# SIKH MEN IN THERAPY

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## DECLARATION

I hereby declare that the work submitted in this thesis is the result of my own investigations, except where otherwise stated.

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**GLOSSARY**

| Punjabi term | Definition |
|---|---|
| *Amritdhari* | A Sikh who has been initiated or baptised as a *Khalsa* by taking *Amrit* (nectar water). |
| *Amrit* | The water of eternal life; the nectar of immortality. |
| *Ang* | Limbs of the *Guru* since the Guru Granth Sahib is the eternal *Guru* for Sikhs. |
| *Bebe* | Mother/grandmother. |
| *Bharosa* | Faith in the Divine. |
| *Chardi Kala* | A mental state of eternal optimism and bliss. |
| *Daas* | Servant to the Almighty. |
| *Dharam* | Righteousness and moral duty. *Dharam Khand* is the realm of righteous action. |
| *Dukh* | Suffering, unhappiness and can also be defined as grief. |
| *Ek Onkar* | The one cosmological essence that unifies all diversity. |
| *Gian* | Knowledge. *Gian Khand* is the realm of knowledge, understanding or consciousness. |
| *Gurbani* | The writings of the *Gurus* as found in the Sikh holy scriptures; the *Gurus'* words; the *Gurus'* teachings. |
| *Gurmukhi* | The script in which the compositions of the *Gurus* were first written. It has become the script in which Punjabi is written by most Sikhs, and by some others. |

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| *Guru* | Is derived from the syllable 'gu' standing for darkness and ‘ru' (light) for the removal of darkness, thus *Guru* is he who banishes the darkness of ignorance. |
| *Guru Granth Sahib* | The sacred text that contains the compositions of the Sikh *Gurus.* |
| *Hukam* | The will of God. |
| *Izzat* | The concept of honour. |
| *Jat* | Punjabi rural caste. |
| *Jadu tona* | Black magic. |
| *Kara* | A steel bangle that symbolises an unbreakable bond with God. |
| *Karam* | Action or deed. |
| *Karma* | Refers to the consequences of a person’s actions and words**.** |
| *Keshdhari* | A non-baptised Sikh who observes *Kesh.* |
| *Khalsa* | Means 'pure' and is the name given by Guru Gobind Singh to all Sikhs who have been baptised. |
| *Khanda* | The symbol of the Sikh faith. The symbol comprises of a *Chakkar* (a circular throwing disk), a *Khanda* (a double-edged sword) and two *Kirpans*. To Guru Gobind Singh Ji the *Khanda* represented God and is held in great reverence by the *Khalsa*. |
| *Kul* | Refers to the *Gurmukhi* term of one’s clan and ancestry. |
| *Maya* | Greed or Wealth. |
| *Mona* | An individual of Sikh heritage who does not keep the basic *kakkar* of *kesh* or untrimmed hair. |
| *Mukti* | Is derived from the word *Mukh* (to let go) and refers to liberation from the bondage of five influences of ego. |
| *Najjar* | Evil eye. |

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| *Nam simran* | The devotional practice of meditating on the divine name or *nam.* |
| *Paath* | Devotional reading, or the study of scripture. |
| *Panj Chor* | The five major weaknesses of the human personality at variance with its spiritual essence. |
| *Panj Khands* | *Panj* (five) *khands* (regions or realms) signify in the Sikh tradition the five stages of spiritual progress leading man to the ultimate truth. |
| *Panth* | Path or Way, system of religious beliefs or practices, community observing particular system or practices. |
| *Rahit* | Manual of conduct. |
| *Rehat Maryada* | Code of Conduct. |
| *Sach* | Truth or reality. *Sach Khand* is the realm of truth. |
| *Sant Sipahi* | *Sant* is used to refer to a wise, knowledgeable and dharmic person. *Sipahi* means warrior or soldier. |
| *Saram* | Modesty or humility. *Saram Khand* is the realm of effort. |
| *Seva (also sewa)* | Selfless service. |
| *Sikhi* | *Sikhi* derives from the word *Sikh.* A term used by Sikhs to describe their path of learning as a lived experience. |
| *Waheguru* | Divine master, teacher (gu-darkness, ru-light) and the name by which Sikhs refer to God. |

## ABBREVIATION

| | |
|---|---|
| APA: | American Psychological Association |
| DA: | Discourse Analysis |
| GGS: | Guru Granth Sahib |
| GP: | General Practitioner |
| GT: | Grounded Theory |
| HCPC: | Health and Care Professions Council |
| IPA: | Interpretive Phenomenological Analysis |
| LMU: | London Metropolitan University |
| MI: | Mental Illness |
| PTSD: | Post-Traumatic Stress Disorder |
| SA: | South Asian |
| UK: | United Kingdom |

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## ABSTRACT

**Background/Aims:** When considering culture, existing literature has identified that there is a key decline in help-seeking behaviour particularly within the South Asian community. However, there is a gap within the literature regarding Sikh men's perspectives of the concepts of therapy. The research explores help-seeking behaviour of Sikh men from the Sikh community. Through this, the aim has been to explore what factors contribute to deciding whether one should seek therapy, which can help understand what impedes or encourages that process.

**Design/Method:** Verbatim accounts of semi-structured interviews were analysed using a constructivist grounded theory approach. The participants were eight Sikh men aged between 18 to 33 years. Four out of the eight participants had experienced some form of psychological therapy, whilst the other four had considered approaching psychological services but never received any therapy.

**Findings:** The findings demonstrated high-level components in describing the highly complex processes a Sikh man identifies with when deciding whether to seek therapeutic help. During the process of analysis three core constructs: 'Barriers from within', 'External barriers' and 'Opening up the barriers' emerged.

**Conclusions:** The model captures how much a Sikh man must consider prior to making a decision about their own mental health. The theory that emerged from this research provides insight into the help-seeking style of the Sikh culture, to help Counselling Psychologists and other health professionals working with this client group to develop culture-specific interventions.

# CHAPTER ONE

## INTRODUCTION

The term 'Sikh' refers to a learner or disciple and the Punjabi verb *sikhana* means 'to learn'. **S**ikhism is a monotheistic religion that originates from Punjab, a provenance of India (Ganeri, 2003, p. 6). It stands as one of the newest formed religions and is the ninth largest religion in the world. It was founded by Guru Nanak Dev Ji in 1469 and Guru Nanak Dev Ji was the first *Guru* of ten. McLeod (1997, p. 166) highlights the primary scripture of the Sikhs is variously referred to as the *Granth Sahib*, the *Guru Granth Sahib* or *Adi Sri Guru Granth Sahib,* due to the varying attitudes towards the holy scripture. For the purpose of this research *Guru Granth Sahib* (GGS) will be used. The GGS was compiled over the lifetime of all ten *Gurus,* completed in 1706 and given Eternal *Guruship* in 1708 (Singh, 2009, p. 16). The first version, referred to as the *Adi Granth,* was compiled by Guru Arjan Dev Ji and this contained the teachings of the first five *Gurus* (Guru Nanak Dev Ji, Guru Angad Dev Ji, Guru Amar Das ji, Guru Ram Das Ji and Guru Arjan Dev Ji). Guru Gobind Singh Ji updated this by adding teachings of his father, Guru Tegh Bahadur Ji (Singh, 2008). It is believed Guru Gobind Singh Ji announced that with his death the line of personal *Gurus* would end and the title would be passed to the Granth Sahib (the Adi Granth) which contained their teachings, and it thus came to be known as the *Guru Granth Sahib* (McLeod, 2005, p. xx). It is the only scripture of its kind containing hymns and utterances of a variety of saints from differing traditions.

There are approximately 25,000,000 Sikhs worldwide (Singh, 2003, p. 24) and form part of the global classification of 'South Asian' (SA). The Census Ward Data suggests there are approximately 423,000 Sikhs in the United Kingdom (UK), with some of the largest communities in Slough (10.6 %), Wolverhampton (9.1 %), Hounslow (9 %), Sandwell (8.7 %) and Ealing (7.9 %) (ONS, 2011a). In the UK the Black, Asian and Minority Ethnic (BAME) population is diverse and quite visible. According to The Census Ward Data, 14% of the population of England and Wales belongs to a BAME group; SA was the largest BAME subgroup with 1.4 million (2.5%) people (ONS, 2011b, as cited in Ruprai, 2016, p. 4). A vast amount of research has explored physical health in BAME groups, but to date, there is a lack of focus on mental health issues (Jhutti-Johal, 2018). We can argue in the absence of this research, it is easy for the specific needs of BAME communities to be overlooked and the idea of mental ill health within the community to be dismissed.

Although passages in the GGS show positive regard to women as integral to the very core of the Sikh tradition (Jakobsh, 2000), the Punjabi, Sikh society is patriarchal in authority and all inheritance is through the male line which ensures the continuity of one's *kul*. "The birth of a son is celebrated with great enthusiasm while the arrival of a daughter remains a comparatively less significant affair" (Kalsi, 1992, p. 150). The Sikh media image is also predominantly male (Nesbitt, 2016, p. 1). The man in a traditional Sikh household is seen as the head of the house; structure of the tree that keeps all the branches together. "The salient values are bravery and sacrifice, and thus, the need to develop courage and fortitude; stress on mental and physical health; emphasis on freedom and honour" (Kapur & Misra, 2003, p. 1). The Sikh community has been shown to be strongly influenced by their

historical roots i.e. the warrior identity, that consist of beliefs of managing hardships without input from external services (Ruprai, 2016).

Research has explored men, masculinity and help seeking patterns (Addis & Mahalik, 2003). Figures of health care service utilisation in the UK indicate that men are less likely than women to voluntarily use mental health care services, including psychological therapies (Hammer et al., 2013). Findings demonstrate men are reluctant to seek help for problems as diverse as depression, substance abuse and stressful life events (Galdas et al., 2005) yet, the literature does not address whether these behaviours are present within the Sikh community. Also, studies comparing genders are inadequate in explaining the processes involved in men's help-seeking behaviour (Galdas et al., 2005). The present study takes both these factors into consideration.

Generally, Sikhs are currently under-represented in the literature of psychological therapies and their needs remain unexplored. The critical literature review will thus investigate how Sikh men respond to distress and their approach to psychological well-being. We question whether Sikh men may feel an increased need to protect their sense of 'maleness' or 'masculinity'. For example, seeking counselling may be perceived as a sense "failure" because it requires asking for help and engaging in emotional vulnerability (Tsan et al., 2011, p. 270). Other research has suggested men do not like the idea of therapy i.e. talking about one's problems (Rochlen & Hoyer, 2005).

Although exploration and examination of the Sikh religion is still in its infancy (Sandhu, 2005), various conversations are taking place to raise awareness of mental health issues within this community. Majority of the literature focusing on

access to mental health support and help-seeking behaviour has studied Sikhs under the umbrella of the greater SA culture. While there are certain similarities between the Sikh community and the broader SA community, there are still distinct spiritual traditions, customs and behaviour patterns (Nayar, 2004, p. 4). Some of these cultural practices may contradict formal Sikh teachings (Jhutti-Johal, 2018), therefore cultural and religious explanations of mental illness (MI) will be thoroughly examined. Moreover, by respecting the uniqueness of each individual religion, its culture specific belief system, and the help-seeking style of a particular culture can be utilised in order to develop culture-specific interventions (Arthur, 2003, p. 65).

The next chapter draws upon critiques from a broad range of literature to identify gaps in research, support the rationale for the present study and evaluate its relevance to Counselling Psychology. The literature review is broken down into the following subsections: *Theological concepts that frame Sikh understanding of mental health*, *Sikhism's values and beliefs, What is a stigma?, East meets West, Men & masculinity and, Spirituality*. To begin with, it felt important to explore literature on *Theological concepts that frame Sikh understanding of mental health* as not many people know about the Sikh faiths view of MI. Further, *Sikhism's values and beliefs* was developed to shed light on the cultural responses to mental health within this community. This would provide some insight on understanding of MI and of help-seeking. The section on *What is a stigma?* was inevitable as majority of the literature that has solely focused on ethnic minority communities has identified various forms of stigma present. The role of migration was identified as playing a key role via the literature search and so, *East meets West* was developed. Exploration

of *Men & masculinity* was deemed necessary to understand the influence of masculinity on lived experiences. Finally, as *Spirituality* sits at the heart of the religion it was crucial to explore its influence on help-seeking behaviour. Overall, the chosen subsections reflected what resulted from the comprehensive literature search and what felt relevant to present in relation to the present study.

# CHAPTER TWO

## CRITICAL LITERATURE REVIEW

This chapter will present the researcher's exploration and review of current literature. The following section summarises the literature and develops the rationale for the current study.

### 2.1 Theological concepts that frame Sikh understanding of mental health

This section presents Sikhism as a religion as it was deemed necessary to present the faith's understanding of MI.

First, I will briefly define how I will be using the terms *religion* and *spirituality* in this thesis. Psychologists tend to describe spirituality and religion as related but separate terms. One view presents spirituality as a private, personal, affective experience with "the Divine" (Richards & Bergin, 2005, p. 21), while religion is recognised as a multidimensional construct and as an institutional set of beliefs and practices (Richards & Bergin, 2005, p. 21). Therefore, we can distinguish religiousness from spirituality as the former involves beliefs and behavioural practices related to God while the latter represents an emotional experience of God.

To begin with, religiosity can play a large role in or is the foundation of the responses of differing populations. Members of the Sikh community represent a population with a unique view of MI and mental healthcare. Mental health issues are acknowledged within Sikh theology and the main source of guidance for this is the GGS. In most SA communities, mental health is viewed through the lenses of religion and culture and, therefore, an individual may not engage with scientific and

evidence-based treatments. Generationally, it seems the older Sikhs may still not grasp the cause of MI from a biomedical point of view, but it is important to note that the younger generation adopt an approach that is negotiated and framed within a cultural, religious and scientific understanding (Jhutti-Johal, 2018).

A variety of research has explored religious interventions and their relationship with depression. Research has mostly investigated the relationship from the perspectives of overall religiosity, attendance to religious institutions, religious intervention, and suicide. According to Bonelli et al. (2012), 67% of studies surrounding religiosity found that religiosity and depression have an inverse relationship. With regard to religious intervention, randomised clinical trials have recognised that interventions that utilise religious beliefs have been shown to reduce depressive symptoms, and these trials are now examining the effects of religious psychotherapy against standard therapies (Bonelli et al., 2012). Also, the researchers specifically focused on suicide and established an inverse relationship between suicide attempts and religiosity (Bonelli et al., 2012). These findings present a clear relationship between faith and wellbeing for those who identify with a religion. This may suggest that aligning with a religious framework may strengthen an individual's personal connection to their beliefs and their ability to cope with depression.

More specifically, Sikhism itself is not a known barrier for help-seeking behaviour (Gill, 2010). Various researchers have illustrated distinctive features of the Sikh religion that promote psychological wellbeing (Nayar, 2004, p. 87; Kalra et al., 2012; Kaur, 2017). It seems that religion communicates a sense of meaning and purpose in life, linked to positive functioning. In particular, Saini (2014) researched quantitatively into identity, perceived discrimination, and psychological wellbeing

(particularly, life satisfaction and resilience) in 228 Sikh Americans. Saini (2014) concluded participants who describe themselves as having a strong psychological identity, such as a Sikh, also report greater life satisfaction. In this case, psychological identity was defined as having positive feelings about being a Sikh, and/or a sense of belonging and similarity with other Sikhs. However, a significant amount of this research has focused on participants from the United States (US) or Western Europe (Kim-Prieto & Miller, 2018). Also, from a Counselling Psychologist's perspective, Kaur (2018) asserts the Sikh religion has not been researched sufficiently since there appears to be limited literature with regard to mental health and wellbeing within the Sikh faith.

The Punjabi language is the official language of the state of Punjab, and the GGS is written in the Gurmukhi script. The religious scripture guides one on how to live, conduct oneself, handle conflicts, and to survive human existence with *Waheguru* (the Divine) at heart (Morjaria-keval & Keval, 2015). In a discussion of the main elements of Sikh theology, Wylam (1965, p. 2) highlighted how the essence of Sikh teachings is to love God, desire a union with Him, and be of service to humankind. Through analysis, one can find what these pillars truly encompass: minute detail and guidance, while leaving an opportunity for personal interpretation. Interestingly, the Punjabi language has no exact translation for *depression* (Krause, 1989), yet the GGS is able to describe how depression may manifest itself (Kalra et al., 2012). Regarding specific descriptions of mental health, it presents a text describing everyday emotions, such as sadness, happiness, and anger, and describes more serious mental health issues, symptoms that could represent Western conditions such as psychosis and depression (Kalra et al., 2012). Various symptoms

of depression are expressed using metaphors; e.g. depressed individuals are said to suffer in sadness and agony and are compared to feeling like 'maggots in manure' (GGS, Ang 1175). Also, the GGS refers to losing interest in previously enjoyed activities such as the loss of sexual interest and self-neglect (GGS, Ang 179). It suggests an afflicted mind may harbour negative thoughts (GGS, Ang 759), a loss of sleep (GGS, Ang 31) and change in appetite (GGS, Ang 98). One can see these symptoms are very much aligned with the traditional Western model of depression.

For those suffering from depression, the religious scripture asserts peace and tranquillity can restore one's mind to a *sehaj avasta* (intuitively balanced state). Many Sikhs meditate by reciting *Waheguru* (the Almighty) during difficult times to remind themselves to have *bharosa* (faith) in God. Meditating in this form has been shown to affect their wellbeing in a positive way. Nonetheless, one can also see the teachings of the GGS as urging individuals to acknowledge their depression, with great emphasis placed on treating the symptoms:

> O physician, you are a competent physician, if you first diagnose the disease.
> Prescribe such a remedy, by which all sorts of illnesses may be cured.
> (GGS, Ang 1279)

To reinforce newly learnt strategies and for one to continue to manage these difficulties in the long-term, the religious scripture recommends remembering and praising the Lord:

Meditate on the Name, worship the Name, and through the Name, you shall be absorbed in intuitive peace and poise.

(GGS, Ang 26)

Dedicating oneself to selfless service of others, which enables one to find eternal peace:

Through selfless service, eternal peace is obtained. The Gurmukh is absorbed in intuitive peace.

(GGS, Ang 125)

When God's name is chanted day and night, it serves as a protective and therapeutic measure for emotional distress:

Twenty-four hours a day, he takes the Name of the Lord.
The Lord gives true instruction to His servant.
He is not polluted by emotional attachment to Maya.
In his mind, he cherishes the One Lord, Har, Har,
In the pitch darkness, a lamp shines forth.
O Nanak, doubt, emotional attachment and pain are erased.
(GGS, Ang 287)

Through a religious lens, explanations attribute MI to a "physical manifestation of a disease of the soul and the spirit, rather than physical illness of the

brain" (Jhutti-Johal, 2011, p. 236). Thus, there is a key emphasis of the GGS on the wellbeing of the soul and the psyche. In the British Sikh Report (2018), a detailed theological perspective on MI is presented, suggesting MI's "have often been attributed to 'spiritual imbalances' arising due to a person's *haumai* (ego and self-centeredness)" (Jhutti-Johal, 2018, p. 4). Sikhs describe the mind as a non-stop thinker, owning the ability to create thought patterns which are *evil* (Singh, 2008). The mind consists of two main levels: the conscious and the unconscious (Ruprai, 2016). Singh (2008) proposes Sikhs believe in an additional level labelled the *super conscious*. This third level is only attainable via meditation, viewed as bringing one peace of mind, and the ability to gain control of evil and unwanted thoughts (Singh, 2008). It is important to note, the Sikh concept of the ego describes it as the experience of "I" and the sense of being different from others, whereas the psychoanalytic view of the ego portrays it as the organised conscious mediator between the person and reality (Sandhu, 2005).

When one is repeatedly drawn towards worldly possessions (*maya*), one becomes *manmukh* (self-centred) and *haumai*, and the accompanying five vices prevent individuals from being with God (Jhutti-Johal, 2018). Guru Nanak Dev Ji and 35 other contributors to the GGS repeatedly refer to the five vices (lust, anger, greed, attachment and false pride or ego) which have to be eradicated in order to transform one from a self-centred individual into a God-oriented human being (Bhogal, 2012). Guru Amar Das Ji explains how a self-centred person who is engrossed in egotism will perish and suffer by not being released from the cycle of rebirth:

> The self-willed manmukhs are polluted. They are filled with the pollution of egotism, wickedness and desire. Without the Shabad, this pollution is not washed off; through the cycle of death and rebirth, they waste away in misery. (GGS, Ang 29)

The "term haumai consists of two words *hau* and *mai"*, meaning 'I am' (Singh, 1989, p. 67). Generally, it would be translated as ego, but ego has some positive sense, whereas *haumai* is "totally negative" (Singh, 1989, p. 67). If one is too engrossed with this state of mind and the five vices, *haumai* can become destructive, controlling and cause despair (Jhutti-Johal, 2011, p. 238). To further understand how *haumai* can lead a person to *dukh*, Mooney (2020) describes *haumai* as a spiritual and social problem. We can view this as an unsettled, confused state of mind, where one cannot distinguish between the real and the unreal because one has been distracted and formed an attachment with *maya* (Mooney, 2020). Attachment to *maya* negatively affects social relationships, potentially leading to heightened stress levels, low self-esteem, negative automatic thoughts and, perhaps, a feeling of emptiness in a person. It is this state of being that is described as a spiritual imbalance and for some, this imbalance is so significant it can act as a trigger for MI and depression (Jhutti-Johal, 2011, p. 238). Therefore, to eliminate the internal sources of suffering, one must detach from worldly possessions as this is detrimental for the spiritual process (Jhutti-Johal, 2018) and, to ensure good health, one must proceed towards giving up one's pride, ego and *haumai* and be humble (Sandhu, 2005).

It is evident, the *Gurus* offered us alternative ways of thinking, and the two key concepts that appear when Sikhs talk about mental ill health are *karma* and *Chardi Kala* (Jhutti-Johal, 2018). Sikhs believe the soul experiences a cycle of birth, death and rebirth (determined by one's *karma)* and the ultimate religious goal is to experience unity with *Ek Oankar* (Sandhu, 2005). When it comes to *karma*, Sikhs believe everything happens in accordance with *hukam* (God's will) and that their *karma* is a result of the good and bad deeds performed in their previous and current lives (Ahluwaila & Alimchandani, 2013). It is important to note that since stressful life events result from deeds (good or bad), it is understandable that some may want to keep their MI a secret (Kaur, 2018). This is because those that are seen as repaying the consequences of bad deeds have to face "stigma, prejudice, and discrimination by the host community" (Jhutti-Johal, 2011, p. 247). Further, it has been suggested that spiritual imbalances can also be caused by one's *karma* (Jhutti-Johal, 2011, p. 239). Thus, Sikhs look for guidance on how to progress spiritually and turn to the GGS, whereby one surrenders to God's will and acts gracefully by moving forward. It suggests that for one to heal from such suffering, whether internal or external, one must proceed through the realisation of the spiritual self and consciousness, which spirals through the *panj khands* (five realms). The descriptions of the five realms are as follows: *dharam* (righteousness), *gian* (knowledge), *saram* (effort), *karam* (grace) and *sach* (truth) (see GGS, Ang 7-8).

The Punjabi phrase *Chardi Kala* refers to a mental state of sheer optimism and joy, evoked in daily prayer and elicited in times of loss, tragedy, fear and pain. In Sikhism, *Chardi Kala* encourages Sikhs to achieve an ideal and cherished mental state (Singh, 2013). Self-discipline seems important for Sikhs to protect against

internal sources of suffering. Various Sikh spiritual leaders prescribe the hearing of *kirtan* (devotional singing) as the path towards *Chardi Kala* and, therefore, a means of combatting MI and depression (Takhar, 2018). The Gurus have proposed the practice of *naam simran* is key in stabilising the mind (Jhutti-Johal, 2018). It is this constant process in which one should mentally be reciting the name of God which allows one to be able to progress spiritually. There is a key focus on meditation as it is viewed as having a therapeutic effect. Guru Arjan Devi Ji emphasises how *naam simran* is vital for finding peace and eliminating a negative state of mind:

> Meditate, meditate, meditate in remembrance of Him and find peace.
> Worry and anguish shall be dispelled from your body.
> (GGS, Ang 262)

A Sikh that engages with the principles of *naam simran* and the act of *seva* (selfless service) embraces the view that God resides in everything, thus shifting from being less self-centred (manmukh) towards becoming more God-centred (gurmukh). While *naam simran* will allow one to conquer *haumai*, engagement with *seva* provides the opportunity for a Sikh to cleanse the mind (Jhutti-Johal, 2011, p. 240). The body, mind and spirit are God-focused, allowing one to live in harmony in accordance with *hukam* and preventing one from mental suffering. All Sikhs are encouraged by the GGS to perform *seva*. Community service and volunteering can help those that suffer from depression because they encourage interaction with others. For example, Lee and Woo (2013) noted that attending religious services provides networking opportunities, thereby helping individuals develop a strong

social support system. This increased social contact helps shift the focus from one's own thoughts to focusing on helping others, where one's actions may feel more valued. Sohi et al. (2017) focused solely on the religious experience of *seva* and, by conducting a bivariate and multivariate analysis, concluded the frequency of ritual participation (*seva*) was positively related with social wellbeing and a sense of community. Also, by providing participants with social solidarity and cohesion as well as physical and mental wellbeing, *seva* helped group members establish and maintain strong community networks and a unique group identity. However, much of this research has relied on participants in India and has not explored differences between age groups and gender groups. Future research should take these factors into consideration. Later in this study, the literature review will further explore the relationship between *seva* and wellbeing (see section 2.6).

While we can interpret the various religious explanations of MI, we still do not know much about access to therapy, specifically for Sikh men. Very little research has been carried out on the Sikh faith in relation to mental health. One can see that Sikhs may prefer to stick to a religious framework for managing their mental health. It has been suggested that "following daily Sikh practices is likely to serve as a protective factor, reducing access to services and hospital admissions" (Ruprai, 2016, p. 25). We must note this seems to differ generationally: while the older generation may seek to understand the causes of MI through divine will and spiritual inadequacies, present understanding of MI is shifting towards a scientific and evidence-based approach (Jhutti-Johal, 2011, p. 254). To further understand the distinct positions adopted by different generations, we must explore the role of culture.

### 2.2 Sikhism's values & beliefs

The aim of this section is to present the values and beliefs the culture embraces in relation to help-seeking behaviour. The line between religion and culture often becomes blurred and it is deemed necessary to explore the cultural views of MI to further shed light on how Sikhs understand mental health.

Therapy is considered to be a Western concept, with psychiatric illness categories formed from Western cultural constructs (McGoldrick et al., 2005, p. 33). Therefore, individuals from Indian backgrounds tend to be cynical and unconvinced by its benefits. Extensive amounts of research highlight distinct patterns of help-seeking amongst the BME population (Kim & Omizo, 2003; Leong et al., 1995, p. 415); they underutilise psychological services, present in crisis situations with more severe symptoms, and are more likely to terminate therapy during treatment (Kim et al., 2005; Abe-Kim et al., 2007; Leong & Lau, 2001; Li & Browne, 2000; Chen et al., 2003). We must note that the larger part of this research is based on American and Canadian populations. This further reinforces the need for research in the UK to explore Sikh men's help-seeking styles, better understand them, and meet their needs in therapy. Sue and Sue (1999) state that, while there has been more awareness of the mental health needs of ethnic minorities over the past ten years, Clinical and Counselling Psychologists have, in the past, failed to meet the mental health needs of such groups. Hodgetts and Wright (2007) argue that with more emphasis placed on evidence-based practice and short-term therapy interventions in the UK, understanding the subjective voice of clients is vital. The inclusion of Sikh clients' experiences of help-seeking would be in line with supporting the development of

services such as The Ten Essential Shared Capabilities in the NHS (National Institute for Mental Health in England, 2004, as cited in Bonsmann, 2010, p. 32).

In the UK, figures reveal Indians underuse mental health services compared to their white counterparts (Hussain & Cochrane, 2004; Johnson & Nadirshaw, 1993). Chew-Graham et al. (2002) conducted an investigation of psychological distress in SA women. The findings revealed mental health services were only accessed at a point of crisis. This 'delayed help-seeking' behaviour in SA women also mirrors the findings presented in a Canadian study (Ahmad et al., 2009). Despite the complex explanations for this delay, in both studies, the women unanimously highlighted the importance of enforced silence in their culture with regard to psychological wellbeing. Other research has suggested SAs are stereotyped as a *model minority* and are held to high standards of social success and personal morality (Mahmud, 2001). This model minority status, alongside strong family and moral values, places a heavy emphasis on educational success, and distinctive acculturation pressures can lead to emotional issues. The notion of a model minority may result in the denial of emotional and psychological difficulties among both mental health professionals and the SA community themselves, and this may explain very low rates of access to services (Ruprai, 2016).

Furthermore, it seems the main source of emotional support comes from the family (Lindesay et al., 1997), and Indians will only see a mental health professional if forced by a relative or a friend (Baptiste, 2005). In an exploration of family therapy, Baptiste (2005) identified major conflicts between the parents' native Indian values and their children's new American values. This has urged therapists to be mindful and to ensure they tailor an approach that must include a willingness to

accept the problem in the manner in which the family frames it. Das and Kemp (2011) explored mental health issues associated with counselling SA immigrants in America. While exploring the structure and values of this culture, they identified there was a cultural proscription against speaking about personal issues with anyone other than a family member (Das & Kemp, 2011, p. 32). Individuals were reluctant to seek counselling as it appeared to not only stigmatise the person who needed help, but also the family. However, these findings only shed light on the experiences of Indian Americans and cannot be generalised to the UK population. They also assume the SA community are equally affected as a whole by such issues and that the SA community is a homogenous group. Thus, they overlook the uniqueness of each community that falls under this term and we cannot distinguish what is most influential and relevant to the Punjabi Sikh community.

Nonetheless, similar results have been presented. In a two-year study of the largest BME communities in Scotland, Knifton (2012) worked with 10 focus groups of participants with Pakistani, Indian and Chinese heritage. A grounded theory technique was employed and consistent beliefs among the groups included views that people with mental health problems were dangerous, not intelligent, not employable, and undesirable as a marriage partner. This frequently taints not only the individual affected but the whole family within the community (Knifton, 2012). Thus, to maintain the family reputation, one may feel the pressure to hide the problem and suffer in secrecy. This research provided valuable findings; the researchers explored the perceptions of the first and second-generation participants and the avoidance of help-seeking stated by both was due to shame associated with MI amongst communities. While these findings tie in with international research

(Fabrega, 1991), there are some limitations: e.g. Scotland is not a very diverse geographical location. Warr (2005) suggests that despite focus groups providing rich data, there are other concerns to be aware of, such as ensuring non-judgemental interaction in the group. Those from BME communities may feel uncomfortable sharing their personal issues in a group setting (Sabry & Vohra, 2013). Using community organisers to facilitate the research raises criticisms and the use of translators (Urdu, Punjabi, Hindi and Cantonese) presents some concerns as not only can questions be interpreted differently in different languages, valuable meaning may get lost in the translation process (Nes et al., 2010). On the other hand, other research has demonstrated similar findings, in which SA clients tend to be reluctant to seek out counselling due to an emphasis on keeping family matters private (Almeida, 1996, p. 400; Segal, 1991; Sharma, 2000). Family matters are a main focus amongst the Sikh community and privacy plays a key principle role for its members; thus, similar factors may deter Sikh men from accessing support, yet this remains unexplored.

Moreover, there is emerging evidence that some cultural and religious beliefs about causation result in shame (Tabassum et al., 2000). Literature has noted a deep-seated cultural norm of saving face, resulting in many Sikhs being reluctant to open up and talk about their personal problems (Nayar, 2004, as cited in Nayar & Sandhu, 2006, p. 148). Instead, to protect their honour, Sikhs have the ritual of discussing their problems in a collective and impersonal philosophical context (Sandhu, 2005). Gill (2011) found in honour-based societies “the man is the defender of his and his family’s honour: it is his duty to defend it against any behaviour that might be seen as shameful or humiliating by his community” (p. 246). Female honour is described

as being static; it cannot be increased nor regained. In contrast, male honour is dynamic and in a constant state of flux; it can be maintained and increased through competition in community life. Family members can also socialise with each other while observing family honour (Wakil et al., 1981). Arif et al. (2014) discuss the collectivistic nature of many SA cultures, where family members are expected to consider the needs, position, and honour of their family over their own needs or desires.

More recently, research exploring mental health and service use in SA women living in Derby (Gilbert, Gilbert & Sanghera, 2004) identified the term used to depict family honour as being *izzat*. *Izzat* is related to shame but has no single meaning. Help-seeking is related to *izzat*, confidentiality and the fear of exposure. The SA women involved in this research describe *'izzat'* as a learnt, complex set of rules an Asian follows to protect the family honour and maintain his/her position in the community. Anxieties around professionals maintaining confidentiality emerged as a barrier to seeking help from a general practitioner (GP), especially where the GP was of the same ethnic background as the client or was known to the family in a shared sociocultural context e.g. a friend or member of the same community. Interestingly, Gilmore (1990, p. 176) proposes manliness in India has been explored and *izzat* forms a key basis for the structure of hyper-masculinity (further explored in section 2.5). Pride and honour are recurring characteristics displayed and valued by Sikhs; however, their connection with male help-seeking behaviour seems to be a relatively unexplored topic, with little to no literature existing.

According to Anand and Cochrane (2005), a preliminary study by the authors (see Anand & Cochrane, 2003) was able to support the finding of Gilbert et al.

(2004), that SA cultures operate within strong dynamics of shame. The authors identified significant relationships between acculturation and psychological distress (mainly depression). The study aimed to position shame within this relationship. The results established low involvement in British society and the development of negative attitudes towards the white culture were key factors in the development of psychological symptoms in both first and second-generation SA women. SA women who adopted rejection and integration strategies received higher levels of prejudice from mainstream society, were identified more with their culture of origin and conversed frequently in their mother tongue (Anand et al., 2003, as cited in Anand et al., 2005, p. 207). The authors hypothesised the relationship between acculturation and mental health is mediated by the capacity to experience shame, concluding, women who were more associated with their SA culture were found to be more vulnerable in experiencing shame about some aspect of themselves. Although these results emphasise the value of shame within SA cultures, the relationship between acculturation and mental health is complex and differences in the cultural expectations of men and women tend to vary by generation and by degree of acculturation. While this research will help configure services that are more responsive to the psychological needs of SA women, we cannot assume the same applies for Sikh men.

Moreover, common beliefs of the causes of mental health problems can be rooted in supernatural explanations (Lauber & Rossler, 2007). According to the GGS and *Sikh Rehat Maryada* (McLeod, 1997, p. 117), Sikhs are not meant to believe in spirit possession but to conceptualise the causes of MI, they may explore other external factors e.g. *jadu tona* (black magic) and *najjar* (evil eye), and these do

affect the understanding of MI (Jhutti-Johal, 2011, p. 245). These cultural beliefs have resulted in the view that MI is something to be ashamed of and, therefore, if one is to protect one's *izzat* and avoid *sharam* (shame), it not to be spoken about (Jhutti-Johal, 2018). Despite minimal discussion on the concept of *najjar,* it is viewed as a key concern for Sikhs in all socioeconomic groups (Jhutti-Johal, 2011, p. 245).

It has been argued that while *najjar* is quite present in the Indian community, beliefs of spirit possession (*jinn* or *djinn*) are mainly present in the Muslim community (Jhutti-Johal, 2011, p. 244). For example, Dein et al. (2008) interviewed 20 members of the East London Bangladeshi community (aged 18-80) and found beliefs in *jinn*, *najjar* and witchcraft to be prevalent in this sample, especially among older and less-educated Bangladeshi individuals. Similarly, Khalifa et al. (2011) examined Muslims' beliefs about *jinn*, black magic and the *najjar* in Leicester, UK, by using a self-report questionnaire. The majority of the sample believed in the existence of *jinn*, black magic and the *najjar*, and approximately half of them stated that these could cause physical and mental health problems.

As a result of such outdated beliefs, the use of traditional healers for the treatment of MI is very common in India (Chadda et al., 2001). This could be due to a lack of awareness of MI or the absence of easily accessible treatment facilities; thus, the patient may prefer to approach an alternative service provider, e.g. a traditional faith healer (Bhattacharya, 1983). Further, SA communities believe the services are unequipped to provide them with culturally appropriate care (Raghavan & Waseem, 2007; McGrother et al., 2002); consequently, they are more likely to

respond to such difficulties by seeking alternative treatment, which often involves consulting folk and religious healers (Dein et al., 2008).

Chadda et al. (2001) conducted a study whereby patients attending psychiatric outpatient services at a mental hospital were asked specifically about various treatment facilities they had used before coming to the hospital. The results indicated the majority (57.7%) of the patients went directly to their psychiatrist and only 30% chose a religious faith healer as the first choice. This contrasts with the study by Weiss et al. (1986), in which the majority of the psychiatric patients were taken to religious specialists before help was sought from medical practitioners like physicians or psychiatrists. The difference in these studies could be due to the many changes that have taken place in the last decade in the health care sector in India (Chadda et al., 2001). In this period, there has been a wide expansion in psychiatric treatment facilities. Thus, the findings evidence the positive changes that are taking place regarding psychiatric illness in the country.

Furthermore, research exploring beliefs of distress in the Punjabi Sikh community has identified that individuals avoid mental health services as they believe they do not suffer from 'ill mental health' (Ruprai, 2016). Similarly, many Asian cultures may regard MI as a physical health problem while psychiatry defines it as a severe MI. It has been proposed that other cultures may not conceptualise distress as an MI (Kleinman, 1987). Nazroo (1997, p. 8) suggests SA's may experience 'culture-bound' syndromes - a cluster of symptoms that is restricted to a particular culture. For example, research by Krause (1989) explored the concept of depression in the Punjabi community and the term *sinking heart* was often used to describe the psychological distress experienced by Punjabis living in Bedford.

According to Krause (1989), the cause of the physical sensations experienced was thought to be due to “excessive heat, exhaustion, worry…” (p. 563). The research proposed the Punjabi model resembled the Western model of stress (Krause, 1989). The study did not outline any specific interventions for a sinking heart but offered a culture-bound explanation of somatic symptoms.

Fenton and Sadiq-Sangster (1996) found similar observations in Punjabi women in Bristol. The researchers found that the *sinking heart* was used to describe various physical sensations felt in the heart. Fenton and Sadiq-Sangster (1996) concluded these women had a clear conception of mental health and illness, but simply chose to describe their mental distress in cultural terms. Their accounts were noted as differing significantly to those who spoke in English. Additionally, the phrase *duk* (also *dukh*) was used when describing feelings and emotions (Fenton & Sadiq-Sangster, 1996, p. 75). While we can see mental distress appears to be expressed differently in different cultures, and there is a need for Counselling Psychologists to acknowledge this, it has been suggested such metaphors are more common in the vocabulary of the older generation (Jhutti-Johal, 2018).

Bhugra et al. (1997) identified similar findings in women living in Punjab. Complaints of *heat* were once again identified when participants made links between bodily and emotional states. The findings have been replicated in the UK in a focus group setting. Participants recognised the word depression yet preferred to use phrases such as *weight on my heart* to describe a low mood state (Bhugra et al., 1997). The terms *gas* and *heat* were also used by participants to describe symptoms of distress (Bhugra et al., 1997), which are consistent with traditional Ayurvedic models used in India, despite not being very common in the UK. Therefore, the

concept of sinking heart may be a culturally sensitive explanation of distress (Ruprai, 2016).

