritchie, J. (2012). In Pursuit of Quality. In David Harper & Andrew. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 227-242). West Sussex: John Wiley & Sons Ltd.

Stahl, S. M. (2000). Four key neurotransmitter systems. In Stephen. M. Stahl (Ed.), *Psychopharmacology of antipsychotics* (pp. 3–13). London: Martin Dunitz.

Stern, G., Cottrell, D., & Holmes, G. (1990). Patterns of attendance of child psychiatry out-patients with special reference to Asian families. *British Journal of Psychiatry*, 156, 384-387.

Stopes-Roe, M., & Cochrane, R. (1989). Traditionalism in the Family: A Comparison Between Asian and British Cultures and Between Generation. *Journal of Comparative Family Studies*, 20, 141-158.

Sumathipala, A., Siribaddana, S. H., & Bhugra, D. (2004). Culture-bound syndromes: The story of dhat syndrome. *British Journal of Psychiatry*, 184, 200–209.

Soorkia, R. Snelgar, R., & Swami, V. (2011) Factors influencing attitudes towards seeking professional psychological help among South Asian students in Britain. *Mental Health, Religion & Culture*, 14, 613-623.

Tata, S. P., & Leong, F. T. L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counseling Psychology*, 41, 280-287.

The Impact of Migration on UK Population Growth Report (2016). Retrieved from: <http://www.migrationobservatory.ox.ac.uk/briefings/impact-migration-uk-population-growth>

The Race Relations (Amendment) Act 2000.

Time for Change. (2010). Report retrieved from: https://www.time-to-change.org.uk/sites/default/files/imce_uploads/Family%20Matters.pdf

Tribe, R. (2014). Disability and the Global South. *Culture, Politics, and Global Mental Health*, 1, 251-265.

Trivedi, J. K., Mishra, M., & Kendurkar, A. (2007). Depression among women in the South-Asian region: The underlying issues. *Journal of Affect Disorder*, 102, 219–25.

Tromans, N., Natamba, E., & Jefferies, J. (2009). "Have Women Born outside the UK Driven the Rise in UK Births since 2001?" *Population Trends* 136, 28-42.

Tucket, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse*, 19, 75-87.

Tucker, C.M., Herman, K.C., Ferdinand, L.A., Beato, C., Adams, D., & Cooper, L. (2007). Providing culturally sensitive healthcare: A formative model. *The Counseling Psychologist*, 35, 679–705.

Tucker, C.M., Marsiske, M., Rice, K. G., Jones, J. D., & Herman, K. C. (2011). Patient-Centered Culturally Sensitive Health Care: Model Testing and Refinement. *Health Psychology*, 30, 342–350.

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report*, 15, 754-760.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Maryland: Public Health Service.

Vogel, D. L., Wester, S. R., & Larson, L. M. (2007). Avoidance of Counseling: Psychological Factors That Inhibit Seeking Help. *Journal of Counseling & Development*, 85, 410-422.

Vontress, C. E., & Epp, L. R. (2000). Ethnopsychiatry: Counselling immigrants in France. *International Journal for the Advancement of Counseling*, 22, 273-278.

Vos, S. J. B., Xiong, C., Visser, P. J., Jasielec, M. S., Hassenstab, J., Grant, E. A., Carins, N. J., Morris, J. C., Holtzman, D. M., & Fagan, A. M. (2013). Preclinical Alzheimer's disease and its outcome: A longitudinal cohort study. *The Lancet Neurology*, 12, 957-965.

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 83, 75-89.

Weissman, M. M., Broadhead, E., Olfson, S., Sheehan, D. V., Hoven, C., Conolly, P., Fireman, B. H., Farber, L., Blacklow, R. S., Higgins, E. S., & Leon, A. C. (1998). A diagnostic aid for detecting (DSM-IV) mental disorders in primary care. *General Hospital Psychiatry*, 20, 1-11.

Williams, R. C. & Arrigo, A. (2006). *Philosophy, crime and theoretical criminology*. IL: University of Illinois Press.

Wilkinson, S. (1999). "Focus Groups." *Psychology of Women Quarterly*, 23, 221–244.

Wilkinson, S., Joffe., H., & Yardley, L. (2004). Qualitative data collection: Interviews and focus groups. In David Marks & Lucy Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 39-55). London: SAGE Publications, Inc.

Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, 19, 576-582.

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

Willig, C. (2008). *Introducing qualitative research methods in psychology*.
Buckingham: Open University Press.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*.
Maidenhead: Open University Press.

Winter, H. (2013). *ADHD: 'Because You're Worth It': The Marketisation of ADHD to Adult Women* (Doctoral dissertation, University of East London).

Wolff, G., Pathare, S., Craig, T., & Leff, J. (1999). Public education for community care: A new approach. In Jose Guimon, Werner Fischer & Norman Sartorius (Eds.), *The Image of Madness: The Public Facing Mental Illness and Psychiatric Treatment* (pp. 105-117). Basel: Karger.

World Health Organisation (1992). *International Classification of Diseases*.
Retrieved from: <http://www.who.int/classifications/icd/en/>

World Health Organisation (2001). Atlas: Mental health resources in the world 2001. Retrieved from: http://www.who.int/mental_health/media/en/244.pdf

World Health Organisation. (2014). Mental health: A state of well-being. Retrieved from: http://www.who.int/features/factfiles/mental_health/en/

World Health Organisation (2015). Mental disorders. Retrieved from: <http://www.who.int/mediacentre/factsheets/fs396/en/>

Wyatt, W. J., & Midkiff, D. M. (2006). Biological psychiatry: A practice in search of a science. *Behaviour and Social Issues*, 15, 132–151.

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

Yardley, L. (2011). Demonstrating validity in qualitative research. In Jonathan A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 234-251). London: SAGE.

Zenner, W. (1996). Ethnicity. In David Levinson & Melvin Ember, M. (Eds.), *Encyclopedia of Cultural Anthropology* (pp.393–395). New York: Holt.