It has been suggested SA men are twice as likely to consult a GP in comparison to European men in the UK (Gillam et al., 1989; Atri et al., 1996; Murray & Williams, 1996; Chaturvedi et al., 1997). In addition, Punjabis are more likely to be diagnosed as having more somatic symptoms than any other SA sub-group (Bhui et al., 2004; Fenton & Sadiq-Sangster, 1996) and have a preference for medication (Cooper et al., 1998). Dhillon (2004) argues research exploring culturally appropriate psychotherapy has found GPs and related organisations are not responding effectively to the mental health needs of patients and not engaging with culture proactively. Bhui et al. (2001), in a two-phase survey, recruited 209 Punjabi and 180 English GP attenders. Comparisons were made of help-seeking and GPs assessments of mental disorders. GPs were less likely to detect depression in Punjabis than Whites among those with depressive symptoms, and more likely to detect somatic presentations. Although these findings are supported by previous research (Jacob et al., 1998; Wilson & MacCarthy, 1994), recruitment took place in five different locations and different minority populations may account for the inconsistency of the results. Notably, Ballard (1999) and Helweg (1999) argue that Punjabis retain an overarching Punjabi identity and that assumed differences are not as relevant in their lived experiences. Punjabis can be Hindu, Sikh or Muslim and we cannot assume commonality across the various communities. The differences in religion and nationality need to be considered.

More recently, a research review was carried out as part of the Racial Disparities in Mental Health project, commissioned by NHS England after an

independent review of the 1983 Mental Health Act, which found profound inequalities, highlighting the poor experiences of care across BME communities (Bignall et al., 2019). Regarding access, the evidence demonstrated minority ethnic communities were less likely to access support in primary care via the GP and more likely to end up in crisis care (Bignall et al., 2019). The review urged practitioners to improve their recognition of symptoms and to acknowledge how these may be expressed in different ethnic groups (Bignall et al., 2019). Practitioners should also work to ensure that services are accessible and non-stigmatising, as the term *wellbeing* was received more favourably than *mental health*.

This section contextualises current literature regarding how the very diverse Indian community within the SA group views and responds to MI. Numerous cultural beliefs have been identified that make it difficult for SAs to engage in therapy. It is crucial for service providers to understand the importance of culture: "every person is affected by his or her own culture so culturally competent therapy is needed" (Tseng, 2005, p. 267). While Punjabi Sikhs share many cultural beliefs and forms of practice with the broader SA community, they are a distinctive, separate entity. Research is often conducted using the broad term *SA*; therefore, current research only gives us a snapshot of why Sikh individuals may underutilise mental health services. We can argue it is limited and reductionist. Also, although the literature enables us to understand the consequences of these cultural beliefs on help-seeking behaviour, it fails to capture the impact of these beliefs when focused on men.

### 2.3 What is a stigma?

The next section explores the decline in mental health care by reviewing current stigmas identified in the literature.

**S**tigma is principally a psychological and social phenomenon (Mantovani et al., 2017). The World Health Organisation (WHO, 2001) cites stigma as a key barrier to successful treatment engagement, including help-seeking and sustaining participation in services. Stigma causes people to suffer in silence and secrecy; this leads to a progression of disability or discontinued treatment, recovery-related rehabilitation support and impediments in rebuilding self-esteem (Shrivastava et al., 2012). Family and friends can also be stigmatised by association with the labelled person or group, although this dimension has received less attention (Goffman, 1963, p. 30).

While stigma is widespread, it can manifest itself in numerous forms (Ahmedani, 2011; Corrigan, 2016). Literature has suggested stigma exists at three interacting levels in society: the self (also internalised or felt stigma), the social (likewise, public or enacted stigma) and the structural (similarly, institutional stigma) (Corrigan et al., 2005). Self-stigma consists of perceptions and experiences held by those possessing stigmatised attributes. Due to stereotyped characteristics, individuals with MI can be socialised into believing they are devalued members of the community or characterised by maladaptive behaviours and identity transformation (i.e. feelings of shame and self-efficiency) (Livingston & Boyd, 2010). According to Scambler (2009), felt stigma is the internalised sense of shame and the immobilising anticipation of enacted stigma; that is, the discrimination by others on grounds of being imperfect.

The literature in the UK seeking to explore cultural beliefs regarding MI is dominated by research referring to external stigma. This refers to the general public's discriminatory response to individuals with MI (Corrigan & Kleinlein, 2005, pp. 13-16). It can cause the person with MI to lose or struggle to obtain employment, adequate housing (Corrigan, 2004) and can increase their interactions with the criminal justice system (Corrigan & Kleinlein, 2005, p. 12). When applying public stigma, discrimination can occur in which a person or system (e.g. the health care system) devalues those with MI (Abdullah & Brown, 2011). There is evidence some BME groups are confronted with ethnically-based prejudice and discrimination by health professionals (Adams et al., 2014).

For example, in the study by Shefer et al. (2013), participants noticed inequalities, particularly in diagnosis, psychosis and treatment. The authors stated external stigma compromises the trust of BME groups and how experiences of stigma directly impact help-seeking styles and treatment outcomes. The experiences of these participants mirror what other authors have presented, e.g. higher rates of diagnoses of psychosis among BME groups as well as compulsory admission (see Boast & Chesterman, 1995; McGovern & Cope 1991; Croudace et al., 1998). Further, Arday (2018) focused on racial inequality and discrimination at university and its impact on the mental health of BME students. From the interviews, Arday (2018) identified difficulties experienced in articulating symptoms. On many occasions, participants experienced overt examples of racism by health professionals within the universities. This included words being misinterpreted, suggesting dialect and accents were viewed as a discriminatory reason for not wanting to understand or objectively assess symptoms. Instead, health professionals concluded poor English

was a reason as to why conclusive medical judgements could not be established. Not only does this prolong experiences with MI for BME individuals, it acts as a key barrier and induces the following: increased stress, reluctance to engage with services and an inability to access appropriate care. Similarly, Burgess et al. (2008) demonstrated stigma from authorities can lead to the underutilisation of the medical system by those from multi-ethnic communities. According to Karlsen et al. (2005), there are ethnic variations associated with common mental disorders and experiences of discrimination. Arguably, it is, therefore, essential that future research with regard to Sikhs should seek to uncover the impact of enacted stigma on access to mental health care.

On the other hand, research focusing on internal stigma is evolving. It is starting to explore how internal stigma may be related to cultural and gender role norms e.g. external views of how one should behave. Among other prescriptions and proscriptions, these norms teach us who is an appropriate person to ask for support. For example, in the field of psychotherapy for men, scholars have presented personal risks, such as a perception of weakness and sense of failure, as being experienced by men when seeking to engage with mental health services (Addis & Mahalik, 2003). Self-stigma applies to men because the traditional male gender role's prescription that men should be independent, controlled and self-sufficient may lead to increased concerns about seeking help as seeking help may mean admitting an inability to handle things on one's own. Thus, a male who thinks they require counselling may feel a sense of failure and this could make the act of seeking help quite difficult. In line with this, Pederson and Vogel (2007) found that men who endorsed more traditionally masculine gender roles were more likely to self-stigmatise when

seeking professional help. More specifically, the relationship between the perceived public stigma and self-stigma was stronger for men than for women. When focusing on the Indian community, symptoms of MI in Indian males may threaten masculinity and the traditional male gender ideals of strength and control. As mentioned previously, alternatively one may endorse culturally accepted models of somatic or physical illness (Mukherji, 1995).

When examining the relationship between cultural norms and internal stigma, there is limited research available concerning BAME communities. A recent report of extended family members of SA people with MI in the UK stands as an exception: the participants identified feelings of fear, shame, guilt, and the need to hide their MI (Time to Change, 2010, as cited in Kayani, 2018, p. 4). Participants voiced how communities are encouraged to maintain secrecy around any mental health needs. Participants feared any information leaking in the community would "contaminate" or "tarnish" everyone associated with the individual in question (Time to Change, 2010, p. 6). It is worth noting the findings were not broken down into different subgroups and the results were presented as if the SA community as a whole were equally affected by such issues. This overlooks the uniqueness of each community that falls within this group.

Furthermore, Shefer et al. (2013), recognised BME participants criticising traditional perceptions and beliefs surrounding MI and the need to educate the communities perpetuating this internal stigma. According to the participants, mental health problems were recognised as illnesses, seen as incurable in some communities or a result of supernatural causes. Thus, an individual who accepts the communities' negative evaluation of MI may incorporate it into their sense of self. This theme

conceptualises the perceived need to educate communities and has also been recognised in previous research (Alvidrez et al., 2008; Rethink, 2010; Wada et al., 2019). It stems from the view the participants had, that internal stigma is communicated through the family or community, which previous research supports (Link & Phelan, 2006). Further, the impact of social rejection and the public's stigma towards MI can result in lowered self-esteem (Corrigan et al., 1999) and self-efficacy (Bandura, 1989) in the person suffering.

More recent reviews across several Asian countries by Ng (1997), Lauber and Rossler (2007) highlight variations within and across countries and cultures in the intensity of stigma. The view of MI seems to differ in the Indian culture compared to Western culture. There is more stigma associated with MI and with access to treatment for Indian individuals. For example, an interpretative phenomenological analysis (IPA) by Virdee (2014) explored Indian fathers' subjective reports of meaning in relation to family therapy. The results established there was a lot of stigma concerning mental health within British society; however, it was arguably worse within the Indian culture. This seems to be due to the sense of dishonour and disgrace on the family felt in relation to perceived negative judgement by others within the community. According to Mukherji (1995), it is because of this societal allure and the cultural sanctions that Indians have a delayed response to accessing treatment. In response to this, Kumar and Nevid (2010) state overt displays of emotional instability are regarded as a poor reflection on the individual which, in turn, reflects negatively on the family.

In the Indian community, the psychological burden and shame associated with MI can prevent one from seeking professional support (Youssef & Deane,

2006). Concerning the British Sikh community, the literature exploring mental health stigma is lacking. Some Punjabi-Brits have voiced seeing shame and stigma everywhere, e.g. in telephone calls, self-help videos on YouTube etc. (Kaur, 2020). It has been suggested MI remains a social taboo and a stigmatised topic and, as a result, most Sikhs are hesitant about discussing any mental health issues with their families, community members or even doctors. It is a topic that is not spoken about openly by many Sikh men and women. This enclosed behaviour is quite different to the open-minded approach to other, physical diseases (diabetes, hypertension and arthritis), where community members are relatively active in seeking advice from healthcare professionals (Jhutti-Johal, 2018). This difference could be due to the fact local governments have been successful in the past in promoting awareness for physical health problems (Ruprai, 2016). While some Punjabi-Brits feel the conversation surrounding MI is getting better, a stigma is still present, and it seems to be driven by the older generation (Kaur, 2020).

Stigma related to schizophrenia in India is particularly high (Thara & Srinivasan, 2000). Research by Shrivastava et al. (2011) explored the perceptions of 100 patients diagnosed with schizophrenia who were attending a psycho-education group in a hospital setting in Mumbai, India. The survey focused on the stigma and discrimination they faced in their lives and this was found to have a significant impact. It was reported that, with respect to perceived causes of stigma, a strikingly large percentage of the participants (97%) believed that stigma was caused by a lack of awareness about schizophrenia, followed by the nature of the illness itself (73%). Behavioural symptoms associated with schizophrenia were also thought to cause stigma. The findings regarding the sources of stigma indicated 69% of patients felt

stigma comes from the attitudes of the general community, 46% from co-workers and 42% from family members (Shrivastava et al., 2011). This study emphasised the need to minimise stigma through anti-stigma programmes and psycho-educational courses. Although Shrivastava et al. (2011) did not explore the differences in the analysis between the views of males and females or between first and second-generation Indians, their sample did consist of 74 males, a sample group whose needs are often neglected. While this study is unique as it is one of few which has been carried out regarding the notion of stigma in India, a key drawback is that a convenience sample was used and, therefore, may not be a representative sample of the population. Also, all the participants were educated to India's equivalent (12th class) of A-levels. This may suggest these individuals were exposed to stigma that differs in degree or type from individuals with schizophrenia who have poorer education or who are of lower socioeconomic status.

Extensive research by Gaiha et al. (2014) supports this notion of stigma resulting from lack of knowledge, leading to inhibitions regarding access to basic mental health information and care. The authors administrated knowledge, attitude and practice surveys to a total of 521 participants (aged 15-60 years) drawn from the general population. The study included mainly respondents from ten districts from the five main states of India.[1] The findings demonstrated that three-quarters of the participants viewed MI as nothing but an evil spirit or a form of black magic and the same number of participants believed going to a traditional healer would improve the illness. What is interesting is that even though 71% of the total participants were aware of someone in their family, circle of friends or community who had a MI, only

[1] Five main states: Andhra Pradesh, Assam, Delhi, Gujrat and Uttar Pradesh.

half of all respondents could identify a single symptom of MI, i.e. name low mood as depression or uneasiness and panic as anxiety, which raises questions as to how knowledgeable people in India are of mental health issues. A third of participants stated that they would not seek medical care and, apart from lack of knowledge on mental health issues, the research showed that, the fear of news spreading, people gossiping and the notion of shame where also factors inhibiting one to admit to having problems and to seek appropriate help.

The evidence seems so far to suggest that first, there is a need to reach out with basic information that MI's are medical disorders that are treatable (15% respondents believed MI was untreatable and 74% viewed traditional healing as a cure). Second, there needs to be an outreach to the Indian community on the sensitive and taboo subject of MI, as the majority of the respondents visualise an individual with MI as violent and dangerous. Although the study produced valuable findings, the authors concluded it should be treated as a snapshot since the idea of a stigma is still to be understood. Regarding the study, there are a number of factors that need to be taken into consideration. Primarily, although there were more female than male respondents, the authors did not present any demographic information detailing how big this difference was in ratio. This suggests that MI is an avoidant topic area for the male gender in the Indian community, but we need further research to understand why. The results are also subjective and none of the participants had an MI or was living with an MI; thus, the findings do not seem to shed much light on to the role of self-stigma and could be considered one-sided. Generalisation of the findings presumes the assumption of similar characteristics across the entire population. Thus, any generalisations and assumptions need to be questioned as the

environment plays a significant role. Moreover, Punjab is a major district in India, where the majority of Sikhs reside, and this area was not included in the research, further illustrating how research within the Sikh community is needed.

In summary, the literature has provided a broad picture of the perceptions of stigma within BME communities and research exploring such stigma has supported an assessment of the broader SA culture or the very diverse Indian community. The existence of a stigma in the Indian community is evident. The literature exploring stigma in the Indian culture encourages the enhancement of mental health literacy, i.e. the ability to access, obtain and use mental health information. This can play a role in stigma reduction by improving public knowledge and attitudes concerning recognition and help-seeking (Jorm, 2000). But this does not take into account the distinct inter-cultural diversity that exists in terms of language, culture and religion within the Sikh community. While the significance of stigma is being challenged (Jhutti-Johal, 2018), for practitioners to encourage Sikh individuals to not suffer in silence and secrecy (Shrivastava et al., 2012), one must understand their perceptions of it.

### 2.4 East meets West

This section explores the current literature to understand whether the choice behind engaging in therapy and the view of stigma could possibly have been affected by immigration.

The American Psychological Association (APA, 2013) highlights three barriers to mental health services for those who have migrated: social-cultural barriers, contextual-structural barriers, and clinical-procedural barriers. Social-cultural barriers support the use of self-help as the best means of dealing with mental health problems. Meanwhile, contextual-structural barriers illustrate a lack of access to appropriate and culturally sensitive mental health services in immigrant languages. Last, the clinical-procedural barriers involve the lack of culturally sensitive and relevant services. Thus, the need to interpret the impact of immigration on help-seeking is crucial in developing culturally competent psychological practice (APA, 2013).

It has been proposed that Eastern values are embedded in collectivism and spirituality (Laungani, 2006, pp. 62-69; Singh, 2009). Healing relationships in the East are perceived as hierarchical and directive versus the egalitarian, non-directive therapeutic relationships in the West (Laungani, 2006, p. 62). Another aspect valuable to the therapeutic relationship within the East is the infusion of faith and religion. Consequently, a Sikh male who immigrated to the UK, US or Canada at an early age may have adopted a more idiosyncratic culture within the family due to being exposed to Western values and beliefs (Virdee, 2014). Therefore, this can contribute to their style of help-seeking behaviour. It is important to note the role that acculturation plays in ethnic and religious minority communities in a bid to

understand nuanced dynamics (Schwartz, 2010). Acculturation can be understood as a phenomenon or a process where groups of individuals having different cultures come into continuous first-hand contact leading to subsequent changes in the original cultural patterns of either or both groups (Sheikh & Furnham, 2000). This process includes psychological, sociocultural and economic acculturation. Attachment to people and places contributes to a stable place identity; this is also threatened by migration and displacement (Bhui et al., 2005).

Farver et al. (2002) research was aimed at understanding how Asian Indian immigrant families adjust to US culture by assessing how acculturation styles may be associated with their children's psychological functioning. This was measured by self-esteem and academic performance. A total of 85 US-born Asian Indian adolescents (45 girls and 40 boys) and one of their immigrant parents completed questionnaires about family demography, self-identification, acculturation, and religiosity. The adolescents were also required to complete a self-perception profile. The results established that although the parents and adolescents had similar styles of acculturation, the adolescents were more likely to self-identify as Indian-American. The adolescents who had an integrated acculturation style had better grades at school and higher scores on the self-perception profile than did those who identified as separated or marginalised. The findings lend tentative support for an integrated style of acculturation in promoting positive outcomes for second-generation Asian Indians. According to Farver et al. (2002), integrated individuals experienced less acculturative stress and anxiety and manifested fewer psychological problems than those who were marginalised, separated or assimilated.

Cross-cultural psychologists have long explored the field of acculturation, immigrant identity and adaptation, and studies have been established on various topics: acculturation and acculturative stress (Berry 1998, p. 119), socialisation and enculturation (Camilleri & Malewska-Peyre,1997), and bicultural identity (LaFromboise et al., 1998). Berry's (1980, 1990, 1997) model of acculturation strategies is quite prominent in the field of acculturation. The model has been widely used in America and Europe and has formed the conceptual foundations for numerous empirical and experimental studies on acculturation and immigrant identity (Bhatia & Ram, 2009). Ontologically, Berry's (Berry & Sam, 1997) research is firmly philosophically positioned in realism, which posits an objective, knowable and universal reality (Williams & Arrigo, 2006). In response to Berry's model, Bhatia (2002) writes: "The formation of immigrant identities in diasporic communities involves a constant process of negotiation, intervention and mediation that is shaped by issues of race, gender, sexuality and power" (p. 59). Interestingly, Bhatia (2002) proposes a dialogical model of acculturation, that presents the complexity of acculturation by drawing on the assumptions of social constructionism, representing a critical, dynamic, and a holistic approach.
It is described as an ongoing process of negotiation between identity positions, and this dialogical process involves "a constant moving back and forth between incompatible cultural positions" (Bhatia, 2002, p. 57). According to Bhatia (2002), acculturation and identity are both dynamic, and those from ethnic groups often create multiple forms of the self, depending on the context they find themselves in.

For Indians who migrate to Britain, the family also moves into a diverse cultural environment and so the changes it faces are even greater (Stopes-Roe &

Cochrane, 1989). In the indigenous cultural tradition identified by Asians in Britain, traditionalism is still a significant extant characteristic of the Indian sub-continent (Stopes-Roe & Cochrane, 1989). A survey was conducted in the West Midlands by Stopes-Roe & Cochrane (1989), demonstrating a comparison of traditionalism between the White British and British Asian cultures in Britain. The British Asians referred to the increase in education and capabilities of their children resulting in them adopting a less authoritarian position. This could signify the way parents raise their children is affected by immigration (Inman et al., 2007). Further, 97% of White British participants selected individual precedence, yet a third of Asians agreed that family decision-making would be selected over individual precedence. Key findings illustrated how young Asians who put their family first did not feel the need to give an explanation and simply stated: "family first-you've got to make the family happy; it's up to father, that's how we do it" (Stopes-Roe & Cochrane, 1989, p. 155). This allows us to understand why family approval is regarded as important in deciding whether one seeks treatment for MI. The close-knit and supportive aspects of family life were also highlighted as present in the rising generation, thus demonstrating the significance of family support when dealing with distress.

More importantly, the study highlighted the key difference of the new generation approving the need to express themselves while the older generation disapproved of this process. When applying this to counselling, one can see why the older generation may not access psychological services. This signifies how generations who have undergone migration could also affect this help-seeking process. The original hypothesis that Asian girls would show a more positive response to the acculturation of English norms than Asian boys is further supported

(Ghuman, 1997). However, the study is very outdated and the survey was only restricted to the Midlands. Also, although the demographics of the participants demonstrated the three ethnic groups clearly (Muslim, Hindu and Sikh), when discussing the findings, the overall Asian category was applied. It would be crucial and beneficial to understand the three different ethnic groups in relation to their answers on the index of traditionalism as all three cultures would have had distinct traditions that would have affected their upbringing.

Research by Panganamala and Plummer (1998) demonstrates differences in attitudes towards counselling across generations of Asian Indians residing in the US. Their research explored attitudes toward counselling amongst 101 Asian Indians. The researchers identified Asian Indian immigrants espousing negative attitudes towards counselling and, thus, dismissing counselling as a coping strategy, while second-generation individuals held more positive opinions than those who had immigrated at a much later age. The findings established individuals who had immigrated before 10 years of age responded with more positive attitudes. This suggests individuals who have had a longer duration of exposure to Western constructs are more inclined towards help-seeking behaviour. Although the authors had already addressed the limitation of generalisability as they only received a 22% return rate of the survey, it is to be noted there were only three Sikh participants. Additionally, participant responses were restricted to a survey; it would have been helpful to have gathered individuals' subjective thoughts as to why they perceived therapy negatively (Virdee, 2014). Exploring Sikh subjective thoughts here will allow us to understand why this client group underuses psychological services.

It is important to recognise the generational differences that exist within the Sikh population in the UK, where the difficulties faced by first-generation Sikhs differ considerably from those faced by second and subsequent generations. For example, in their quantitative study, Furnham and Sheikh (1993) found 35 second-generation immigrants of SA origin in the UK had experienced significantly higher levels of psychological difficulties (e.g. stress and depression) compared to 60 first-generation immigrants from South Asia. It seems the difficulties first-generation immigrants faced included adjustment and language difficulties, while second-generation immigrants experienced conflicting pressures of having to conform to family norms and traditional Eastern values while simultaneously having to fit in with the Western way of life. Similarly, a qualitative study by Dhillon and Ubhi (2003) established this cultural dynamic places second-generation SA's in the UK under considerable pressure since they feel unable to affiliate to, and be comfortable with, both their own and the host culture. As a result, the participants reported that they did not feel British, Indian or Pakistani, and had difficulties in affirming these aspects of their cultural identities.

It is crucial to note education plays a factor when comparing British Asians to those immigrating to the UK. Existing research has already portrayed individuals with higher education as less likely to stigmatise than those who are less educated (Corrigan & Watson, 2007). The vast majority of British Punjabi Sikhs go on to achieve further education, with only 1% listing an apprenticeship as their highest level of education (Jandu, 2016). Therefore, an increase in acculturation and education for young Sikhs who are seemingly caught between Western and Eastern cultures is resulting in them viewing MI differently to their parents and

grandparents (Jhutti-Johal, 2018). Prominent Sikh mental health professionals have argued for a greater physical presence of mental health support in *Gurdwaras* (the Sikh place of worship) to show and educate the community about what help is available. Some have argued that the need for such initiatives has increased particularly since Sikhs have had to deal with hate crime post 9/11 leading to many becoming depressed and even suicidal (Verma, 2008, p. 39). Sikhs are often misidentified as Muslim and many Sikh men have been vilified because of their skin colour and turbans (Arora, 2013). The traumatic experiences of Sikh men in America have left them vulnerable to poor physical and psychological outcomes resulting from increased stress and challenges (Ahluwalia & Zaman, 2009, p. 467). Sikhs have faced various verbal and physical attacks during this period and those who have experienced discrimination have been able to gain assistance from various community organisations: United Sikhs, Sikh Coalition and the Sikh American Legal Defence and Education Fund (Ahluwalia & Zaman, 2009, p. 473).

It is important to note that several members of the Sikh community are now trying to speak about the taboo subject of MI, and we must acknowledge the work that is being done in the community to raise awareness of mental health. In Satnam Sanghera's The Boy with the Topknot: A Memoir of Love, Secrets and Lies in Wolverhampton, the author shares his experience of MI and reveals the shame, vulnerability, guilt and trauma behind his journey, to challenge the silence on the sensitive subject (Sanghera, 2012, as cited in Bhanot, 2020, p. 222). In an interview with the BBC, cricketer Monty Panesar has spoken openly about his own struggles with MI that have led him to use medication to cope with symptoms of anxiety and paranoia (Wilson, 2016). Since 2010, Sangat Television (a Sikh

lifestyle channel) has been airing Sangat Health, a weekly programme that aims to address the health issues of the Punjabi community. This highlights the motivation held by Sikh individuals to challenge the stigma and encourage such discussions to take place. Likewise, Sikh Your Mind is a UK-based charity that raises awareness and supports the Sikh/Punjabi community in the mental health space. There exist various other Sikh representative bodies: Sikh Helpline, Khalsa Aid, Sikh Forgiveness, City Sikhs, SOCH, Taraki, BOSS (British Organisation of Sikh Students), all of which are exploring the subject. Thus, the community have started promoting various platforms where MI is openly discussed, with the aim of increasing understanding and challenge it being viewed as a sign of weakness. Taraki is one such initiative, founded by the young Shuranjeet Singh Takhar, which acknowledges the patriarchal and masculine culture of Punjab has reinforced the view that men should be strong (Takhar, n.d.). The movement is designed to challenge how the Punjabi community understand, approach and treat mental health conditions and those suffering from them.

In summary, as the established Sikh community (second and subsequent generations) continues to grow, there is a need for more psychological research to understand the complexities of British Sikh men's reciprocal interactions with their environments. There is still a need for research to explore the subjective experiences of Sikhs within the UK. The differing positions between first and second-generation Sikhs show the community conversations about MI have started and are heading the right way but the issue still needs further exploration. We argue that little is known about the mental health needs and the utilisation of mental health services for Sikh men. Research into this would enable psychologists to understand if the new

generation of Sikhs is continuing to abide by the negative perceptions held by the older generation, and if so, what is causing this avoidance behaviour to prevail. Identifying this will allow us to provide culturally competent services to these populations and to better understand how to support and promote resilience.

## 2.5 Men and masculinity

This section presents relevant literature on the study of masculinity to help understand the blurred lines between various notions of the Sikh identity. This is vital as many authors claim men's help-seeking behaviour can be directly related to the social construction and cultural representation of masculinities (see Addis & Mahalik, 2003; Courtenay, 2009, p. 13; Lee & Owens, 2002).

The constructionist viewpoint, embedded in the social learning paradigm, recognises that masculinities are constructed through social, cultural and contextual norms (Kimmel et al., 2004, p. 3). These can be defined via socially and psychologically enacted behaviours that are in line with socially constructed ideas about what it means to be masculine or feminine (Levant et al., 1996) and through this, men learn the expected norms of masculine behaviour (Mahalik et al., 2003). Social constructionist scholars see gender not as residing within the person but as something that resides in social interactions (Wharton, 2009, p. 10), and it is enacted by the person within a transaction that is bound by a cultural context. Therefore, a social constructionist stance appreciates a wide contextual variation in masculinities, and cross-cultural studies are becoming more prominent in the field of studying men and masculinities (Blazina & Shen-Miller, 2011, p. 120).

Following in the footsteps of the feminist movement of the 1960s and 1970s, the newly emerging field of masculinities and men has made some significant progress in recent years (Dasgupta & Gokulsing, 2013, pp. 5-6). The contemporary theories of masculinity suggest there are numerous ways of being a man and, therefore, they offer pluralistic interpretations of masculinity. Over the years, Connell's (1995) theory of hegemonic masculinity, in which the idea of men being a

homogenous group of oppressors is rejected, has been particularly influential (Connell, 1995, p. 77). In this theory, masculinities are hierarchically structured and some masculinities are more honoured than others (Connell, 2001). According to the scholar, hegemonic masculinity represents a vision of idealised masculinity that does not necessarily correspond to the real lives of most men but is, nonetheless, a form of aspiration for them (Connell, 1995, p. 33). Research has suggested hegemonic masculinity' refers to the current and locally dominant masculine ideology which, in Western societies, defines real men as powerful, competitive, physically strong and invulnerable (Connell, 1995, p. 45). The intention behind this concept of hegemonic masculinity is not to describe an archetype of masculinity, nor to form a category of man that embodies the characteristics that render him inherently masculine.

A reason to focus on men's mental health is because, according to the literature, men underutilise health services (Tarabi et al., 2018). According to Addis & Mahalik (2003), men seek less support than women for every mental and physical health problem for which help-seeking has been studied. There are a few possible reasons as to why men may not engage with mental health services. First, the client-clinician relationship has been highlighted in the literature as a key barrier to men's engagement (Courtenay, 2000). It has been suggested the views clinicians hold about men and masculinity may influence the treatment style adopted with male clients. For instance, Seymour-Smith et al. (2002) discovered hegemonic masculinity was indulged and shielded by some complicit clinicians: men who appeared emotionally detached seemed to gain more respect from the clinicians, potentially perpetuating male clients' behaviour of independence and resilience (Seymour-Smith et al., 2002, p. 265). Therefore, the beliefs and biases held by clinicians regarding what are, and

are not, appropriate gendered behaviours may impact their approach to male clients. Undeniably, negotiated clinician competency on issues specific to men and masculinities has been linked with poorer treatment outcomes (Owen et al., 2009).

Second, some scholars state the nature of seeking help for psychological issues appears to be incongruous with many masculine norms (Addis & Mahalik, 2003; Vogel & Heath, 2016, p. 687). The literature appears to mainly highlight emotional control and self-reliance (Levant et al., 2009; Tsan et al., 2011), suggesting men that are emotionally controlled may be hesitant to engage in therapy where emotional disclosure is key and a male who is self-reliant may be hesitant to seek help as it requires an admission of needing help. The gender role conflict model allows us to further understand attitudes towards psychological help-seeking. The model proposes common therapeutic mechanisms of change (e.g., introspection, vulnerability and disclosure) which contradict traditional masculine norms (e.g., stoicism, strength and self-reliance), resulting in men being less likely to seek, engage in or benefit from psychological treatment (Pederson & Vogel, 2007; Westwood & Black, 2012; Johnson et al., 2012).

Moreover, masculinity is a social process and is "accomplished in social action" (Connell & Messerschmidt, 2005, p. 837), thus there is a need to consider spatial and localised forms of hegemonic masculinities. An intersectional approach may offer a theoretical tool for analysing the complexities of multiple identities in men. Research argues men's identities are far more complex than what quantitative studies can present; the identities of BAME men intersect and create unique masculinities (Griffith et al., 2011). Recently, Brah and Phoenix (2004) reviewed various debates surrounding intersectionality; they presented a range of literature

illustrating various markers of social difference (gender, class, race, sexuality and age, etc.) that intersect and interact to create diverse experiences. Men's health literature also presents issues of sexual identity, disability status and geography as significant determinants of men's health, yet they are rarely integrated into analyses of men's identities and health practices. The study of intersectionality is suited to Sikh men for a variety of reasons. First, intersectionality suggests these men have unique experiences that differ from those of men in general, and from Sikh women; thus, they deserve to be studied in their own right rather than as men. Second, intersectionality not only reflects the reality but the complexities of BAME men's lives in that they consist of multiple social identities (Shields, 2008).

Following on from Connell's (1995, p. 65) insight into multiplicity, Hopkins (2019) adopts the domain of geography to examine how masculinities are played out in different spaces, how those spaces shape the very nature of the experience of masculinity, and how this articulates with other key dimensions of social relations. Geographical work on men and masculinities has expanded and diversified since the 1990s. Hopkins (2019) suggests geographies of religion have now developed into a strong sub-field of the discipline (e.g. Olson et al., 2013, p. 21). Research has focused on issues as diverse as youthful geographies of religion (Dwyer, 1999; Hopkins et al., 2011; Mills, 2012), religious institutions (Sharma, 2012), schools (Kong, 2005) and university campuses (Hopkins, 2011; Sharma & Guest, 2013); religion, migration and development (Olson & Silvey, 2006), and religion and sexuality (Andersson et al., 2011). However, the research has mainly focused on Islam and Christianity, with fewer contributions to the Sikh religion. Despite some valuable contributions (e.g. Walton-Roberts, 1998; Frost, 2010; Peach & Gale, 2003;

Nesbitt, 2005, 2009; Singh, 2011; Jaspal, 2013), geographic studies of Sikhs are rather limited.

One exception is the research by Gill (2005) that identified a collective, contradictory discursive space of *being a Sikh*. This space "provides a range of intersectional gendered, heterosexist, religious, cultural and ethnic narratives that specifically relate to the subjective location of being diasporic, British-born, young Sikh males" (Gill, 2005, p. 5). Being a Sikh was identified as a shared identity or form of identification and was viewed as both religious and ethnic, an extension of culture, family, community and various other forms of belonging. While this space is gendered, heterosexual and patriarchal, it is a distinctive space involving an active process in which individuals navigate who they are through choice and conformity, agency, limitations and restriction, and which is characterised by what is accepted and respected (Gill, 2005). Further, Sikhs from Punjab are seen and view themselves as a religious, ethnic and racial group (Gill, 2005). Therefore, it is vital we consider ethnicity in order to understand the contemporary and diasporic experience of being a British-born Sikh, in terms of how it structures a sense of belonging (Gill, 2005).

According to Cornell and Hartman (1998, p. 33) the domains of race and ethnicity overlap and intersect, with ethnicity being a contested and complex category. When exploring Sikh identity, there is a *Khalsa* and *non-Khalsa* identity within the *Panth* (McLeod, 1989, p. 110). Thus, there are different types of Sikhs on the basis of observance and initiation: *Amritdhari (*baptised and required to wear all of the 5 Ks*)* and *Sahajdhari* (comprised of two major groups: *Keshdhari* and *Mona)* (McLeod, 2005, p. 110). Those who have taken initiation into the *Khalsa* are identified as *Amritdhari* Sikhs, as they have received *Amrit* (McLeod, 2005, p. xxvi).

Whilst those who do not take initiation but observe the fundamentals of the *Rahit* (particularly the uncut hair) are known as *Keshdhari* Sikhs (McLeod, 2005, p. xxvi). The term *Mona* Sikhs is sometimes used "but has pejorative overtones" (McLeod, 2005, p. 97).

Further, Sikhs seek to identify with specific aspects of ethnicity (customs, symbols and history) and this defines their differences and marks out their shared ethnicity (McLeod, 1989, pp. 114-115; Madra & Singh, 1999, p. xiv; Kalra, 2005). Thus, according to Gill (2005) being a Sikh consists of an ethnic aspect and, when it is combined with the domains of religion and race, it differentiates British Sikhs from other groups from the Punjab who may share similar cultural practices. Sikh masculinities can be understood via a social constructionist framework in which ethnicity is located within individual subjectivities. Hall (1992) is significant here and, according to the scholar, ethnicity is not fixed and contained but rather a narrative which acknowledges the encounter of the old and new, a constant blending of change, memory and fantasy. Therefore, ethnic identification is a constant process, and a dynamic phenomenon that shifts with time, space and location.

To be able to theorise Sikh masculinity is a challenge in itself. Generally, masculinity refers to characteristics or qualities which are considered typical or appropriate to a man. This, therefore, gives rise to the following question: How does a Sikh man differ from others?

The processes of colonialism and the racialisation of Sikhs has impacted what constitutes a Sikh (Oberoi, 1997, as cited in Gill, 2005, p. 25). Grewal (1998, pp. 42-205) highlights key phases in Sikh history, including: the early shaping of a community with the ten Gurus, which saw a change in Mughal behaviour towards

Sikhs, shifting from one of tolerance to open hostility; an intense period of persecution followed by Sikh resistance during the eighteenth century; Sikh sovereignty over the Punjab under Maharaja Ranjit Singh (1801 to 1839), which resulted in the rule of its first and last Sikh indigenous Punjabi ruler; the Punjab as a province of the British empire until Indian independence, and the division of the Punjab during 1947 into two new nations of India and Pakistan, which led to extreme violence and several riots.

Regarding Sikh identity and Sikh masculinity, there is a consciousness which defines, shapes and configures Sikh masculinity and the performance of the male self, and there are ideas in which many Sikh men root their identity (Kohli, 2016). Existing studies have focused on: the role of military recruitment (Kohli, 2016); land ownership and property (Chopra, 2004); caste issues; a presence in social media (Gill, 2012), and the symbols of Sikh masculinity, such as the turban (Mandair, 2005; Kalra, 2005; Gill, 2014; Chanda & Ford, 2010). Anthropological studies of gender in India have observed that beliefs about caste purity, caste superiority and chastity have constituted culturally valued beliefs about masculinity (Dube, 2001, p. 268; Malhotra, 2002, p. 182; Wadley, 1991, p. 154). Research conducted by Gilmore (1990, p. 176) is able to provide some insight into caste differentiated masculinity in Punjab. Gilmore (1990, p. 177) noted that *izzat* is a philosophy of life for Sikh *Jats* of the Punjab which reflects their paramount concern for male power, in which "a man's duty is to be stalwart in defence of his family. Above all, the Sikh *Jat* man must never give in to threats that might diminish his family's position" (Gilmore, 1990, p. 177).

Gill (2014) suggests historical representations of Sikh masculinities are not only informed via the colonial period; they have constructed a hyper-masculine, martial "Sikh warrior (often Jat) as the ideal and 'authentic' Sikh male" (Gill, 2014, p. 336). The impact of British rule in India on the shaping of modern Sikh identity has been much debated by contemporary scholars (see Grewal, 1998; Oberoi, 1994, p. 351; Mandair, 2005; Nesbitt, 2005; Ballantyne, 2006, pp. 1-86). Connell and Messerschmidt (2005) argue that hegemonic masculinity is a very specific and dominant form of masculinity. Thus, it is crucial to examine why *Khalsa* Sikh martial identity and, more specifically, why martial masculinity has turned out to be the dominant and hegemonic form of masculinity in Punjab.

In Punjabi culture, the general popular perception of Sikhs is to view them as martial, brave and willing to sacrifice. Punjab is valued as the homeland of Sikhs and is widely respected as the "land of the brave, or the land of the lions" (Kohli, 2016, p. 44). Although Sikh martial masculinity is not a universal category of masculinity, as argued in the context of Sikh identity by Oberoi (1994, p. 55), McLeod (1976, pp. 95-104) and Fox (1985, p. 8), it is that one particular form of masculinity which has emerged at the intersection of religious, social, political and cultural factors. To understand this form of masculinity, one must critically explore *martial Khalsa identity*. I seek to do this through an examination of the important developments in masculinity and militancy in early Sikh history, up to the twentieth century; this includes the legendary accounts of the *Gurus*, Sikh battles, and the racism of the British.

The timeline of Sikh battles begins with Guru Gobind Singh Ji (1666-1708), the tenth and final living *Guru*, who formed the *Khalsa*, which is the initiated group

within the Sikh community. The *Khalsa* are an order of Sikh initiates who are distinguished by their honourable maintenance of five articles of faith on the body *(panj kakar*): the *kirpan* (a curved steel sword), the *kara* (a steel bangle), *kachera* (cotton underwear - dignified attire reflective of modesty and control), the *kesh* (unshorn hair) which, in the case of male Sikhs, is draped by the turban (*pagh*) and the *kanga* (wooden comb) for the maintenance of the *kesh* (Mandair, 2005). The events that lead to the formation of the *Khalsa* group are summarised by historian Louis E. Fenech (cited in Gill, 2012):

> The martyrdom of Guru Arjan, the fifth Guru, led to the militarisation of the Sikh community in 1606, while the martyrdom of his grandson, the ninth Sikh Master, Guru Tegh Bahadur, in 1675 was the event which precipitated the creation of the *Khalsa*, the elite, militant order formed in 1699 by the tenth and last Guru of the Sikhs, Guru Gobind Singh Ji.