APPENDICES

APPENDIX A: Literature Search Terms

S1	Punjabi
S2	Panjabi
S3	Sikh
S4	Sikhism
S5	Indian
S6	South Asian
S7	Understanding
S8	Beliefs
S9	Meaning
S10	Explanations of
S11	Attitudes
S12	Psychological Wellbeing
S13	Emotional Wellbeing
S14	Mental Health
S15	Mental Illness
S16	Mental Disorders
S17	Mental Health Difficulties
S18	Psychological Distress
S19	Cultural Differences
S20	Religious Differences
S21	S1 or S2 or S3 or S4 or S5 or S6
S22	S7 or S8 or S9 or S10 or S11
S23	S12 or S13 or S14 or S15 or S16 or S17 or S18

S24	S19 or S20
S25	S21 + S22 + S23
S26	S21 + S23 + S24
S27	S21 + S22 + S23 + S24

Literature Search Results: ESBSCO PsychINFO, PsychArticles & CINAHL

Search No.	Search Terms	No. of Articles
S1	Punjabi	494
S2	Panjabi	41
S3	Sikh	302
S4	Sikhism	54
S5	Indian	37,168
S6	South Asian	6,133
S7	Understanding	407,921
S8	Beliefs	147,100
S9	Meaning	120,702
S10	Explanations of	88,433
S11	Attitudes	661,622
S12	Psychological Wellbeing	1,439
S13	Emotional Wellbeing	777
S14	Mental Health	563,044
S15	Mental Illness	56,167
S16	Mental Disorders	171,150
S17	Mental Health Difficulties	1,978
S18	Psychological Distress	21,475
S19	Cultural Differences	57,264

S20	Religious Differences	1,473
S21	S1 or S2 or S3 or S4 or S5 or S6	42,807
S22	S7 or S8 or S9 or S10 or S11	1,235,058
S23	S12 or S13 or S14 or S15 or S16 or S17 or S18	694,390
S24	S19 or S20	58,443
S25	S21 + S22 + S23	530
S26	S21 + S23 + S24	115
S27	S21 + S22 + S23 + S24	88

Literature Search Results: Science Direct

Search No.	Search Terms	No. of Articles
S1	Punjabi	3,324
S2	Panjabi	2,404
S3	Sikh	1,351
S4	Sikhism	229
S5	Indian	313,685
S6	South Asian	99,445
S7	Understanding	3,350,732
S8	Beliefs	340,208
S9	Meaning	6,246,522
S10	Explanations of	1,420,260
S11	Attitudes	377,918
S12	Psychological Wellbeing	63,111
S13	Emotional Wellbeing	54,979
S14	Mental Health	374,265
S15	Mental Illness	163,182

S16	Mental Disorders	296,218
S17	Mental Health Difficulties	124,936
S18	Psychological Distress	77,986
S19	Cultural Differences	238,451
S20	Religious Differences	57,975
S21	S1 or S2 or S3 or S4 or S5 or S6	129,618
S22	S7 or S8 or S9 or S10 or S11	379,788
S23	S12 or S13 or S14 or S15 or S16 or S17 or S18	41,892
S24	S19 or S20	66,410
S25	S21 + S22 + S23	1,341
S26	S21 + S23 + S24	459
S27	S21 + S22 + S23 + S24	387

APPENDIX B: Sample Extract from Reflective Journal of Pilot Interview

Pilot Interview: "Harpreet"

Prior to this interview I had not been nervous at all. I was not even sure I needed to conduct a pilot interview believing myself to possess the necessary skills to conduct interviews, but I knew it would be good practice to do so. I could not be more relieved that I did as it served as an important learning point, both in enhancing my research skills and informing me of my biases when working with others.

I had anticipated the interview was going to be easier than it was and I did not expect so much of my own knowledge to cloud my interviewing style. During the interview I had become so immersed that I did not realise I was dominating it. When listening back to the interview and discussing it with my DoS I felt uncomfortable. I had completely led the interview and introduced new ideas that had stemmed from my own experiences and personal interests. I had conducted that interview not as a neutral researcher but as a fellow member of the Punjabi community. Although I had not disclosed any personal experiences, I had aligned myself with Harpreet and found myself making assumptions about her experiences. For example, Harpreet had referred to a Sikh practise I was familiar with, and instead of seeking clarification about this, I responded to her indicating I knew what she had meant. When listening back to the interview I realised that a listener from a different ethnic or religious background would not have had a clear understanding of what we had referred to.

This interview has highlighted to me that in my subsequent interviews I need to ask more open questions and not introduce new topics based on my existing knowledge about the Punjabi community. I need to take more of a curious stance and not assume I have a shared understanding with the participants. There are always going to be differences within communities and I need to create the space to explore that. I also need to ensure my research is accessible to others that are

not of a Punjabi Sikh background therefore I have to probe more into responses and seek clarification so that discussion points are clear.

APPENDIX C: UEL Ethical Approval Document

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Claire Higgins

REVIEWER: Kenneth Gannon

STUDENT: Sukhi Ruprai

Title of proposed study: "A Sinking Heart": Beliefs of Distress in the Punjabi Community

Course: Professional Doctorate in Clinical Psychology (ClinPsyD)

DECISION (*Delete as necessary*):

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required (*for reviewer*):

The title and details of the study imply that the aim is to recruit a sample from the general Punjabi population in order to explore beliefs about distress and attitudes to help-seeking. However, the recruitment poster suggests that the researcher is seeking participants that have experienced distress but have not felt able to speak to anyone about it. This should be clarified because it could have implications for the wellbeing of participants.

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*): Sukhjinder Ruprai
Student number: u1331813

Date: 20th Feb 2015

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

☐

MEDIUM

☒

LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer (*Typed name to act as signature*): Dr Kenneth Gannon

Date: 20 February 2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

APPENDIX D: UEL Ethical Approval Letter following Amendments

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology



18th December 2015

To whom this may concern,

Notice of Ethics Review Decision

This is to confirm that Sukhjinder Ruprai, Student number: u1331813 on the Clinical Psychology Professional Doctorate programme has been awarded ethical approval.

Supervisor: Claire Higgins

Reviewer: Kenneth Gannon

Student: Sukhjinder Ruprai

Student Number: u1331813

Title of proposed study: "A Sinking Heart": Beliefs of Distress in the Punjabi Community

Please do not hesitate to contact me should you have any questions relating to the above.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'M Shingadia'.

Minal Shingadia
Psychology School Office Administrator
Direct line: 020 8223 4503
Email: m.shingadia@uel.ac.uk

APPENDIX E: Risk Assessment

University of East London

Professional Doctorate in Clinical Psychology

Risk assessment for interviews that are being conducted away from UEL

Title of study	Location(s) of interviews	Name of local contact (if available)	Severity of hazard (H, M, L)	Likelihood of hazard (H, M, L)	Risk (H, M, L)	Approved (Yes/No)
"A SINKING HEART": BELIEFS OF DISTRESS IN THE PUNJABI COMMUNITY	Outside of UEL premises - Community centres, Religious places of worship and participant homes					

Brief details of nature of potential risks and how these will be addressed:

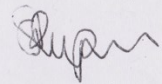
Although I have a preference for conducting my research interviews on UEL premises, there may be occasions when potential participants are unable to make it onto the proposed site. This may mean conducting my interviews at alternative premises such as the homes of participants or other locations such as community centres and religious places of worship. To minimise any associated risks to myself as a result of these interviews I propose the following:

I will inform a third party (this will usually be my thesis supervisors, in the event they are unavailable I will inform my personal tutor) that I will be conducting my interviews off site and provide them with details of the location and anticipated end time. I will keep my mobile phone with me during the interview. I will then contact the same third party after the interview has been completed. If I am in a public area (e.g. a community

centre) using a private interview room I will inform the appropriate person in charge prior to the interview and check in with them after the interview is completed. I do not anticipate any other risks to myself. I will also familiarise myself and adhere to the all health and safety and fire and evacuation policies and procedures of each premise I am in. If I am carrying out interviews in the homes of participants I will follow NHS Lone Working policy again ensuring my supervisor/tutor knows of my whereabouts and checking in after the interview has been completed.

Trainee: Sukhjinder Ruprai

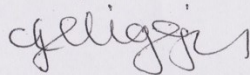
Signature:



Date: 23/03/15

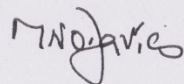
Director of Studies:

Signature:



Date: 20/4/15

Dean of School or designate:



Signature:

Date:

13.04.15.

APPENDIX F: Registration Letter

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology



SUKHJINDER RUPRAI
644 GREEN LANE
ILFORD, ESSEX
IG3 9RZ

Date: 05/05/2015

Student Number: 1331813

Dear Sukhjinder,

Registration as a Candidate for the University's Research Degree

I am pleased to inform you that the Research Degrees Subcommittee on behalf of the University Quality and Standards Committee, has registered you for the degree of Professional Doctorate.

Title of Professional Doctorate: Professional Doctorate in Clinical Psychology

Director of Studies: Dr Claire Higgins

Supervisor/s: Dr Nimisha Patel

Expected completion: According to your actual date of registration, which is **1st October 2014**, the registration period is as follows:

Minimum 18 months maximum 48 months (4 years), according to a full time mode of study.

Your thesis is therefore due to be submitted between:

1st April 2015 and 1st October 2018

I wish you all the best with your intended research degree programme. Please contact me if you have any further queries regarding to this matter.

Yours sincerely,

Dr Kenneth Gannon
School Research Degrees Leader
Direct line: 020 8223 4576
Email: k.n.gannon@uel.ac.uk

Stratford Campus, Water Lane, Stratford, London E15 4LZ
Tel: +44 (0)20 8223 4966 Fax: +44 (0)20 8223 4937
Email: mno.davies@uel.ac.uk





UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)

Sukhjinder Ruprai

Contact Details: u1331813@uel.ac.uk +4479 [REDACTED]

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Clinical Psychology Doctorate degree at the University of East London. Please read the following information carefully.

Project Title

“A SINKING HEART”: BELIEFS OF DISTRESS IN THE PUNJABI COMMUNITY

What is the purpose of the study?

In the UK healthcare services have a moral, professional and legal duty to ensure they are providing fair and equal access to all. This includes recognising the need to provide culturally appropriate services. The aim of this research is to learn how mental health issues are perceived by those who are of Punjabi (from India) origin.

The research also aims to explore how these perceptions may impact the likelihood to seek help and how organisations can overcome some of the current barriers to access. It is hoped this research will provide further insight into your perceptions of mental health and mental health services.

What does it involve?

If you agree to take part you will be asked to sign a consent form. Following this you will be contacted to arrange an interview with the researcher. The interview will typically last 90 minutes but you are able to leave at any time if you wish. If you require a break at any point during the interview, this will be facilitated. The discussion will be audio tape recorded so that the researcher is able to transcribe all the information provided. You will have the opportunity to ask any questions both before and after the interview.

Will the study cause me distress?

This is unlikely; however you may find the topic of mental health distressing even if you have not been affected by mental health issues directly. If you find that you become distressed at any stage of the process, please speak to the researcher at any time. The researcher will be able to provide information about appropriate services and support that you will be able to access following this research if required. The main disadvantage is the time required to take part in the interview. Although it will be a one off meeting, the researcher is aware that providing this time may be difficult. The time is required to allow for a detailed discussion to obtain meaningful information.

Confidentiality of the Data

All information which is collected during this study will be kept strictly confidential. Your identity will as kept anonymous as names are not required in any of the research. Any names mentioned in the interviews will be removed from transcription. When information is reported a code name will be used to ensure no one can identify you as a participant. The researcher will be the only person who will enter the information from the tapes onto a secure computer and this data will be password protected. Once the study is complete, the data will be removed from the hard drive and securely stored by the Graduate School in line with the 1997 Data Protection Act.

Location

These interviews will be held in an agreed private space such as a university interview suite. There is flexibility to consider other locations given the space allows for safe discussion.

Remuneration

Participants will not be reimbursed for any travel costs incurred as a result of attending the interview.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher. If you decide not to participate in this research it will not affect any healthcare that you receive now or in the future.

Ethical Approval

The researcher was granted ethical approval for the research study by the Ethics Committee at the University of East London.

Contact for further information

Thank you for taking the time to read this leaflet. Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor, Dr. Claire Higgins, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email:

██████████@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn,
School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Sukhjinder Ruprai

Trainee Clinical Psychologist

21/11/2014



UNIVERSITY OF EAST LONDON

Consent to participate in a research study
“A Sinking Heart”: Beliefs of Distress in the Punjabi Community

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

APPENDIX I: Demographic Questionnaire

Participant Code

Age:

Gender:

Marital status:

Do you have any dependents?

Highest education level:

Employment status:

Occupation:

Would you consider yourself a practising Sikh?
If yes, please explain

Would you consider yourself to be spiritual?
If yes, please explain

What country were you born in?

If not UK, how long have you lived in UK?

Where were your parents born?

First language

Preferred language

What are your thoughts on emotional wellbeing?

**I am interested in hearing how you think people cope with
stress...**

Should people talk to others about their feelings?

Do you think people access services?

What are the barriers to accessing support?