These martyrs in history served as key examples of the bravery Sikhs were to possess (Gill, 2012). Guru Hargobind Singh Ji introduced the concept of *Sant-Siphai*, individuals who meditated in the name of God and were religious in their morality, but at the same time were ready to take up arms to fight oppression and strive for justice. Guru Hargobind Ji took two swords, one for temporal and the other for spiritual, *Miri* and *Piri*, to protect the oppressed from the oppressor (Singh, 2008). Guru Gobind Singh Ji upheld the teachings of his predecessors. Including instituting the principle of *Sant-Sipahi*, developing a strong foundation of spirituality

(*Sant*) and assuming the role of a warrior (*Sipahi*) when necessary (Singh, 1991, as cited in Mundi, 2019, p. 9). The traits of the *Sant-Sipahi*, which reflected the holy warrior and Saint-Soldier, was seen as an inspiration, a warrior to meditate in God's name and wield arms when called upon to do so (Kohli, 2016; Nesbitt, 2016, p. 55). This warrior identity was further reinforced through the creation of the *Khalsa* by Guru Gobind Singh Ji in 1699, which had a significant effect upon the psyche of the Sikh people, transforming them from humble peasants of Punjab into some of the greatest and most noble warriors of all time (Madra & Singh, 1999, pp. xiii-xiv). Guru Gobind Singh Ji called the baptised Sikhs Saint-Soldiers, the Soldiers of God (Singh, 2008). The baptised Sikhs were required to carry the five articles of faith and the *kirpan* represented a Sikh's commitment to justice, to protect the oppressed from the oppressor (Singh, 2008). The battles fought between the 16th and 17th centuries by the Sikhs, and the show of courage and accounts of heroisms that circulated thereafter cemented the Sikh commitment to martial ideals (Nesbit, 2016, p. 55).

According to Gill (2005), this aspect of Sikh religious history; with its various interpretations, continues to shape the diasporic Sikh male psyche and the sense of self. Interestingly, the display of macho behaviour appears to be related to the Sikh martial tradition, and a clear reflection of the ongoing negotiation of colonial discourses in relation to Sikh masculine identities (Gill, 2014). Kalra (2005) proposes, through the lens of masculinity, that the *pagh* be deemed to be symbolic of male honour. Sikh men who reject the turban would be viewed as engaging in a dishonourable act, and young Sikh men who cut their *kesh* are likely to be construed as "giving in to Western culture" (Verma 2006, as cited in Gill, 2014, p. 14), thus displaying a sense of modernity and hegemonic masculinity (Gill, 2014). Not only

does the turban differentiate the Sikh diaspora as a distinct religious group, but it is also viewed as an integral part of the *Khalsa* identity (Singh, 2005).

There even exists a Sikh form of martial arts known as *Gatka*. This martial art is connected with the first *Guru* himself, being one of the many arts he was a master of. *Khalsa* Sikhs, specifically, were seen as formidable warriors. Working as mercenaries in the armies of the Sikh chiefs was perhaps seen as enhancing the masculine status of this group (Roy, 2011). Hence, the *Khalsa* Sikhs themselves acknowledged their own identity as a warrior group with distinct martial qualities (Soherwordi, 2010). The *Khalsa* male continues to produce the normative model which all other Sikh identities are weighed against, generally through negation or deferral, and they are the authoritative reference of Sikh identity (Axel, 2004). The Sikh look (Gell, 1996) is that of a turbaned male. It is asserted that ideal and authentic Sikh masculinity are reflected in the *Amritdhari* orthodox male, who maintains all the markers of the religion, notably the turban, which signifies respect for male honour. However, this research also inferred that many second and third-generation Sikh males in Britain construct and perform their masculinity in a variety of ways (Johal, 2015). For example, it has been suggested the upper-caste 'Jat' Sikh men, who are considered to be landowners in Punjab, represent the average hegemonic masculinity in the Sikh community (Garha, 2020). The result of this caste system is that men from other castes "are measured according to their ability to live up to this form of masculinity" (Sevea, 2014, p. 186). The turban, which is an important symbol of religious and cultural identity of Sikhs (Chanda & Ford, 2010), is also a symbol of pride and manhood for these upper-caste Sikh men.

According to Gill (2014), the *pagh* and *kesh* facilitate a sense of pride. This study aimed to explore British-born Sikh men's identification to Sikhism, establishing the turban as a marker of respect and of an authentic Sikh masculinity. Despite the participants in the study themselves not wearing turbans, they described themselves as being Sikh. Thus, Gill (2014) concluded that while the turban is a representation of a *Khalsa* Sikh, it is not central to being a Sikh, suggesting there are various dominant views as to what constitutes the ideal form of Sikh masculinity and that, more specifically, second and third-generation Sikh men construct their masculinity in multiple ways regarding the Sikh faith. Also, men were proud of the recognition of being Sikh by exhibiting their individual interpretation of Sikh *Khalsa* masculine identity (Gill, 2014). In present times, for many young Sikhs in the UK, wearing the *kara* or using the *khanda* symbolically denotes their Sikh masculinity and promotes a hyper-masculine ethnic identity. Based on participant accounts, Gill (2014) asserted that "the use of the Khanda as a visual symbol of 'being' Sikh can also become commoditised, for example taking the form of miniature car flags, on gold chains or earrings, symbolised through tattoos or even evident in garden fencing... the selective use of symbols remains representative markers of being a Sikh and an active means of asserting group belonging for young men" (p. 20). This points to the dynamic nature of how Sikh masculinities are performed in Britain, particularly in light of the localised geographic spaces and the intersection of race, gender and faith.

The label of a *martial* race by the British encouraged the participation in violent, emotionless and masculine behaviours. It is well known that the British greatly admired the martial character and strong physique of Sikh men and, thus,

recruited them in large numbers to serve in the British army (Singh, 2013, pp. 116-117). This eventually led to several Sikhs migrating to the UK for work purposes. It was during this period many Sikhs experienced racial discrimination as many conflicts occurred over uniform rules and safety legislation, sparking well-documented controversies over Sikh masculinity. During the 1950s and 1960s, in Manchester and Wolverhampton, Gurharpal Singh documented *turban campaigns* in which local authorities expressed intransigence towards the wearing of turbans by Sikhs employed in the transport sector (Delap & Morgan, 2013, p. 8). The historical and cultural investment in the turban as a marker of Sikh masculinity is well-known, yet some had to sacrifice their hair due to fear of being discriminated against in the UK. In the 1960s, the notion of Sikh culture as manly was reinforced throughout the Midlands through the increasing popularity of Sikh wrestling and Kabaddi games (Delap & Morgan, 2013, p. 8).

Living in an unfamiliar environment with a lot of pressure to work and send their income back home, these men experienced severe isolation and had minimal support networks, leading many to use alcohol to cope (Jhutti-Johal, 2018). The use of alcohol as a coping mechanism has been explored in Indian men living in Britain. A higher rate of psychiatric admission in relation to alcohol dependence has been noted, and Sikh men in Britain have been observed as drinking more units of alcohol than any other ethnic group (Vora et al., 2000; Cochrane & Bal, 1989; McKeigue & Karmi, 1993). Some studies indicate that Sikhs and Hindus are equally likely to report drinking (Heim et al., 2004). When broken down by ethnicity and gender, however, some research finds relatively high rates of drinking (around 70 per cent) reported among Sikh men (Cochrane, 1999, p. 74; Orford et al., 2004) compared to

rates typically reported for Muslim and Hindu men. According to Jhutti-Johal (2018), men face various pressures to behave in a masculine manner and, at times, even express hyper-masculinity in the Sikh/Punjabi community. Due to the expectations associated with this hyper-masculinity, alcohol abuse is prevalent (Jhutti-Johal, 2018). Similarly, alcohol consumption as a defining feature of masculinity has been demonstrated by other researchers (Oliffe et al., 2010).

Recently, Taak et al. (2020) adopted a qualitative approach to explore the views of UK based Punjabi Sikh men on alcohol consumption within the community and the usefulness of an evidence-informed alcohol reduction app. Interestingly, participants expressed a strong desire for their relationship with alcohol to be viewed differently from that of the older generation, who tended to drink to cope with stressors. It seems, observing the older generation turn to alcohol to manage stress or as a pain killer and this resulting in physical health problems or the negative impact on family relationships has led the younger generation to avoid using alcohol as a means of coping. Importantly, other researchers have put forward a strong tie between alcohol consumption and perceptions of masculinity (De Visser & Smith, 2007). Heavy drinking especially is frequently accepted as part of male Punjabi culture and this, in particular, may be problematic for the younger generation.

Overall, masculinity or masculinities can be seen to comprise of various cultural traits and values that are used to define what constitutes male behaviour and the expression of gender. The dominant, collectively aspired and idealised assertions of being male are characterised by ‘hegemonic masculinities’ (Connell, 1995, pp. 77-78). The traditional vocations of Sikh men in agriculture or armed services, alongside the misogynistic social normalities and predominant practices in broader

Indian society, have collectively played a role in the procreation and reinforcement of the patriarchal structure in Sikh society. In addition, Sikh men have shaped their masculinity in the form of chief providers and guardians of their families. Ultimately, the esteemed view of upper-caste men in the eyes of the public, their solitary control over resources and the British perception of Sikhism as a masculine faith have become crucial components in the formation of hegemonic Sikh masculinity. The research specifically focusing on men and masculinity suggests that while there are multiple ways of being a Sikh man and being marked as belonging to the Sikh faith, there is also a collectively understood idea of what an ideal Sikh man should be like. Finally, although some researchers have already begun to examine the ways that masculinity and health might be related (Watson, 2000, p. 36; Roberston, 2006; Chapple & Ziebland, 2002), there is certainly room for further qualitative studies that explore other aspects of masculinity that might not have previously been considered.

## 2.6 Spirituality

This section explores the practice of spirituality as a coping mechanism (Singh, 2008). As mentioned previously throughout this thesis, spirituality and religion are used interchangeably.

The literature has established a direct correlation between spirituality and coping amongst a diverse range of traumas: spiritual wellbeing correlating with low levels of anxiety in cancer patients (McCroubie & Davis, 2006), a negative correlation between post-traumatic stress disorder symptoms, spiritual wellbeing in sexual trauma victims (Krejcki et al., 2004), and a significant negative correlation between spiritual wellbeing and pain intensity in those with spinal cord injury (Siddall et al., 2017). As a result, there is a consensus that practitioners should engage with their clients' meaning-making systems and life worlds (British Psychological Society (BPS), 2014). Historically the benefits of psychoanalysis have been noted, whereby religion and spirituality have been seen as neurotic, regressive and comforting illusions that people use to defend themselves against the reality of human vulnerability, limitations and hopelessness (Freud, 1989, p. 44). Other scholars have proposed the element of spirituality to be incorporated into the discipline again (Ellor et al., 1999, p. 108), and those practitioners who disregard it may be depriving themselves of the ability to help empower individuals to achieve improved mental health (Vader, 2006).

In the UK, there is widespread research exploring spiritual factors in the Muslim and Hindu population, yet not many studies have explored the influence of Sikhism on health beliefs, whereas in Canada, studies have been able to assess the relationship between Sikhism and health, suggesting Sikhs have a tendency to refer

to spiritualism as a way of life (Labun & Emblen, 2007). Research by Labun and Emblen (2007) identified Sikhs as more spiritual during times of sickness and they appeared to call on God when medical interventions were unsuccessful. Also, the interview extracts revealed a correlation between health and maintaining a positive mindset, where mind and body were viewed as intertwined (Labun & Emblen, 2007). It has been suggested their integrated understanding of health as mind, body and spirit, and the approaches of the family play a central role in influencing the decision to seek medical attention (Kaur, 2010). Thus, culturally-adapted counselling should be central in the clinical work of many mental health professionals. Yet, it is often difficult to find reputable systematic guidance when working with specific ethnic minority groups that can be readily utilised by a practitioner (Currie & Bedi, 2019).

Regarding Punjabi Sikh individuals, practitioners need to be aware not only of the religious and spiritual beliefs but also work with these as this group has high rates of religiosity and often bring up religion in therapeutic settings (Dhillon & Ubhi, 2003; Hussain & Cochrane, 2002). The literature suggests Sikh spiritual values are important for this client group. For example, Miller (2005) interviewed four devout Sikhs and identified key positive feelings such as relaxation, peace, emotional wellbeing, and positivity in relation to prayer. These findings are consistent with other studies regarding prayer (Plante, 2008; Çoruh et al., 2005). All of these are interrelated in that they all affect emotional health. However, a key limitation of this study is its sample size and the question of generalisability.

Similarly, Parkes and Gilbert (2010) assessed the mental health needs of those belonging to the Sikh community in Birmingham and reported participants

stressed how their spiritual beliefs formed a vital part of daily functioning and were key for their recovery. Those that practice Sikhism are known to not only have a better sense of self (Froggett, 2001) but also a stronger internal locus of control (Bhugra, 2003). Nonetheless, Parkes and Gilbert (2010) concluded services should collaborate with communities and integrate religious and spiritual beliefs into their clinical work. This is further supported by other scholars: Vontress and Epp (2000) have highlighted the need to integrate traditional views into therapy and Morjaria-Keval and Keval (2015) have suggested Western therapists must take into account the cultural backgrounds of their service users. Nayar (2004, p. 118) also stressed that the Punjabi communities' mental health needs can be attended to by encompassing traditional Sikh values into the therapeutic framework. Therefore, to help meet the therapeutic needs of Punjabi Sikh individuals, a growing ethnic community in the UK, Counselling Psychologists should endeavour to incorporate traditional healing practices into culturally-adapted counselling with Punjabi Sikh clients.

Furthermore, spiritual participation, whether public or private, reinforces healthy behaviours that promote physical health, positive emotions and social supports and this may in turn promote wellbeing. Two studies have demonstrated this. A study in Amritsar on the regular reciters of *Sukhmani Sahib* showed a lower prevalence of hypertension in reciters versus non-reciters (4.76% vs. 9.7%) (Singh & Singh, 1979, as cited in Kalra et al., 2013, para. 23). Mattis (2002) has suggested that individuals who class themselves as religious have used their religion to cope with adversity and have found it helpful when accepting reality, gaining courage, confronting limitations, recognising purpose and achieving growth. Also, the

practice of yoga is quite common amongst Sikhs, with Baba Ramdev gaining recognition over the years. Interestingly, the practice of Kundalini Yoga has become visibly present amongst some Sikhs through the efforts of Harbhajan Singh Khalsa, popularly known as Yogi Bhajan. It is not practised by mainstream Punjabi Sikhs (Jhutti-Johal, 2011, p. 241) and is quite popular amongst a group of converts known as *Gora* Sikhs (baptised White American Sikhs), who associate with the 'Healthy, Happy, Holy Organisation (3HO)' in the US.[2] Its emphasis on energy centres, chakras and the ability to tone the body has resulted in many young people leaning towards it for general wellbeing and relaxation. For example, various Sikh bodies have promoted the practice of Kundalini Yoga via their social media platforms (SOCH, 2019). Notably, the efficiency of Kundalini Yoga versus cognitive behavioural therapy has been explored. Simon et al. (2020) found Kundalini Yoga was efficacious for generalised anxiety disorder, but the results support cognitive behavioural therapy as remaining first-line treatment. These findings on anxiety-reducing benefits are supported by other research (Gabriel et al., 2018), one such benefit being an eight week Kundalini Yoga intervention which resulted in lower levels of anxiety. However, future studies are required to inform us how yoga could be integrated into a stepped-care personalised approach to anxiety disorders (Simon et al., 2020).

Overall, there is limited literature in the field of counselling psychology seeking to explore mental health and wellbeing within the Sikh faith. Singh's (2008)

[2] The 3HO (Healthy, Happy, Holy), originated in the US and is an organisation that is also known as
the Sikh Dharma of the Western Hemisphere.

model of counselling is able to offer a way in which one integrates CBT with the spiritual beliefs of the person, their health, distress and illness. The hexagon model is claimed to be universal and presents six steps to help a Sikh client promote better wellbeing. According to Singh (2008), knowledge of Sikh spirituality could reduce stress in the individual and help clients improve their overall mental health. He has suggested Sikh clients need assistance in believing they are responsible for their own will to shape their destiny. Despite presenting a comprehensive analysis of the Sikh religion and spirituality, only three vignettes were presented to demonstrate the application of the model. Thus, further universal evidence is required to assess whether or not this model is relevant or applicable for use in practice. Similarly, The Sikh Life Stress Model (Sandhu, 2005) and The Sikh Model of the Person, Suffering and Healing (Sandhu, 2004) lack supportive findings. However, we must recognise all three models fostered the client's connection to their religion and spirituality as a prominent theme throughout the case studies presented. The importance of being close to God was also frequently mentioned in the interventions through, for example, spiritual meditation, reading the GGS and practising the Sikh religion with more dedication. This further encourages practitioners to seriously consider incorporating religious content or relate religion to their clients' current situation throughout the therapeutic process (Currie & Bedi, 2019).

"Sikh spirituality is centred around the need to understand and experience God, and eventually become one with God" (Chandra, 2007, p. 88). It has been proposed that "a notion of spirituality is at the core functioning of Sikh individuals" (Kalra et al., 2012, p. 1). A review of the GGS has been presented by Kalra et al.

(2012) which sheds light on descriptions from the scripture in the context of clinical depression:

> He alone is said to be a Guru, he alone is said to be a Sikh, and he alone is said to be a physician, who knows the patient's illness.
> (GGS, Ang 503)

> My conversation is with the Lord's Name, and my counselling is with the Lord's Name; the Lord's Name always takes care of me.
> (GGS, Ang 592)

The GGS (Ang 114 & Ang 832) describes five crucial ways to achieve salvation: "listening (*suniyai*) to the spiritual hymns (*Bani*), obeying (*mannai*) these hymns, reciting the name of the Lord (*Naam***),** meditating and subjective experience of the name, and with the company of saints" (Rahi, 1999, as cited in Kalra et al., 2012, p. 342). Thus, adopting key principles from cognitive reframing, the religious scriptures place key emphasis on helping people deal with *dukh* at an individual level (Kalra et al., 2012). Although the review by Kalra et al. (2012) encourages the consideration of the descriptions of the GGS in clinical scenarios, there is no supporting evidence, and many of the points are applicable only to depression.

Research by Bawa & Chadha (2013) can provide supporting evidence of the impact of the GGS on wellbeing. The study conducted semi-structured interviews with ten Sikh women in India which were analysed using grounded theory. The

results demonstrated that certain tenets of Sikhism, like *paath* from the GGS and *seva*, act as a source of peace and comfort during times of distress by inducing positivity in the thought process (Bawa & Chadha, 2013). The results confirm the link between spirituality and wellbeing in the Sikh religion. In planning any therapeutic interventions, it is critical that the clinicians are aware of how these religious beliefs affect attitudes and help-seeking. However, despite the evident need of a culturally enriching mental health approach, the literature has failed to explore this link on larger sample sizes. The existing literature that does acknowledge this fails to focus on the Sikh religion.

In summarising this section, the absence of a clear theoretical framework, human uncertainty and limited opportunities for training in the area of religion and spirituality has led to the neglect of these aspects in therapy (Cobb & Robshaw, 1998, pp. 4-5). Also, most supportive evidence for the existing models or frameworks for incorporating traditional healing practices into counselling or psychotherapy with individuals of Punjabi Sikh descent is anecdotal and case study based. The proposed strategies and interventions should be subject to further investigation and ought to be clinically tested by practitioners to further increase confidence in their application. Nonetheless, culturally-adapted counselling is evidently effective for individuals. Although one can see the positive use of prayer and the GGS as a coping mechanism within the Sikh community, gender differences in spirituality seems to be an area that is fairly understudied. As far as Counselling Psychology is concerned with the subjectivity of the individual (BPS, 2005, p. 1), it will be valuable to understand what spirituality means for Sikh men. It would be helpful for Counselling Psychologists to understand the functioning and dynamics of

this spiritual element and to develop a collaborative approach when working with this client group in their practice. As mentioned previously, religion could aid the success of these treatment plans by acting as a source of psychological support (Lee, 2013, p. 61).

### 2.7 Concluding points, rationale and research question

The literature review so far appears to have revealed that the Sikh community is growing yet is fairly unexplored, particularly in the field of mental health. Existing literature demonstrates how Indians perceive MI, thus, to an extent, one can deduce conclusions about the relationship of these values and beliefs in regard to their effect on help-seeking in the Sikh culture. However, to have effective therapeutic relationships in place (Everall & Paulson, 2002), the therapist must reflect on the clients' cultural background, something we remain unaware of. The few studies that have explored the Sikh community so far have been able to recruit Sikh female participants only. As of yet, research has been unable to focus solely on this religion and explore how Sikh men perceive the concepts of therapy and how this shapes their help-seeking style. There is a gap in the literature in giving a platform to the subjective voice of Sikh men in relation to their perspectives of the concepts of therapy. Therefore, a study is proposed that hopes to enable insight into their perceptions, and what factors contribute towards deciding whether to engage in therapy or not. Exploring these experiences will bring a vision of what factors helped the process and the aspects that could be improved. Employing a qualitative methodology will help understand the processes involved and help generate a theory of a phenomenon that has not yet been investigated. With these findings, we can enlarge our current knowledge base. Counselling Psychologists will be able to improve existing services and techniques to better suit this client group. This is key as the underlying value system of Counselling Psychology facilitates practice with diversity (Woolfe et al., 2003, p. 204), the findings will also allow Counselling Psychologists to understand what could promote the accessibility of current therapy

services for this community. Moreover, they will allow Counselling Psychologists to understand Sikh men's subjective voice, rather than categorising them into the existing, broader literature on other religions that currently exists. It further opens the door to the concept of universality regarding how people from different ethnic minority backgrounds experience wellbeing and psychological distress (Woolfe et al., 2003, p. 444).

The research question: ***How do Sikh men perceive the processes of seeking therapeutic help?*** can seek knowledge in the gap(s) identified and would be in accordance with the Counselling Psychology philosophy and practice, as explained below**.**

There are several questions that the gap identified would seek to answer: What barriers prevent Sikh men from getting counselling services, and what should be done to overcome these barriers? Which counselling theories and techniques apply best when working with Sikhs? Should Counselling Psychologists incorporate spiritual elements into their work when working with this client group? From this proposed study, we can explore these inquiries to identify what we as Counselling Psychologists can do to build trust and rapport with this client group.

## REFLEXIVITY PART 1

The research process and outcome is inevitably mediated by the author's identity and role as a researcher. This process is referred to as the reflexive process (Russell & Kelly, 2002). This subjectivity replaces the idea of the value-free objective researcher, and the inter-subjectivity between participants and researchers is argued to enhance the research process (Wheatley, 1992). Instead, research outcomes are considered to be due to co-authorship and active participation (Russell & Kelly, 2002). Thus, the reflexive statement seeks to recognise ways in which the researcher may be influencing and interacting with the research through her experiences, views and beliefs. The reflexive statement has been split into three sections: the first section goes through reflections prior to the research taking place, the second part (following analytic strategy) focuses on the research approach and the third part (following the discussion chapter) discusses the reflective points of the entire research process and how the researcher managed any underlying assumptions. All three reflective sections will use the "I" frame of reference as it is based on the researcher's subjective beliefs.

I am a 26 year old British-born Punjabi Sikh, from a middle class family and I grew up in a fairly traditional Sikh household in London. My mother also identifies as a British-born Punjabi Sikh and my father was born in Punjab and migrated to the UK after marrying my mother. I have always embraced the cultural identities presented by both my parents, which at times have felt conflicting and challenging. While my mother also grew up in London, my experiences have differed from hers in the sense she often felt like a minority whereas I have lived on a culturally diverse

road with many Sikh families close by. My parents have always tried to keep me and my siblings in touch with our Punjabi roots, whether this was through attending Punjabi school on the weekends or ensuring we celebrate all the religious holidays. For most part of my childhood, my mother had to earn a living and so I was raised by my *bebe* who kept me in touch with my heritage via her teachings of *Sikhi* and by regularly taking me to the *Gurdwara*. This is because my *bebe* is the only one in my family who identifies as a baptised Sikh. At school I would engage with my British side whilst a home, we were not to speak in English and were to converse in Punjabi only. As such, I often felt like I had two identities.

The purpose of engaging with this research is a personal search for me in trying to find an answer that will perhaps validate what I do. Growing up cross-culturally in both British and Asian environments has taught me that Western societies are more open minded and able to recognise psychological therapies than Eastern cultures. It is often difficult to explain and validate my purpose as a trainee psychologist to family members and others from within the Sikh community. When entering this choice of career, as the eldest child, my parents naturally were intrigued to know the educational path I would pursue as it would set the standard for my younger siblings. Initially, my parents and *bebe* could not understand the role of a counsellor, before I could even begin to explain the role of a Counselling Psychologist. Perhaps there is an aspect of myself that would like to ask other Sikhs if they acknowledge what psychology is and therefore recognise what it is that I do. I have experienced people questioning 'the point' of me being a counselling psychology trainee and whether the profession I have chosen is a wise choice as I will be exposed to "ill people". I seek to show that there can be psychological help

from a contemporary, westernised perspective, within Sikhism and Sikhs can consider therapy as an option.

Alongside this, I have witnessed my father being comfortable with speaking to me and my siblings about any emotional difficulties we may be experiencing, whilst also informing us we are Punjabi, we are strong and if ever faced with any injustice, we fight. Looking back, I felt he did this to protect us and to prepare us for what lays ahead. My father has always supported my mother with any domestic chores or cooking in the house. Which other family members would often say my mother is fortunate as this is not the norm for a Sikh man, a man should not be cooking or cleaning as this is the duty of his wife. I have seen my father be comfortable in his version of his masculine identity, which I did not see in other men in my family. I have always wondered what does he have that allows him to engage in behaviours that other men usually shy away from. This led me to explore literature on Sikh men and their approach to vulnerability, which appeared almost non-existent.

Former to the literature review, I knew there were some outdated beliefs surrounding MI from the stories I have heard about other family members whilst growing up. However, I was shocked to see recent literature presenting views of MI resulting from black magic or for a sin from God. Similarly, research showing individuals with a MI being viewed as ‘dangerous’ came as surprise and made me feel sorry for those that suffer from a MI, as they may have to bear this judgement. This goes against my own thoughts and belief system. I was also astonished to find that the role of family was seen to have a negative impact on help-seeking. My experience of a supportive family life goes against this. My parents have always

tried to adjust to British culture and made space for my own views and beliefs. I was surprised to see that in today's age, these factors could potentially have a negative role to play as to whether an individual seeks therapeutic help. I have been raised in a very close family and *Waheguru* has aided me to get through my difficulties. Exploring literature surrounding spirituality and help-seeking made me feel in touch with my religion, which acted as a source of motivation. It allowed me to learn things I did not know before, I was amazed to see an essence of counselling within the GGS. Whenever I feel I need someone to speak to or need to let some things of my mind, I resort to prayer. I felt I could relate to the literature that presented prayer as having a positive outcome on distress. However, this further puzzled me because if the GGS highlights the importance of addressing mental distress, surely help-seeking behaviour should be encouraged? I felt a sense of anger and went to blame society for restricting individuals. My rationale for my topic began to connect: to move the Sikh culture a bit "forward".

On the positive side, when exploring MI and Sikhs I was able to recognise various platforms that are already encouraging the need for a change within the community. These organisations are promoting the importance of mental health and whilst exploring their Instagram pages (Sikh Your Mind, n.d.; SOCH mental health, n.d.; Taraki, n.d.), I had a moment of realisation that they are doing what I seek to do with this thesis, with the hope to shape society in which we do not feel shame, guilt, or 'weakness' when discussing these issues. Perhaps my feelings of frustration are in line with theirs and creates a desire to increase the awareness of therapy. These negative feelings soon converted into curiosity and the need to find out, what are the processes involved and any potential barriers for Sikh men in seeking help.

My beliefs have influenced how I have approached my topic, as I now seem to value the importance of ‘mutual creation of knowledge by the viewer and the viewed’ (Charmaz, 2000, p. 510). I am aware of my own assumptions regarding my topic area and so, foresee the possibility of my own influences on my observance of the emergent theory. However, every effort will be made to remain as objective. This effort will involve ongoing contact and discussion with my supervisor on the research process and the interview processes, any material that comes up for me personally as well as the data and checking what her understanding is.

# CHAPTER THREE

## METHODOLOGY

This section will discuss the rationale for employing a qualitative research methodology and detail the choice of grounded theory (GT), with a focus on its epistemological underpinnings. In addition, ethical considerations and the analytical process will be discussed herein.

## 3.1 Design

### *3.1.1 Rationale for methodology*

A review of the research conducted in the field of Counselling Psychology shows that the majority of the studies are framed in the quantitative paradigm (Berríos & Lucca, 2006). It was previously thought that relatively little attention had been given to qualitative research in the counselling profession. However, qualitative methodology has moved from 'margin to mainstream' and is now well established (Frost, 2011, p. 3).

Qualitative data provides depth and detail by looking deeper than when analysing just ranks. As such, a key feature of qualitative data is its richness and holism, with the solid potential for revealing complexity (Miles et al., 2014, p. 8); such data can provide "thick descriptions" (Geertz, 1973, p. 26) that are nested in subjectivity. The data ignites people's individual experiences; a detailed picture can be built based on naturally occurring events in natural settings. It is through this that openness is created: encouraging participants to expand on their responses can open areas not initially considered.

In contrast to quantitative research, qualitative research allows us to understand why a particular response was given. They are not concerned with isolating variables from their milieu and do not view human interpretations as biased (Virdee, 2014). As pointed out by Strauss and Corbin (1998, p. 11), qualitative methods allow us to obtain the intricate details about phenomena such as feelings, thought processes and emotions that are difficult to extract through conventional research approaches. Therefore, the qualitative paradigm can be claimed to correspond better with the central principles of Counselling Psychology which are concerned with individuals' subjective experiences and their meaning-making (BPS, 2005; 2014).

A qualitative paradigm was selected over a quantitative paradigm based on two key factors: First, existing research in the topic area the researcher aimed to explore was nascent, and qualitative methods suit a topic area where research is lacking. The researcher proposed a need to explore the complexity of the issue and was not interested in quantifiable constructs (Reiss & Thomas, 2007, p. 159). There have been recent attempts at analysing the relationship between help-seeking and religion or culture in relation to mental health using quantitative methods (e.g. Masuda & Boone, 2011; Al-Krenawi & Graham, 2011), but we do not know the essence of how culture and religion interact with accessing mental health services, especially in Sikhs. Second, the qualitative research paradigm is rooted in a philosophical position that is interpretivist as it is concerned with how individuals experience, create, explain, maintain and attribute meaning to their social worlds, i.e. how they interpret their experience (Mason, 2017, p. 226). In relation to this research, this depth of understanding of Sikh men's help-seeking behaviour can

allow participant-generated meaning to be uncovered which, according to Willig (2013, pp. 23-25), enables the possibility of new unanticipated meanings and findings to surface.

### *3.1.2 Research paradigm and epistemological framework*

Leading on from a qualitative approach, the chosen method was GT. At present, there are three key approaches within GT: the traditional Glaserian method (Glaser, 1978, p. 142), evolved grounded theory (Strauss & Corbin, 1998, p. 10) and constructivist GT (Charmaz, 2006, p. 10). The traditional approach proposed by Glaser, (1992, as cited in Giles et al., 2013, p. 30) was immediately deemed to be unsuitable as it requires data to be collected before a literature review is undertaken; this is a doctoral project which has been formed from a critical literature review. During the development of the methodology, the researcher was initially leaning towards the *evolved grounded theory* of Strauss and Corbin (1998, p. 10). This is because GT began evolving into a constructivist approach. Strauss and Corbin's (1998) work demonstrates a "mixture of language that vacillates between post-positivism and constructivism, with a reliance on terms such as recognising bias and maintaining objectivity when describing the position the researcher should assume in relation to the participants and the data" (Mills et al., 2006, p. 28). Ontologically relativist and epistemologically subjectivist, constructivist GT reshapes the interaction between the researcher and the participants in the research process and, in doing so, brings to the fore the notion of the researcher as author (Mills et al., 2006). The researcher's philosophical position adopts a constructivist stance through

identification with the view that “truth or meaning comes into existence in and out of our engagement with the realities in our world” (Crotty, 1998, p. 8).

Constructivist GT methods were selected based on the qualitative work of a student of Glaser and Strauss, Charmaz (2000, 2006), who has emerged as the leading creator of constructivist GT. This is because, historically, GT has been judged as mutely authored; that is, researchers have maintained a position of “distant expert” (Charmaz, 2000, p. 513). Being the researcher as the author of a co-construction of experience and meaning is important to me. Adopting Charmaz’s work in developing a methodological model of constructivist GT addresses this (Charmaz, 2000, as cited in Mills et al., 2006, p. 32). The researcher coming from an ethnic background has also influenced the researcher adopting a constructivist epistemological position. This is because the presence of culture within experience is taken into consideration.

The researcher aimed to capture the broader picture as this was deemed to be most important. There may be many factors that inhibit Sikh men’s access to psychological care. Similarly, there could be a range of factors that could encourage Sikhs to be positive towards psychological help-seeking. Generating a theory would allow us to better understand the overlap of these factors and account for why Sikh men would or would not engage in therapy. The Sikh religion and Punjabi culture encompass a lot of variation and Charmaz’s model accepts this since constructivist GT attempts to capture the views and multiple meanings held by individuals. By embracing Charmaz’s (2006, p. 154) modern approach, the researcher aimed to allow the free discovery of theory.

As the researcher already works in a therapeutic setting, utilising a constructivist GT presented many advantages. It would permit the researcher to stay as close as possible to the data. The analytic methods of this approach, e.g. line-by-line coding and constant comparative analysis, would allow the researcher to bring vision to interpretations of the data at the later stages of the analysis, once categories had been drawn out from the texts (Dallos & Vetere, 2005, p. 55). The constructivist method also places great emphasis on reflexivity and centralises the researcher's role during the formation and analysis phase (Charmaz, 2006, p. 131). This emphasis on reflexivity hopefully helps the researcher to be much more aware of any potential biases and preconceptions and, thus, decrease their influence on the emerging theory. Moreover, the emphasis on reflexivity makes the interaction of the researcher and data more transparent to the reader and the findings can be better understood and appreciated within that context.

As previously mentioned, the researcher felt the methodological approach selected would provide a systemic approach leading to theory development, which is best suited to an under-researched subject area. This approach was evaluated as the best-suited methodological design due to the current lack of understanding surrounding Sikh men in the UK. Several researchers have suggested that because of the emphasis placed on discovery and the need to enter the research process with an open mind, this approach is most suitable for phenomena where a deeper understanding is required (Glaser & Strauss, 1967, p. 223; Holloway & Wheeler, 2002; Denscombe, 2014, p. 109). Therefore, using this approach will enable the researcher to explain the phenomena from the perspective of Sikh men and facilitate an in-depth understanding of the help-seeking style of these men. As far too little is

known about the current subject matter, GT would be valuable as it will aim to draw out the important issues for this group of individuals, and generate meaning about those issues through the analytic process and theory building stages (Glaser, 1965; McCann & Clark, 2003). The methodology would therefore provide a means of answering the research questions posed and fulfil the aims of this study.

### *3.1.3 Other qualitative methods considered*

Initially, IPA was also taken into consideration. Both IPA and GT aim to produce a cognitive map that represents an individual's view of the world (Willig, 2013, p. 98). GT methodology was considered the best suited for the research question because the researcher's aim was to discover the processes (GT) involved during the decision-making of whether to engage in therapy. IPA is considered to be a suitable approach when the researcher is trying to find out how individuals perceive the situations they face, and how they make sense of their personal worlds (Smith & Osborn, 2015, pp. 27-28). The researcher was concerned with more than just the experiences of Sikh men in therapy (IPA).

Working as a Counselling Psychologist trainee has enabled me to understand: "much of what human beings perceive is not a direct reflection of the conditions that give rise to the perception" (Willig, 2013, p. 95). GT methods employ a more comparative, iterative, and interactive method that provides a way to study empirical processes (Charmaz, 2015, p. 54). The study endeavours to explore Sikh men's personal lived experiences to gain new understandings of those subjective experiences. Also, the study aims to generate a new knowledge base on the unchartered area of Sikhism, and GT is known to best suit the exploration of a new

phenomenon (Ke & Wenglensky, 2010). The selection of this method would, therefore, allow the researcher to collect new data from which one can generate a new theory. Moreover, discovering patterns in the human experience within the Sikh culture requires the close, inductive examination of unique cases plus the application of deductive reasoning. GT involves a set of systematic techniques that do this (Bernard & Bernard, 2013, p. 525).

Discourse analysis (DA) was also considered for it is closely aligned with social constructionism but was discarded as DA mainly investigates how individuals use language to construct versions of their world. If DA was to be employed, the research could predominantly focus on the language Sikh men use to construct their experiences. This would shift the research focus away from exploring individual social processes to understanding social interactions.

## 3.2 Procedure

### *3.2.1 Participants*

To follow the GT guidelines in respect to sampling, a total sample of eight British born Sikh men were recruited from counselling services, *Gurdwaras* and community centres across London, Nottingham and Birmingham. The chosen locations were based on official statistics released by The Census Ward Data (ONS, 2011b) in the UK, which indicates the largest proportion of Sikhs live in the West Midlands (31.57%), with the next largest proportion of Sikhs residing in London (29.84%). Five participants were recruited from London, two participants from Birmingham and one participant from Nottingham. Only one out of eight participants identified as a baptised Sikh, whilst the other seven participants

identified as a non-baptised Sikh (see Appendix A). The researcher aimed to stay in line with GT guidelines to achieve saturation of information (Corbin & Strauss, 1990) by ideally recruiting a total of eight participants. Initially four participants were recruited and, following the analysis of data, four additional participants were recruited with more specific inclusion criteria based on the categories and theory generated from the initial interviews. The total participant number is what was anticipated would achieve doctoral capacity and cover the duration of the research (Mason, 2010). The age of the participants had to be broad and range between 18-65 years, but it actually ranged between 18-33 years, with a mean age of 25 years (see Table 1). This would allow exploration from young adulthood to middle adulthood (Erikson, 1994, p. 89) and allow us to gain an insight across generations. For further demographic information, please see Appendix A.

**Table 1**

*Summary of demographic data*

| Pseudonym | Age | Nationality | Participation in religious activity | Help-seeking style | Presentation | Number of sessions |
|---|---|---|---|---|---|---|
| Aman | 24 | British Indian | Everyday | RTP/CRT | OCD | 22 |
| Sukhdeep | 23 | British Indian | Everyday | CT | Bereavement | 0 |
| Eishwar | 28 | British Indian | Monthly | RTP | Depression | 14 |
| Harminder | 31 | British Indian | Weekly | CT | Anxiety | 0 |
| Anveer | 18 | British Indian | Monthly | RTP | Depression/Anxiety | 18 |
| Raj | 25 | British Indian | Weekly | CT | Stress | 0 |
| Akshay | 21 | British Indian | Monthly | CT | Stress | 0 |
| Taran | 33 | British Indian | Monthly | RTP | Anxiety | 6 |

*Note.* RTP = received therapy in past, CRT = currently receiving therapy and CT = considered therapy.

### *3.2.2 Inclusion criteria*

The inclusion criteria for four of these participants, based upon which homogeneity could be achieved, were: A male who was born in a Sikh household and who adheres to the Sikh religion. They must have accessed a counselling service and have received therapy within the last five years. Participant eligibility had no limitations regarding the nature of counselling; clients with a broad range of issues were included. The inclusion criteria for the remaining participants, based upon which homogeneity could be achieved were: A male who was born in a Sikh household and who adheres to the Sikh religion. An individual who has considered approaching psychological services but has never received any form of therapy, with no form of contact with any mental health care service or counselling service.

### *3.2.3 Exclusion criteria*

Participants who were deemed as vulnerable were omitted from participating. This was determined by their performance on the PHQ-9, in which participants who scored above *mild* presentations were to be excluded. Exclusion would include people who call themselves Sikhs but are not practising Sikhism. A follow-up phone call was made to all participants to explain why they had been excluded. These individuals were provided with information about appropriate support services, such as Mind and the Samaritans, the details of which were included in the debrief letter that all participating individuals received. They were thanked for their time and given an opportunity to talk with the external sources of support, if necessary**.** They were also told to contact their GP if they needed any further support or if their participation had raised any concerns.

### *3.2.4 Recruitment*

During the recruitment process, participants had either seen the poster and developed an interest in taking part in the research or were supplied information about the research by the organisations they were attending. Once potential participants were identified, further information was sent out by either email or post. As soon as participants had agreed to take part, interviews were arranged by email or via telephone. All appointments were scheduled to last between 1-1.5 hours.