**If you are aged 18+ AND are Sikh Punjabi, get involved
and have your say about the unspoken**

Contact Sukhi Ruprai

u1331813@uel.ac.uk

ਜਜ਼ਬਾਤ ਬਾਰੇ ਗੱਲ ਕਰੋ

ਕੀ ਤੁਸੀਂ ਕਦੇ ਵੀ ਤਣਾਅ ਅਤੇ ਹਾਰੇ ਹੋਏ ਮਹਿਸੂਸ ਕਰਦੇ ਹੋ
ਕੀ ਤੁਸੀਂ ਇਸ ਦਾ ਸਾਮ੍ਹਣਾ ਕਰਨ ਲਈ ਸੰਪਰਕ ਮਹਿਸੂਸ ਕਰਦੇ ਹੋ
ਤੁਹਾਡੇ ਲਈ ਇਸ ਬਾਰੇ ਗੱਲ ਕਰਨੀ ਮੁਸ਼ਕਲ ਹੈ
ਵਿੱਚ ਸ਼ਾਮਲ ਹੋਕੇ ਇਸ ਬਾਰੇ ਗੱਲ ਕਰੋ

ਮੇਰੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ

ਸੁੱਖੀ ਰੂਪਰਾਏ

u1331813@uel.ac.uk

APPENDIX L: Interview Schedule

The following is a guide of topics to be covered in the interviews to facilitate discussion. The interviews will be participant-led.

- Introductions and build rapport
- Consent/Confidentiality

Broad topics areas to be covered:

- Definition of psychologically wellbeing and mental health issues
- Appraisals to mental health issues
- Relationship to help
- Main influences of help seeking behaviours
- Barriers to accessing services

Question Guide:

- What does psychological distress mean to you? What concepts define mental health and psychological distress?
- What causes psychological distress? Do you think this is the same for everyone?
- What other causes have you heard about? What are your views on this?
- What do you think has influenced your beliefs around psychological distress?
- Attitudes/beliefs of family and friends?
- How openly can you discuss MH in your family? In your community/social circles?
- What issues, if any, may you face talking about MH in your community?
- Are you religious? How do your religious views shape your beliefs about MH?
- What is your view of people that have a MH diagnosis/require MH support?

- What are your current coping strategies?
- What are the consequences for people who may have a MH issue? How would life change?
- What services do you think are available for people requiring support around any MH issues?
- Have you accessed MH services previously? Have your friends or family?
- Would you access such services? What would help/hinder your access of them?
- What the attitudes/beliefs of family and friends about MH services?
- What are your main concerns about accessing services?
- Do you think MH services are able to meet your needs? Do you think you would benefit from such services?
- How easy/difficult do you think it is to access services?
- What are your main concerns about accessing MH services or receiving a MH diagnosis?
- What is your view of the Western MH?
- Would you prefer talking to a HCP of the same ethnicity/religion as you?
- What others factors would influence your decision to seek support?
- How can services be improved?
- Should services be made culturally appropriate? How can services be made more culturally accessible?
- If a family member or friend was affected by any MH issues, would you seek external support? If so, from where?
- What could develop your relationship with MH services?

Ending: Questions/Debriefing

APPENDIX M: Transcription Convention – Adapted from Parker (2005)

P	Indicates participant
I	Indicates interviewer
()	Indicates pause in speech
[unclear]	Indicates speech was unclear
[]	Indicates when a comment has been added by the author
< >	Indicates interruption
/	Indicates overlapping speech
-	Indicates unfinished word

APPENDIX N: Coded Interview Excerpt

1 I: Ok, so when you hear the word, the term psychological
2 wellbeing. What springs to mind? What do you think that
3 means?

4 P4: How you feel mentally? I think psychological wellbeing,
5 how you feel mentally? Your perception of like your self-
6 esteem. So high, low and so on. Levels of confidence.
7 Basically, I think it's an important thing for you to function
8 and do well in anything that you do. Society wise, work wise
9 and so on. That's psychological wellbeing for me. So it's
10 linked with stress, stress factors and so on. It's good to. So
11 when people ask about your wellbeing, I think that they are
12 referring to "do you get stressed easily? How you respond to
13 stress?" and so on.

14 I: How do you look after your own wellbeing?

15 P4: I do a lot of prayers. So I feel that I'm quite spiritual. I'm
16 strong at that end. Secondly, I think mentally I relax by
17 reading, reading a lot. So read different books. Mainly
18 spiritual type of related books. I hang out with other friends,
19 have a chill-out. I don't have too serious an outlook on life. I
20 always see the fun side of life.

21 I: Ok.

22 P4: So I always. So when everything else is stressed around
23 me. I always have like, a bit like, I don't know if you've read
24 the book 'The secret life of Walter Mitty?' I can't remember
25 who it's by. But it's this character, whenever they're stressed
26 in real life, they always go into this jokey version and they're
27 like amazing in their sort of dream world. So for me,
28 whenever I see everything else around me. If it seems
29 people are getting really stressed or it's getting really, really
30 tense. I'll always have a very funny version of seeing things.

31 I: Where has that idea come from? Where have you learnt
32 that coping strategy?

33 P4: Where have I learnt that from? Like I said. I've learnt that
34 from boarding school. As a child for three years I went to
35 India when I was 8 years old. 8 ½ years old for 3 years. So
36 there, obviously no parents, different lands. Very strict
37 discipline.

38 I: How comes they sent you there?

39 P4: They wanted me to learn my culture about Sikh faith.
40 They saw the way I was growing up here and they thought it
41 would be good for you learn a lot of your traditional values,
42 ethics. So they wanted me to learn, abroad. Because my
43 dad was quite a strong leader here in the Sikh community.

Handwritten notes:

- PW → how you see yourself
- PW → Important. there is an awareness of PW.
- PW → Spirituality?
- Says it like it is his choice
- Books - education?
- denial of problems? escapism?
- humour → avoidance?
- different cultural influences
- keeping strong ties to Culture.
- Religion/culture Imp. for PW?
- Strong ties
- Ideas around being strong

Keeping ties in India

Dealing
with problems
↑ indep.

Self control
autonomy.

Not
needing
others.

I
not
even
asking for
help →
being
self
reliant

no space
to not
know!

Discrimination

Challenged
sounds
true?

Seen as
something
he could
overcome...

44 So he had good connections in India and one of these
45 flagship schools in Punjab.

46 I: Ok.

47 P4: That was opening at the time. So he had a really close
48 relationship with that principal and he thought it was a good
49 idea to send me there. So there, basically, I had to sort of
50 fend for myself at moments. So the emotional support,
51 psychological support not much there. But, I with my own
52 personality, just created a whole group of friends. Things
53 were, they could be very strict, very hard whereas over here
54 it's the total opposite. So then in my own mind, I always
55 created a buffer zone. So whenever things got too serious,
56 then I would always think of a funny way to deal with it.