### *3.2.5 Materials*

The materials consisted of: a recruitment poster (Appendix B) that was displayed in several Asian counselling services and *Gurdwaras* in Southall, London and Birmingham. A recruitment letter and preliminary email was also sent out to these services (Appendix C). A PHQ-9 questionnaire (Appendix D) and demographic form (Appendix E) was used to contextualise the sample. Prior to the interviews, an information sheet (Appendix F) and a consent form (Appendix G) was collaboratively completed with the participants. An interview schedule (Appendix H) was created to guide the interview in the right direction. Following the completion of the interviews, a debrief sheet (Appendix I) detailed the purpose of the study and outlined the sensitivity of the topic area. A distress protocol (Appendix J) was also included to protect participants and to prevent those that are vulnerable from participating. Additional materials utilised in the research included a Dictaphone to record the interviews (owned by the researcher).

### *3.2.6 Data collection*

The interviews took place in secure locations that offered privacy and safety for both the participants and the researcher, e.g. rooms within the premises of London Metropolitan University (LMU) or private clinical rooms. The main method of data collection was via semi-structured interviews; this was to align with the stated objective of allowing rich data to emerge. Intensive interviewing was the technique employed to generate data (Charmaz, 2014, p. 57). This was used so emphasis could be placed on understanding the research participants' perspectives, meanings and experiences, which could best be obtained through detailed responses. Another reason for adopting intensive interviewing concerned the sensitivity of the topic area, and another was that these interviews create and open an interactional space in which the participant can relate his or her experience (Charmaz, 2014, pp. 56-58).

The actual recorded interview lasted between 1-1.5 hours per person and was based on a series of predetermined prompts in the interview schedule. The interview schedule (see Appendix H) was used to guide the interview in the right direction. The development of the initial interview schedule was informed by reading about the research topic and by supervision. There were three phases to the data collection (see Appendix H). The first phase consisted of the pilot study and two interviews. The pilot study was valuable in that it tested the adequacy of the initial interview schedule. The findings of the first phase suggested some preliminary assumptions were present that required further investigation. In light of the developing categories, the interview questions were, therefore, revised and modified in line with constructivist GT (Charmaz, 2014, p. 73). Additional questions that could enhance the discovery of new ideas were added to the schedule. The second phase, based on

the initial findings, saw a further two participants interviewed. Additional amendments were made to the interview schedule as a result of the analysis of the transcripts of these two interviews. In phase three, the final four participants were interviewed to explore the validity of the previous findings and to account for the amendments made to the interview schedule.

### *3.2.7 Ethical considerations*

The study was carried out in accordance with the BPS's Code of Human Research (2014), HCPC's Confidentiality Guidelines (2017) and LMU's Research Code of Practice (2005). A 'Research Ethics Review Form' was submitted and was approved by the Research Ethics Committee at LMU prior to the commencement of the research (Appendix K).

A distress protocol was included to protect participants and to prevent those that are vulnerable from participating. Also, to address risk related to emotional distress before engaging in interviews which may cover sensitive topics. Further, there are many phenomena that within specific cultural and social context are sensitive (Draucker et al., 2009). Once participants were selected, the aims of the research were informed via an information sheet prior to the interview. It also offered a clear statement of all the aspects of the research that are relevant for their decision about whether to agree to participation (BPS, 2014). Therefore, the research did not involve any intentional deception nor the withholding of any information and protects the dignity and autonomy of the participants.

Valid consent was gained through signed consent forms from every participant prior to the interviews. Two copies of the consent form were created, one

retained by the client and one for the researcher's records. The form informed participants of their involvement in the study, thus, protecting their codified human right. The participants were also informed via the consent form about the importance of participant withdrawal, further stating participation is voluntary and that they may withdraw from the research during testing and up until *14 days after the first set of interviews*, without giving any reason. The consent form detailed how the data will be used and how the results of the research will be made available to participants. At this stage, participants were given the opportunity to discuss any potential concerns they may have with any aspects of the study.

Participants were informed about the use of audio recording, and how all recordings were to be used for research purposes only. They were also informed that anonymity will be ensured using pseudonyms for all the participants, and all other information that could lead to identification would either be changed or removed immediately to protect confidentiality. In regards to data storage, all data was to be stored to protect confidentiality. This is to achieve protection of commercially sensitive data, personal data and other confidential information where appropriate. All material was placed at the researcher's home in a locked filling cabinet. In terms of electronic data e.g. audio recording and transcripts, these were stored on the researcher's password protected USB drive. All data will be securely held for a period of 5 years after the completion of the study. It will then be disposed using appropriate methods to achieve data security, in line with the 1998 Data Protection Act (Tarafdar & Fay, 2017).

Towards the end of the interview, all participants were debriefed. The purposes of the study were detailed, and the sensitivity of the topic area was

outlined. As participants had been speaking about subjective experiences, they were informed the interview may have touched on a sensitive topic area. The BPS (2014) defines risk “as the potential physical or psychological harm, discomfort or stress to human participants” (p. 13). Therefore, the debrief detailed information about the aims and objectives of the research in which the participants are involved, including sources of help, advice, support and treatment if they experienced any ill effects of the interviewing process.

### *3.2.8 Pilot study*

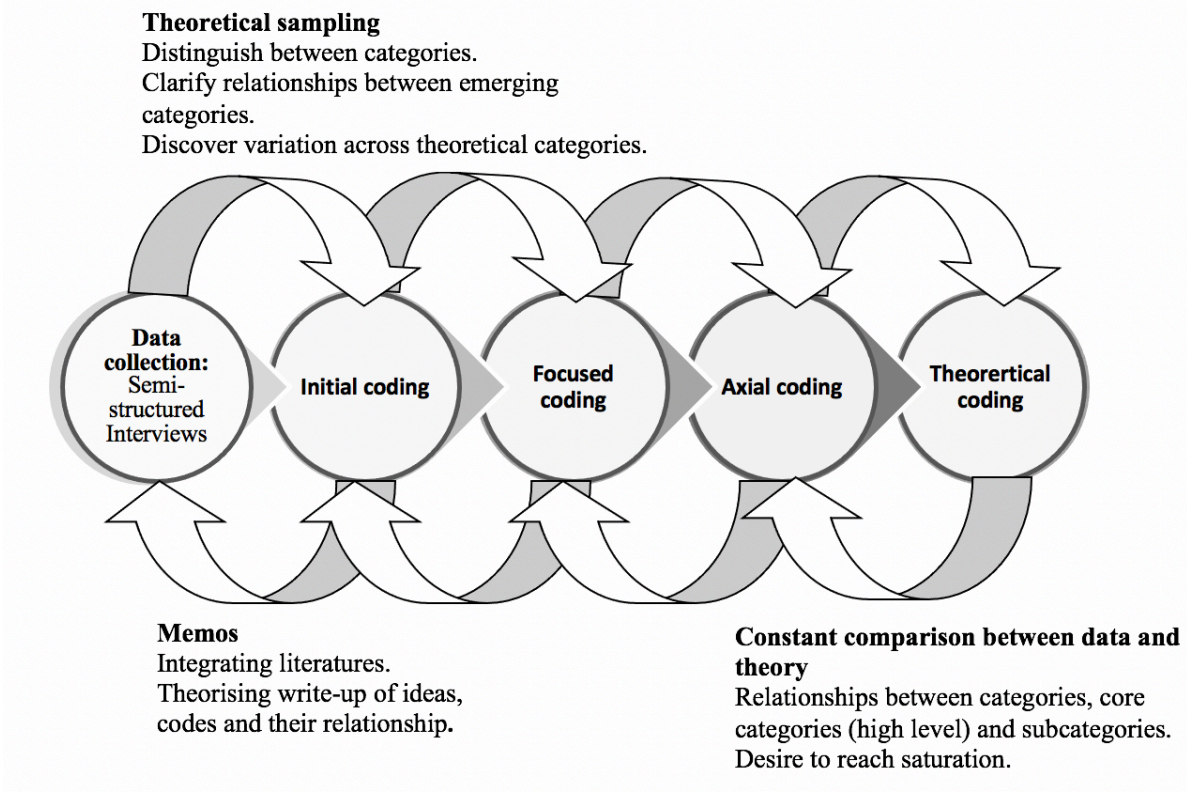
The researcher conducted one pilot interview. Minor amendments were made to the interview schedule. The pilot interviewee was made aware that their interview might not be used.

### 3.3 Analytic strategy

The analytic strategy followed the directions outlined by Charmaz (2014, pp. 109-225). Figure 1 illustrates the analytic strategy for the interpretation and written process.

**Figure 1**

*Data analysis procedure for grounded theory method*




#### *3.3.1 Initial coding*

Initial stages of analysis adopted a process of 'open coding' in attempts to make the data comprehensible (Corbin & Strauss, 1990). This open coding strategy involved an analytic process whereby one categorises phenomena through systematic

examination of the data (Corbin & Strauss, 1990). During this constant comparative method of analysis (Corbin & Strauss, 1990), the data was compared for similarities and differences, and questions were asked about the phenomena reflected in the data. Thus, keeping the researcher engaged in directly studying the data and allowing the theory to be built inductively.

### *3.3.2 Focused coding*

Engaging in 'focused coding' was the second major phase in the analyses (Charmaz, 2014, p. 138). This allowed the researcher to identify the most frequent and significant codes. These codes were used to sift, sort, synthesize and analyse large amounts of data (Charmaz, 2014, p. 138). This type of coding stage not only expedite the analytic work, but also condensed and sharpened previous work by highlighting what is important in the emerging analysis.

### *3.3.3 Axial coding*

Once focused coding was completed, a process of 'axial coding' was engaged with. This involved the evaluation of each open code in detail, exploring, expanding and examining the relationship between the identified codes (Corbin & Strauss, 1990). During this stage, the development of 'core-codes' took place, where one can see a refinement of the relationship between categories and subcategories of the open codes. Thus, we can relate categories to subcategories; specifying the properties and dimensions of a category. This reassembles the data that was fractured during the initial coding to give coherence to the emerging analysis (Charmaz, 2014, p. 147).

### *3.3.4 Theoretical coding*

On successful completion of axial coding, the method of 'theoretical coding' was implemented (Corbin & Strauss, 1990). This process was carried out in integration of codes and categories. Accomplished through extension of the process of constant comparison (Corbin & Strauss, 1990) between codes, categories and interview protocol (Holmberg & Wahlberg, 2000). Throughout analysis and interpretation, the researcher was aware of being reflective. The researcher aimed to be aware of any preconceptions as she engaged in the iterative process of coding, memo-writing, and collecting data as this enriches the analysis (Charmaz, 2014, p. 150).

### *3.3.5 Memo-writing*

The researcher wrote several memos recording reflections on observations, interactions and data content (Appendix L). The memos helped in making comparisons between data, which allowed the researcher to identify relationships between categories: identification of major and minor categories. These memos were revisited, reviewed and elaborated with a critical eye to record the path of theory construction (Charmaz, 2014, p. 162). As memo-writing created an interactive space for the researcher to converse with herself about the data, ideas and hunches, it allowed the researcher to engage in critical reflexivity (Charmaz, 2014, p. 163).

### *3.3.6 Generating the model*

At the end of data collection and the analysis (see Appendix M), the factors that contribute to the decision-making process of a Sikh man, when considering engaging in therapy were developed.

## 3.4 METHODOLOGICAL & PERSONAL REFLEXIVITY

When proceeding through the stages of coding, various social processes were highlighted, reflecting a social constructionist stance where people are inherently social, constantly considering how they relate and compare to others. As such, there seemed to be multiple realities in the process of help-seeking, for instance, the reality one aspires to, the reality experienced privately and the various realities presented to others. This upholds the selection of grounded theory, due to its' ontological stance that there is no objective reality (Ponterotto, 2005). The challenge of this approach, as with any qualitative approach, is that the interpretation is inevitably influenced by the views of the researcher, no matter how rigorously they attempt to bracket. This is the epistemological nature of the relationship between researcher and those being researched (Ponterotto, 2005). While being mindful of this active role I would have in shaping the research, I posed the need for methodological reflexivity. Reflexivity helped me gain awareness of my own assumptions and biases during the interpretation of data. A methodological journal was kept to consciously acknowledge any personal assumptions and thus, to remain transparent throughout the research process (see Appendix N). This is also in line with Counselling Psychology's values of being reflective and aware of one's own processes (BPS, 2014).

Carrying out this research has encouraged me to reflect on my own experiences with Sikh males, and to see how this might have impacted any process of my research. Growing up I have always been surrounded by *strong* and *independent* men in my family. Men who have always been appreciated by women

and children as the *protectors*. Seeing a Sikh male vulnerable and seeking external help has never really been the case for me. I grew up in an environment where MI was rarely discussed. From young childhood through to young adulthood I was surrounded by Sikh men who always appeared *mentally strong*. When I was placing posters it came to awareness that I had never had the opportunity to form a therapeutic alliance with any Sikh client. I am from West London and I work in various geographical locations that could be classified as diverse. This enabled me to reflect on the discovery of my own thoughts that Sikhs potentially may be under-utilising psychological services. I was aware this identification might influence my research and so, I reviewed my interview schedule. This was to ensure my questions were aiming to explore participants experiences of therapy and not trying to understand my own experiences. Additionally, I have used supervision and personal therapy to reflect on my assumptions and beliefs about the world, people, therapy, religion, masculinity, and to explore the impact of my preconceptions on the study. Throughout my analysis I ensured I submitted a random selection of my interpretations of the data to my peer researchers (of different genders, and religious and cultural backgrounds), and I regularly discussed my analysis with my supervisor, who is of a different cultural background, so that I could explore and monitor my interpretations.

During the interviews I felt conscious and anxious about how participants may respond to me. All the participants were of a similar age and we shared the same religion. I had concerns of how participants may perceive me as the interviewer. This concern surrounded the thought of whether these male participants would open up to me, regard me as one of their own or feel embarrassed to share

their thoughts with me due to me being a female. Also, some of my anxiety surrounded the validity of their answers and whether their view of me could potentially influence their responses about their experiences. I was mindful of all of these assumptions I had and my reflective journal allowed me to differentiate between what was my own and what was relevant to the research itself.

Nonetheless, the ethics of insider research allowed me to understand the benefit of conducting research with a population that I am also a member (Kanuha, 2000) would be that as the researcher, I would share an identity, language, and an experiential base with my participants (Asselin, 2003). Through acceptance ones membership automatically provides a level of trust and openness in participants that may not have been present otherwise (Dwyer & Buckle, 2009). I felt I now had a starting point because it has been suggested 'this commonality' provides access to groups that might otherwise be closed to 'outsiders'. I reflected, participants may be more willing to shed light on their experiences due to "an assumption of understanding and an assumption of shared distinctiveness" (Dwyer & Buckle, 2009, p. 58). I was mindful that I may have to look out for thoughts and behaviours that may suggest they feel, 'you are one of us and it is us versus them'. Also, I was aware this 'shared status' has the potential to impede the research process, however, my training as a counsellor has always highlighted the necessity of remaining reflexive and so, I used this to my advantage.

Through reflection, perhaps my experiences of my family and society have influenced my view of a Sikh male as someone who represents themselves as a fighter. Using a GT approach meant that memo-writing was an integral part of data collection and analysis. Consequently, I addressed any assumptions by ensuring I

was writing memos prior to and after each interview (See Appendix L). This aided my ability to adopt a non-judgemental attitude (Rogers, 1992), as I was constantly reflecting on my thoughts and impressions about the interviews. The process enabled me to maintain self-awareness by facilitating a reflective stance on the nature of the study and consideration of the general and specific effects of my actions and characteristics on the research process. Further allowing me to continuously reflect on any possible emerging concepts. Nonetheless, one cannot simply block out one's own cultural understanding and experiences completely. This was an important constituent of the dynamics of the process and I was mindful of it, particularly during the interviews and then during the analysis of my data.

# CHAPTER FOUR

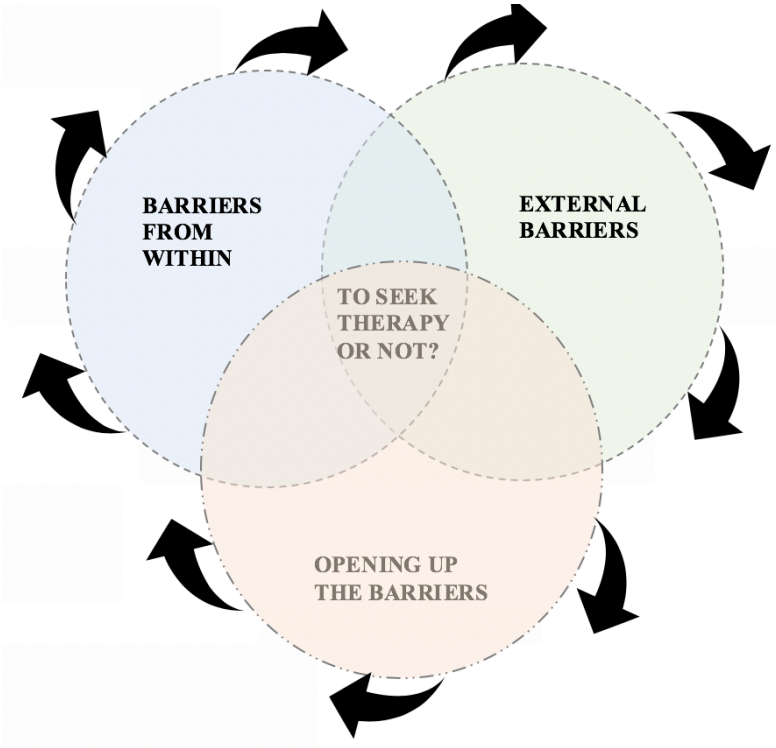
## ANALYSIS

This chapter evaluates the findings of the GT analysis. The conceptual model elicited from the analysis is introduced in section 4.1, where it is depicted graphically to illustrate the processes involved in Sikh men engaging (or not) in therapy. The model provides a summary of the main categories and sub-categories comprising the model. Each of these components will be discussed in narrative form using illustrative verbatim quotations to explain the grounded nature of the analysis. For clarity, a table of the major categories and sub-categories is included (see Table 2, pp. 104-106).

### 4.1 The research model

**Figure 2**

*The research model: A grounded theory model of how Sikh men perceive the processes of seeking therapeutic help.*



The development of the model was a gradual process and was continuously shaped by coding and analysis of the interviews. The high-level components of the model are deceptively simple in describing the highly complex processes a Sikh man identifies with when deciding whether to seek therapeutic help. These processes gave insight into the barriers the men anticipate they will have to face if they were to seek help. These barriers were described as either *barriers from within* (theoretical construct 1) or *external barriers* (theoretical construct 2). The data suggested that even if an individual does not surpass the barriers, he will proceed and find himself in a position where he experiences a sense of urgency towards *opening up the barriers* (theoretical construct 3). The three constructs are designed in the diagram as interconnecting and this was because each participant reflected on experiencing all three at some stage of the process, some constructs being experienced stronger than others. The arrows around the diagram represent all three constructs as constantly circulating. Construct 3 was important for those that had not accessed therapy as they emphasised the need to make the process easier for individuals to even consider therapy as an option. Meanwhile, those that had accessed therapy understood the importance of encouraging other Sikh men to take that step and, thus, recommended improving specific areas that could allow this client group to better utilise culturally appropriate services.

### *4.1.1 The inter-relationship of the identified theoretical constructs*

The analysis displayed a pattern of developing constructs that could be classified as either internal or external barriers. The desire to open up the barriers was a general theme for all the participants.

### *4.1.2 The model in detail*

The analysis highlighted three higher-level theoretical constructs, as summarised in Table 2. The three theoretical constructs were identified as the key processes involved when deciding whether one should seek therapy.

**Table 2**

*4.1.3 Summary of theoretical codes*

| **Theoretical construct 1: Barriers from within**<br>Barriers to therapy within the self, a part of the process of seeking or not seeking mental health support. | | |
|---|---|---|
| | Focused Codes | Initial Codes |
| | The ideal self | 1. Viewed internally/externally as failing to manage on one's own<br>2. The Sikh warrior spirit<br>3. The expectation of a young Sikh male taking an active role and eventually becoming the breadwinner |
| | Importance of self-image | 1. Wary of what others may think (finding out/information leaking)<br>2. The focus on pride in society – a hush-hush topic |

| | | |
|---|---|---|
| **Theoretical construct 2: External barriers**<br><br>Barriers to therapy as perceived from within the family and the wider culture (including community and religion) as part of seeking or not seeking mental health support. | | |
| | Keeping it within the circle – to access existing means of support | 1. Parents and family come first<br>2. Keeping it within an inner circle and aiming to resolve it within the close circle<br>3. Therapy as a last resort – entering therapy only if the problem is severe enough |
| | Therapy: an unfamiliar route for the "set minded" older generation | 1. Difference in knowledge in East/West impacting help-seeking styles across generations<br>2. Raised with no awareness or knowledge of mental health |
| | Therapy - a foreign concept within the Sikh community | 1. Therapy is not the normal route<br>2. The tendency is to focus on the medical model/lack of psychological understanding<br>3. External environment developing with more exposure to mental illness |

| **Theoretical construct 3: Opening up the barriers**<br>Having sought mental health support or being open to it and what could help the process of seeking mental health support. | | |
|---|---|---|
| | Gains from therapy | 1. Engagement with therapy changes views of mental health and help-seeking styles, in relation to the self<br>2. First step perceived as the biggest hurdle<br>3. Sharing one's own positive experience of therapy may encourage others to take a step forward |
| | What can improve help-seeking behaviour within the Sikh community | 1. The positive role/use of religion in mental health<br>2. The need to encourage therapy as a norm within Sikh culture/society<br>3. Limited awareness of mental health in educational settings<br>4. Healthcare professionals to get more actively involved |

### *4.1.4 Summary*

The model is able to provide insight into Sikh men's perceptions of therapy and what factors contribute in deciding whether to engage in therapy. Exploring these experiences has brought to light the factors that have helped the process and aspects that could be improved. Each theme identified will now be described and supported by verbatim quotes from the interviews.

### 4.2 Theoretical construct 1: Barriers from within

The first theoretical construct highlights the internal barriers individuals may face when making the decision of whether to access therapy. The significance of this construct is that it expresses the importance of self-reflection that takes place during the decision-making process. It demonstrates the difficulties one may experience within the self, due to cultural attitudes held in Sikhism, and the influence of social and historical periods that have shaped Sikh male identity, potentially leading to self-stigma and, thus, preventing one from accessing therapeutic help. The focused codes identified within this theoretical construct are described in Table 2 (all other theoretical constructs and focused codes will be presented in the same manner).

| **Theoretical construct 1: Barriers from within**<br>Barriers to therapy within the self, a part of the process of seeking or not seeking mental health support. | | |
|---|---|---|
| | Focused Codes | Initial Codes |
| | The ideal self | 1. Viewed internally/externally as failing to manage on one's own<br>2. The Sikh warrior spirit<br>3. The expectation of a young Sikh male taking an active role and eventually becoming the breadwinner |
| | Importance of self-image | 1. Wary of what others may think (finding out/information leaking)<br>2. The focus on pride in society – a hush-hush topic |

#### *4.2.1 The ideal self*

It is important to note, Sikhs throughout history have always been the sword arm of India (Fernandes, 2007, p. 22). Sikhism has had a turbulent history, in which followers have needed to fight for their faith and traditions. The main concept of being a warrior in *Gurbani*, from *daas's* limited knowledge, helps one understand that by taking on the warrior aspects in life (never giving up the fight, pushing

forward and keeping faith in one's mission) and by adopting these principles, it allows one to subdue the evils of the *panj chor* and other distractions which obstruct one's meeting with the truth:

> O Nanak, he is a brave warrior, who conquers and subdues his vicious inner ego.
> (GGS, Ang 86)

> One who eradicates his own evil is a brave warrior.
> (GGS, Ang 258)

However, this is a complex phenomenon which is open to individuals to develop their own interpretation. For some Sikhs, fighting injustices against those who are defenceless and powerless is regarded as *hukam*:

> One who dies fighting in the hour of peril and recites the word in the ambrosial hour is known as the true warrior.
> (GGS, Ang 353)

> The warrior who fights on the battlefield should keep up and press on.
> (GGS, Ang 340)

The influence of Sikh history in identity formation has already been demonstrated in other research (Oberoi, 1994, pp. 25-49; Fenech, 1997; Dhillon,

2004; Dhavan, 2011, pp. 124-149; Gill, 2014; Puller, 2014; Kohli, 2016; Ruprai, 2016), the current theoretical concept is able to take us one step further. It raises the question*: If individuals continue to make reference to the metaphor of 'being a fighter' and needing to resist the oppression the Sikhs faced several hundred years ago, how may this shift their help-seeking style?*

Gill (2005) investigates the Sikh martial history discourse which, he says, as "an aspect of a wider collective space of 'being Sikh' also provokes certain connotations of ideal masculinity that are re-conceptualised within an acceptable framework of normality in contemporary times" (pp. 272-273). With regard to the current findings, the warrior spirit was presented in mapping out strength and its influence on the participants' sense of manhood, and presenting itself as one version of hegemonic masculinities in British Sikh men. The participants recognised themselves as descendants of a martial race and this carries with it pride and honour. Literature has demonstrated the *Khalsa* are viewed as the 'pure ones' (Singh, 2005, p. xi) and the group of Solider-Saints. It is important to note both, initiated Sikh men and Sikh women conform to this warrior saint model. Singh (2005, p. 46) highlights "Guru Gobind Singh does not exclude women from a full and active participation in the birth of the Khalsa". In regards to this research, in contemporary times young Sikh men negotiate what an ideal and authentic Sikh masculine identity is that is closely aligned with the *Khalsa* discourse (Gill, 2014). The *Khalsa* discourse, also referred to as a *Khalsa episteme* has been extensively explored when seeking to understand Sikh identity (see Oberoi, 1994, p. 59; Mandair, 2009). It seems participants negotiated this discourse, which informs the performance of masculinity, and some adapted their help-seeking in accordance with the collectively understood

idea of what is viewed as normal, appropriate and acceptable (Hall, 1992). Therefore, the warrior notion is culturally negotiated and continues to be a prominent feature of Sikh masculinity. This theme gives insight to the idealised version of the self, which appears to be constructed through the participants' subjective interpretation of what society values, history portrays and the family expects. Importantly, not all the participants related to the martial masculine identity, suggesting "there is complexity involved in relation to how young men negotiate this identification or non-identification within Sikh and Khalsa identities" (Gill, 2014, p. 3). Nonetheless, there was a collective idea of the martial Sikh warrior continuing to constitute Sikh masculine identity which conflicted with help-seeking. By acknowledging the plurality of the social constructionist perspective of masculinities, Sikh men felt the need to demonstrate behaviours as prescribed by different constructions of masculinity and were able to establish which masculinities were deemed as ideal.

This form of masculinity shares some similarities with the dominant male model and traditional masculinity ideology. At times, the participants were conscious of not being able to live up to the cultural masculine ideal, and they employed a variety of strategies in negotiating their manhood or counteracting the demands thrust upon them. Amongst the strategies used, some indulged in care in the family home, while others withdrew themselves from help-seeking completely. Seeking external support appeared to challenge hegemonic masculinity and one's view of the self. If one was not able to get through any hardships on his own, he felt a sense of failure. Previous research has suggested even if people do not ascribe to this dominant form of masculinity, they appear to measure themselves and others

against it (Pattman et al., 2005; O'Brien et al., 2005; Timlin-Scalera et al., 2003). Thus, an underlying fear was present that others would judge them and view them as not being strong enough if they reached out. The need to fit in and present themselves in a similar manner informed their sense of self and dictated their help-seeking behaviour.

Finally, the participants had a vision of how an ideal Sikh male should present himself, which is largely defined by a man's ability to adhere to the moral code of responsibility and to earn and provide. When engaging with this form of masculinity, some felt compelled to strive towards this ideal and, thus, felt they were limited to displaying a sense of hyper-masculinity (a display of strength and endurance). This masculine ideal appeared to be underpinned by reputation and honour. As Connell and Messerschmidt (2005) observed, hegemonic masculinity captures "a pattern of practice . . . [that embodies] the currently most honoured way of being a man" (p. 832). The behaviour displayed by their fathers informed this image and their perception of self was explained and understood through this interaction. The findings give a strong impression that responsibilities are usually contained in the script of what defines masculinity. Participants stressed they would not engage in an act that could conflict with these masculine ideals as this may jeopardise how their fathers viewed them and, potentially, question their ability to embrace this role in the future. Some reflected on their own ability in the fulfilment of responsibilities in the context of discussing their family life. It is already known that men suffer from mental ill health due to the pressure of family (Jhutti-Johal, 2018) and here, the interviews suggested men felt pressured into acting according to the duty associated with their roles at home.

*4.2.1.1 Viewed internally/externally as failing to manage on one's own*

This concept illustrates the common view held amongst all participants that one only seeks help when one fails to manage on one's own. The participants focused on being self-reliant and were hesitant to seek support as it required an admission of needing help. When applying the gender role conflict model (O'Neil et al., 1986), it seems access to therapy contradicts traditional masculine norms (e.g., stoicism, strength & self-reliance). It appears unwillingness to seek help is due to the belief that it goes against the traditional male gender role stereotypes, whereby men do not talk about emotional issues.

> Anveer: Like, just males in general, their egos get in the way.. especially in our culture..being a man is being strong (…) (L187-188)
> (…) it would break that image..you cannot be weak in front of another male..that's all I can really say. (L189-190)

Those who had accessed therapy were originally aiming to resolve their issues unaided; however, situations were getting out of control and, thus, they decided to seek help. The inability to manage on one's own was either identified via self-recognition or externally by close friends and/or family. Some of the participants that had engaged with therapy only accessed external support because they identified they had reached a breaking point.

> Eishwar: So I think it's just all the things got on top of me and then it got to the point where I couldn't cope anymore and..I couldn't function (…) (L266-269)

> So it got to a point where I was like I can't keep doing this to myself, I need to get help. (L274-275)

> Aman: (…) it was five and a half years ago and er, it's just kind of somewhat takin'..not takin' over completely but it was just creeping in far too much into my day-to-day life. (L98-99)

For those that had not accessed therapy, they were continuing to manage their problems alone. Across all the participants, there seemed to be this belief that one must be able to manage, reinforced with a "get up and get on with it" male attitude.

> Aman: I know that I kinda just get up and get on with attitude..you know brush it off. (L237)
> Err you know it'll be alright..you know carry on, don't worry. (L239)

> Raj: (…) it may not be seen as something that's the right thing to do or the..the strong thing to do. Erm like even just talking about it amongst people..people will just say 'oh it's fine, just get on with it' (…) (L262-267)

It appears for the participants who have not accessed therapy, there is the perception that if one accesses external support, one has internally failed; therefore, they see themselves as weak. As a result, there is a tendency to remain reserved with regard to any problems one may face, and behave as if they do not exist. These men seem to get on with everyday life by engaging in self-talk and reassuring themselves.

Aman: I don't want to be perceived as weak and I don't want myself to start believing that. (L130-133)
(…) and by seeking help I'm somewhat er giving in and it's a, it's a sign of weakness. (L257-258)

Raj: (…) because you have to go to someone else cos you can't fix your own problems..erm and it sort of may be feeling a little bit of weakness but not feeling as strong as I was (…) (L194-198)

Akshay: (…) the misconception will come is that I can't handle myself, basically. (L160)

There appears to be a view that emotional vulnerability among men is seen as a sign of weakness and failure. Participants acknowledged that, at times, they experienced some difficulties and for some, the pressure to manage on their own resulted in a delayed help-seeking response. While mental ill health has already been linked to a sign of weakness in the Sikh community (Jhutti-Johal, 2018; Takhar, 2018), by adopting this mindset with oneself, Sikh men may act as their own barrier towards help-seeking behaviour.

#### *4.2.1.2 The Sikh warrior spirit*

The mindset of one needing to cope seems greatly influenced by the thought of being judged and results from the view participants had of the culture encouraging them to be strong. The desire to present with strength was viewed as the norm and

the dominant perception of Sikhs as martial and brave is reflected in the culture at large (Kohli, 2016). While the *Khalsa* discourse continues to present the ideal and authentic Sikh male (see discussions by Oberoi 1994, p. 62; Gill, 2014; Kohli, 2016), Sikh martial masculinity is interpreted as a form of strength in contemporary times, which projects ideals that seem to directly influence the young generation of British Sikh men's help-seeking behaviour. The participants appeared to reference key aspects of the Sikh warrior when reflecting on their identity. As previously mentioned, this aspect of Sikh history continues to shape the diasporic Sikh male psyche and the sense of self (Gill, 2005) and here, the narratives are further able to explore how it plays a role in Sikh men's approach to mental distress. The phrases participants used to describe their understanding of warriors suggested they embodied the idea of needing to be a fighter in response to their emotional distress. According to the participants, Sikh men continue to value the traditional male gender ideals of strength and control. The warrior notion, which seems to be rooted in their identity, sets out characteristics and traits for the male gender and constructs a version of masculinity that is aimed to be displayed during times of adversity.

Akshay and Eishwar, in particular, emphasised the gender-related assumptions that are bound within a cultural context and derive from the historical underpinnings of the religion.

> Akshay: (…) if you talk about Sikhs in general, you think of obviously a warrior race, they should be tough, they should be hard. Obviously going to

> therapy doesn't really, doesn't really sit with that, it's a bit, it's a bit of the opposite. (L212-218)
>
> Mention the word Sikh they think about soldiers (…) (L221-223)

> Eishwar: (…) try and mask the pain or mask any sort of emotions (…) (L178)
>
> It's just like a foreign thing for us really. I think in our culture it's just foreign and Sikhs have always been fierce (…) (L458)

A sense of resilience and strength appeared to be passed down through generations. The participants described their fathers' behaviour forming their masculinity ideology and the gender role expectation.

> Eishwar: (...) and it's hard to see my dad go through that after seeing him be such a strong man (…) (L159-160)
>
> Anveer: I feel like he's strong and thinks that I should be strong and not be weak and not look weak. (L311-313)

Some participants kept their engagement with therapy private, as seeking help is not the usual route for a Sikh man. The participants discussed a general cultural view, to always be strong and to be able to manage any problems that they might face. This inner strength was viewed as inspiration to face any difficulties. Yet, at the same time, some felt obliged to follow in these footsteps.

> Sukhdeep: (…) it makes me just, I feel like I have to battle my battles myself and I have to just, you know, fight through it and be strong. (L306-307)

> Anveer: (…) in our culture you cannot slip, in history our people got through their issues and we have to follow, you know (...) (L305-306)

> Aman: (…) and may not and they may just see it like everyone goes through hardships in life, deal with it and to a certain extent. I do see that as a trait which you should have. (L458-462)

Sukhdeep in particular, spoke about feeling as though this expectation was the norm. Being emotionally strong was a quality he felt he always had to uphold and a vital component of his Sikh male identity.

> Sukhdeep: It's just something they believe that is in-built in you, not even expected. It's like you can't be weak, you're a man, you have to be strong, you don't need therapy. (L315-316)

He expressed how the impact of this expectation was that it vocalised that Sikh men did not need external help, they had the traits and skills "in-built" that would allow them to manage any difficulties thrown at them.

Similarly, Aman describes seeking help as being perceived as not masculine enough.

> Aman: I wouldn't of maybe would of, felt too macho about it I suppose. (L221-222)

Although Aman was able to access therapy because he had encouragement from his aunt, he felt he was too macho to seek help on his own. He describes a general taboo of therapy within the Sikh community and how this links with the reinforcement of *sher bhanja*. Aman expressed how this specific notion made him reluctant about seeking mental health treatment. Therefore, such dominant beliefs may inform the social construction of masculinity and prevent Sikh men from seeking any help they may need.

> Aman: I feel it is umm a taboo definitely it is kind of as I said our culture is very much you know, much you know, sher bhanja (laughs). Kind of you know man up kind of a thing. (L452-454)

Reflecting on the processes, being aware of the historical underpinnings created a sense of internal pressure for these men to sustain the expectations attached to the gender role. The traditional cultural gender ideals held some importance for them. Further, accessing therapy would disrupt the desired image and challenge the idealised form of masculinity. As such, anything that damaged the image of *sher* that is, to be like a lion, would be interpreted as taboo.

#### *4.2.1.3 The expectation of a young Sikh male taking an active role and eventually becoming the breadwinner*

The 2018 BSR survey highlighted family responsibilities as one of the main causes of stress for Sikhs (Jhutti-Johal, 2018). This suggests family responsibilities weigh heavily on their shoulders. In the process of the construction of masculinity, Sikh boys are expected to learn skills that make them capable of earning a living (Garha, 2020); from their childhood, they are expected to learn their role in the family and society and construct their masculinity as providers and protectors. A similar theme was present here and it appears the role a Sikh man adopts in his household may influence their response to emotional distress. Becoming a man can be thought of as trying to achieve a certain dominant status of manhood (Gilmore 1990, p. 4). For many young Punjabi men, it operates as a powerful motivator that is factored into their families' decisions. For Sikh men, family life comes above their own self-care. The participants described the need to be strong in order to embrace their father's role in the near future. Generally, the participants considered looking after the family to be one of the most important attributes of masculinity (Ng et al., 2008). They assumed their fathers and families expected this from them. To meet this expectation, they experienced indirect pressure to step up and present themselves in a contained manner.

> Anveer: Just after my dad gets old I feel like I am the next person that will be looking after the house, looking after the family and it feels like I should be really strong to do that. (L317-318)

> I am the one that will have to take care of him and I am going to be the man of the house (…) (L327)

> Raj: Any problems and arguments or any things which haven't been cleared, it's always been me to sort of deal with that. (L171-172)
> I've never wanted to show myself as one who didn't know or didn't have the answers so to sort of become that person then would not so much be a shock but it would be quite different to what the norm is and what I've been. (L175-179)

Anveer, in particular, stressed the importance of duty of care towards the family. There appears to be several expectations of a Sikh male in terms of contributing to the household financially, providing protection and maintaining a strong family unit. Anveer stated the role of the male in the household was changing as not all Sikh families expected this from their children. He related this to how gender role ideals were shifting with modern times and, also, some parents were more understanding as they had experienced it themselves.

> Anveer: (…) and no because um some modern Sikh families don't expect that from their kids with how modern times are getting..they believe that oh, like some parents have been through this themselves. So people understand and perhaps have experienced therapy. (L331-335)

Lines of hierarchy and authority are clearly drawn as this helps maintain family harmony. Raj specifically spoke about his role as the eldest son, expected to take an active role in family life after his father, regardless of what anyone may want.

> Raj: (…) support the family, pay the bills over the last few years. I have been paying most of the bills and any kind of issues that have required someone to stand up, it's always been me. (L163-169)
> Although, I've never wanted to (…) (L74-75)

Some participants were unable to be emotionally expressive around their fathers to maintain this masculine role. There was a strong emphasis on feeling embarrassed if one was to share emotional content with them.

> Taran: I thought it's a bit weird, like first I didn't really want to be going to therapy and then, like secondly, I didn't really want to tell him that somethings going on like with my emotions because erm, I don't really like sharing that information with him. I am his son. (L304-308)

> Harminder: I just I don't know to be honest with you. I don't know, it's just because he's my dad and I don't wanna embarrass him. Perhaps you can see it like that, I'm not really sure but I just don't like discussing things with my dad. I'm a man so. (L113-115)

For Harminder, discussing emotional content appeared to conflict with his masculinity; he felt this would embarrass his father. It appears the family unit sits at the core and serves as a priority in the processes involved when deciding whether to access help. For both groups, the men experienced severe pressure to always present themselves in a managed and contained manner, to be able to provide for, protect and manage family life. Those that had accessed help reflected on the unconscious anxieties that a young Sikh male experiences concerning his cultural duty to embrace the father's role in the future. For those that did not access help, they could not cross these boundaries and continued to uphold a manly-like persona in front of their fathers.