57 I: That's quite an advanced coping strategy for like an 8-
58 year-old?

59 P4: You have to. So yeah. I had to learn the language really
60 quickly as well. So they talk Punjabi and Hindi. And I didn't
61 know any Punjabi when I was in this country. But there the
62 teachers were really strict, the whole system was strict. So
63 there I just thought, I had to find someone who knew the
64 language and then I would write it in English at the top of the
65 Punjabi and Hindi script. So that's how I learnt. I learnt it self-
66 taught but with a bit of assistance with friends. So yeah,
67 when you're put in a situation, you kind of have to pick up
68 the skills.

69 I: Not everybody could do that though.

70 P4: No.

71 I: What do you think has maintained your ability to function.
72 Like you were saying, not get stressed and keep a healthy
73 outlook on life. That's not something every 8-year-old could
74 have done.

75 P4: No. But I. Childhood experiences are very different, I
76 think, for myself. We grew up in a very white neighbourhood.
77 A lot of racism at the time. And, so we had to. We were
78 challenged every day. From verbal abuse to anyone sort of
79 attacking you. So we kind of had to defend for ourselves.
80 Quite young. And then they didn't really have any policies
81 on, you know, this whole multi-cultural approach and so on.
82 They didn't know what Sikhism is let alone what's that thing
83 on your head kind of thing. So they. So generally, just as a
84 child growing up, I used to interact with a lot with the children
85 so we had much more of adventurous approach when we
86 were growing up. So we didn't have what it is nowadays
87 where you can't let your kid within a 100 meters away from

Sticking together

Keeping
relationships

Strong with
other Sikh
Ppl.

or Sikh
Ppl in
high
positions?

high achievers

Influences -
teachers.

Learning
to manage
problems
alone,

attitude
of "you have
to"

White ppl vs.
Punjabi's?

Standing up
for yourself.

Racism

Being challenged
everyday →
needing to
defend yourself.

was even encouraged by mother to be strong. → PW talked abt as being in personal control. PW simply + pragmatically talks abt deal with probs. indep. mum = important influence Religion/ Sikh hx. CBT → reframe -ve things to spin them.

No mention of asking for help. We learnt by ourselves.

Gurm Gobind
↓
known as military leader. encouraged Sikhs to stand up for themselves

narrative around being strong
→ passing down stones in family DS vs them.

Supporting family
[migration]

self agency/
Faith in yourself to overcome difficulties
Internal locus of control.
* not needing others, belief in oneself *

88 you below a certain age. We used to be able to travel from
 89 here ourselves, go all the way to [name of place in London].
 90 Walk there by ourselves unattended. No parents, no one
 91 around. So that's how we, so that kind of exploration from
 92 childhood. So these are kind of like the soft skills, life skills
 93 which we picked up anyway. So on one end you had to sort
 94 of deal with the racism. So it was really simple. So if they
 95 swore at you, you sort of swore back or heard their abuse or
 96 and so. So you just kind of dealt with it there and then at a
 97 kiddy level. And then we also, like myself and my parents
 98 who were both very staunch Sikhs. So my mum was really
 99 good with this concept, which I read in the NLP thing about
 100 'reframing'. She was very good at 'reframing' things. So
 101 when I say "I feel really bad because I look odd as a Sikh",
 102 my mum would always reframe it and say "but no, you guys
 103 are the children of a great leader Guru Gobind Singh Ji
 104 [tenth Sikh Guru] And these other people don't know
 105 anything. Treat them as ignorant and leave it at that". And
 106 then she would always reframe it so we would say "no, we
 107 got hit". She would say "today you got hit, tomorrow they'll
 108 get hit". She would always twist it and then just positively
 109 reframe our lives to give us a positive outlook in life.
 110 I: That sounds like you mum was a really big influence.
 111 P4: Huge.
 112 I: In religion and the wider... < P4: Religion faith. The
 113 external bit she said "you're not allowed to cut your hair". But
 114 she was. She's very spiritual I'd say, she was very spiritual.
 115 So she always had a way of, sort of, dealing with things.
 116 Very pragmatic. But she was a very a staunch believer >
 117 I: You mentioned 'faith'. 'Faith' in? What does that look like?
 118 P4: Faith for my mum was a very. Like I said, she's very
 119 pragmatic in life. But she always. She herself went through a
 120 lot of struggles because she came here when she was 19.
 121 And she had to support brothers, sisters, parents back
 122 home. Very unusual. She came in the mid 50's. No Asians.
 123 Very few Asians. And she always, sort of, expressed her
 124 stories of her lifestyle of how she confronted racists. The
 125 way she actively as a single person here, struggle, sending
 126 money back home, that kind of thing. So that was the faith
 127 and the belief that she had. Which I think she sort of inspired
 128 all of us; myself, my brother and my sister into being faithful,
 129 having faith. Believing in a power outside there that's for the
 130 best for you.

Being a minority
↓ impact?
[Being Strong]

APPENDIX O: List of codes

Code Number	Code Name
1	Being positive
2	Problem solving
3	Reflecting/Being self-aware
4	Being able to identify stress
5	Exposure to the distress of others
6	Traumatic life events causing distress
7	Being normal vs different
8	Depression affects PW
9	Intergenerational trauma
10	Asking for help is a weakness
11	Power of community
12	Losing control
13	The concept of capacity
14	Trust
15	Learning about MH from popular TV shows
16	Punjabi's are judgemental
17	Hospitals make people more sick
18	Who needs to know my private business?
19	Being a burden
20	People create their own barriers
21	Migration struggles
22	Not wanting to worry people
23	Self-determination
24	Not openly talking about your problems
25	People with MH problems not valued

26	Medication is given out too readily
27	Self-diagnosis
28	Negative attitudes towards people with MH diagnosis
29	Medication is the only treatment available
30	Not enough resources are available
31	Drugs and alcohol affect PW
32	MH problems can make people commit crime
33	Stigma
34	PW can be controlled
35	MH services are a last resort
36	Shame around wider community finding out about problems
37	Stigma by association
38	Denial of problems
39	Pride
40	It is a Punjabi thing
41	We can deal with things by ourselves
42	Internal locus of control
43	Autonomy
44	India is backwards
45	We are Punjabi warriors
46	Sikh history
47	Western understandings of MH problems
48	Spiritual understanding of MH problems
49	Cultural explanation of MH problems
50	Doctors/Psychologists are the experts
51	Western influences
52	Explanation of ghosts in India
53	Secrecy
54	It is no one else's business