### *4.2.2 Importance of self-image*

There emerged from the data a number of social pressures experienced by the men due to the existence of the public stigma of help-seeking behaviour. Some cultures believe admitting to having a mental health problem is a form of loss of face and is shameful (Aloud & Rathur, 2009; Cauce et al., 2002; Sarfraz & Castle, 2002; Vogel et al., 2007) and this component illustrates the participants' understanding of how they must present themselves, and highlights the difficulties men may experience when trying to save face, and the need to be accepted by a collectivist society. Individuals were conscious of the negative views held in the community of MI. The participants were aware of others who had accessed therapy and the labels that were assigned to them. This can be explained by the social constructionist notion that people shape their identities according to societal discourses. The possibility of information leaking into the community led to some feeling afraid to seek help. Seeking therapy was deemed difficult as it appeared to challenge one's

image. It seems the participants wanted to maintain their respect and prove their manliness in family and society at large due to the high expectations that exist.

While the phrase *izzat* was not used when describing fear of exposure (Gilbert et al., 2004; Gilbert et al., 2007; Jhutti-Johal, 2018), there was, indeed, a strong focus on pride and honour, and this was a key basis in the structuring of hyper-masculinity (Gilmore, 1990, p. 75). In order to maintain the pride of the family and to maintain a positive sense of collective and public self (Dhillon, 2004), help-seeking was navigated in accordance with what was deemed acceptable and could be adopted in the family home. Family affects how British Sikh men behave (Gill, 2005) and they were mindful of the judgement they may face and, for some, confidentiality appeared to encourage them to take that step to reach out for support. While traditional masculine norms can govern the way Sikh men seek help, confidentiality created reassurance and served as a protective factor for some, allowing them to trust the process.

#### *4.2.2.1 Wary of what others may think (others finding out/information leaking)*

For the participants, there was a strong influence of external views on their own perceptions. They were conscious of others finding out and this was mainly associated with the negative labels attached to therapy. The public stigma attached to having an MI was key in inhibiting the decision to seek therapy. There was also a public stigma associated with seeking professional services, separate from the public stigma associated with having an MI.

Both Harminder and Sukhdeep stated that those accessing therapy were often labelled as *crazy* in the community.

> Harminder: (…) but people might just like call someone mental..or something so..I don't think someone may want to seek therapy at all. (L274-278)

> Sukhdeep: (…) they may think these people are nuts or crazy, or whatever, but yeah. (L37)
> (…) mentally disturbed or so..or you know, something's really wrong with you (…) (L68)

Harminder and Sukhdeep seem to imply that the awareness of such a label would prevent people from seeking help because they do not want to be associated with it.

For Taran, this label resulted in him feeling hesitant to seek support. After some time, he managed to seek therapy as a last resort. This is a theme which will be discussed in detail later on in the analysis. This hesitant behaviour seems to be related to his view of therapy as not being socially acceptable in his culture.

> Taran: Erm so it just seems like you go to therapy so there must be something pretty wrong with you, mentally. (L95-98)

Taran brings to the attention the association of therapy with MI in the culture. One may be afraid to access help in case one obtains the label of *mental*.

Eishwar and Harminder expressed how the negative connotations attached to therapy made the thought of accessing help feel daunting. Eishwar interpreted others as afraid to seek help due to the existence of such undesirable views being held.

> Eishwar: I think it is a good thing to have ..um having therapy there, but I think a lot of people are scared to seek for help. (L10-11)

> Harminder: Er probably a bit of a negative view on therapy overall then because I don't know, I just feel like perhaps just the whole therapy sector as a whole maybe (…) (L164-165)

As with Eishwar, worrying about others finding out was a consistent view held by all the participants. That is, the underlying thought was present that if they were to access therapy, others would find out and this would result in people gossiping. The fear of information leaking out and people talking appeared to be a strong barrier against help-seeking behaviour.

> Akshay: (…) and a lot of people talk about this that and the other so it's something that's rarely spoken of 'cos obviously, as soon as one little thing gets mentioned within one family and the other families find out (…) (L296-301)

> (…) obviously people be a lot more ashamed because they know in our culture a lot of people talk and it's what people love to do, they like to bitch, they like to talk about other families (...) (L349-356)

Akshay discusses feelings of shame and, in order to avoid this shame, one must engage in such an action that sits well with the people in society. Moreover, for those that did access therapy, confidentiality appeared to create some peace of mind in responding to these worries and motivated them to access help.

> Eishwar: It's just that, if they don't know you, you have that peace of mind that it's not gonna..basically, leak within the family or your friends circle (…) (L369-373)

Eishwar had engaged with therapy and confidentiality was the main factor that encouraged him. This was because some of his family members were unaware of his engagement with therapy and the need to keep personal matters private was important for him. The need to keep engagement with therapy secret was due to the lack of understanding his family had of the concept. Anveer suggested there was a need to inform others within the community about the role of confidentiality within therapy.

> Anveer: (…) tell them the bit where it's confidential 'cos I think that's what their most scared of…that it'll be blurted out…people will find out...and if they wanna go in the process, they can (…) (L667-675)

For Harminder, participation in the research was motivated by anonymity. This suggests how even speaking about help-seeking within mental health evokes some feelings of shame.

> Harminder: Yeah definitely, that's one of the main reasons why I ensure that even this interview is anonymous because I do get embarrassed by the whole concept of it. (L37-40)

Harminder stated he felt a sense of embarrassment even just speaking about the topic, suggesting how uncomfortable the concept is perceived and how conscious Sikh men are of judgement.

Views held by others greatly influenced the decision of whether to pursue therapy or not. The views held in the family, circle of friends, Sikh society and the wider Indian community all formed a part of a process that they felt they had to evaluate prior to making any decision. Those that looked beyond the generally negative views of therapy were able to take that step forward and confidentiality encouraged this behaviour. It is also important to notice whether if one accessed help or not, there was strong anxiety present regarding others finding out. It seems as though these men have experiences of information circulating in their close units.

#### *4.2.2.2 The focus on pride in society – a hush-hush topic*

There is now good evidence that in collective cultures emotions are more linked to how behaviours reflect on others, whereas in individualistic cultures

emotions such as pride and shame relate to reflections on the self (Mesquita, 2001). The fear of bringing shame to the family, which can be called *reflected shame* (Gilbert et al., 2007), has created socially defined rules and prescriptions for maintaining reputation. Culturally transmitted systems of pride were present and pride appeared to pose an interesting challenge in that the participants had a hard time admitting they needed help and surrendering to the treatment process. The findings suggest the importance of sustaining family pride was key; the participants emphasised how their duty towards upholding family pride was a key reason some of them could not accept therapy.

> Akshay: I think, I think pride is definitely the biggest thing. A big thing amongst Indian families new and old is about pride and being the better family and just being the untouchables. (L318-323)
>
> (…) as soon as say one family finds out that the other families kid goes to therapy…that's all they're going to talk about. (L325-331)

As Akshay states, this notion of pride is strongly valued within the wider Indian community and it is competed over across Indian families. For him, accessing therapy would jeopardise the family's image in the community and, while this created a delayed approach to accessing psychological therapy, it did not rule it out as an option.

> Akshay: Erm I think it - it again is the same reason that I would look at it.. at it as a last option. It wouldn't be something that I would go to straight away (…) (L361-364)

Individuals may feel discouraged to seek help to blend in with the wider group identity. Blending in is highly valued while being different, abnormal or deviating from social norms can feel even more threatening in collectivistic cultures.

> Harminder: It's not something that's erm seen as a norm in my household for example, and perhaps like even my extended family members or the community, so if I did seek therapy, I don't know how to break it to one person (…) (L138-143)

> Raj: (…) and erm for someone to have taken that last step, then there's always the negative perceptions that people will have (…)(L329-330)

> Sukhdeep: (…) In my family or in my culture, it is the case where people think…I don't know what word to use…poorly of it or badly of it they don't think it's a good thing to do. (L82-84)

Raj and Sukhdeep observed that if anyone was to access therapy, they would have to face the negative judgements from those around them. The external views of therapy were assumed to be negative and this presented therapy as an undesirable act to

engage with. This appeared to impact the participants' motivation in considering it as an option in times of need.

> Raj: So therapy probably isn't an easy option for people..erm especially when you've got to sort of uphold your image. (L250-252)

Raj said, like others in his community, he could not engage with therapy as he felt it would impact his image. Upholding your image was important and it made the choice of seeking support seem even more challenging.

There was a general view that if men were to access therapy it would be kept private. Akshay suggested individuals may remain conservative about any hardships they may face, to maintain pride and due to the intensely private nature in Sikh families.

> Akshay: (…) it just becomes a big mayhem so it's something that's kept very hush-hush. (L303-307)
> (…) if they do go to therapy, they wouldn't tell anyone is what a Sikh does.. I don't know anyone who would have. (L309-313)

Keeping personal things private appeared to be the main strategy adopted at home for Akshay. For Eishwar and Harminder, moving away from the family household to seek help may elicit uncomfortable feelings as this was perceived as an unfamiliar step.

> Eishwar: (…) it's a bit awkward....going and seeking for help, it's not really brought up within the household. (L234-236)

> Harminder: Erm I just feel a bit embarrassed by it to be honest. Yeah, if I'm being honest with you like I like just keeping things to myself. (L31-32)

Experiences with family members and friends is likely to influence one's own views on the usefulness of counselling.

Further, there was a strong focus on both keeping engagement with therapy private and informing others only on a need to know basis. Most of these men wanted to keep their engagement with therapy 'hush-hush'.

> Raj: Erm I think first of all I would only tell people sort of on a need to know basis. My immediate family would know…erm because obviously I would spend time away from home and tell everyone where I'm at and what I'm doing (…) (L115-119)

> Eishwar: I'll be honest with you, I probably wouldn't of told my mum or my sister. It's only because my mum and my sister are around the house and there's only so much you can avoid. (L439-444)

Eishwar had no intention of disclosing his access to therapy to his loved ones. He said he had to engage with disclosure due to unavoidable contact in his living situation.

When asked whether anything discouraged anyone from seeking therapy, Anveer placed strong emphasis on fear of information leaking.

> Anveer: (…) what if they posted it on the internet..what if I was made fun of but then I realised it was confidential? (L113-115)

As Anveer states, this fear is rooted in the thought that if accessing therapy is found out, then one would be judged negatively. It seems for those that accessed therapy keeping it ‘hush-hush’ appeared to allow them to continue to protect the families pride. Any individual decision regarding one’s psychological wellbeing was viewed as having a collective impact. Those who could not access help kept things to themselves as this felt like the easier option.

### 4.3 Theoretical construct 2: External barriers

The second theoretical construct illustrates the impact of external factors on the decision-making process e.g. family, culture and the role of migration. Several participants discussed the importance of resolving problems within the family home or within close networks. Often, participants spoke about how their help-seeking style mirrored the behaviour of their parents and those from the older generation. Therapy itself was identified as an unfamiliar and an unknown route for the Sikh community. Understanding the general behavioural patterns of help-seeking within this group is important as it may represent a learnt behaviour for the upcoming generations.

| **Theoretical construct 2: External barriers**<br>Barriers to therapy as perceived from within the family and the wider culture (including community and religion) as part of seeking or not seeking mental health support. | | |
|---|---|---|
| | Keeping it within the circle – to access existing means of support | 1. Parents and family come first<br>2. Keeping it within an inner circle and aiming to resolve it within the close circle<br>3. Therapy as a last resort – entering therapy only if the problem is severe enough |
| | Therapy: an unfamiliar route for the "set minded" older generation | 1. Difference in knowledge in East/West impacting help-seeking styles across generations<br>2. Raised with no awareness or knowledge of mental health |
| | Therapy - a foreign concept within the Sikh community | 1. Therapy is not the normal route<br>2. The tendency is to focus on the medical model/lack of psychological understanding<br>3. External environment developing with more exposure to mental illness |

#### *4.3.1 Keeping it within the circle – to access existing means of support*

Literature has found that family is regarded as the most important structure in caring for its vulnerable members (Conrad & Pacquiao, 2005; Commander et al.,

2004; Lawrence et al., 2006; Gill, 2010). When specifically focusing on the Sikh community, the BSR (Jhutti-Johal, 2018) established it is traditional for Asian families to live together within extended households; the survey concluded that the majority of Sikhs (61% males and 52% females) preferred to live with the extended family as they grew older (Jhutti-Johal, 2018). From the interview excerpts, family and the closest ones were described as pillars of support and primary sources of support (Ahluwalia et al., 2009, p. 280). The cultural values described by the participants highlighted a collectivist orientation, with a key emphasis on privacy (Singh, 2009).

Further, the *cultural script* (Mehrotra, 2016) which informs British Sikh men's performance of masculinities is one which places value on commitment to family. Researchers examining men's lived experience of MI suggest social support and connectedness may be more complex (Bryant-Bedell et al., 2010; Liang & George, 2012). The data implied participants had strong alliances at home in whom they could and should confide. The process of help-seeking was socially constructed (Rickwood et al., 2005) and mirrored the values and beliefs present in the family home, where the participants had to consider the impact of voicing the need to access therapy. All the participants identified those within their immediate circle as being their first point of contact when needing support. The participants seemed to rely on their families and community in times of need, and counselling and psychotherapy was often a last resort (Ahluwalia & Pellettiere, 2010). They stressed that this close unit was duty-bound to take care of one another (Ruprai, 2016), and this was viewed as positive yet, at times, restrictive. This support network meant one could not seek help elsewhere without evoking negative emotions within the household. This

component illustrates the impact of the existing means of support on the process of help-seeking.

#### *4.3.1.1 Parents and family come first*

When exploring family life and help-seeking, it appeared from the data that having a supportive, strong system of family and friends was a fundamental part of Sikh life. The data portrayed family as the major source of identity and protection against any hardships in life. Great emphasis was placed on ensuring one continued to engage with receiving support from the family if experiencing any difficulties.

> Raj: Er being very traditional erm and sort of homely, people just either just avoid the problems or..just, just deal with them and pretend that they're not there. (L245-248)

> Taran: (…) or you want to seek help from someone..then you can do it from your friends or your family. I don't think you need to go out to a therapist to do it. (L16-19)

> Harminder: Um well, I wouldn't want to actually go seek therapy myself because um I dunno it's just something that is not, something that me and my family do or something. We erm prefer to talk about things amongst ourselves (…) (L13-16)
> (…) that's just how it is in our culture (..) (L225)

The quotes above indicate that decisions affecting one's personal life are generally made in consultation with one's family. Furthermore, it appeared that some of these men held an assumption their parents would forbid them from accessing help outside of their homes.

> Harminder: (…) don't think they'll see it as an option for whatever I have, they probably want me to solve everything at home first. And even if it's not solvable at home, I don't think they will want me to go seek therapy (…) (L80-84)

> Anveer: (…) family that's what discouraged me. I didn't really know if family would be happy if I went to therapy. (L131-132)

Both, Harminder and Anveer discussed the importance of parental approval when thinking about stepping towards help-seeking. If parental consent was not given, men would resort to battling through it alone or make do with any existing means of support. It is important to consider that some parents, like Sukhdeep's, could act as a barrier towards help-seeking behaviour.

> Sukhdeep: (…) just the direct effect of my.. of the people I live with so my family I mean that's the most…the most important people in my life so their opinion matters the most (…) (L288-290)
>
> So yeah I mean the greatest barrier to entry for therapy is probably your closest family members that are, either support you with it or they don't. (L395-396)

Sukhdeep described the difficulties experienced if wanting to discuss therapy as an option with his parents, anticipating they would start looking for faults in their parenting. Sukhdeep said his parents would start blaming themselves if external help were to be accessed. He emphasised how he and his parents would have conflicting beliefs concerning accessing help.

> Sukhdeep: (…) ludacris idea they would be like it's ridiculous..what have you..what have you okay..you need to…oh my..they'd react.. they'd have very extreme reaction to it...they'd think that there is something very wrong with me...or they would actually you know what..knowing my parents they would doubt…. their own parenting skills. (L166-172)

Sukhdeep thought he could deal with his grievances on his own by seeking comfort in his family. There appeared to be an inability to discuss help-seeking options with his parents due to their extreme reactions.

Akshay and Raj described the possibility of parents experiencing personal shame.

> Akshay: (…) they would probably feel ashamed..in the sense that they weren't able to help their son, their son had to go seeking help elsewhere. (L113-116)

> Raj: Erm so they generally try and keep from what I understand they try and keep it within that community...erm so that it's not so much that people outside

> of the circle know..there's no shame to the family and they keep their problems to themselves...so they try and make it all happy on the outside. (L278-284)

This notion of shame resulted from the belief that one would be judged for not being able to help their child. It appeared parents feared they would be viewed as failing at parenthood. The need to present the family as happy and contained was to show they were managing just fine.

Eishwar suggested his mother could have been more supportive of the concept.

> Eishwar: (…) my mum wasn't discouraging me from it. I wouldn't say, but at the same time I feel like she could of given me a bit more support (…) (L384-387)

His mother could have played a more active role and, perhaps, this could have made the process easier for him.

Gaining approval to access help outside the home from the family system played an important role in the process. Families had set ways of dealing with things and participants felt anxious discussing any unfamiliar methods of treatment, so participants felt the family members would react in a negative way. Those that had not accessed therapy felt they could not bear these reactions while those that had accessed therapy suggested parents should be more supportive.

#### *4.3.1.2 Keeping it within an inner circle and aiming to resolve it within the close circle*

Aiming to resolve any difficulties one may be experiencing with close ones was identified as one of the main strategies embraced by Sikh men. The comments made by the participants presented some similarities with Hall's (2002) research with young Sikhs in Leeds, in which private and public spaces were culturally differentiated, with the home being the Indian space in which cultural practices were adhered to. As Hall (2002) also notes: "the emotional and communal pressure to respect one's elders, protect family honour, and submit to what is best for the family as a whole continues to keep families together, for the most part, as a solid supportive social unit" (p. 178). Harminder, in particular, talks about his family's tendency to keep problems within this close-knit circle. Once again, the notion of shame was quite present within this theme.

> Harminder: Erm definitely a no go to, to be honest, you should just solve the problems at home I guess that's how my family see it that's..that's the whole society..that's one of the main reasons why I actually haven't even gone to seek therapy, actually. (L152-154)

He suggests this strategy being implemented at home is similar to what happened in wider society. Difficulties were not openly spoken about and to only disclose personal matters to immediate family or to very close friends appeared to be important. Aman was able to limit the number of people he felt comfortable sharing this personal content with.

> Aman: (…) a few people erm my very nearest and dearest family and friends (…) (L116)

This closed and reserved behaviour appeared to be facilitated by the older generation. The data suggested prior to migration, Sikh families kept things to themselves. This strategy of getting through it alone was to prevent people from talking.

> Raj: Er back then, I believe everyone just kept it to themselves. I believe that nobody could really tell anyone about something like this because people talk (…) (L389-392)
>
> (…) so they try and make it all happy on the outside. (L284)

As Raj suggested, if this strategy to resolve problems internally failed, to uphold the family image, one may have to avoid them by wearing a mask for the external world.

If one was to suggest seeking help outside of this circle, it would raise concerns within the family, as Eishwar goes on to suggest. It appears, traditionally, Sikh families expected everything to be discussed within this secure unit.

> Eishwar: (...) or what's his, what's his problem? why can't he talk to us or why does he have to go through therapy? (L245-246)

For Eishwar, there is strong promotion of cohesion and interdependence. These family systems appear to be an important dimension of Sikh culture.

The men interviewed showed signs of acting in the best interest of their families' reputations, as the act of an individual may impact the community's perception of the entire family.

> Akshay: (…) I understand, they try and keep it within that community...erm so that it's not so much that people outside of the circle know..there's no shame to the family and they keep their problems to themselves (…) (L278-282)

Akshay emphasises how keeping the circle tight helps prevent any shame from coming to the family. Similarly, Eishwar said keeping his engagement with therapy within his private circle was important for him.

> Eishwar: So my mum knew I was going through it and my sister. And erm they were a bit surprised. (L380)

Limiting awareness of his engagement to his immediate family appeared to create some peace of mind for him as he had only a select few reactions to deal with.

As the participants stated, there are concrete, inflexible and enclosed methods in place on how to manage conflict: e.g. to approach a close one or discuss matters at home. There appears to be no space to try out new methods of treatment and the

existing techniques are continuously reinforced across generations. It is important to note that one may feel guilty accessing help from outside of the home because there is a strong focus on keeping things private to prevent any information from leaking and, thus, prevent shame from coming to the family.

#### *4.3.1.3 Therapy as a last resort – entering therapy only if the problem is severe enough*

Therapy was considered as the last option for all the participants. The data suggested that while at times traditional masculine norms (e.g. self-reliance, difficulty in expressing emotions, and autonomy) constrained men's help-seeking for any psychological issues, over time, some participants were able to rework or reject the conventional notions of masculinity. Coping with MI occurred alongside a process of redefining masculine identity to accommodate emotional wellbeing, including being entitled to feel vulnerable. While some were able to create a more positive attitude towards help-seeking, it was often a delayed response in which mental health had deteriorated and was presenting with additional challenges.

Those that had accessed therapy only did so due to a lack of options available or they felt they were unable to manage on their own.

> Eishwar: (...) so I think it’s just all the things got on top of me and then it got to the point where I couldn’t cope anymore and I couldn’t function (…) (L266-269)

Eishwar, in particular, states he accessed therapy as he was able to see that he had reached breaking point. Breaking point was described as not being able to function and, similarly, this was experienced by Taran, who was unable to focus on everyday tasks.

> Taran: (…) like I could not even read the paper (…) (L62).

For Anveer, there appeared to be a lack of options available regarding who to approach to talk to about the bullying he was experiencing. It seems he was open to talking things through with a health professional and appreciated being listened to and cared for, which represents a traditionally more feminine position.

> Anveer: It was the bullying and I just didn't have no one to talk to. I felt lonely so the therapist was the person I mostly talked to and they helped me. (L74-77)

It was this unavailability of close ones which caused Anveer to resort to therapy. Those that had not accessed therapy stated they would first evaluate whether they already had existing means of support and to only access help if all other methods did not work.

> Akshay: I think they would possibly initially brush it off but if it was a serious enough situation, they would consider it if they had already..if they had already tried everything else...but I think it would be similar where they would try not to unless they absolutely had to. (L460-466)

Further, Akshay somewhat expected others within the same culture to react in a similar manner – to access therapy if nothing else worked. Sukhdeep discussed how therapy as the last resort could relate back to the strong belief Sikh men have of helping oneself.

> Sukhdeep: (…) a lot of people think they can resolve the issue themselves but they don't realise it's just going to get worse and worse and worse (…) (L708-712)
>
> I think a lot of the times people just push it at the back of their brain and they forget about it (…) (L716-718)

According to Sukhdeep, individuals avoid and forget problems, a strategy that is continuously implemented until the situation gets out of control. These men allow their mental health to get to a detrimental state because of fixed ways of managing distress.

There appeared to be a strong assumption within the community that therapy was for those that were battling through something severe. As such, the common perception of someone engaging with therapy was that they were experiencing extreme distress. There was a general view among the participants that therapy was only accessible for those in real need.

> Akshay: (…) you'd go to a therapist if - if everything's hit the fan already and there is no other option..'cos I think people only think you go to a therapist if you absolutely have to (…) (L469-473)

Akshay goes on to suggest that there is a misunderstanding within the Sikh culture of how severe a problem must be to enter therapy, and you only go to see a therapist when it is already out of control.

Raj discussed how therapy was advertised on TV for those in a negative state.

> Raj: (…) erm and you hear a lot about it on tv and in the news and stuff about people going into therapy cos they're in a bad state. (L23-25)

This is important because the way therapy is advertised on social media platforms contributes to the overall understanding of it. The impression Sikh men may have as a result of this is that therapy is for those that are vulnerable.

The data suggests Sikh men go to mental health professionals for help only after all other possible resources have been exhausted, often waiting until their conditions become severe and unmanageable. It appears they already experience some difficulty considering support for their mental health and, if media advertises it for those in extreme states, then this could further negatively impact their decision-making.

### *4.3.2 Therapy: an unfamiliar route for the "set minded" older generation*

The differences in the teaching of mental health across generations appeared to play a role in the understanding these men had of help-seeking behaviour. The participants stressed how the lack of understanding their parents had of the concept had a strong impact on their own knowledge. They suggested psycho-education was a priority when providing mental health services to the older generation. Some of their parents grew up in India where schools did not educate students on the topic of mental health. They stressed it was important to explain to this client group what was involved in the counselling process and the role of the mental health counsellor. The data presented the need to explain and clarify stigmas and misconceptions about mental health and MI, to challenge the stigma driven by the older generation (Kaur, 2020) as this would increase accessibility for the younger generation. This is because the present understanding of MI was shifting and the younger generation were more open to adopting a more modern approach. Patterns of help-seeking vary across generations and this seems to shift depending on age and acculturation (Jhutti-Johal, 2011, p. 249).

#### *4.3.2.1 Difference in knowledge in East/West impacting help-seeking styles across generations*

Nearly all the participants interviewed were raised by parents who were born in India and migrated to England. It seems the study of mental health was not really touched upon in Indian schools and the "Indian educational system yields myriad opportunities for enhancing mental health awareness" (Srivastava et al., 2016, p. 134). Participants stressed their parents lacked the opportunity to gain an awareness

of MI, and the data saw a similar theme of variations in teaching in the East and West creating differences in mental health literacy (Jorm et al., 2005). Education was interpreted as a predictor of higher mental health literacy and was viewed as having a fundamental role to play in the style of help-seeking adopted.

> Anveer: Erm back then education was not that good not that great there wasn't that many good teachers some of them didn't even go to school back home. (L411-414)
>
> And obviously, the way they were raised in India, the school was not that great and yeah, compared to life here in London and nowadays the educations good. (L430-437)
>
> (…) so there's more information available about such services. (L441)

Anveer reflected on the standard of teaching in India in comparison to the teaching in England impacting ones understanding of mental health. He also highlighted the competency of teachers and quality of education as being a key difference in attitudes adopted across generations. Education was not compulsory in India until 2010 (Singh & Nagpal, 2010) and it seems the recent educational opportunities have made the young generation aware of alternative ways to approach MI.

In some cases, participants assumed their parents did not understand the concept of therapy. Anveer and Raj suggested this may be due to first-generation Sikh parents not being given the opportunity to access it.

> Anveer: (…) my parents are born and raised in India so I don't think they understand, they didn't understand what therapy was 'cos they never got maybe the chance to do therapy themselves (…) (L134-137)

> Raj: I think..I think the biggest difference would be just opportunity. Obviously, the previous generation before myself were mainly from India and I'm not too sure about what sort of facilities they would have there. (L230-233)

For them, this opportunity to seek help may shape the way one views it. It seems the existence of mental health facilities in India are limited and this contributes to the lack of understanding.

Further, Sukhdeep stressed how a lack of evolvement after migrating in the older generation is causing individuals to continue to have fixed beliefs.

> Sukhdeep: (…) the environment they were raised in didn't have room for teaching them about the importance of mental health and the importance of you know therapy itself. (L117-119)
> That idea of it being something very negative has always stuck from, from I guess their upbringing and how it's perceived in my country back home. (L123-124)

He expressed the frustration he felt in regard to what he described as “backward thinking” in his culture. Older Sikhs turn to more traditional explanations of MI, and these do not resonate with Western views (Jhutti-Johal, 2011, pp. 250-251; Gill, 2010; Lawrence, 2006), which these young Sikh men seem to be leaning towards. According to him, the majority of the families within the Sikh community have adopted similar thinking styles.

> Sukhdeep: (…) they still don’t seem to have become educated to the, to the things that how we are evolving as a world we need to do these things to sort of be you know to help us live our lives properly and they haven’t, they haven’t, I still feel that they, they still have that backward thinking and that, that same thinking is present in my family and in my culture and I think it’s there in the entire Sikh community (…) (L278-285)

Sukhdeep emphasised the need to promote the importance of educating parents in order to challenge some of the beliefs they may have about the concept. This could internally help the process for the younger generation.

Generally, there were key differences in the understanding of help-seeking behaviour across generations, and the younger generation was viewed as having more awareness of mental health.

> Akshay: (…) if they speak to someone from an older generation then that person would obviously say look we’ve never had to do it you don’t need to do

> it but obviously if they speak to someone from a younger generation they would say look it's an option, it's out there, people use it you can use it as well. (L270-279)

As a result of this understanding, the younger generation are considered to be more open-minded, as Akshay stated. The older generation is viewed as classifying distress as simple hardships everyone faces.

> Aman: (…) so I feel like some people, especially the oldies, may not understand it and they may just see it like everyone goes through hardships (…) (L456-459)

> Anveer: (…) in the past, there was nothing really you could do about mental illness and some people from the older generation may still see things like that. (L467-468)

Their tendency to stick with a consistent strategy when dealing with any issues one may face relates to their lack of understanding that was identified by Aman and Anveer.

The younger generation are viewed as more open to new concepts, Anveer suggests this difference may relate to accessibility and how it is now easier to seek help. The opportunity to access mental health services and an increase in resources appears to be the main difference across generations that impacts help-seeking style.

> Anveer: (…) difference is nowadays people tend to seek help from people. Back in the day, I don't think anyone had the chance or the choice, so I think the older generation would still be reluctant because of this experience. (L404-406)

> Raj: (…) the younger generation would definitely be more likely to er being more open to things in, in terms of growing up, in what we're doing. With the older generation especially with their older views they, they will follow what their parents taught them. (L387-390)
>
> With the previous generation er to myself they've, they've grown up erm without access to the internet, without erm sort of open information (…) (L356-358)

The variations in the views held across generations seemed to influence whether one would recommend therapy to a loved one. The ingrained attitudes towards mental health are preventing older Sikhs from seeking help and discouraging the younger generation from advising a family member from this generation to seek treatment for any mental health issues.

> Sukhdeep: (…) would have the same thinking as my parents. He would have the same thinking and he would think, well, well that's a bit that's a bit ridiculous how can you even say that to me, you think I'm you think I'm sick in the head (…) (L415-421)

> Anveer: I believe if it was someone older they wouldn't understand they would just say oh leave it, it's fine. Someone younger I can maybe help them. (L611-612)

Both, Sukhdeep and Anveer felt they were able to advise the younger generation to seek any help they may need but unable to advise the older generation due to an overall lack of understanding of the concept. They assumed they would receive a negative reaction and interpreted an unwillingness to try new methods as misconceptions about MI and a belief in just getting on with life.

Eishwar felt he was unable to suggest his mother take a step towards therapy as he felt she had set beliefs and saw it as foreign to her culture.

> Eishwar: Like I would like to tell my mum to maybe go and speak to a therapist, but like I said because it's so foreign in our religion I don't think I'd be able to get my mum to take that step. (L755-758)
>
> But I feel like if they knew more about it I would of potentially would of got a little more support about it. (L451-452)

Friends were seen as more approving of the help-seeking process as they are from the same generation. They were described as being accepting of therapy and this led the participants to feel comfortable about speaking about any mental health issues and the disclosure of needing some professional input. This interaction with friends created the opportunity to challenge any stereotypes in the community. Support from

friends created a sense of motivation to understand the benefits and whether therapy could be considered as an option.

> Sukhdeep: I would say that I have always heard about it and always been…always been told about the benefits of having therapy. Um from..from friends (…) (L3-4)
> (…) having recommended it once by my friend to go to therapy I feel like my friends are a lot more you know accepting and a lot more err supportive of me going to therapy and because and I feel the reason because of that is because they have grown up beside me they are my generation they do know a bit more (…) (211-214)

Opportunity to have discussions about mental health was achievable in this space. Friends were described as being open-minded because they were able to guide the participants on how to get some support put in place.

> Anveer: My friends in class would just talk about it and I didn't really know what it was or how you went about getting into it..so they explained it to me and then I thought about it, yeah, and made the decision to go. (L232-235)

> Raj: Erm also the fact that a couple of my friends have mentioned that they've gone through it and it really helped them in the times of need. (L20-21)

Overall, friends were able to encourage the participants to make space for mental health and the participants stressed the need to increase an understanding in the older generation, to not only help improve access for the younger generation but also allow the older generation to adopt a more flexible approach. The need to increase an understanding will be discussed in-depth later on in the analysis.

#### *4.3.2.2 Raised with no awareness or knowledge of mental health*

As discussed previously, Asian parents lacking mental health literacy have influenced the understanding their children have gone on to develop. It appears from the data the participants identified the older generation as having a limited understanding of where to seek professional help, the services available or how to contact them. Mental health literacy is an essential life skill that must be taught before the need arises (Kelly et al., 2007). Framing help-seeking as an important life skill that needs to be learnt, mastered and used as needed, rather than be seen as evidence of weakness (Rickwood et al., 2005). Such an approach may be particularly important to encourage Sikh men to seek help.

The response from Sukhdeep suggests Sikh men learn to deal with their distress via their upbringing and from their social circles. If they were to suggest seeking help via other avenues, they feel others in the family would not understand and they view this as a key barrier to accessing psychological therapy.

> Sukhdeep: (…) partly because of my upbringing and what my parents and family would of thought about it, it did, it did discourage me from going ahead

> with it and I thought maybe I could just battle this on my own. I have my family around me and I sort of tried to seek comfort in my family as opposed to trying to overcome the problem myself and seek therapy and talk to someone about it. I, I think that's what I sort of thought that I should go for this because I mean, I mean my parents had completely different views about, about going into therapy, so yeah. (L147-160)

> Anveer: Erm people not understanding it does impact my view because erm then people won't really know where I am coming from. And because of that, not many people themselves will seek help. (L406-409)

For Anveer the lack of understanding in Sikh families appeared to create a position of opposition for these men.

In some families, therapy was never mentioned while growing up. This lack of exposure would influence ones understanding of what other forms of help may be available outside the family home.

> Eishwar: Generally, our family don't tell us about therapy you don't generally learn much in it (…) (L227-228)

For Eishwar, his family would not list therapy as an option. There appeared to be no room to learn the concept within the family. Whether one could access therapy or not

was explained via differences in upbringing. Here, the participants explained the idea of modern versus traditional parents.

> Anveer: And no because um some modern Sikh families don't expect that from their kids with how modern times are getting..they believe that oh like some parents have been through this themselves (…) (L331-333)

Anveer suggested how some modern parents were more understanding of the concept as they had experienced some form of distress themselves.

Akshay goes on to appreciate his current modern family situation. For him, a modern family generates a sense of openness that is considered to be supportive and encouraging. According to him, "old school parents" exhibit gender assumptions and encourage the expression of traditional masculinity.

> Akshay: I think I am definitely appreciative of the fact that my family are quite open. As in I know if they were definitely more old school and they said no just be a man don't… you don't need to go to therapy it would..it would make me think that as well. (L186-190)

Akshay compares his upbringing to his friends; he speaks about the impact of modern versus traditional parenting on upbringing and how "old school parents" would put their image first.

> Akshay: (…) I do know friends who have a lot more old school parents..who wouldn't be so open to it, who would like I said be a bit more embarrassed, be a bit more ashamed about it. (L206-210)

Anveer stated his father aspired to learn more about depression. While his father initially struggled to understand what he described as his "highly functioning" son could suffer from a chronic illness, he said this experience allowed his father to become more open to the concept.

> Anveer: (…) gradually, as I started engaging in therapy more they started to understand as they perhaps saw a difference in me. (L218-220)
> (…) Like my parents believed therapy is or was a bad thing, to do it was a waste of time but with time now, because of me having gone to therapy, they believe that it does help. (L341-346)

Anveer's parents' understanding increased in line with his engagement with therapy. They were able to visually notice an improvement and so this may serve as a fundamental part of the approval process.

Being exposed to the concept of therapy via film was brought to my attention by Taran when he differentiated between the openness to mental health as displayed in Hollywood in comparison to Bollywood and Punjabi movies. While the relationship between media and MI is complex, feature films and the cinema can be used as a

means of psycho-education (Bhattacharyya, 2016). Here, Taran highlights how engagement with therapy is rarely highlighted in Indian movies.

> Taran: (…) like Hollywood movies that couples are going to therapy all the time. (L117-118)
>
> (…) it may not be in Bollywood movies or in Punjabi movies (…) (L360-362)

Exposure, therefore, serves as an important factor that can shape the process. If one comes from an educated background with exposure to mental health, then it is likely the process will be easier for you to access help. Whereas for others, having very traditional parents who are not as knowledgeable, or have very limited mental health literacy, it is likely to cause some difficulties for them.

### *4.3.3 Therapy – a foreign concept within the Sikh community*

The findings presented in this theme focus on the British Sikh community. Mental health in India is found to be mild in comparison to Western countries, which may reflect a cultural tendency to ignore or normalise symptoms (Chakraborty, 1991). Majority of Sikhs that migrated to the UK are from agricultural villages in Punjab, India, where Western-style talking therapies are a foreign concept. All the participants were second-generation Punjabi Sikhs, and it seems their parents have bought with them their own set of beliefs and understandings of mental health, which differs from the Western perspective. Therapy was described as a foreign concept in the culture, which sets a tone in the community and this acts as a key barrier in the help-seeking process for the younger generation. The older generation

was described as not having the background or mindset required to fully understand therapy. As seen in the data above, Sikh men tend to endorse coping sources and practices that emphasise talking with familial and social relations rather than professionals such as therapists. Therefore, in this culture, there is no cultural analogy to psychological therapy and the utilisation of mental health services may not be viewed as a treatment option.

#### *4.3.3.1 Therapy is not the normal route*

Therapy has been described throughout the interviews as a foreign concept in Sikhism. Participants have stated that many individuals in the Sikh culture are unaware of what it entails and how it can help. While Sikh men may find solutions for their mental health in different ways, e.g. support resources as well as empowerment activities (Ahluwalia & Pellettiere, 2010), the data has presented a need to guide this community in acquiring the necessary information to shift some of the attitudes towards help-seeking.

Sukhdeep noted a lack of exposure to the concept of therapy in India may have prevented many first-generation Punjabi Sikh parents from understanding what therapy involves.

> Sukhdeep: Never something that was touched upon in their schooling life or in their youth so when they came here they may have heard about it but it's still that..that idea of it being something very negative has always stuck

> from…from I guess their upbringing...and how it's perceived in my country back home. (L122-126)

Therapy was described as not the normal route and the participants suggested that an increase in understanding could shift this view.

> Raj: (…) it's not a um..a normal thing within the community or within the people (…) (241-243)

> Eishwar: If you're not knowledgeable on what therapy can do and how it can help. I don't blame them for potentially maybe finding it a bit weird (…) (L398-400)

For Eishwar, this could explain why it may not be viewed as an option during the help-seeking process. The general understanding of therapy is that it is going to solve the problem by just going to talk about one's difficulties. This rigid view may contribute to accessibility and participants vocalised how the Asian culture does not make space for "just going to talk".

> Sukhdeep: It's..it's…it's perceived as a bit different and it's perceived as almost someone who has a problem as opposed to someone who's just going… to you know talk about their life or talk about (…) (L58-60)
> (…) they think completely different to us. (L433-434)

Sukhdeep linked this to how the East and West think in profoundly different ways, suggesting Western cultures focus on levels of subjective wellbeing, while Eastern societies appear to neglect emotional disorders and look at their difficulties in a logical and analytical way.

For the participants, therapy being classified as *not the normal route* created some difficulty for individuals to take that initial step.

> Eishwar: (…) our culture's generally not used to it. This is why maybe took me as long as it did to seek the help in the first place. (L434-436)

For Eishwar, this lack of exposure inhibited and delayed his access to therapy. Therapy was regarded as an unfamiliar option in the culture, one that was not often considered. Individuals were unaware of anyone having accessed it from their close-knit circles.

> Eishwar: I've never really, like with my family I don't know anyone that seeks therapy. (L239-240)

Generally, therapy not being considered as an option in society resulted in participants viewing the help-seeking process as consisting of many barriers to overcome. Sukhdeep described feeling overwhelmed by these barriers, and this may have contributed to therapy being underutilised by this particular client group.

> Sukhdeep: It's even harder for people like myself or people in other…other people in my culture to give in to get to ge-get-getting some therapy like cos it's...they have more barriers to overcome (…) (L265-267)

There were some misconceptions of what therapy entails, and a need was expressed to increase exposure to enable therapy to be considered as an option, thus making the process easier for this client group. Further, this increase in exposure may allow this client group to learn how to think holistically as opposed to continuously adopting the analytical approach that is well-embedded in Eastern culture.