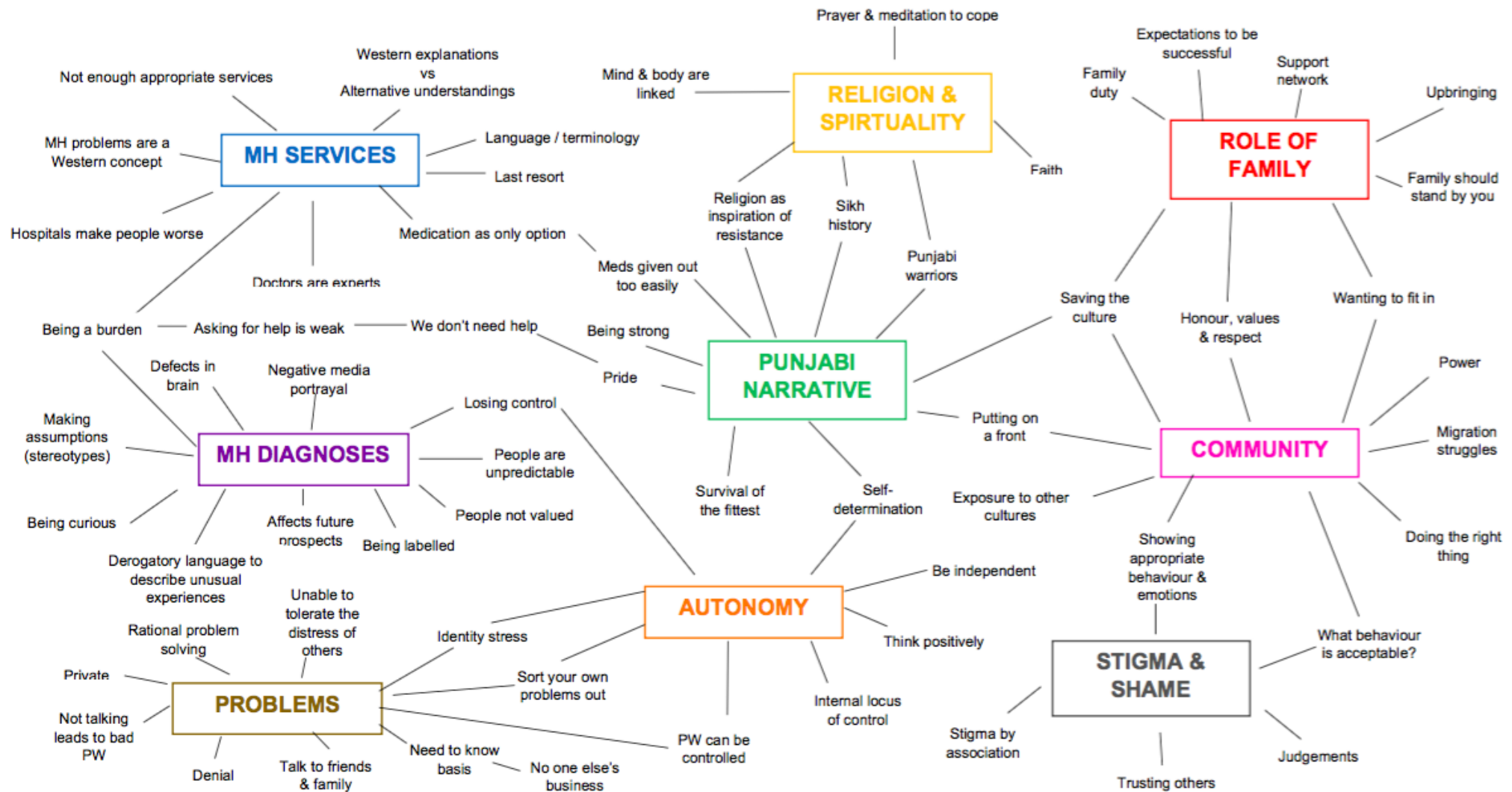
55	MH problems affect other areas of life
56	Sort your own problems out
57	Seeking alternative support
58	Mind and body are linked
59	Knowing right from wrong
60	Having morals & being ethical
61	Doing what makes you happy
62	Bottling up problems leads to MH problems
63	Knowing what you want in life is good for PW
64	Talking to friends & family
65	Friends & family are good support network
66	Being strong
67	Not talking about problems causes harm to the mind
68	Upbringing
69	Acceptance & keeping an open mind
70	Cultural norms influence what behaviour is appropriate
71	Doing the right thing
72	Generational differences
73	Education, awareness & understanding is important
74	Exposure to other cultures
75	Honour, respect & values
76	Not trusting the wider community
77	Putting on a front
78	Behaving properly
79	Showing appropriately emotions
80	Not being vulnerable
81	Importance of religion
82	Biological causes of MH problems
83	Exposure to distress

84	Normal vs outcast
85	Media influence
86	Making assumptions about MH diagnoses
87	Environment/life events important to PW
88	Problems are personal & private
89	Being true to yourself
90	Family are supposed to stand by you
91	Not having access to information
92	Living a balanced life
93	Staying active & busy to maintain PW
94	Having peace of mind
95	Faith
96	Family duty
97	Services are racist
98	The Punjabi culture is competitive
99	Need to know basis only
100	Dementia is a big concern in the Punjabi community
101	Family influence
102	Social inequalities
103	Punjabi's have different priorities
104	Confidence affects PW
105	Meeting family expectations to be successful
106	You have to help yourself
107	Personal responsibility to maintain PW
108	Wanting to be normal
109	Stereotypes
110	Unable to tolerate the distress of others
111	MH problems are contagious
112	The person is the problem