#### *4.3.3.2 The tendency is to focus on the medical model/lack of psychological understanding*

For SA's in general, there is a tendency to replace psychological symptoms with somatic ones (Krause, 1989; Bhugra et al., 1997; Ruprai, 2016; Fenton et al., 1996; Jhutti-Johal, 2018) and a similar theme has been presented here. The participants highlighted the cultural variations in the context and interpretation of symptoms related to psychological distress, which other scholars have also recognised (Anand & Cochrane, 2005; Karasz, 2005). They stressed the culture's approach to mental health could relate to the culturally sanctioned values regarding emotional expression.

> Sukhdeep: (…) I wanna go talk to someone about it why can't they look at it like in that way, why can't they look at it in the way that you know I'm just..I'm

> trying to let my emotions out and tryna tell someone how I feel and it's helping me and it's making me feel better (…) (L294-302)

Sukhdeep emphasises how this prevents one from conversing and understanding their emotional distress. These families, potentially unaware, reinforce the suppression of negative emotions. Sukhdeep was aware of the benefits of talking through his difficulties, yet he felt his loved ones were unable to see it in the same way.

Sikhs finding it more acceptable to somatise emotional distress or empathise with physical or behavioural symptoms could explain why they value the doctor-patient relationship.

> Sukhdeep: (…) in our culture it's like if you are going to see a therapist or if you're going..you're going to see a doctor..like, you got some problem (…) (L62-63)
>
> Oh this persons going to the doctor because he's messed up in his head (…) (L105-106)

Consequently, Sukhdeep speaks about how this community associates MI with the need to see a doctor. Due to a lack of awareness regarding wellbeing services and putting less focus on the comprehensive approach to therapy, the burden is placed on medicine and physiatrists.

> Taran: It's like for something serious like this guys on drugs and needs to come off or something so think of it more like a rehab kind of a thing. (L107-108)

For Taran, if he were to suggest potential engagement with therapy, he was able to predict his parents would assume he is going to see a rehabilitation doctor rather than going to see a therapist. According to the participants, their community appeared to rely on being directed by their GP, and their awareness of therapy was limited to information provided by this professional.

> Eishwar: (…) the only time we will know about therapy is if you go to the doctor's and you tell the doctor certain things they'll tell you to call this number and this or do that. (L224-225)

Eishwar felt individuals relied heavily on instructions given by a professional with a medical background. It seems the guidance that is given results in the individual independently having the power to decide whether they want to engage with therapeutic services. This could be problematic; individuals may not follow through with the GPs recommendations as a sense of uncertainty may be present and/or they may not want to admit they need the support.

Further, Eishwar states there is a strong reliance on medication and this was a direct result of going to the GP. Participants reported they were not aware of what mental

health services in the UK offered therapeutic interventions and their families viewed medication as the main treatment option available.

> Eishwar: I think people just go to the doctors when they're feeling down or upset. I've had an aunty that was on anti-depressants. I feel like they don't generally um go and seek help or go and initially ask they just go to the doctors, the doctors will obviously tell them about certain things. But the doctors will be like I've got tablets as well, anti-depressants. (L487-492)

Culture influences the form of illness experience, symptomatology, the interpretation of symptoms, modes of coping with distress, help-seeking, and the social response to distress. This has a strong impact on the process, as views are limited to medical solutions and responses, thus limiting opportunity to engage with emotion expression and therefore, creating implications in clinical settings.

#### *4.3.3.3 External environment developing with more exposure to mental illness*

The data has suggested the Sikh society is continuously evolving with more exposure to Western constructs. Sikhs tend to migrate out of India for educational or professional opportunities (Chopra, 2012, p. 61) and this exposure seems to be normalising the accessibility of therapeutic services. While mental health continues to be largely conceptualised in Western terms, with an increase in acculturation and education, younger generation British Sikh men appear to be approaching MI with a more open mind. This attitude seems to be different from the one held by their parents and grandparents (Jhutti-Johal, 2018).

Anveer viewed therapy as becoming more established as he felt the Sikh society was developing. He sheds light on the many changes that are taking place and acknowledges this with a positive outlook.

> Anveer: (…) and yeah so it's becoming a thing. Overall I think society has changed like..like there's more therapists nowadays..back then there weren't as many and people talk more now, whereas back then they kept it to themselves. (L374-L382)
>
> (…) but nowadays I feel like we've done better. (L416)

According to him, this change was identified as partially resulting from the increase in therapists in the community; therefore, creating more opportunity for individuals to engage with emotional expression with a therapist from the same cultural background. Sharing this similarity may encourage one to be open about one's difficulties as one may assume they share a common understanding.
Also, an increase in access to education for Sikhs appears to have had a role to play in the development of knowledge concerning mental health in the current generation, as Raj states.

> Raj: fact that a lot more people are going to university there's a lot more education so the understanding of it is a lot er has developed a lot further than it has in the past. (L368-371)

He was able to identify education as being far more prominent than it had been in the past and this has shaped the process of where to seek therapeutic help. It is argued access to higher education for many ethnic minorities can provide a platform where one can learn more about positive mental health e.g. creating safe environments, social and emotional learning, etc. It seems this has helped young Sikhs in developing some of their understanding of general wellbeing.

According to some of the participants, developments in society appear to be creating more opportunities for help-seeking behaviour. For Raj, there are more help-seeking options available and access to these resources will further allow understanding of mental health to develop in the younger generation.

> Raj: Now we're..we're growing up within the digital..digital media where you can just go out and google anything or you can make a phone call anywhere..everything is so easily accessible. (L361-363)

Therapy being advertised on various media platforms makes a difference in raising awareness and influences the understanding of mental health issues and, thus, the seeking of support. The participants praised the Sikh media as a helpful avenue for increasing awareness of mental health and playing a fundamental role in the acceptance of seeking help.

> Aman: (…) like certain Sikh organisations you know different channels on tv that er um have certain shows on and reinforce that it's okay. I definitely feel

> that by having that push from the wider community from certain parts of the community it's definitely making it more acceptable, yeah. (L501-505)

According to Raj, promoting MI via television appears to feel as though one is gaining a push from the wider community. Similarly, Taran had often heard about individuals accessing therapy in the news.

> Taran: Erm and you hear a lot about it on tv and in the news and stuff about people going into therapy cos they're in a bad state (…) (L333-334)

Although this could positively encourage some men to take the step, he noticed therapy was being advertised for those in a critical state. This may create some concerns for Sikhs regarding how severe a problem must be before they go and access help.

Overall, there are positive signs of the Sikh community developing in line with the current progress that is being made in the area of mental health. It appears from the data that participants feel positive in regard to the changes that are taking place, e.g. mental health being openly discussed on various media platforms. However, there is a need for further information to be shared with this client group, to develop mental health literacy and to clarify the level of distress that one can take to therapy as this may shift the processes of seeking therapeutic help.

### 4.4 Theoretical construct 3: Opening up the barriers

The third theoretical construct summarises how all the men interviewed advocated the importance of challenging existing barriers. The majority of the men that had previously accessed therapy felt strongly about the positive gains from it. Meanwhile, those that had not accessed therapy had heard about the benefits via others accessing support. The initial step was viewed as the most challenging by the participants. Some proposed that sharing their own positive experiences may encourage others to seek help from professionals for their difficulties, and the need to normalise therapy within society was emphasised. The data also demonstrates a fine line between religion and culture: while culture was seen as discouraging help-seeking, there was a clear indication of the positive role of religion in mental health. For Sikhism to progress in the field of mental health, the participants spoke of the need for an increase in knowledge and understanding via educational settings or through more active input from healthcare professionals.

| **Theoretical construct 3: Opening up the barriers**<br>Having sought mental health support or being open to it and what could help the process of seeking mental health support. | | |
|---|---|---|
| | Gains from therapy | 1. Engagement with therapy changes views of mental health and help-seeking styles, in relation to the self<br>2. First step perceived as the biggest hurdle<br>3. Sharing one's own positive experience of therapy may encourage others to take a step forward |
| | What can improve help-seeking behaviour within the Sikh community | 1. The positive role/use of religion in mental health<br>2. The need to encourage therapy as a norm within Sikh culture/society<br>3. Limited awareness of mental health in educational settings<br>4. Healthcare professionals to get more actively involved |

### *4.4.1 Gains from therapy*

Gains from therapy was developed to illustrate the positive experience of those that have accessed it. It also demonstrates young Sikh men are currently able to access mental health services more readily than they have in the past and, while we can identify this as a positive change in help-seeking behaviour, this change was not mirrored across all of the participants. Nonetheless, when engaging with therapy, the participants saw valuable shifts within themselves. According to the social constructionist notion, identity is fluid and individuals can construct new identities when provided with a context where they can challenge the dominant societal discourses and renegotiate new self-constructs (Raskin, 2002; Shotter, 1997). It seems this was made possible within the context of their engagement with therapy. While taking the first step was challenging, it was deemed rewarding because it informed them and their families of the value of expression of emotional distress. Help-seeking seemed to have stages and, therefore, can be viewed as a multidimensional construct that shifts according to social processes of beliefs and values, rules about social behaviour, and social practice (Arnault, 2009).

This theme acknowledges and commends the participants' efforts in this recent shift towards accessing services. While barriers to accessing mental health services persist (Rastogi, 2014), the data demonstrates some Sikh men are willing to challenge cultural beliefs and seek mental health care. Acknowledgement of this would provide the Punjabi Sikh community with an opportunity to recognise the progress it has made in addressing the issue of mental ill health. The participants expressed the importance of sharing their experiences as this would inform the community that MI does affect people of Punjabi Sikh background and that some are

open to receiving professional help in dealing with any distress. This is consistent with the view that young Sikhs are empowered enough to begin a conversation around mental ill health (Jhutti-Johal, 2018).

#### *4.4.1.1 Engagement with therapy changes views of mental health and help-seeking styles, in relation to the self*

Although the literature has indicated that self-disclosure can be in conflict with men's internalised messages, such as being strong, self-reliant, and independent (Hammer et al., 2013), the men who accessed therapy were able to take a step to develop their sense of self. This experience allowed them to place themselves centrally and explore internalised thoughts without any restrictions or pressure to present themselves in a certain way.

The importance of external human contact was appreciated by Anveer. He was able to understand how exploring feelings with another human of no relational meaning was more beneficial for his mental health than just bottling things up. For him and Aman, therapy served as a platform where expression of feelings was permitted.

> Anveer: I feel therapy is a good way to express yourself um instead of keeping it in you can tell people how you feel and keeping it in is worse and yeah just you know. (L16-17)

> Aman: I just feel a very relaxed and free and open and almost like I can let myself loose, let myself open to the person I'm speaking to (…) (L5-8)

> (…) I just feel that it's a place where I can go and erm yeah..unload if you will. (L11-12)

Their help-seeking style altered as they only accessed help when they were experiencing severe low points. Thus, their existing methods adopted to deal with any challenges failed and so, these men reached out to try other avenues.

Some participants felt they were increasing their awareness in therapy as they were learning new strategies. Placing the *self* first appeared to be unusual and unrecognised behaviour for these Sikh men. This was strongly experienced by Aman.

> Aman: I was trying to find myself more during this period. (L63)
> (…) compassion and having self-compassion at the same time felt that's a big aspect and that's why it really made me feel like sometimes you gotta be your own best friend. (L550-551)

After experiencing therapy, Aman appreciated how his mental health issues were placed more in context.

> Aman: (…) yeah just accepting that they are thoughts and they don't necessarily have any power over you or you..they don't control anything, it doesn't cause anything that happens. (L283-285)

For him, therapy made his experiences not so stigmatising or as frightening as he had anticipated.

Similarly, for others who had had contact with therapy, their positive experience influenced their overall view of it. For Eishwar, therapy was viewed as a good service where comforting emotions were elicited. It is vital we recognise and advocate these positive experiences in order to encourage access to wellbeing services in the future. As Eishwar states, these services are heavily underused by this culture group.

> Eishwar: Um but I feel from my experience having therapy and opening up and talking to someone does make you feel at ease and does make you feel better at that time. So, I think therapy is a good thing but at the same time, I don't feel a lot of people take advantage of. (L13-19)

Furthermore, for Eishwar, having options available was important in making that final decision. He was able to discuss therapy options with a therapist via the phone whereby he was given the opportunity to select from face-to-face individual therapy, group therapy and online therapy. He described initially feeling very hesitant and reserved and so having the option of online therapy made the experience seem easier as it put him at ease.

> Eishwar: I feel more comfortable doing it online cos I've never opened up. it would of been a bit weird for me with a group of people there talking about similar sort of issues. (L338-344)

He is now aware of the benefits that he gained from online therapy and so were he to have issues again, he might consider it, while being generally more open to mental health issues. Also, his progressive experience with online therapy may open other avenues of therapy.

Engagement with therapy appeared to also challenge external views held within the family home. As previously discussed above in a different theoretical construct (*Raised with no awareness or knowledge of mental health),* parents' understanding increased in line with their children's engagement with therapy. For Anveer, this had a strong internal impact as it appeared to create a sense of acceptance with oneself and with others.

> Anveer: (...) as soon as I engaged with it more, they began to understand, it was making me feel better about myself..making me happier. (L148-149)

Those participants who had experienced therapy would find it easier to engage in the process again as they felt they had already broken some barriers down. Moreover, it appears one must engage with therapy to gain a better understanding of the benefits it can bring.

*4.4.1.2 First step perceived as the biggest hurdle*

As presented throughout this thesis, there are many factors that may delay accessibility to psychological care. There are several hurdles to be crossed before an Indian with MI actually seeks treatment (Dutta et al., 2019) and the initial step holds a lot of value for Sikh men. Taking the first step was perceived as the biggest hurdle by all the participants.

Raj and Sukhdeep discussed the power of the initial step as if there are stages to help-seeking behaviour.

> Raj: Erm but if there's something people need to go to therapy for..for whatever reason then that's almost a large step that they take (…) (L326-327)
>
> Sukhdeep: But once they take that first step, I think that's when everything will start falling into place for them. So I think it's just that initial step really. (L34-37)

It appears participants instantly assume the first step will be a challenging one. It can either put one off from entering the process of seeking help or it can act as motivation to push forward.

Initially, Eishwar had felt too overwhelmed to engage with face-to-face therapy and had opted for the online option. He said he could access help in the future, if in need, because he had taken that first step already. Having the option to do it online made the process easier for him.

> Eishwar: I've overcome that hurdle like you've said I've come, I've broken down those barriers (…) (L661-662)
>
> 'Cos I have taken that initial step already, it wouldn't be that hard for me to take that step again in the future. (L666-668)

Breaking down the steps of help-seeking is, therefore, regarded as beneficial to the process. It is important to ensure that Sikh men are aware of the local face-to-face services as well as the online options available. As clinicians, we must promote this form of therapy for this particular client group because, as Eishwar suggests, they will always have access to it if in need.

> Eishwar: I still tried to help myself. (L604)
>
> I've still got my therapy er my online login, where I can just log in and if I ever feel down (…) (L606-607)

Therefore, after understanding the processes involved, there is a strong indication these men will want to take smaller steps as this would feel easier to manage. Experiencing online therapy may feel like a smaller barrier to overcome and if experienced positively, may open up other avenues of therapy, as previously suggested.

*4.4.1.3 Sharing one's own positive experience of therapy may encourage others to take a step forward*

To challenge the negative beliefs associated with mental health support, various organisations have voiced the need to share individual experiences (see Mind, n.d.; Time to Change, n.d.; Mental Health Foundation, n.d.), hoping this will present an opportunity for individuals to relate to one another, voice their subjective experiences of MI and challenge any negative attitudes towards it. This is consistent with what was observed in the data with the participants having a similar thought process.

Raj had not accessed therapy in the past, yet hearing the positive views held by others who had experienced it gave him the impetus to learn more about it. These conversations encouraged him to research further and he developed a sense of curiosity as to what it involved and how it could help.

> Raj: Erm from what I've seen and from having..speaking to other people who have had it and erm doing a bit of research myself it definitely looks like a method which helps people..just let out stuff, just talk to someone and helps them get through things. (L11-14)

For Eishwar, the use of success stories is one of the most effective ways of challenging the stigma towards help-seeking behaviour. He felt sharing his journey with his mental health may allow other Sikh men to realise that they needed to take action.

> Eishwar: (…) opening up about my experiences and them finding out that I've been down that route myself will maybe give them that push. (L793-796)

This suggests sharing success stories may reduce mental health stigmatisation and increase intentions to seek help. Having other Sikh men such as those that have sought counselling is one way where help-seeking can be normalised.

Talking to someone about mental health requires emotional sensitivity and some people do not know where to start when it comes to seeking help. Raj discussed the importance of giving appropriate suggestions if a close Sikh friend disclosed they needed help. Sharing that other friends had reached out may serve as a form of reassurance that can progress their help-seeking style.

> Raj: (…) speak to other people who, maybe, have been to therapy such as one of my friends who's done…..erm and try and find success stories. (L592-595)

Also, Raj suggested individuals are mostly concerned about whether therapy will help or not. Sharing success stories when advising one to access therapy may allow them to use this as a comparison with their current state, and to then identify how engagement can benefit their current situation.

#### *4.4.2 What can improve help-seeking behaviour within the Sikh community?*

The last theoretical concept incorporates the common view that there is a need to further expose mental health in the Sikh community. The participants felt

frustrated at the lack of knowledge as a key barrier to entry, and that therapy was not immediately considered to be an option. They presented key routes on how to improve mental health literacy within this community. The younger generation expressed how they wanted to challenge the way Sikhs look at and talk about mental health. Thus, the younger generation appears to be looking at their MI in a more broad-minded way; they are continuing to open up a dialogue on MI within the community (Jhutti-Johal, 2018) and urging the Sikh community to be educated on the benefits of psychological help. They discussed several ways this shift can happen:

First, a misconception seems to be present that some Sikhs view religion as not supporting mental wellbeing and the data clearly shows religion encourages mental health care. When exploring MI in Sikhism, the cultural and religious explanatory models have been presented in research (Singh, 2008; Jhutti-Johal, 2011, p. 252; Kalra et al., 2012; Ruprai, 2016) and here, the data has demonstrated a positive relationship between religion, spirituality and mental health. The participants were aware of the religious framework for managing their mental health and were able to engage with this during times of need. Distinctive features of the Sikh religion promote psychological wellbeing (Nayar, 2004, p. 87; Kalra et al., 2012; Singh, 2008) and the data presented meditation and prayer serving as key coping mechanisms.

Second, the need to encourage therapy as a norm was vocalised. The word *therapy* was shown to be associated with layers of stigmatised beliefs. According to the participants, Sikhs, like many other SA cultures, do not normally see talking therapies as a way of resolving issues and problems in their lives (Singh, 2008).

Once again, participants had a shared view on the lack of understanding of psychological therapies, and the need to inform the community of the importance of talking about your emotions, struggles, and hardships.

Third, there is limited awareness of mental health in educational settings. According to the participants school years are key to developing social and emotional skills, knowledge and behaviours. This period sets a pattern for how a young person will manage their own mental health and wellbeing into adulthood (Hayes et al., 2019). The participants felt a focus on wellbeing was lacking in the school system. Putting this alongside the limited scope to discuss MI in their existing support systems led them to have gaps in their knowledge of the process of seeking help.

Finally, participants urged health care professionals to become more involved. The interview excerpts revealed that often GPs are the first point of contact for many Sikhs; therefore, they need to have some provision for helping Sikh people in understanding what therapy is. The GPs were described as leaning towards prescribing medication and were not promoting therapy enough. These findings, alongside the evidence showing minority ethnic communities as being less likely to access support in primary care via the GP (Bignall et al., 2019), suggest GPs need to socialise and help guide individuals on what therapy involves. An opportunity exists for professionals to assist their patients in understanding how therapy works and what it may look like.

*4.4.2.1 The positive role/use of religion in mental health*

The participants suggested Sikhism promotes mental wellbeing within its scriptures and teachings. There was a strong link between religion and mental health (Jhutti-Johal, 2018; Kalra et al., 2012; Sandhu, 2005; Singh, 2008) and Sikhism appeared to normalise psychological and emotional distress for the participants. A range in opinions held in society of the different religions' view of the treatment of MI was highlighted in the data. For the participants, Sikhism itself does not prevent help-seeking. Religion was perceived as encouraging one to actively seek support when in need.

> Anveer: Erm like any other religion the view of seeking help is good (…) (L494)

> Sukhdeep: (…) you're not allowed to seek help anywhere it doesn't say anything in fact, it might even say that it's good to seek help when you need it (…) (L343-345)
> (…) but from my understanding, I-I don't think there is any barriers in my religion that stops people from having therapy. (L351-352)

Both Anveer and Sukhdeep spoke against the stigma of help-seeking behaviour. Emphasising that it was not religion that prevented individuals from accessing help. For Sukhdeep, he appeared to feel a sense of frustration that others in society may be advocating religion as forbidding it.

The data suggested religion has a strong influence on help-seeking. Some of the participants suggested Sikhs, in general, have a tendency to conform to what one thinks others are doing.

> Sukhdeep: People perceive things differently so they would read one thing..in…in the religion and perceive it in a different way and they'll think no no this is what it means. (L346-348)

Sukhdeep provided insight on how there are individual interpretations of religious beliefs and its implications for mental health. It appears some may interpret the beliefs as discouraging help-seeking and, therefore, contributing to the stigma, the maintenance of MI, and restricting access to care and support.

Akshay thought that these mixed beliefs were derived from the culture as opposed to the religion. He highlighted how religion encouraged individuals to develop healthy ways of coping, with a key aim of achieving a balanced state and encouraged Sikhs to continue working on themselves.

> Akshay: Erm I think Sikhism as a religion itself talks a lot about obviously being mentally healthy, being healthy in general, being physically fit and as far as I know there's no physical restrictions on you shouldn't help yourself in this way. I think there is, from what I know, as long as you're helping yourself.. there shouldn't be..I think that's where it gets mixed between the culture and the religion. (L374-383)

Akshay reflects on how culture appears to influence the perception of help-seeking, the understanding of mental health and presents the acceptable methods of managing wellbeing. Akshay states that while he does not turn to religion during times of distress, he is able to understand why the older generation may lean towards it during times of adversity.

> Akshay: No, I can understand why people do it. I know why elders do it, but I myself don't know. Erm 'cos I think it gives them..gives them some sort of hope 'cos obviously the whole basis of religion is on obviously you have someone to look up to, you have someone looking over you...obviously you feel you are part of something bigger..so obviously as soon as you engage in that you obviously forget about your day-to-day stresses and you start thinking about the bigger picture and obviously God looking out for you. (L399-412)

On the other hand, Raj expressed how religion has a therapeutic effect on his mental health by granting him valuable coping skills that he can access when he may be feeling low or stressed out.

> Raj: (…) our scriptures and we've got our the meditation and there's.. there's a balance as we practice our lives we live in harmony with nature. (L402-403)

It appears the meditation aspect of the religion allows for deep reflection, thus enabling him to have a better balance of life.

> Raj: Sikhism as a religion is about er simple things like waking up early in the morning er bathing and meditating and then meditating throughout the day. (L416-417)

He was able to highlight the importance of self-care as a fundamental part of the religion.

Similarly, Anveer noted the parallel between religion and therapy, where individuals should respond to any difficulties in a manner that is beneficial to their wellbeing.

> Anveer: I think the Sikh religion helps promote meditation and internal peace which is in line with what therapy does. (L512-513)

Anveer expressed how religion encourages healthy lifestyle practices, similar to mindfulness in therapy. For him, the spiritual aspect incorporated the mind and body, which positively influenced his mental health and emotional wellbeing. For Anveer, engaging with the religious act of going to the *Gurdwara* or the religious ritual of *seva* seemed to have provided a way to sit with his thoughts. With reference to Pargament et al. (2000), functions of religious coping helped him to gain control of his thoughts.

> Anveer: Erm sometimes I go Gurdwara and sometimes I help out through seva and that being a good deed obviously and it allows me to reflect sometimes. Like I think about it and thinking helps. (L524-529)

Further, prayer was a part of the spiritual practice that was viewed as improving and protecting emotional health.

> Anveer: I feel like praying can help me..it's like a way of talking to God if you understand. (L518-519)

Anveer felt conversing with God was a source of comfort and through prayer, he felt he was able to enter an intimate and safe relationship, where he could express whatever he felt without any worry of how it may be perceived. Hence, it appears spiritual coping serves as a valuable resource for individuals who are affected by MI.

Overall, culturally determined beliefs of how religion views MI contributes to attitudes towards help-seeking. The importance of separating culture and religion has been highlighted and the data indicates the participants view their religion as promoting help-seeking behaviour. Also, it is important we clinicians understand the importance of spirituality for Sikhs. This will allow us to understand what coping mechanisms may already be in place:

> Raj: So religion is something that gives me the..sort of becomes the cornerstone in my life that gives me something to fall back on. (L467-468)

Finally, awareness and understanding between the practitioner and the client is vital to achieve the desired goals for any client. By implementing Sikh spirituality, the

client can learn to reduce stress and improve their mental health, and this is universally applied (Singh, 2008).

*4.4.2.2 The need to encourage therapy as a norm within Sikh culture/society*

The participants advocated the need to normalise engagement with therapy to increase utilisation of the wellbeing services. According to them, the concept of therapy was not well understood in the community. There was a need to clarify what may cause access to therapy and to inform this population on how engagement with psychological therapies can help them, thus challenging the various stigmas present.

> Sukhdeep: (…) I feel that they will understand one day maybe even if I make them or understand or someone maybe you know some initiative has come out of…comes out where they start teaching people of the importance of therapy then maybe they will understand one day and I think that day will come I feel.. feel like it's important to sort of for people to do (…) (L361-366)

Anveer was able to identify that many Sikhs were unaware of its existence. He encouraged the need for such conversations to take place in the Sikh community and for Sikhs to continue expanding their knowledge base.

> Anveer: (…) thing about our religion is not many Sikh males and females know about therapy (…) (L494-495)
>
> I think that if we talk about it more, learn about it more then it will help us (…) (L497)

In order to normalise therapy, there is a need to provide more information and guidance to shape how MI and help-seeking are perceived. Thus, if anyone from this community did wish to seek support they would be well informed and know which steps to take.

Moreover, there is a perception of MI as being a sickness in society; some were put off accessing help due to the view of talking therapy was like going to a "mental hospital".

> Harminder: (…) try making it erm as a norm as in so if you got a problem just go to therapy and they will sort it out. It's not something that should be seen as oh because you should only go because your mental they need to make that, make that erm out there that people should go (…) (L175-181)

According to Harminder, the perceptions held in the Sikh community regarding who can access therapy need to be addressed and challenged for it to be normalised.

Further, the negative view of therapy appears to be tied in with the misconception that therapy is for crazy people. In order to normalise it, we must first address these misconceptions that make individuals perceive it as something bad. According to Sukhdeep, this can be achieved by informing this client group about the benefits of therapy as this will establish a better understanding of what it can offer.

> Sukhdeep: (…) there are people in my culture who don't perceive therapy as a good thing and…and if they were to sort of learn the benefits of it and if they were to sort of understand what it can do and..and realise that it's not just for sick people or it's not just not for people erm just there's something really wrong with them. (L75-79)

The potential positive impact of an increase in knowledge on help-seeking behaviour was viewed as a sign of hope for Sukhdeep. For him, further education could not only promote the importance of therapy but also create opportunity for "openness to change".

The need to continue raising awareness and promoting mental health via media was implied by both Aman and Eishwar.

> Aman: (…) like certain Sikh organisations you know different channels on tv that er um have certain shows on and reinforce that it's okay, I definitely feel that by having that push from the wider community from certain parts of the community it's definitely making it more acceptable yeah. (L501-504)

> Eishwar: So the thing is if, like I said if there was like a leaflet or something to show this is what these people have been feeling like this is what a lot of people do (…) (L471-472)

This may reinforce help-seeking behaviour and influence the understanding of mental health issues and, thus, the seeking of support. The push from the wider community may encourage therapy to be viewed as normal. The negative preconceptions can be challenged once Sikhs have been made aware of the use of counselling services.

#### *4.4.2.3 Limited awareness of mental health in educational settings*

Most chronic and debilitating MI's have their onset before 24 years of age when most sufferers are in the educational system (Srivastava et al., 2016). This indicates these years are crucial and education about mental health should start at an early age. Some of the participants said they developed an understanding of mental health during awareness days in school. However, they expressed how limited the awareness was and voiced the need to expand upon the topic of mental health in the educational system.

Sukhdeep talked about receiving some contacts of services he could approach when feeling distressed.

> Sukhdeep: (…) after leaving school it's not something that's been touched upon (…) (L5-6)
> (…) they don't really completely make kids understand what it can do and how it's done and how to actually..get the help when you need it. (L96-98)

It appears the little awareness that is available regarding the benefits of therapy is limited to these school years. Sukhdeep stressed the school environment needed to teach students how to recognise mental health issues and emphasise mental health as an integral part of health. The lack of input from the educational system resulted in individuals having gaps in their understanding of how to go about accessing psychological help. He suggested this is an area that could be improved in many ways. Eishwar also indicated there were limited opportunities to learn about therapy, and this created a sense of 'awkwardness' for him to engage with the topic.

> Eishwar: Generally, our family don't tell us about therapy you don't generally learn much in it....in school about it...so I think because it'sss a topic that's not really mentioned..it's a bit awkward. (L227-234)

For some, access to therapeutic help at school can be the only means of receiving support when dealing with great emotional distress or suffering from serious mental health problems. If an individual's family find the topic of MI too stigmatising, schools would be the next available option to develop a support system. If both are unavailable, it is likely the needs of these individuals will be unmet. Thus, making constructive conversations about mental health as part of the daily school routine (Radez et al., 2020) could create a shift in the help-seeking process.

Taran asserted the importance of these academic years as it is when coping strategies are learnt and developed.

> Taran: (…) that's when you really learn how to deal with things and if they're not telling you what you can do then obviously you won't take any action (…) (L101-102).

Mental health in schooling can, therefore, be expanded as schools are the strongest social and educational institutions available to learn in, and to practise skills. This could influence how one approaches the process of seeking help. The collaboration between schools and mental health services is essential (Radez et al., 2020) to enable young Sikh men to access evidence-based support within this setting or be equipped in seeking psychological support at a later stage in life.

#### *4.4.2.4 Healthcare professionals to get more actively involved*

Some felt GPs need to promote counselling in the Asian community. The participants identified the GP as the main point of contact for any form of illness experienced by this community, whether mental or physical. Due to the high somatisation of psychological and emotional distress in this population (Krause, 1989; Fenton et al., 1996; Bhugra et al., 1997; Bhui et al., 2004), GPs need to adopt more of an informative role when exploring treatment options to ensure Sikh men understand how to best approach any mental distress so their psychological needs are not neglected.

> Eishwar: We don't really seek therapy, we don't really know much about therapy.. the only time we will know about therapy is if you go to the doctors and ask. (L222-225)

For Raj, having the opportunity to talk through his options elicited feelings of comfort.

> Raj: Let's explore the options and then so that we are in a more of a comfortable position to understand okay maybe therapy, maybe not. Let's look at something. (L533-536)

For Taran, his GP and the other professionals involved were not fully aware of the range of counselling services which were available to meet the specific needs of this cultural group.

> Taran: Never heard of any Sikh therapists so I don't even know if that's possible. (L157)

As a result, his experience of the help-seeking process was described as overwhelming, potentially discouraging him from seeking help again.

Eishwar suggested this community has a cultural tendency to sustain a reliance on medication alongside having poor awareness about the symptoms of MI. This is an area where the GP can adopt a more active role, as he states.

> Eishwar: (…) the doctors will be like I've got tablets as well..antidepressants. (L492)

> I feel like, maybe if the doc..the GPs were pushing a bit more out there for Asians. It would maybe push that individual to go down that route instead of taking pills. (L496-500)

Primarily, GPs should promote wellbeing services over encouraging the use of medication. Also, they should be transparent about the nature of the service they offer to their patients and make appropriate referrals where necessary, to encourage Sikh men to engage with the process of seeking therapeutic help.

# CHAPTER FIVE

## DISCUSSION

This chapter discusses the findings in relation to the existing literature and draws upon implications of these findings for future research and clinical practice. References will be made to the original aims and objectives.

## 5.1 Research findings in relation to existing literature and the implications of these findings

### *5.1.1 First theoretical construct: Internal barriers*

In the data, the participants spoke of proceeding through a process of internal conflict when deciding whether to access therapeutic help. *The ideal self* captured the participants' construction of hegemonic masculinity and the findings support the view that the practices of masculinity the men engage with are integral to and have major implications for men's health (Sabo & Gordon, 1995, p. 2). The ideal self was comprised of three key themes: to not be seen as failing, a warrior identity and the role of the breadwinner. The men's perspective on health behaviours, particularly help-seeking, was viewed as a practice that contributes to the active construction of their gendered identities (Courtenay, 2000). A common theme was participants who tried to live according to the hegemonic masculine ideals that comprised the ideal self appeared to be reluctant to seek mental health support for any mental health issues. There were multiple expressions of masculinities with overarching sets of ideals and masculine expectations the participants actively adapted to and negotiated,

and those that were able to resist masculine expectations proceeded to seek therapy. The findings are unique in presenting the men's beliefs, and the constructions of masculinity directly affected their capacity to embrace or reject mental health care, their decisions regarding help-seeking and their perception of themselves when experiencing mental distress.

According to Connell (1995, p. 77), *hegemonic masculinity* represents a vision of idealised masculinity that does not necessarily correspond to the real lives of most men but is, nonetheless, a form of aspiration for them. Constructivist perspectives of masculinity claim health-related beliefs and behaviours men adopt vary depending on whether a man is performing a hegemonic, subordinate, or marginalised form of masculinity (Courtenay 2000). The participants aligned themselves with views that were consistent with hegemonic ideals of masculinity (e.g. self-reliance and resilience) to convince themselves and others that they were coping. They associated seeking help with having to rely upon another and having to express emotions, and these are behaviours which are incompatible with the norms of being self-reliant and emotionally controlled (Addis & Mahalik, 2003; Lane & Addis, 2005). The majority of them engaged in self-talk and/or reinforced a "get up and get on with it" attitude, as described by the participants. This is consistent with existing identifications on Punjabi Sikhs being the most vulnerable to suffer MI in silence due to a strongly held belief of self-sufficiency and a belief in being capable enough to manage their own hardships (Kesvani, 2018). It can be concluded, to an extent, that the need to appear acceptably masculine took greater precedence over concern for their health. The aim to restrict the expression of their emotions was to avoid projecting a weaker or vulnerable self, which they felt others would

disapprove of. The thought of accessing help also resulted in the participants seeing themselves as weak, with some believing others in the community will question their ability to manage any hardships.

There appeared to be a strong perception that if one accesses external support, one has internally failed to help oneself and that external views will mirror this belief. The participants tried to manage any hardships they faced on their own and the option of accessing support was only considered if this self-help strategy failed. It is important to note the delay in help-seeking implies some participants did not hesitate to accept that they are struggling. The data also suggested the participants differed in their perceptions of failing to manage independently and the behavioural responses that followed, eventually leading to those that needed support to reaching out. It could be argued that for some of the participants, their willingness to accept they were no longer coping and the seeking of help corresponded to a non-complicity with hegemonic patterns of masculine behaviour. This argument would also point towards their representations of masculinity being marginalised, whereby their behaviour is seen to be measured against, and marginalised from, dominant hegemonic representations of masculinity.

Generally, psychological help-seeking was seen to be in direct conflict with dominant masculine gender roles. In any given social context, there are dominant behaviours that were considered by the participants to represent how a real man is seen to act. Consistent with aspects of gender role theory (Thompson & Pleck, 1995, p. 130), the participants may have been socialised into learning gendered attitudes and behaviour in terms of what it means to be manly by their cultural values, norms and ideologies. The need to convince themselves and others that they were coping

suggests they felt they must display an internal locus of control (Rotter, 1966). This desire to always be able to help oneself can lead to self-stigma, as some of the participants stated they would not seek help even if they were struggling. When exploring gender role conflict, self-stigma is applicable because the traditional male gender role's characteristics may lead to increased concerns about seeking help as seeking help may mean admitting an inability to handle things on one's own (Pederson & Vogel, 2007). Literature exploring stigma has focused on assessing the broader Indian culture (see Knifton, 2012; Shrivastava et al., 2012) and has previously failed to explore gender differences by mainly studying female respondents. This research, therefore, presents original findings in which the existence of self-stigma appears to exist for Sikh men. It seems society generates social norms dictating what it is to be a man (Addis & Mahalik, 2003) and these strongly held attitudes may be detrimental as they may prevent someone from seeking or receiving treatment.

When applying Connell's (2000, 2001) notion of some masculinities being more honoured than others, according to the participants, the Sikh martial tradition (Gill, 2014) has left a sense of aspiration, and the notion of the warrior has defined the characteristics a Sikh male should embrace: e.g. to be strong and fierce. The participants' help-seeking approach indicated the label of a martial race continues to define, shape and configure Sikh masculinity (Kohli, 2016). They navigated their help-seeking in accordance with what they deemed was the honourable way to engage with the performance of the male self (Kohli, 2016). As Gill (2014) has previously suggested, the construction of a hyper-masculine, martial Sikh warrior as the authentic Sikh male continues to shape the sense of self and a similar theme was

present in the current data. The data demonstrated being viewed as displaying the hegemonic view of men in terms of getting on with it held some honour and was assumed to be the common enactment of masculinity. The participants described themselves as descendants of a religious group whose people have experienced hardships, displayed strength and been fierce throughout history. According to the data, the traits exhibited by their ancestors reflect the conventional gender standards of being strong and in control (Bhui et al., 2002) and it seems access to therapy threatens this identity.

As previously mentioned, Guru Hargobind Ji's vision of the *Sant-Siphai* was to protect the Sikh community (Singh, 2008). This was further reinforced when Guru Gobind Singh Ji initiated the *Khalsa*, to create a warrior group with a duty to protect the innocent from any form of religious persecution (Kohli, 2016; Madra & Singh, 1999, p. 23). While this religious phenomenon was not reflected in this way by the participants, it seems British Sikh men have constructed that one particular form of masculinity, which has emerged at the intersection of religious, social, political and cultural factors (Kohli, 2016). The warrior spirit allowed the participants to believe they can and must overcome any emotional and psychological distress themselves, and they asserted this was how Sikhs are known to deal with any adversity. Kohli (2016) focused on the postcolonial framework, proposing Sikhs have actively worked on this identity over the years, one that comprised *Khalsa* warriors, mercenaries, enlisting in the army and self-identifying as a martial community that was "habituated to war, and upholding those ideals and notions" (Kohli, 2016, p. 60). In relation to the present findings, young British Sikh men continue to embrace this identity and, while they value the image of warriors, they feel the pressure to

maintain this warrior ethos because it is a prominent feature of Sikh masculine consciousness. While we can assume there are multiple identities at any given time, this dominant form of masculinity has been the most beneficial over time (Kohli, 2016) and, therefore, continues to create an intention in young British Sikh men to make it their own.

Theoretical understandings of masculinity from a constructivist perspective suggests men are assumed to think and act in the ways they do, not because of their role identities or psychological traits, but because of concepts of masculinity that they have adopted from their culture (Courtenay 2000). In the range of choices available to them, the image of warriors was selected and there appeared to be a process where the participants experienced difficulties within the self, as they weighed themselves against this image. There appeared to be a sense of loyalty to the warrior spirit. As previously discussed, bravery is one of the salient values of the religion that reinforces the need to develop courage (Kapur & Misra, 2003) and this continues to create culturally influenced beliefs of what defines masculinity. Although these young men were no longer warriors on the battlefield, it felt important for them to continue to present themselves as fearless. Sikhs are known to be proud of their identity and perhaps some of these men felt the need to sustain this sense of pride.

It also seems Sikh men construct and enact their masculinities in a number of different ways in a number of different contexts (O'Brien et al., 2005). For example, in the data, both Harminder and Akshay felt they could not access therapy because this conflicts with ideal gender norms, yet they were able to deal with emotional distress within the context of the family home, in which emotions are to be dealt

with through communication with family members. This supports the view that Sikh martial masculinity is not a universal category of masculinity which can be attributed to all Sikhs at all times (Oberoi, 1997, p. 55; McLeod, 1976, pp. 95-104; Fox, 1985, p. 8), and it is just one particular form of masculinity. Punjabi Sikh men are regularly stereotyped in the media and popular representations as physically powerful and aggressive (Kalra, 2009) and Punjab is valued as the homeland of Sikhs and is widely respected as the "land of the brave, or the land of the lions" (Kohli, 2016, p. 44). This positions Sikh men's help-seeking style within their social systems, and the media is one source which has informed them of how a real man is seen to act.

Moreover, Oberoi (1994, p. 48) highlights that cultural assumptions prevalent at certain times influence perceptions of gender, interpretations of religion, religious texts and religious practices. In relation to the present findings, the participants constructed their male identities in accordance with their understanding of how masculinity has been socially defined, accepted and enacted throughout history, and where pride has also held some significance. For example, anything that damaged the image of a *sher* would be interpreted as a taboo, and this may explain why Sikh men, in particular, refrain from accessing external support. When exploring this image, it should be noted that the surname Singh (a common surname or middle name), which means lion, was given in 1699 by Guru Gobind Singh (Mcleod, 1976, p. 15), and Kohli (2016) mentioned Punjab as being known as the land of the lions.[3] Sikh men are commonly recognised by this title, and the extent to which this truly affects help-seeking has not been fully understood in the current findings. It is an

[3] derived from the Sanskrit word simba, meaning lion.

area for further research as the participants expressed how Sikh men aim to live up to this ideal of a lion to be accepted and valued by society.

Further, Oberoi's (1994, p. 23) assertion of plural and fluid Sikh identities proposes that the conception of religion and culture is embedded in everyday life, it is not a fixed state of being and is a process. The Sikh warrior tradition is forever shifting; it appears to be a complex entity encountering social pressures of all kinds that influence how these men should respond. Particular interpretations of group histories of heroism and martyrdom continue to play an active part in identity construction for young Sikh men, which is personal and subjective (Oberoi, 1994, pp. 330-331), and here, some of the participants felt they had inherited the legacy of the Sikh warrior spirit and related this to their approach to mental distress. Mandair (2005) focused on theorising Sikh identity and proposed "the militant ontology of Sikhism meant that its male members could not be conceived other than as real men" (p. 48). It seems in contemporary times the historical Sikh warrior identity is employed when displaying a sense of strength.

The norms displayed by their ancestors, to create a distinct ethnic and religious group, are salient in the current decision to seek help for mental wellbeing and play a significant role in the performance of masculinity. Mental health-related practices seem to challenge the view of a warrior race, as reflected on by Akshay, thus constraining help-seeking and, perhaps, subconsciously preventing some Sikh men from initiating mental health treatment. Some of the participants felt others would align them with the warrior tradition and they viewed this as their inherent identity that mapped their decision-making. It has been suggested that the Sikh warrior tradition can be internalised to reflect more current experiences, endorsing a

hyper-masculine ideal (Gill, 2005). In contemporary times, it is one form of hegemonic masculinity within society (Connell & Messerschmidt, 2005) that regulates the thoughts and expectations of men; it acts like a vision, an aspiration, a collective ideal. At times, this ideal has been used as a coping strategy by focusing on inner strength and self-agency. The history tied in with the warrior tradition is an important feature of this client group's religious and ethnic distinction (Madra & Singh, 1999, p. v; Fox, 1985, p. 27) and continues to shift help-seeking.

It is vital we consider ethnicity to fully understand the contemporary experience of being a British-born Sikh male (Gill, 2005). Gill (2005) found an ethnic aspect in being a Sikh and combined it with the domains of religion and race. Sikh masculinities can be understood via a social constructionist framework in which ethnicity is located within individual subjectivities. Ethnicity is not fixed and contained but rather a narrative, it is a constant process, and a dynamic phenomenon that shifts with time, space and location (Hall, 1992). The findings from this study have drawn attention to ethnicity as an important determinant in the representation of masculinity in the context of help-seeking; there is not a single representation of Sikh masculinity, rather multiple masculine identities are likely to be constructed through the various positionings of the self and others with regard to interconnected social divisions of gender, ethnicity and class. The social constructionist stance appreciates the notion of ethnicity as fluid and changeable depending on the context, group and individual (Cornell & Hartmann, 2006, pp. 36-44). Interestingly, the participants displayed different approaches to their ethnicity, Akshay referred to himself as Indian, which suggests identifying oneself as being Sikh in terms of an ethnic/religious label is, indeed, negotiable (Gill, 2005). While the majority of the

participants in this research were not baptised Sikhs and some did not engage with regular religious activities, the impact of Sikh history was significant in constituting and forming a part of their identities.

When exploring the participants' individual subjectivities, in line with Hall's (1992) assertion of new ethnicities, the men in this research built upon narratives that constructed a group history, reflecting on shared cultural practices and distinctions that set them apart from others. The view of Sikhs as a martial race was identified by the indivisibly masculine signature of a colonial culture (Mandair, 2005), an ethnic stereotype whose imprint persisted in the interview excerpts. Lyons (1996, pp. 31-38) defines an ethnic group as a collection of people who (a) possess a distinctive culture; (b) identify themselves with a common set of beliefs and values and (c) interact in such a way as to be socially distinct. This definition is in accordance with how the participants integrated their sense of belonging as they drew distinctions between themselves and others, which also shaped their sense of masculinity. While cultural traits and identity were maintained in this theoretical construct, it was considered less relevant in the other themes, which presented ethnicity as flexible and variable.

Nayar (2004, p. 118) stressed that the Punjabi community's mental health needs can be attended to by encompassing traditional Sikh values into the therapeutic context. The importance of understanding this key component of Sikh history is vital for any practitioner to begin to develop a sense of how this client group approaches their psychological wellbeing. This theme expands upon existing research by Ruprai (2016), who identified that the warrior stance was being adopted by Sikhs in response to emotional and psychological distress, whereby individuals

aimed to confront problems head-on and displayed a sense of resilience. It is important to note that Ruprai's (2016) research explored the beliefs surrounding psychological wellbeing in both male and female respondents, unlike the present study which focuses solely on identifying the processes involved when a Sikh man considers seeking external support. Ruprai (2016) also proposed the need for future research to adopt a social constructionist epistemological position to explore how the Punjabi community constructs distress, and this is where the present study takes a stance.

The theme '*The expectation of a young Sikh male taking an active role and eventually becoming the breadwinner'* expands on why Sikh males feel the need to maintain a male-like persona that resembles the Sikh warrior. It is to be noted that, even in Western societies, there is the assumption that a real man will have a full-time permanent job which supports his family financially - a breadwinner identity (Price et al., 1998; Connell, 2000, p. 63). In relation to British Asian men, there is evidence of a cultural script whereby ideal manhood is "informed by notions of responsibility towards parents and their care" (Gill, 2018, p. 276). In relation to the present findings, the construction of a breadwinner masculinity, to be seen to enact or maintain a masculine identity with a breadwinner in mind, was a significant feature of the participants' help-seeking decision-making process. As Chopra (2004), has previously observed, the young men drew on notions of hegemonic masculinity as embodied by their fathers and other adult men in their families. The data presented the masking of weakness or vulnerability and the refusal to seek support could be seen as behaviours taken as a means of preserving and enacting a hegemonic masculine identity that embodies the perception of men as `breadwinners'

(Connell 1995, p. 28; Courtenay, 2000; Petersen, 1998, p. 49). The participants said discussing emotional content appeared to conflict with this form of masculinity. The findings highlight how they experience multiple pressures to present themselves as contained to then be able to provide for and protect the family. This is similar to Gilmore's (1990) notion of *izzat* being a philosophy of life for Sikh *Jats* of the Punjab that "reflects their paramount concern for male power, in which a man's duty is to be stalwart in defence of his family" (p. 177). The participants said they did not want to let their fathers down and that supporting the household was conceptualised as a responsibility and duty, similar to how Gill (2018) presented the notion of care and supporting the family as a central feature of British Asian men's lives. This was described to be the rightful duty of every male and, as the majority of the participants were from the young generation, there appeared to be a key anxiety present, one that surrounded the cultural duty to embrace the father's role in the future. For those that did not access help, they could not cross these boundaries and continue to uphold a male-like persona.

People with mental health difficulties have often been stereotyped as crazy, weak or out of control, again contrasting with the traditional masculine ideologies of being strong, independent and rational (Corrigan, 2004). This incongruence between conformity to masculine norms and help-seeking behaviour was viewed as a key explanation for the participants' reluctance to seek help. Overall, the importance of self-image was noted and they were wary of what others may think. Previous literature has noted a deep-seated cultural norm of saving face (Nayar, 2004, p. 169). This appeared in the present study whereby the participants were reluctant to open up and talk about their personal problems due to the views held in the family/friends

circle, Sikh society and the wider Indian community. This all formed a part of a process that one must evaluate prior to making any decision. When exploring why they were wary of what others might think, their hesitancy seemed to be related to the potential assignment of a label of crazy or mental during help-seeking, which was perceived to be stigmatising. The findings presented by Das and Kemp (2011) established Indian Americans were reluctant to seek counselling as it appeared to not only stigmatise the person who needed help but also the family. Similarly, the participants felt their families could be affected by their access to therapy: for example, Akshay said rumours and gossip were common in the community and to avoid shame, individuals would be mindful of the impact of their own help-seeking on family honour. Other research has established cultural and religious beliefs surrounding mental ill health can result in shame (Tabassum et al., 2000), and here we can conclude these beliefs appear to have more of a cultural basis.

Knifton (2012) suggested that to maintain family reputation, one may feel the pressure to hide the problem and suffer in secrecy. The findings demonstrated the participants were conscious of maintaining secrecy due to the negative views associated with therapy which directly hindered accessibility. However, after some time, they were able to make the most of confidentiality. For some, discussing their views of therapy and help-seeking in the interviews triggered some anxieties and, knowing that their responses would be anonymised, gave them the reassurance them to take part in the research. This suggests that, moving forward, clinicians should seek to promote the role of trust in therapy and emphasise the role of confidentiality (in the context of duty of care) in the initial session as this may encourage engagement with therapy throughout the course of the treatment. The role of

confidentiality will be discussed in-depth later in this paper. A report by Rethink (2010) identified key themes of fear, shame and guilt in the SA population regarding MI. This negative evaluation of MI and help-seeking appeared to be incorporated into the sense of self for those who could not consider help as an option. Eishwar mentioned some Sikhs may be afraid of seeking help, suggesting there is stigma concerning help-seeking for British Sikhs in general as he did not mention gender differences. A sense of dishonour and disgrace for the family being felt in relation to perceived negative judgement by others within the community holds significance, and parallels Mukherji's (1995) identification of societal allure and cultural sanctions causing Indians to have a delayed response in accessing treatment.

There was a key focus on pride in society; whether one accessed help or not, the need to protect one's reputation was deemed as vital. While pride and honour have been identified as recurring characteristics in Sikhism (Gilbert et al., 2004), these findings are the first to demonstrate that for young Sikh men, a delay in help-seeking or an inability to consider therapy as an effective coping method are a means of protecting pride, social identity and a positive self-image. While pride emerges from a sense of self, it has been suggested people experience pride in achieving a standard recognised by their culture (Corrigan et al., 2013), and this influenced the process of help-seeking as the participants had an understanding of what would be deemed as acceptable and appropriate in society. To protect their honour, Sikhs have the ritual of discussing their problems in a collective and impersonal philosophical context (Sandhu, 2005), and this was present in the current findings. Some Sikh men wanted to keep their engagement with therapy private, first, because there appeared to be a strong perception of shame being associated with seeking help and second,

this was deemed necessary to avoid any reflected shame (Gilbert et al., 2007). Shame has already been identified as being associated with MI amongst communities in international research (Fabrega, 1991) and for the participants, shame made the process of seeking help seem even more challenging.

### *5.1.2 Second theoretical construct: External barriers*

For the participants, access to therapy was strongly influenced by several external factors: parents, family, society, and the effect of migration across generations. These external factors allow us to understand what may contribute towards therapy being regarded as an unfamiliar concept.

In the SA community, the main source of emotional support comes from the family (Baptiste, 2005). This is in line with what has been identified in the present research, where great emphasis was placed on ensuring one continued to engage with receiving this support. Other literature has found family is regarded as the most important structure in caring for its vulnerable members (Conrad & Pacquiao, 2005; Commander et al., 2004; Lawrence, 2006; Gill, 2010) and here, the family was of great importance during both the help-seeking and decision-making process. Matters were to be discussed at home and collective decision-making was extremely important for the participants. They did not want to engage with an act that may have defied this solid unit, and the cultural proscription against speaking about personal issues with anyone other than a family member (Das & Kemp, 1997) was present in the findings. As such, it was apparent the participants' help-seeking and decision-making process became a mutual process. Some displayed a strong preference for dealing with any issues in this manner, while for others, this mutual process was

dominated by how their parents and family members made sense of their difficulties, and this often prevented them from considering therapy as an option. Since the family was viewed as a strong network (Singh, 2008), any negative decisions by family members were viewed as dispiriting.

As the participants stated, there are concrete, inflexible and enclosed methods in place on how to manage conflict: e.g. approach a loved one or discuss difficulties at home. They described themselves as coming from a culture which values close and inter-dependent family systems (Dhillon, 2004) and, therefore, could define the importance of accessing their inner circle during the help-seeking process. This finding is consistent with Chadda et al. (2001), who found that 90% of people experiencing chronic mental health problems lived with their families and did not access external support. There appears to be no space to try out new methods of treatment and perhaps this is because family decision-making would be selected over individual preference (Stopes-Roe & Cochrane, 1989). As discussed previously, existing findings on young Asians have illustrated those who put their family first simply stated: “family first - you’ve got to make the family happy” (Stopes-Roe & Cochrane, 1989, p. 155). This was similar to the present findings where participants were unaware if the family would be happy if they went to therapy and, while the participants had conflicting beliefs with their parents, they would lean towards their parents’ decision-making to not disappoint them. Hall (2002) suggested Sikh “parents enforce communal norms, teens feel, because of what others will think, not because they themselves believe in them” (p. 180), and this seems relevant here. Once again, parents seemed to focus on shame and, in this theme, shame was associated with being viewed as not being able to help their child. Implying notions

of shame differ according to interpersonal connections, and the importance of the role of the social and cultural in the experience of shame has relevance (Leeming, 2004). Nonetheless, there were some concerns regarding gaining approval, and family approval had already been noted as important in deciding whether one sought treatment for MI when exploring the wider British Asian community (Stopes-Roe & Cochrane, 1989). However, the current research is original in demonstrating the importance of parental approval in help-seeking as it serves the most fundamental part of the process. If parental consent was not given, the young men would not have pursued external help. Some participants also assumed their family members would react in a negative manner and so, chose not to have the conversation in the first place.

Interestingly, disclosing vulnerability to family members was not perceived by most of the participants as being unmanly; it was admitting to needing support that was perceived as the most threatening towards masculine ideals. It seems disclosing any mental distress was not consistent with the participants' perceptions of acting like a man in the context of help-seeking and incongruent with their perceived need to demonstrate a sense of strength. However, when in social interaction with their fathers, being a man became a performance of recognised and common-sense attributes of masculinity (Connell, 2000, p. 28; Hopkins, 2006) for some of the participants. Therefore, when the performance of Sikh masculinities is remade and played out in different spaces, those spaces shape the very nature of the experience of masculinity and how it articulates with other key dimensions of social relations (Hopkins, 2019; Gill, 2012).

Research has demonstrated that SA clients tend to be reluctant to seek out counselling due to an emphasis on keeping family matters private (Almeida, 1996, p. 400; Segal, 1991; Sharma, 2000). Family honour and the cultural concept of *izzat* is frequently presented in the literature as preventing Sikhs from speaking about their MI (Dhillon, 2004; Gill, 2005; Gilmore 1990; Gilbert et al., 2004; Jhutti-Johal, 2018), and these valuable characteristics create a sense of responsibility: i.e. to ensure family success and prevent others from holding any negative attitudes towards the household. Due to family matters being a main focus amongst the Sikh community, this privacy, therefore, plays a key role. The cultural values of Punjabi communities emphasise that issues should remain within the family and be dealt with privately (Singh, 2009). Going elsewhere was viewed as a "no go to" option, suggesting disclosing personal problems to anyone outside of this circle may be deemed a breach of loyalty (Ruprai, 2016), and the acknowledgement of needing external input may make family members feel as if they had failed each other. The participants were able to define private and public spaces, with the cultural fields of family deemed as private (Hall, 2002, p. 178).

Due to the concrete methods in place for dealing with distress, e.g. sharing with parents and family, another key construct that was identified was therapy being considered as the last resort. The data suggests Sikh men rarely access mental health facilities and aim to exhaust all other possible resources, often waiting until their conditions become severe. Chew-Graham et al. (2002) and Ahmad et al. (2009) presented Indians as underusing psychological services with mental health services only accessed at the point of crisis and here, the data presented a similar delayed response in accessing treatment for the participants. While there is an array of

complex explanations for this, we can see the beliefs Sikh men hold (fuelled by many social mechanisms) of therapeutic treatment has a key role to play in the delay in the process of seeking help. The participants only accessed therapy due to situations getting out of control or via family encouragement. This finding is supported by other research that demonstrated SA clients will only see a mental health professional if forced to by a relative or friend (Baptiste, 2005).

It is key to note that therapy may be considered as a last option due to therapy being an unfamiliar route, specifically unfamiliar for the older generation. Literature has highlighted that despite the prevalence of MI through successive generations, the condition has generally not been openly discussed in the Sikh community (Jhutti-Johal, 2018) and this seems to be due to the older generation having set views on dealing with distress. The present research supports some of the notions proposed by Panganamala and Plummer (1998) which suggest first-generation immigrants appear to hold negative attitudes towards counselling and, therefore, dismiss it as a coping strategy, while second-generation individuals hold more positive views. In the data, friends from the younger generation were seen as more approving of the help-seeking process and were viewed as being more open to initiating conversations on mental health, while those from the older generation were perceived as a barrier. Hastings (2000) noted SA's have greater opportunities for self-expression when they are outside the immediate family context. Friendship groups are, therefore, important in allowing British Sikh men to negotiate the intersections of culture, ethnicity and identity (Dhillon, 2004). Thus, friendships allow Sikh men to enact and enjoy their male identities.

Nearly all the participants interviewed were raised by parents who were born in India and migrated to England. It seems mental health was not touched upon in Indian schools. This could explain why individuals from Indian backgrounds may be cynical and unconvinced by mental health services and their benefits, and why Indians are underusing them compared to their white counterparts (Hussain et al., 2004). The process of seeking therapeutic help is viewed as challenging due to gaps in understanding and knowledge in the older generation, which also projects onto the younger generation. Young Sikhs in the UK are faced with the difficult challenge of preserving their own cultural standards and principles while becoming acclimatised to Western cultural values (Hall, 2002, p. 172). It can, therefore, be argued that they are caught between two cultures, with a desire to make the process easier for them by challenging the views held by the older generation, highlighting how they are beginning to view MI and the methods to treat distress differently to the older generation (Jhutti-Johal, 2018). Consequently, we can see the differences in the teaching of mental health in the East and West having a fundamental role to play in help-seeking across generations. The participants stressed their parents lacked the opportunity to gain an awareness of MI and the data illustrated the differences in teaching in the East and West, creating differences in mental health literacy (Jorm et al., 2005). Thus, education was interpreted as a predictor of higher mental health literacy and was viewed as having a fundamental role to play in the style of help-seeking adopted. The participants were able to highlight how their own views seemed to have shifted due to an increase in education, the opportunities to learn new strategies and the subsequent advancement in mental health literacy. The present findings concluded that those who had successfully acculturated to Western

culture were more inclined towards help-seeking behaviour, a theme which is further explored later in this discussion.

Due to parents lacking mental health literacy, the participants noticed their parents had a tendency to reject psychological symptoms. Literature has previously proposed that some cultures may not conceptualise distress as an MI (Kleinman, 1987) and for Sikhs, mental health tends to be viewed through the lens of culture and religion rather than scientific and evidence-based perspectives (Jhutti-Johal, 2018). This appeared to shape the help-seeking process for the younger generation and the participants learnt to deal with any distress from observing how their parents responded to any issues. The men reported help-seeking was not spoken of while growing up and claimed any alternative means of coping may not be understood by their parents. According to Laungani (2006, p. 4), this cultural conflict arises from the difference between Western individualist perspectives and Eastern collectivist ideology. This notion was reflected when the participants differentiated between modern and traditional parents. Modern parents were seen as accepting of modern options and viewed as more aligned with British culture. Traditional parents, or "old school parents", were viewed as endorsing traditional attitudes about male behaviour and were linked to negative attitudes toward seeking professional help. Nevertheless, the East-West dichotomy is a conceptual framework which has historically been used as the basis for analysing cultural differences and interaction (Zon, 2012). However, it is important to note, the researchers intention was not to uncover, or construct the East-West dichotomy. Rather, the participants themselves rationalised such generational differences and presented assumptions within this framework.

Further, participants spoke about the Sikh community's natural response in associating MI with the need to see a doctor. The process of help-seeking involves engagement with a GP and this interaction is crucial in beginning to address psychological needs. The culture's tendency to replace psychological symptoms with somatic ones (Krause, 1989; Bhugra et al., 1997; Ruprai, 2016; Fenton et al., 1996; Jhutti-Johal, 2018) has resulted in a lack of awareness concerning wellbeing services and less focus on the comprehensive approach to therapy, suggesting the culture appears to influence illness experience. Being unable to distinguish between emotional and medical difficulties, alongside the observation that SAs tend not to perceive depression as an illness and, consequently, are less likely to disclose their psychological problems to their GPs (Jacob et al., 1998), allows us to understand why families were perceiving health treatments as strange, foreign and unhelpful (Lindesay et al., 1997). The participants presented a sense of frustration regarding the medical model as it prevented loved ones from understanding the benefits of engaging in therapy. Punjabis being more likely to be diagnosed as having more somatic symptoms than any other SA sub-group (Bhui et al., 2004; Fenton & Sadiq-Sangster, 1996) suggests clinicians need to acknowledge how symptoms may be expressed in different ethnic groups (Bignall et al., 2019) to make services more accessible and non-stigmatising.

Overall, therapy was described throughout the interviews as a foreign concept in Sikhism. The participants stated many individuals in the Sikh culture were unaware of what it entailed and how it can help. There is further information that needs clarifying about this cultural group, e.g. the level of distress that one can take to therapy. Therapy, therefore, may not be viewed as an option when

individuals proceed through the process of seeking help. Therapy, being foreign in the Sikh community, not only results in first-generation individuals continuing to have fixed methods but also inhibits access to help for the second-generation. A lack of knowledge of mental health and symptomology is a clear barrier: this finding is supported by previous research that has demonstrated Sikhs were not fully aware of what services were available for those experiencing mental health difficulties (Ruprai, 2016). It is evident there is a need to develop mental health exposure in this community. Counselling Psychologists need to get actively involved by offering guidance which could potentially dispel the shame associated with seeking help (Shapiro, 2003). The present research urges the need for exposure as it serves as an important factor that can shape the process. Exposure is vital as only those with families from an educated background will be knowledgeable about mental health, while those with traditional parents who have migrated are more likely to find the process difficult. Level of exposure experienced will influence the process of seeking therapeutic help. Further ways on how clinicians can have an active role in challenging existing barriers will be discussed below.

### *5.1.3 Third theoretical construct: Opening up the barriers*

The final theoretical construct captures a sense of urgency displayed by participants to challenge existing barriers. Bhugra and Bhui's (1998) observation that physical and psychological barriers exist for ethnic minorities accessing mental health services suggested that cultural issues are present. Dhillon (2004) identified three key cultural issues that may prevent Punjabi Sikh men from accessing psychotherapeutic services: the cultural inappropriateness of the service itself, the

role of family and community and, finally, the participants' stance. Throughout this research, cultural issues have been discussed to understand the emotional and behavioural challenges for participants and, despite the barriers to accessing meaningful services, there was a motivation in the participants' accounts to move towards a context where mental health services were truly inclusive, universal and accessible in this community. To challenge existing barriers, various shifts are beginning to occur in the Sikh community and Jhutti-Johal (2018) refers to the younger generation, the Millennials and the Generation Z, as those who have started the discussion on MI within the Sikh community. In the data, those that had previously accessed therapy felt strongly about the positive gains from it. Meanwhile, those with no contact with therapy had only heard about the benefits via others accessing external support. This suggests interacting on a personal level and having discussions of mental health is of great importance in increasing awareness. Exposure is required for an individual to truly understand what therapy entails and how it can be of benefit to one's mental health. It also allows us to recognise the positive views of therapy that are held by Sikh men, which is not evident in the current literature. Previous research has not considered how Sikh men perceive therapy and the role this plays in shaping their help-seeking.

Various ways clinicians could make the process of help-seeking easier for this particular client group will now be discussed. The analysis identified '*Engagement with therapy changes views of mental health and help-seeking styles, in relation to the self'.* Therapy has allowed those that had the opportunity to access it gain a deeper understanding of their beliefs. It was found that those who had experienced therapy highly valued the confidential nature of the counselling process

and reported a number of benefits (such as the ability to discuss problems more openly and the ability to consider problems from a fresh perspective) they had gained from it. The therapeutic alliance between the client and therapist, plus being comfortable, were considered crucial in ensuring a positive outcome claimed one of the participants. This echoed the findings of Everall and Paulson (2002), which emphasised the importance of good therapeutic relationships for better therapy outcomes. Although existing research has suggested men do not like the idea of therapy i.e. talking about one's problems (Rochlen et al., 2005), the present study noted access to external human contact was appreciated. Some participants were able to understand the benefits of exploring feelings with a human of no relational meaning. Perhaps this was because therapy served as a platform where expression of feelings was permitted.

The literature has already highlighted the key difference between generations, whereby second-generation individuals have been seen as valuing expression of self (Stopes-Roe & Cochrane, 1989), and the current study demonstrates similar findings in second-generation Sikh men. For some, the existing methods to deal with internal conflict had failed and they attempted to try other avenues, thus presenting second-generation Sikh men as being open-minded towards managing their distress, with them creating multiple presentations of the self, depending on other individuals and the situations encountered (Phinney, 1996). In the therapeutic context, the participants were able to challenge gender role stereotypes and engage with self-care. Many values define what constitutes male behaviour and the expression of gender (Gill, 2005) and, in the clinical setting, the men were able to adapt and rebuild, allowing themselves to make sense of another

version of their masculinity. Although placing the *self* first appeared to be an unusual and unrecognised behaviour, the benefits of therapy appeared to challenge self-stigma and the overall views of therapy.

It appeared the first step was perceived as the biggest hurdle to overcome because a) the participants anticipated they would have to overcome a few challenges (parental consent, family approval, gaining acceptance in society and the community, etc.) and b) they recognised several stages of help-seeking. This somewhat hindered individuals from accessing the help they may have needed due to the large emotional investment they perceived it would require and because they felt they would have to justify their decision. Lindridge et al. (2004), Stropes-Roe and Cochrane (1990) and Wakil et al. (1981) noted that British Indian children are often socialised to be obedient to family honour and to values their traditions. While Dhillon (2004) proposed the extent to which this is held by SA children today is unclear, the current data presented the participants frequently trying to adapt to their parents' cultural values and the family playing a central role in the help-seeking process. Those that could not bypass parent-child conflict and who viewed decision-making as out of their control were completely unaware of where to begin in seeking help. Only one out of the eight participants had engaged in online therapy, this being because he was too overwhelmed to pursue face-to-face therapy. This research suggests breaking down the steps of help-seeking will benefit the process as taking a smaller step, e.g. online therapy, might encourage more Sikhs to come forward. While this area needs further research, clinically, therapists should promote the online options available as well as local face-to-face services.

The literature on stigma repeatedly demonstrates the impact it can have on men's motivation to access therapeutic services (Addis & Mahalik, 2003; Pederson & Vogel, 2007) and how it often causes people to suffer in silence and secrecy (Goffman, 1963, p. 71). The participants' comments suggested success stories may reduce mental health stigmatisation and increase intentions to seek help. In terms of awareness, they advocated sharing personal positive experiences of therapy in that it may encourage others to take a step. This idea is consistent with Corrigan's (2016) strategic stigma change model, which proposes that sharing stories impacts others, and Wada et al.'s (2019) idea that normalising MI by becoming aware of its prevalence will lead to success in dealing with any psychological issues. This will not only help socialise Sikh men to the concept of therapy but also promote therapy as an acceptable choice. Despite barriers being present, the participants were optimistic regarding the progress that is being made in the area of mental health in the Sikh community. Many Sikhs are starting to discuss mental health on various Sikh media platforms (Sikh Your Mind, n.d.; SOCH mental health, n.d.; Taraki, n.d.) and the participants felt this was the best approach to try and improve the help-seeking process for this client group.

A key theme present across all interviews was: *What can improve help-seeking behaviour within the Sikh community?* The role of religion in mental health was discussed in the interviews. The data illustrated the fine line between culture and religion, whereby religion was viewed as promoting help-seeking. The participants emphasised that it is not religion that prevents individuals from accessing help, and it appeared that others within society may be advocating religion as forbidding it. Researchers have presented the various explanations within the culture and religion

that are often used by Sikhs to make sense of MI (Jhutti-Johal, 2011, p. 250, 2018). The present research is the first to illustrate how culturally determined beliefs of how religion views MI contributes to attitudes towards help-seeking in Sikh society. It is crucial that clinicians understand the importance of spirituality for Sikhs as it may serve as a coping mechanism. The power of spiritual beliefs on coping strategies and on attitudes to treatment methods has been identified in older Sikhs (Jhutti-Johal, 2011, p. 248), and the current data saw similar patterns in the participants, which is consistent with Kaur's (2018) findings of spirituality and religion holding importance for younger Sikhs in the therapeutic context. As previously mentioned, aspects of religion could aid the success of treatment plans by acting as a source of psychological support (Lee, 2013, p. 61).

The research presented by Singh (2008) and Sandhu (2004, 2005) is able to provide a perspective on a Sikh client's world view and cultural models of counselling. While there is a need to verify the success of these models through wider research, the notions presented can assist Counselling Psychologists to become more knowledgeable about the Sikh religion so that they can access this client group and build a therapeutic relationship to make good sound clinical judgements. The direct correlation between spirituality and coping has been established (Krejcki et al., 2004; McCroubie et al., 2006; Siddall et al., 2017) and it has been proposed that "a notion of spirituality is at the core functioning of Sikh individuals" (Kalra et al., 2012, p. 1). Similar findings were identified in the present research, and the positive relationship between religion, spirituality and mental health was demonstrated in the data. Specific tenets of Sikhism like *paath* and *seva* acted as a source of peace and comfort during distress by inducing positivity in the thought process (Bawa et al.,

2013; Labun & Emblen, 2007), and the meditation aspect of Sikhism allowed for deep reflection, whereby conversing with God served as a source of comfort and through prayer one entered an intimate and safe relationship. Similarly, other research has provided supporting evidence of the positive impact of the GGS on wellbeing (Bawa et al., 2013; Kalra et al., 2012). Thus, the interplay of health and spirituality (Labun & Emblen, 2007) needs to be factored in when supporting Sikh men in a clinical setting and it appears spiritual coping serves as a valuable resource for those who are affected by MI.

*The need to encourage therapy as a norm within Sikh culture/society* was emphasised. The negative view of therapy appears to be tied in with the misconception that therapy is for those that are crazy and that you will obtain the label of mental if you were to access it. This supports the finding by Gaiha et al. (2014), who found the majority of their Indian respondents visualised an individual with MI as violent and dangerous. The general public's discriminatory response to individuals with MI (Corrigan & Kleinlein, 2005, pp. 13-16) hindered the participants in the process of seeking help, and they saw those with MI being devalued by others in the community (Abdullah & Brown, 2011). Sikhs, to date, have been apprehensive and reluctant to talk about mental health issues due to the social taboo and stigma surrounding MI (Jhutti-Johal, 2018), and therapy is also viewed as being accompanied by layers of stigmatised beliefs. Another misconception is you need to be mentally sick to access it and there appears to be a lack of understanding regarding the severity of mental distress experienced to access therapy. In other words, individuals may not even engage with the process of seeking therapeutic help because they classify their distress as *not severe enough*. In order to

normalise access to therapy, there is a need to first address these misconceptions that make individuals perceive it as something negative.

The data suggested the two key methods to challenge the negative connotations attached to therapy are: a) address the *Limited awareness of mental health in educational settings* and b) for *Healthcare professionals to get more actively involved.* The participants felt frustrated how the little education they had received about therapy was limited to their school years, where they had received some helpline numbers. Mental health awareness in schools is evidently an area that needs further input. This is vital as during these academic years coping strategies are learnt and developed and, therefore, could influence how one approaches the process of seeking help. It is important to note that none of the participants mentioned existing initiatives that already seek to work with Punjabi communities to reshape approaches to mental health. As previously mentioned, Taraki is a movement that was set up within the Punjabi Sikh community with the goal of empowering men to talk openly about mental health issues that have often been overlooked (Taraki, n.d.). The organisation aims to increase mental awareness via an education strategy of interacting with Punjabi & Sikh societies at British universities. Perhaps this is an area that needs further input as in the present study, only four out of the eight participants had been to university. To target more individuals, this initiative could also be ventured out into schools. It is a route which would not only allow young people to access a space which was exclusively for them to use for their mental health, but also create powerful visibility on mental health in young Sikhs.

The position of the GP as the first point of contact gives clinicians insight into the earlier phases of the help-seeking process for Sikh men. For example, many

survey studies have established SA men are twice as likely to consult a GP in comparison to European men in the UK (Gillam et al., 1989; Atri et al., 1996; Murray & Williams, 1996; Chaturvedi et al., 1997), and young people from SA ethnic groups have also been found to be more likely to consult a GP compared to white children and children of other ethnic groups in the UK (Cooper et al., 1998). Further, a cultural tendency to sustain a reliance on medication has been identified. This is interesting to note as previous research has suggested individuals from ethnic backgrounds get prescribed medication more readily than they are referred to therapy compared to their white counterparts (Johnson et al., 1993). According to the participants, the reliance on medication in this community could be due to poor awareness of the symptoms of MI. Alongside this, research has demonstrated GPs are less likely to detect depression in Punjabis than Whites among those with depressive ideas and are more likely to detect somatic presentations (Bhui et al., 2001; Wilson & MacCarthy, 1994), and this further highlights how practitioners need to be mindful of how symptoms may be culturally expressed during an assessment (Bignall et al., 2019). This is an area where GPs can adopt a more central role by promoting wellbeing services over medication. As previously suggested, GPs should be transparent about the nature of the service they offer to their patients and make appropriate referrals where necessary to encourage Sikh men to engage with the process of seeking help, rather than avoiding it.

### 5.2 Evaluation of the research

This section will evaluate the methodological issues and limitations of this study.

First, the participants' responses in the interviews may have been affected by the researcher's gender, age and ethnicity. Being a young Sikh female could be interpreted as being the same as them as participants were from a similar age group and would often say *we* or *us*. Also, the researcher displaying a modern appearance, e.g. short hair, may have also been an influential factor because it may have impacted on how freely they spoke about their experiences. To understand whether this was indeed an influential factor, other methods for interviewing would need to be considered for future research, e.g. conducting the interviews via telephone or having a male interviewer. However, the importance of masculinity for these Sikh men needs to be noted and, so, they may struggle to open up to another male.

Another factor to take into consideration is the disclosure of personal information. Sikh men belong to a culture where talking about emotional difficulties may not always be encouraged. A lot of the participants were concerned about the confidentiality of the research and their anxiety surrounding this could have influenced their transparency, how much they disclosed and could have prevented how freely they spoke about their experiences and beliefs. As mentioned in the interviews, confidentiality appeared to create some peace of mind as some did not want to be judged or exposed. Thus, it may have been useful to have some time prior to the interviews to build rapport with the participants and/or use non-face-face interviews via the telephone. These methods could also help minimise the interviewer being an influential factor in the participants' responses.

The sample size consisted of eight Sikh men and this is a limitation in the current study. The sample size is not representative of Sikh men and, therefore, only provides a small comprehensive analysis that limits the conclusions identified to the current sample. In order to gain more insight into Sikh men's processes of seeking therapeutic help, more participants would be required. This would not only add more richness to the current data but also approach a point of theoretical saturation (Bryant & Charmaz, 2007, p. 281) as only theoretical sufficiency was achieved. However, theoretical sampling was adopted and, therefore, the most knowledgeable participants of the topic of research were selected, increasing the quality of the data gathered (Thomson, 2010). The sufficiency of the sample size was determined by the quality of the data because data collection and analysis was a continuous process until no new theoretical insights emerged.

Homogeneity could also be an issue. Those that had accessed therapy had experienced different forms of therapy, e.g. online or face-to-face, the 6-session model or long-term therapy, and various models of therapy. The researcher attempted to emphasise at significant points throughout the analysis where themes may have arisen which reflected theoretical beliefs, but the integration of these variations proved challenging. Future research could aim for the exploration of Sikh men's experiences of therapy with a particular focus on one specific mode of therapy and with a set number of sessions accessed to help ensure homogeneity. This is because clients' experiences of therapy are likely to be influenced by the duration and types of therapy being delivered (Pick, 1992, p. 25; Schottenbauer et al., 2005, p. 473).

Finally, regarding recruitment, the researcher was only able to recruit participants from specific geographical locations in England: i.e. London, Nottingham and Birmingham. It would be interesting for future research to investigate whether there is a consensus amongst other Sikh men in other areas in England to explore whether the findings can be generalised.

### 5.3 Applications for research and clinical practice

The findings have offered the profession of Counselling Psychology a theory about the processes involved in Sikh men seeking therapy. The uniqueness of the methodological design in the current study is that its aim to develop a theory in an area that has not been previously explored in the literature is a strength in itself. It is the first study to provide valuable insight into how this particular culture group view the processes of seeking therapeutic help. Its original contribution to the profession of Counselling Psychology is valuable as no research to date has solely focused on giving Sikh men a voice to shed some light on their views of therapy. Also, due to taboo associations, such information is currently limited. However, this research has demonstrated that although they belong to a culture in which speaking about emotional difficulties is not always encouraged, Sikh men are willing to talk as they took part in the research. This illustrates the role of utilising qualitative research methods to gather sensitive in-depth information that may not have been achieved via quantitative methods (Pannu et al., 2009). If further research were to be conducted, it is important to note that it may not be appropriate to utilise quantitative methods in isolation due to the sensitivity of the subject area of seeking help.

These findings might be useful for clinicians to challenge the existing barriers. Some participants did not have a thorough understanding of what therapy may involve. For Counselling Psychologists, it would, therefore, be useful and ethical to discuss what therapy is, including the potential risks and benefits, as part of the initial assessment process. The third construct, in particular, will help clinicians to develop some of the strategies identified (e.g. promoting online therapy, sharing success stories, GPs to encourage counselling, the incorporation of spiritual elements into treatment as religion promotes help-seeking, encouraging therapy as a norm, and increasing knowledge of MI) that can allow this client group to better utilise culturally appropriate services.

This research suggests Sikh men with prior experience in therapy can help advocate it to others. This could be achieved via expert patient seminars or workshops where they have the opportunity to talk about their experience of therapy, whether experienced online or face-to-face. This would allow clinicians to challenge the perception of therapy as a Western concept and, thus, proceed towards normalising it in this community. Location would be important to consider as such education would need to be delivered in areas where Sikh's have access and feel comfortable, e.g. places of worship (*Gurdwaras*) and community centres. The current study urges the need for more awareness in the Sikh community of what therapy is. The findings indicated the participants either had no knowledge of therapy or had very sceptical views of it. As they suggested, GPs are often the first point of contact for clients due to the community's reliance on medication-based treatments. Therefore, there is a need for GPs to help educate this client group on what therapy entails. This could be achieved via significant figures from this

community (religious figures or expert clinicians from similar backgrounds) conducting various workshops that focus on psycho-education. Counselling Psychologists should consider using initial treatment sessions to socialise individuals to the concept of therapy.