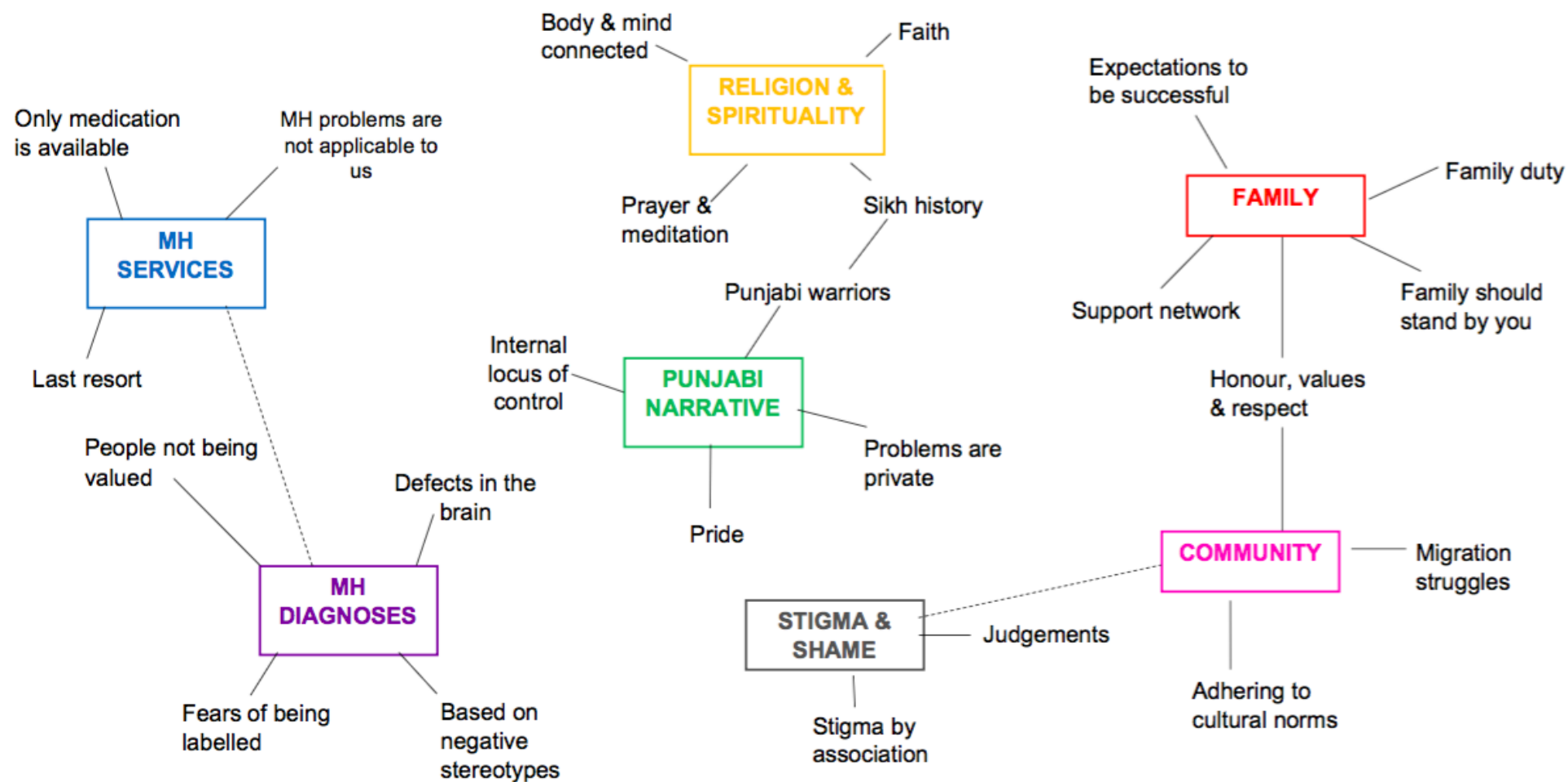
113	Community power
114	Treatment from hospital vs family support
115	Rumination is not good for PW
116	Having a happy soul
117	A problem shared is a problem halved
118	Confidentiality
119	Pathologising unusual behaviour
120	MH problems are a reaction to traumatic life events
121	Being treated differently
122	Fear of unknown
123	We can look after ourselves
124	Being independent
125	MH diagnosis is a disability
126	Sikh history inspires strength
127	Empowerment
128	Saving the culture
129	MH problems does not exist in India
130	MH diagnoses are a Western concept
131	Denial
132	Recognising your own stress
133	Acculturation
134	Coping is part of a everyday life
135	Taking time out
136	Hiding out you really feel
137	Asking for help is a last resort
138	Diagnoses are a barrier
139	Being out into a box
140	Just deal with problems
141	Punjabi's are strong

142	Not wanting to be labelled
143	Being curious about MH
144	Derogatory language to describe unusual experiences
145	Prayer & meditation to cope
146	Punjabi's are fighters
147	People with MH problems are unpredictable

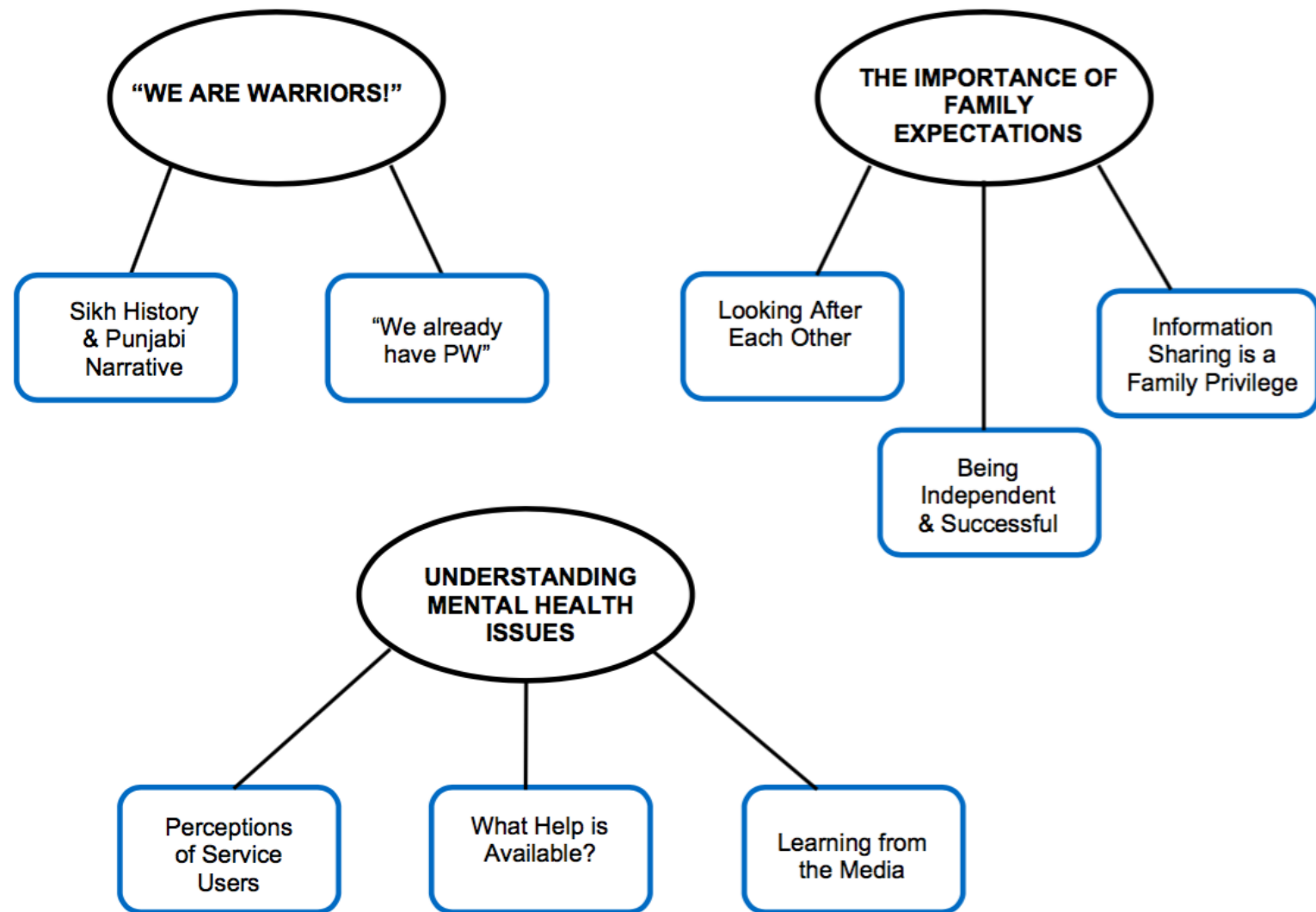
APPENDIX P: Mind Map 1



APPENDIX Q: Mind Map 2



APPENDIX R: Mind Map 3 Final Themes



APPENDIX S: Braun & Clarke's (2006) 15-Point Checklist of Criteria

Process	No	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each theme have been collated.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysis – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other- the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written Report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do and what you show you have done i.e, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'.

Interview 2: "Suman"

I met with Suman in her home and I was instantly drawn to her warmth. She offered me a cup of tea which put me at ease. This was when I realised I was a little nervous about the interview. Suman was very interested in me and asked what had motivated my interest in the topic area. As the introduction and rapport building continued, she admitted to me that she did not think I looked Punjabi and asked if I was mixed-race. It was a question I had been asked many times throughout my life in various contexts. This question always makes me feel defensive, as though I have to prove I am Punjabi enough. I informed her that I was Punjabi and not mixed-race, and that both of my parents practised Sikhism. I had been curious about Suman's need to ask about my ethnicity and wondered how differently the interview would have progressed had I been a different ethnicity, or if she had not confirmed her curiosity about my background.

The actual interview was challenging as Suman kept talking about her husband and daughter who had both passed away, which made her become tearful⁹. We had stopped the interview three times while Suman regained her composure. During these pauses I found it difficult not to slip into the role of a clinician in a therapeutic session. Although I was very conscious of the fact I was not there as her therapist, it was difficult to not offer her words of comfort and allow her the space to feel heard. Despite Suman getting upset she was determined to continue with the interview, apologising for digressing from the topic. It felt unethical to carry on and I offered her the opportunity to wrap up the interview and arrange another time but she was adamant she wanted to continue.

⁹ The interview was terminated as I consoled Suman. After talking about the loss, she insisted we continue with the interview. I emphasised that she could stop the interview again at any time and if necessary we could abandon the interview altogether. Details of bereavement services in the area were offered but she declined.

I had been inspired by her strength as she talked about how she had moved forward with her life, especially after the death of her daughter. She spoke about needing to “pull her socks up” and get on with life. She made me think about the way I have heard my own family talk about loss and the way they have encouraged me to be strong. She frequently referred to the idea of Sikhs being strong people and I had suddenly felt proud to be Sikh, even though I would not consider myself a practising Sikh. In fact, I felt like a fraud when Suman spoke about Sikhism and looked to me for validation, because I am not very religious. However, I started to realise that being Sikh was about more than just believing in God. The values around equality, tolerance, and accepting difference were instilled in me, but this was the first time I had really acknowledged that they were such an integral part of Sikhism. Perhaps I am ‘more’ Sikh than even I give myself credit for.

There were times when Suman had assumed a shared meaning between us. I wanted to ensure the data was reliable so I sought clarification and asked her to explain particular terms. I was a little embarrassed when Suman jovially scolded me for not knowing about my heritage and traditional customs. I found myself feeling defensive and wanting to tell her I knew enough about my heritage but I could not make assumptions, because I wanted to conduct the research as fairly as possible. At the end of the interview she thanked me graciously saying I was doing a service to Punjabis. I felt a mixture of sadness and pride and this feeling has stayed with me all evening.

Analysis Process

I had not anticipated that the process of analysis would evoke such a strong emotional response in me. Listening back to the interviews I realised the story of the survival of Sikhs was very dominant and had been so influential in shaping current beliefs, even for topics such as mental health and psychological wellbeing, which on the surface appear to be very unrelated. Despite my research not explicitly asking about Sikh history, it was a subject that had come up in every interview. Although my participants had not been directly affected by the anti-Sikh violence in the Punjab, it was evident that the wounds had stayed with them and had become an intrinsic part of who they are today. I was reminded of similar stories told to me as a child from my own family, especially my paternal Grandfather.

Coding the data made me realise how personally connected I feel to the research study I have chosen. It was challenging to put my own experiences aside and not let them influence my analysis. I could relate to a lot of the themes that were starting to emerge, and felt naïve for not acknowledging some of the cultural narratives in own upbringing around help-seeking before I had started the research. I felt conflicted; as a trainee clinical psychologist I assumed that there was a need for psychological services in the Punjabi community and I was curious as to why Punjabis under-utilised them. However, perhaps I was wrong to assume Punjabis needed this input, and arrogant to assume that I as a Punjabi person had the expertise to know how to provide this. The data challenged some of the assumptions I had made about connecting with this community, and perhaps they do not need psychological input.

Holding this in mind I had put a lot of pressure on myself to do the participants 'justice' as I felt they had given so much of themselves to me. They had all been so candid in their responses that I had wanted to get the analysis 'right'. I had been a little disappointed that some of the participants had followed up on their responses with further comments once the interview was over and the

recorder had been switched off. These comments were relevant to the topic area I was researching. It is interesting they did not feel able to disclose such comments during the actual interview. Some may have considered the comments a little controversial but I would have welcomed them to allow for richer discussion points. This highlighted how unsafe other ethnic groups may appear to some Punjabis.