The present study contributes to the valuing system of Counselling Psychology, which facilitates practice with diversity (Woolfe et al., 2003, p. 204). The findings offer the profession of Counselling Psychology a better understanding of the therapeutic needs of Sikh men, allowing practitioners to develop interventions which are tailored to suit this specific client group. As previously mentioned, the meditation aspect of their religion serves as a source of comfort and through prayer, one creates a safe bond with *Waheguru*. Clinicians should, therefore, consider the spiritual aspect of the religion during the treatment process if it were seen to benefit the individual. Most importantly, Sikhism remains fairly unknown, so continued efforts should be made to raise the importance of religion and spirituality in psychology training programmes.

Sikh men tend to prioritise family values and parental consent is an important factor. Likewise, self-image appears to be key for the men in this culture and, in some cases, there appears to be an underlying fear that considering therapy may damage this masculine image. Clinicians should, therefore, be mindful and aware of gender and culture being interwoven. The study highlights the need for Counselling Psychologists to consider the role that masculine socialisation may play in the lives of Sikh men. For instance, it points to an understanding of how Sikh men's masculinity ideologies and their endorsement of strict masculine roles might affect their willingness to seek professional psychological help. Counselling Psychologists

need to understand that they may enact their masculinities in a number of different ways and that such diversity needs to be taken into account. Sikh men appear to inherit their understanding of what masculinity is and the cultural responsibility of this gender role from their parents and the Sikh community. Counselling Psychologists should acknowledge these collectivist values and take the opportunity to explore them with their clients. This would allow for the opportunity to deliver tailored treatment methods that consider their values.

The current study proposes the need for further research to be conducted in the Sikh community. As voiced throughout this thesis, in order to encourage this community to come forward, there is a need for deeper knowledge. Perhaps an increase in research into the community would increase an awareness of MI. Finally, research could aim to uncover which counselling theories and techniques Sikhs find most useful as this was a question that was not fully addressed in the current study.

### 5.4 Conclusion & Final reflections

The aim of this study was to explore how Sikh men experience the processes of seeking therapeutic help. It appears they continue to underutilise mental health services and, although previous research has demonstrated men as reluctant to seek psychological help (Hammer et al., 2013), the sole exploration of the male Sikhs in this context is still in its infancy (Sandhu, 2005). The rationale for the present study was to explore what literature fails to address: how Sikh men respond to distress and their approach to managing conflict. This included specifically examining the participants' beliefs in utilising coping methods and exploring their feelings

regarding their experience of therapy or the possibility of using psychological services.

A qualitative GT methodology from a constructionist stance was chosen to answer the research question. The findings demonstrated high-level components in describing the highly complex processes a Sikh man identifies with when deciding whether to seek therapeutic help. These processes gave insight into the barriers Sikh men anticipate they will have to face if they were to seek help. The first two theoretical constructs were described as either *barriers from within* (theoretical construct 1) or *external barriers* (theoretical construct 2). The results indicated that Sikh men seemed to align themselves with hegemonic ideals of masculinity, with various masculinities presented as fluid, emerging and developing with the shifting needs of the community within which they unfold. They are also susceptible to the forces surrounding them, be they political, economic, social or cultural. The increased tendency to reveal a stronger and independent aspect of the self, while highlighting the factor of restrictive emotionality, was identified. The model captures how much a Sikh man must consider prior to making a decision about their mental health. Perhaps the concern for others, especially parents and family members, that is central in the teachings of Sikhism (Singh, 2001) plays a role here. However, this is a speculation that would need further exploration.

Needless to say, the final theoretical construct illustrates a position where the participants experienced a sense of urgency towards *opening up the barriers* (theoretical construct 3). This construct supports the view that mental health provision within the UK needs to prioritise both culturally tailored services and work towards advancing mental health literacy in this community. A final thought is that

current studies solely focusing on Sikh men are limited; it is hoped that this study has contributed something original to the evidence base.

## REFLEXIVITY PART 2

This part of the reflexive statement concludes this thesis by providing my reflections and insight into the processes that arose from the data collection and analysis stages. Reflexivity was deemed necessary throughout this thesis, as it serves an important part of assessing rigour in research (Spencer et al., 2012).

During the time where participants were beginning to show interest in the research, I found myself quite surprised as I had anticipated I would struggle with recruitment. I placed a lot of focus on making my poster as creative as possible, reflecting the multimedia driven society we currently live in and perhaps, because I assumed attracting participants to this study would be a test in itself. My family and friends who are also second-generation, continuously reiterated "stigma" and "taboo" may prevent Sikh men from coming forward. However, recruitment was not as challenging as I expected and it seemed as though participants were coming forward due to their own agenda to raise awareness of mental health in the Sikh community. This is because I often found participants ending the interviews with comments like "this will really help us" and "there needs to be more studies like this". This gave me a sense of proudness, I was engaging in research that could possibly progress the relationship my community has with mental health. I ensured I kept my responses of validation short, and engaged in gestures such as nodding or "mmm", as I felt it was important to validate their experiences, but at the same time I did not want to move the focus away from exploring their experience.

A part me of me was thrilled as I constantly found myself eager to know more. Utilising semi-structured interviews, which are a central feature of GT, was useful in building a rapport between myself and the Sikh men in this study. As the

interviews went on, I found myself getting more confident. However, I still felt the need to stick to my interview schedule as I was conscious that my therapeutic hat may begin to appear. Previous research has identified that qualitative interviews can unintentionally become a therapeutic process for participants (Sivell et al., 2019) and so, I ensured boundaries were in place and all questions asked were relevant to the research. The interview schedule itself felt as though it served as a boundary and made me feel at ease. On reflection, after these interviews, I wondered whether this interview space allowed these men to take a second to pause and make sense of their own experiences and, due to my own focus on the interview schedule, did I deny them the chance to explore this even further? I was able to take such thoughts to my personal therapy and explore this new learning experience, to understand how my role as a researcher differs from my position as a trainee Counselling Psychologist.

In addition to the above, during the analysis stage I noticed that I was being drawn towards themes related to a second generation identity. Perhaps a part of me has always felt *stuck* between two contrasting cultures that I have always been socialised in, and it is possible my own uncertainty of my own identity led me in being driven towards themes that confirmed my own experiences. It can be argued my findings may have been a reflection of my own experiences, rather than purely those of the participants. However, talking about my interest in my topic and regular discussions with my peer researchers allowed me to adopt a more neutral and reflective position, to explore transcripts more objectively and in a way that allowed me to select themes that were important to the participants rather than those that simply made sense to me. I was mindful I may hold particular biases and assumptions, I attempted to contain these in my personal journal and discussions in

supervision allowed me to increase my awareness and to remain as open-minded as possible in regards to my personal and epistemological reflexivity.

To conclude, as a 26 year old British Sikh, my cultural background and demographics are quite similar to that of the participants in this study. It is important to consider that my analysis may have been influenced by this identification and sense of belonging with those that could be seen as similar to myself. However, it appeared my own ethnicity as a Punjabi Sikh promoted rich discussion as I was perhaps perceived as one of them. I was mindful of this, particularly during the interviews and then during the analysis of my data. I approached the obtained data with an open mind and I kept thorough memos reflecting impressions, responses, whilst ensuring that pre-existing assumptions are left to the side. By reflecting on my memos, I noticed I was quite surprised with the theoretical construct *opening up the barriers*. I did not expect participants to be as hopeful or as optimistic about Sikhism progressing in the field of mental health. Majority of the participants were able to identify key areas that need to shift to challenge existing barriers. This felt rewarding as the purpose of the research was to allow individuals to think about how we can move forward. I guess a part of me feels I have only just started and I am hopeful, future research will be able to pick up from where I have left of from.

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# APPENDIX

## Appendix A

*Further information of sample group*

| Participant name | Geographical location | Religious stance | Turban wearing | Marital status | Socio-economic status | Level of education | Parents background |
|---|---|---|---|---|---|---|---|
| Aman | Ilford | Non-baptised | Yes | Unmarried | Middle class | Undergraduate | Second-generation |
| Sukhdeep | Smethwick | Non-baptised | No | Unmarried | Middle class | Postgraduate | Second-generation |
| Eishwar | Sutton Coldfield | Non-baptised | No | Unmarried | Middle class | Undergraduate | Second-generation |
| Harminder | Greenford | Non-baptised | No | Unmarried | Middle class | Undergraduate | Second-generation |
| Anveer | Hayes | Non-baptised | No | Unmarried | Middle class | A-levels | Second-generation |
| Raj | Southall | Baptised | No | Unmarried | Middle class | A-levels | Second-generation |
| Akshay | Southall | Non-baptised | Yes | Unmarried | Middle class | A-levels | Second-generation |
| Taran | Nottingham Central | Non-baptised | Yes | Unmarried | Middle class | Postgraduate | Second-generation |

Appendix B

*Recruitment Poster*

# SIKH MEN IN THERAPY

Are you a Sikh male practicing Sikhism?

IF **YES**:

Are you attending therapy/ previously completed therapy **or** ever considered therapy?

If YES

**My name is Jasmeen Bhangu; I am a trainee Counselling Psychologist studying at London Metropolitan University. I am currently carrying out my doctoral research on the experiences of Sikh men in therapy.**

**The university has ethically approved this study.**

**If you are interested in taking part in the study, please contact me via email: jkb0068@my.londonmet.ac.uk**

Appendix C

*Recruitment Letter*

School of Psychology
London Metropolitan University
166-220 Holloway Rd
London
N7 8DB

Date:

Dear Sir/Madam

I obtained your details from (state manager name from service) and I hope you do not mind me contacting you. I am currently studying at London Metropolitan University. For my research, I am exploring Sikh men in a therapeutic setting. I am currently in the process of recruiting my participants and I am writing to ask if you would consider taking part. Taking part in this research would mean meeting for around an hour, at a scheduled date/time, whenever is convenient for you, and being interviewed.

I am hereby attaching a debrief sheet with this letter to give all the details regarding the nature of my research. The debrief sheet will also detail my contact information. As stated on the debrief sheet my research has received ethical clearance from London Metropolitan University, however, if you require any further information please do not hesitate to contact myself, or my supervisor, Dr Angela Loulopoulou (contact details specified on the debrief sheet).

I would like to state that you are under no obligation to take part in this research.

I obtained your phone number from (state managers name) and I will give you a call in about a week to find out if you are interested. If you are not I will shred your contact information and I will not get in touch with you again.

Kind regards,

Jasmeen Kaur Bhangu

Trainee Counselling Psychologist

*Email Accompanying Information Sheet*

Dear Sir/Madam,

I am a first year counselling psychology trainee at London Metropolitan University. I am looking for Sikh male participants who currently receive or have received therapy, to take part in my research for my doctoral thesis.

The title of the research is:

**How do Sikh men perceive the processes of seeking therapeutic help?**

Taking part in the research would involve a conversation lasting about an hour with me to explore their experiences of therapy. Also, there will be a debrief to discuss the experiences of being interviewed and to raise any concerns and questions potential participants may have.

I am intending to interview participants in my second-third year (late 2017-2018). I am reaching out to make a general enquiry of the possible availability to do my recruitment at your service.

If you think it will be possible to recruit and interview at your service, or if you would like more information about the study, please email me at: jkb0068@my.londonmet.ac.uk.

Kind regards,

Jasmeen Bhangu

Trainee Counselling Psychologist

Appendix D

*PHQ-9*

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Appendix E

*Demographic form*

LONDON METROPOLITAN UNIVERSITY

## PARTICIPATION QUESTIONNAIRE

**1. NAME:**

**2. CONTACT DETAILS:**

**3. AGE:**

**4. GENDER**: MALE ☐ FEMALE ☐ **(PLEASE TICK)**

**5. WHAT IS YOUR RELIGIOUS BACKGROUND?**

HINDU ☐ SIKH ☐ MUSLIM ☐ JAIN ☐ OTHER _____

**6. HOW OFTEN DO YOU PARTICIPATE IN RELIGIOUS ACTIVITY?**

EVERYDAY ☐ ONCE A WEEK ☐ ONCE A MONTH ☐

ALMOST NEVER ☐ OTHER _____

**7. ARE YOU CURRENTLY RECEIVING THERAPY?**

YES ☐ NO ☐ DURATION _____

**IF YES PROCEED TO QUESTION 8.**

**IF NO, HAVE YOU EVER RECEIVED THERAPY IN THE PAST**?

YES ☐ NO ☐ DURATION _____

**8. Please state what type of therapy service you are presently receiving, or have received:**

_____

Appendix F

*Information sheet*

LONDON METROPOLITAN UNIVERSITY

# Information Sheet

My name is Jasmeen Kaur Bhangu and I am conducting research on 'Sikh Men In Therapy'. This research is conducted as part of my Professional Doctorate in Counselling Psychology at London Metropolitan University, where I am supervised by Dr Angela Loulopoulou.

**PURPOSE OF THE STUDY:** I am writing to request your help in the form of participation. The purpose of the study is to explore how men, within the Sikh community, experience help-seeking.

**YOUR CONTRIBUTION TO THE STUDY:** There is a gap within the literature which fails to focus on the subjective voice of Sikh men in relation to their perspective on the concept of therapy. The current study proposes to enable insight on their perception, and what factors contribute in deciding of whether to engage in therapy. Exploring these experiences will bring vision on what factors helped the process and aspects that could be improved. Utilising qualitative methodology will be helpful to understand the processes involved and will help generate a theory of a phenomenon which has not yet been investigated. With these findings, we can enlarge our current knowledge base.

**WHAT IS EXPECTED OF YOU:**

A) A male who is born in a Sikh household and who adheres to the Sikh religion. You must have accessed a counselling service where one has received therapy within the last five years. Participant eligibility has no limitations regarding the nature of counselling; clients with a broad range of issues are included.

**OR**

B) A male who is born in a Sikh household and who adheres to the Sikh religion. An individual who has considered approaching psychological services but has never received any form of therapy, with no form of contact with any mental health care service or counselling service.

**CONFIDENTIALITY:** Before participating in the study, you will be required to sign a consent form indicating your approval to the recording of the interview and your participation in the research. In line with the British Psychological Society's guidelines on principles for Conducting Research with Human Participants. The researcher guarantees complete anonymity and confidentiality of any collected

information. Breaches to confidentiality will only occur if the research participant indicates involvement in unlawful behaviour including breaches of national security, or if the research participant indicates a risk of harm to self or others. All collected data will be securely stored at all time and kept for five years for the purpose of publication. Should you have any further concerns regarding anonymity or confidentiality, the researcher will be happy to discuss this with you prior to engagement in the study.

**PARTICIPATION:** All participation is entirely voluntary. Should you wish to withdraw from the study, or retract your contribution, you are free to do so without further explanation up to two weeks following the completion of your interview.

**HOW TO PARTICIPATE:** If you are interested in taking part in this study I would be grateful if you could contact me by email so that we can arrange a suitable time and place to conduct the interview.

**STUDY FINDINGS:** Should you wish to obtain a summary of the research findings, please inform the researcher and provide your contact details. All contact details and identifying material will be securely stored away from the material recorded during the research interview. If the findings of the research project are published in a journal, no identifying information will be included, and complete anonymity will be upheld.

**COSTS:** The study will take place within the premises of London Metropolitan University or an alternative London-based location. If you attend the research interview you will be reimbursed for your purchased travel ticket within London. No additional costs are expected.

**RISKS:** Due to the focus on subjective experiences that will be explored in the interview, it is possible that the research interview will evoke distressing thoughts, feelings or images. You are entitled to decline to answer any interview question and you may take short breaks during the interview to process difficult emotions that may occur should you wish to. To ensure the safeguarding of your wellbeing, both you and I, the researcher, will reserve the right to terminate the interview at any point should you become excessively distressed following your participation in the interview.

Should you experience unwanted distress because of participation in this research project you will be provided with information about appropriate forms of support that you can access. This information will include contact details of counselling and therapeutic services. Alternatively, please contact your personal therapist for further support.

**MAKING A COMPLAINT:** Please contact my research supervisor to address any objections related to any aspects of this research project: Dr. Angela Loulopoulou a.loulopoulou@londonmet.ac.uk

Should you wish to take part or have any further questions regarding this research project, please do not hesitate to contact me on the email address below.
Principal investigator: Jasmeen Kaur Bhangu  Email: jkb0068@mylondonmet.ac.uk

Thank you for your time and consideration.

Yours faithfully,
Jasmeen Kaur Bhangu
Counselling Psychology Trainee

Appendix G

*Consent form*

LONDON METROPOLITAN UNIVERSITY

**PARTICIPANT CONSENT FORM**

**BACKGROUND INFORMATION**

**Title:** How do Sikh men perceive the processes of seeking therapeutic help?
**Researchers:** *Jasmeen Kaur Bhangu & Dr. Angela Ioanna Loulopoulou* from London Metropolitan University.
**Purpose of data collection:** *Doctoral research.*
**Details of Participation:** 2 interviews scheduled on separate dates.

**CONSENT STATEMENT**

1. I understand that my participation is voluntary and that I may withdraw from the research at any time during testing and up until *14 days after the first set of interviews*, without giving any reason.

2. I am aware of what my participation will involve.

3. My data are to be held confidentially and only the researcher and/or supervisor will have access to them.

4. My data will be kept securely for a period of at least five years after the appearance of any associated publications. Any aggregate data (e.g. spreadsheets) will be kept in electronic form indefinitely but will be anonymous and will not have any identifying information (e.g. names/emails) included on them.

5. In accordance with the requirements of some scientific journals and organisations, my coded data may be shared with other competent researchers. My coded data may also be used in other related studies. My name and other identifying details will not be shared with anyone.

6. The overall findings may be submitted for publication in a scientific journal or presented at scientific conferences.

7. This study will be completed by *September 2019* (approximately).

8. I will be able to obtain general information about the results of this research by giving the researcher my email address now.

I am giving my consent for data to be used for the outlined purposes of the present study.

All questions that I have about the research have been satisfactorily answered.

I agree to participate.

Participant's signature: _____

Participant's name (please print): _____ Date: _____

If you would like to receive a summary of the results by e-mail,
when this is available, please provide your email address:

_____

**Please note that this form will be kept separately from your data**

If you have further questions about this study, you may contact me: jkb0068@my.londonmet.ac.uk. This study was reviewed by London Metropolitan University Research Ethics Committee. You may contact my research supervisor Dr. Angela Ioanna Loulopoulou at a.loulopoulou@londonmet.ac.uk if you have any questions or concerns regarding the ethics of this project.

Appendix H

*Interview schedule*

**FOR PARTICIPANTS WHO HAVE, OR ARE CURRENTLY ENGAGING IN THERAPY**

*PHASE 1:*
We agreed to talk about your perceptions of 'help-seeking behaviour' so I am going to ask a couple of questions surrounding your experiences in therapy.

**What are your thoughts and feelings of the concept of therapy?**

Possible prompts: -

- How did you feel whilst engaging in therapy on a personal level?
- How would you describe your experiences of therapy?

**Can you please tell me about how you came to enter therapy?**

Possible prompts: -

- Describe, in general terms, the topic that you came to therapy to discuss?
- What encouraged you to take the steps in making this decision?
- Did anything discourage you to seek therapy in the first instance?

**What were your friends/families' views of you engaging in therapy?**

Possible prompts: -

- What did you think of these views?
- Did this have an impact on how you perceive help-seeking behaviour/therapy?

**How do you perceive the view of therapy to be in your society/religion?**

Possible prompts: -

- What factors do you think determines these views?
- How does this impact your own views?

**How has the overall process been for you?**

Possible prompts: -

- How do you think this has impacted you and others around you?
- Did you find anything particularly helpful/not helpful?

**Based on your experiences of therapy, if need be, would you engage in therapy again in the future?**

Possible prompts: -

- If response is no:
  - What other means of support do you have?
  - What makes you not want to seek it again?
- If response is yes:
  - Why, so?
  - Is there anything you would do different in the process?

**Would you advise friends/family to engage in therapy if they required it?**

Possible prompts: -

- What do you think their responses would be in reply to your advice?
- Would you give different advice to different people?

**How have you experienced taking part in this interview today?**

*PHASE 2:*
We agreed to talk about your perceptions of 'help-seeking behaviour' so I am going to ask a couple of questions surrounding your experiences in therapy.

**What are your thoughts and feelings of the concept of therapy?**

Possible prompts: -

- How did you feel whilst engaging in therapy on a personal level?
- How would you describe your experiences of therapy?
- Was the experience like you expected it to be?

**Can you please tell me about how you came to enter therapy?**

Possible prompts: -

- Describe, in general terms, the topic that you came to therapy to discuss?
- What encouraged you to take the steps in making this decision?
- Did anything discourage you to seek therapy in the first instance?
- What made you go ahead with that type of service/intervention style?

**What were your friends/families' views of you engaging in therapy?**

Possible prompts: -

- What did you think of these views?
- Did this have an impact on how you perceive help-seeking behaviour/therapy?
- Did anything come to mind when disclosing this information to friends/family?

**What do you think is your friends and families understanding of therapy?**

Possible prompts: -

- How does this affect your own view?
- How does this sit within your culture and society?

**What do you think is the relationship between what generation one is in and their help-seeking style? e.g. your parents' generation and it's help-seeking style and your generation and it's help-seeking style.**

Possible prompts: -

- How may this impact ones decision of whether or not to enter therapy?

**How do you perceive the view of therapy to be in your society/religion?**

Possible prompts: -

- What factors do you think determines these views?
- How does this impact your own views?
- Where do you think, your religious stance sits with your help-seeking style?

- If you are feeling down do you engage in religious activities to help you?

**How has the overall process been for you?**

Possible prompts: -

- How do you think this has impacted you and others around you?
- Did you find anything particularly helpful/not helpful?
- Would you change anything during this process?

**Based on your experiences of therapy, if need be, would you engage in therapy again in the future?**

Possible prompts: -

- If response is no:
  - What other means of support do you have?
  - What makes you not want to seek it again?
- If response is yes:
  - Why, so?
  - Is there anything you would do different in the process?

**Would you advise friends/family to engage in therapy if they required it?**

Possible prompts: -

- What do you think their responses would be in reply to your advice?
- Would you give different advice to different people?
  - What would determine who you advise to engage in therapy?

**How have you experienced taking part in this interview today?**

*PHASE 3:*
We agreed to talk about your perceptions of 'help-seeking behaviour' so I am going to ask a couple of questions surrounding your experiences in therapy.

**What are your thoughts and feelings of the concept of therapy?**

Possible prompts: -

- How did you feel whilst engaging in therapy on a personal level?
- How would you describe your experiences of therapy?
- Was the experience like you expected it to be?

**Can you please tell me about how you came to enter therapy?**

Possible prompts: -

- Describe, in general terms, the topic that you came to therapy to discuss?
- What encouraged you to take the steps in making this decision?
- Did anything discourage you to seek therapy in the first instance?
- What made you go ahead with that type of service/intervention style?
- What factors did you consider in selecting your therapist? (i.e. background, gender and age-range).

**What were your friends/families' views of you engaging in therapy?**

Possible prompts: -

- What did you think of these views?
- Did this have an impact on how you perceive help-seeking behaviour/therapy?
- Did anything come to mind when disclosing this information to friends/family?

**What do you think is your friends and families understanding of therapy?**

Possible prompts: -

- How does this affect your own view?
- How does this sit within your culture and society?

**What do you think is the relationship between what generation one is in and their help-seeking style? e.g. your parents' generation and it's help-seeking style and your generation and it's help-seeking style.**

Possible prompts: -

- How may this impact ones decision of whether or not to enter therapy?

**How do you perceive the view of therapy to be in your society/religion?**

Possible prompts: -

- What factors do you think determines these views?
- How does this impact your own views?
- Where do you think, your religious stance sits with your help-seeking style?
- If you are feeling down do you engage in religious activities to help you?

**How has the overall process been for you?**

Possible prompts: -

- How do you think this has impacted you and others around you?
- Did you find anything particularly helpful/not helpful?
- Would you change anything during this process?

**Based on your experiences of therapy, if need be, would you engage in therapy again in the future?**

Possible prompts: -

- If response is no:
  - What other means of support do you have?
  - What makes you not want to seek it again?
- If response is yes:
  - Why, so?
  - Is there anything you would do different in the process?

**Would you advise friends/family to engage in therapy if they required it?**

Possible prompts: -

- What do you think their responses would be in reply to your advice?
- Would you give different advice to different people?
  - What would determine who you advise to engage in therapy?
  - How would you go about doing this?

**How have you experienced taking part in this interview today?**

**FOR PARTICIPANTS WHO HAVE NOT ENGAGED IN THERAPY**

*PHASE 1:*
We agreed to talk about your perceptions of 'help-seeking behaviour' so I am going to ask a couple of questions surrounding your views of therapy.

**What are your thoughts and feelings of the concept of therapy?**

Possible prompts: -

- How would you describe your perceptions of those that engage in therapy?

**If need be, can you please tell me whether you think you will ever engage in therapy?**

Possible prompts: -

- Describe, in general terms, the topic that you think you could take to therapy to discuss?
- What do you think could encourage you to take the steps in engaging in therapy?

**What do you think would be your friends/families' views if you were to engage in therapy?**

Possible prompts: -

- Would this have an impact on how you perceive help-seeking behaviour/therapy?
- Would anything come to mind if you were to disclose this information to friends/family?

**How do you perceive the view of therapy to be in your society/religion?**

Possible prompts: -

- What factors do you think determines these views?
- How does this impact your own views?

**Based on your perceptions of therapy, if need be, would you engage in therapy in the future?**

Possible prompts: -

- If response is no:
  - What other means of support do you have?
  - What makes you not want to seek it?
- If response is yes:
  - Why, so?
  - Is there anything you would consider?

**Would you advise friends/family to engage in therapy if they required it?**

Possible prompts: -

- What do you think their responses would be in reply to your advice?
- Would you give different advice to different people?

**How have you experienced taking part in this interview today?**

*PHASE 2:*
We agreed to talk about your perceptions of 'help-seeking behaviour' so I am going to ask a couple of questions surrounding your views of therapy.

**What are your thoughts and feelings of the concept of therapy?**

Possible prompts: -

- How would you describe your perceptions of those that engage in therapy?

**If need be, can you please tell me whether you think you will ever engage in therapy?**

Possible prompts: -

- Describe, in general terms, the topic that you think you could take to therapy to discuss?
- What do you think could encourage you to take the steps in engaging in therapy?

- Has anything discouraged you to seek therapy in the past?
- What factors do you think hypothetically may determine the therapist you select? (i.e. background, gender and age-range).

**What do you think would be your friends/families' views if you were to engage in therapy?**

Possible prompts: -

- Would this have an impact on how you perceive help-seeking behaviour/therapy?
- Would anything come to mind if you were to disclose this information to friends/family?

**What do you think is your friends and families understanding of therapy?**

Possible prompts: -

- How does this affect your own view?
- How does this sit within your culture and society?

**What do you think is the relationship between what generation one is in and their help-seeking style? e.g. your parents' generation and it's help-seeking style and your generation and it's help-seeking style.**

Possible prompts: -

- How may this impact ones decision of whether or not to enter therapy?

**How do you perceive the view of therapy to be in your society/religion?**

Possible prompts: -

- What factors do you think determines these views?
- How does this impact your own views?
- Where do you think, your religious stance sits with your help-seeking style?
- If you are feeling down do you engage in religious activities to help you?

**Based on your perceptions of therapy, if need be, would you engage in therapy in the future?**

Possible prompts: -

- If response is no:
  - What other means of support do you have?
  - What makes you not want to seek it?
- If response is yes:
  - Why, so?
  - Is there anything you would consider?

**Would you advise friends/family to engage in therapy if they required it?**

Possible prompts: -

- What do you think their responses would be in reply to your advice?
- Would you give different advice to different people?
  - What would determine who you advise to engage in therapy?

**How have you experienced taking part in this interview today?**

*PHASE 3:*
We agreed to talk about your perceptions of 'help-seeking behaviour' so I am going to ask a couple of questions surrounding your views of therapy.

**What are your thoughts and feelings of the concept of therapy?**

Possible prompts: -

- How would you describe your perceptions of those that engage in therapy?

**If need be, can you please tell me whether you think you will ever engage in therapy?**

Possible prompts: -

- Describe, in general terms, the topic that you think you could take to therapy to discuss?

- What do you think could encourage you to take the steps in engaging in therapy?
- Has anything discouraged you to seek therapy in the past?
- What factors do you think hypothetically may determine the therapist you select? (i.e. background, gender and age-range).

**What do you think would be your friends/families' views if you were to engage in therapy?**

Possible prompts: -

- Would this have an impact on how you perceive help-seeking behaviour/therapy?
- Would anything come to mind if you were to disclose this information to friends/family?

**What do you think is your friends and families understanding of therapy?**

Possible prompts: -

- How does this affect your own view?
- How does this sit within your culture and society?

**What do you think is the relationship between what generation one is in and their help-seeking style? e.g. your parents' generation and it's help-seeking style and your generation and it's help-seeking style.**

Possible prompts: -

- How may this impact ones decision of whether or not to enter therapy?

**How do you perceive the view of therapy to be in your society/religion?**

Possible prompts: -

- What factors do you think determines these views?
- How does this impact your own views?
- Where do you think, your religious stance sits with your help-seeking style?

- If you are feeling down do you engage in religious activities to help you?

**Based on your perceptions of therapy, if need be, would you engage in therapy in the future?**

Possible prompts: -

- If response is no:
  - What other means of support do you have?
  - What makes you not want to seek it?
- If response is yes:
  - Why, so?
  - Is there anything you would consider?

**Would you advise friends/family to engage in therapy if they required it?**

Possible prompts: -

- What do you think their responses would be in reply to your advice?
- Would you give different advice to different people?
  - What would determine who you advise to engage in therapy?
  - How would you go about doing this?

**How have you experienced taking part in this interview today?**

# Appendix I

*Debrief sheet*

LONDON METROPOLITAN UNIVERSITY

## DEBRIEF FORM

Thank you for taking the time to participate in this research. The data from the interviews will be used for my Doctoral project.

This study aims to explore: Sikh men in therapy.

Literature has studied Sikhs under the umbrella of the greater South Asian culture. Although there are certain similarities between the Sikh community and the broader South Asian community, there are still distinct spiritual traditions, customs and behaviour patterns (Nayar, 2004). Thus, exploration and examination of the Sikh religion is still in its infancy (Sandhu, 2005). Moreover, by respecting the uniqueness of each individual religion, its culture specific belief system, and the help-seeking style of a particular culture can be utilised in order to develop culture-specific interventions (Arthur & Stewart, 1971).

Previous research has demonstrated men as reluctant to seek psychological help (Vogel & Heimerdinger-Edwards, 2013), but the literature does not address whether these behaviours are present within the Sikh culture. Also, studies comparing genders are inadequate in explaining the processes involved in men's help-seeking behaviour (Galdas et al., 2005). The present study takes both these factors into consideration. By carrying out this research I hope to understand Sikh men's experiences consequently advancing existing literature on Sikhism and therapy, therefore making an original contribution to the field of Counselling Psychology. This study also aims to help Counselling Psychologists/practitioners to better engage Sikh men, therefore helping the process of intercultural therapy.

Please contact the researcher on the following email address jkb0068@my.londonmet.ac.uk if you would either like a summary of the results or have any queries or questions about the study. Please remember if you would like to withdraw from the study it should be done within 14 days of the interview date.

If you have any queries or complaints regarding any aspect of the study please contact my research supervisor Dr Angela Ioanna Loulopoulou at London Metropolitan University on a.loulopoulou@londonmet.ac.uk

I understand that it may have been difficult for you to discuss particular topics in the interview. I deeply appreciate you taking the time to take part in the study and if you feel you need any further support or if participation has raised any concerns please contact one of the following agencies for one to one counselling support or advice:

- Local GP
- Keyworker
- Samaritans: 08457 90 90 90
- Mind: 0300 123 3393 & info@mind.org.uk

Appendix J

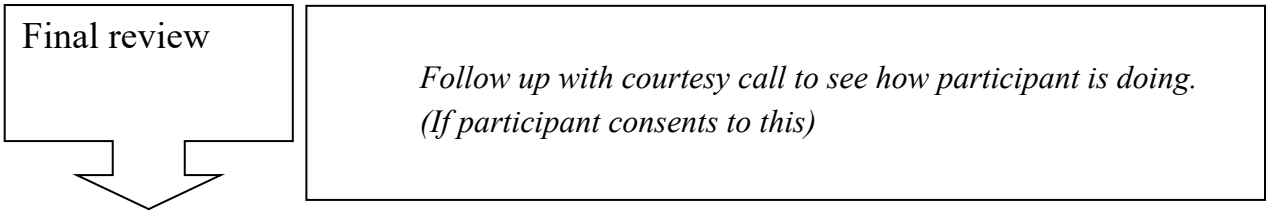
*Distress protocol*

**DISTRESS PROTOCOL**

**This Distress Protocol outlines the actions of the researcher if a participant exhibits acute distress (**Modified from: Draucker, Martsolf & Poole, 2009)

*Training as a Counselling Psychologist, the researcher has gained valuable skills whilst working with individuals displaying a range of psychological difficulties. These set of skills will allow the researcher to identify when a participant may experience some distress and how to ensure the safety of a participant where it may occur. The study is not expected to cause **extreme distress** because all measures are put in place to ensure potential vulnerable participants (psychotic, unstable or suicidal) are to be excluded from the research.*

| | |
|---|---|
| Sign of distress | • *Individual states they are experiencing some level of stress or emotional stress **OR*** <br> • *demonstrates behaviour suggestive that the interview is too stressful (i.e. crying, shaking etc.)* |
| Follow up questions 1 | 1. *STOP the interview* <br> 2. *Researcher as a Counselling Psychologist trainee to offer immediate support.* <br> 3. *To assess mental status:* <br> *What thoughts are you currently having?* <br> *What are you feeling right now?* <br> *Do you feel you are able to carry on with your day?* <br> *Has taking part in the interview caused you any distress or concern, and if so would you like to talk about it?* |
| Review | • *IF participant states they are able to carry on with the interview: **CONTINUE with interview schedule.*** <br> • *IF participant unable to continue then proceed to: **'Follow up questions - 2'*** |
| Follow up questions 2 | 1. ***STOP** the interview* <br> 2. *Express concern and conduct a safety assessment* <br> 3. *Encourage participant to contact GP or mental health provider for further advice/support **OR** contact them with participants consent.* <br> 4. *Provide participant with additional contact numbers and encourage participant to call if he/she experiences increased distress in the hours/days following the interview.* <br><br> ***IF participant represents immediate danger to themselves, the researcher OR other participants, the researcher will explain her duty to notify mental health services such as a Community Psychiatric Nurse or the participant's General Practitioner.*** |


Final review
*Follow up with courtesy call to see how participant is doing. (If participant consents to this)*

# Appendix K

*Ethical approval*

Dear Jas,

Your Ethics Review form has been approved, i.e. your research has gained ethical approval and you can proceed with data collection.

Kind Regards,

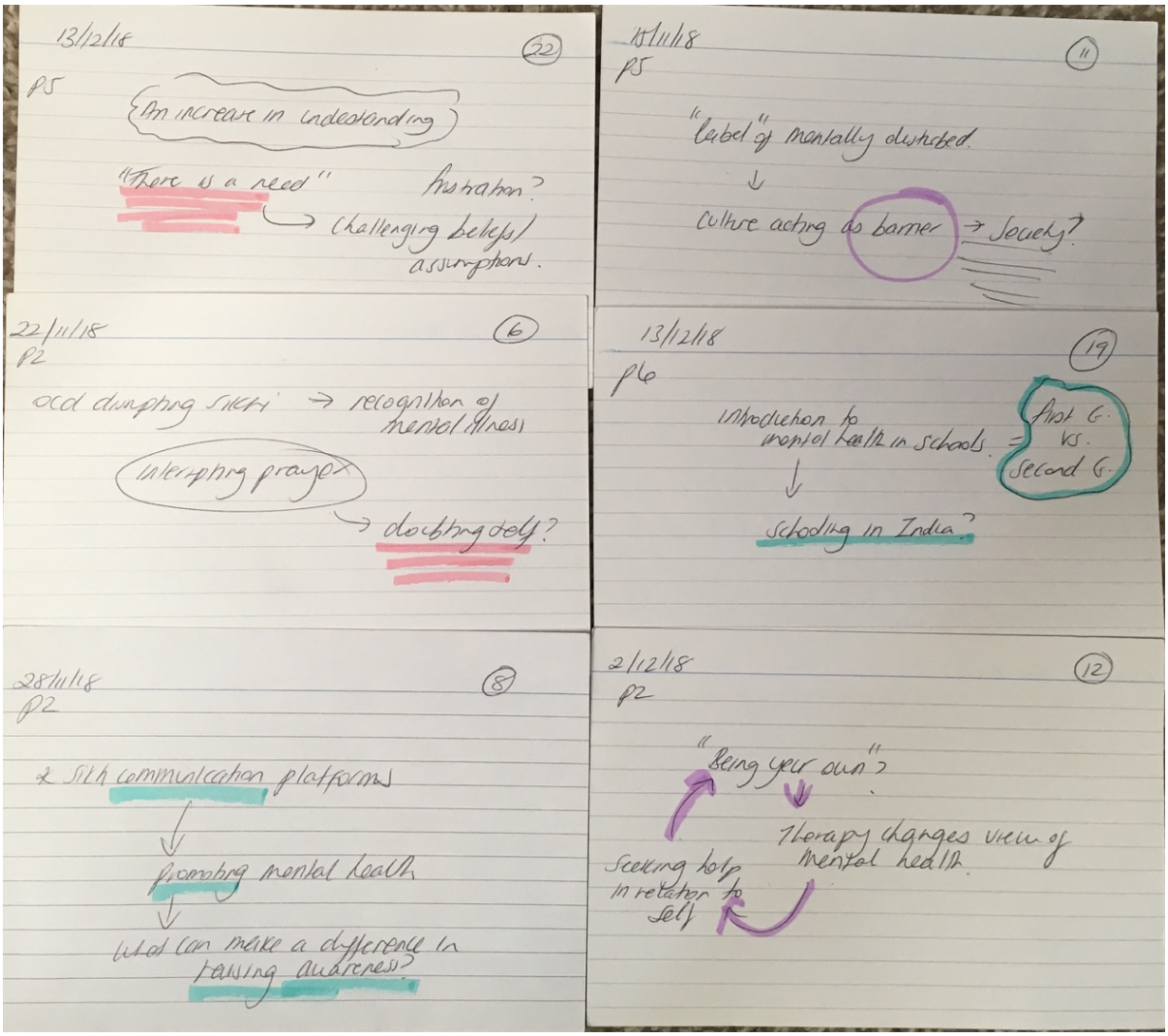
Angela

*Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA*

Principal Lecturer in Counselling Psychology
Programme Director of the **Professional Doctorate in Counselling Psychology**
**School of Social Sciences**
Subject Standards Board Chair for PG Psychology
Chair of Ethics Review Panel for Psychology

Appendix L

*Examples of memos*



# Appendix M

*Illustration of coding approach and development of theoretical constructs*

*Phase 1:*

| Interview 1 | | | | |
|---|---|---|---|---|
| Line number | Transcript | Initial coding | Focused coding | Axial coding |
| 1. | I: Okay, so as you are engaging in therapy we'll start of by discussing what are your | | | |
| 2. | thoughts and feelings regarding the concept of therapy? | | | |
| 3. | P: Erm, so I am currently seeing a psychologist. | Seeking external support | | |
| 4. | I: Okay. | | | |
| 5. | P: erm..and my thoughts on it…I just feel a very relaxed and free and open and | Sense of comfort | Benefits from therapy | |
| 6. | almost like I can let myself…loose let myself open to the.. | Open through therapy/allowing self-disclosure | Benefits from therapy | |
| 7. | I: Yeah. | | | |
| 8. | P: ..person I'm speaking to so.. | Opening up to another | Benefits from therapy | |
| 9. | I: Yeah. | | | |
| 10. | P:..so whatever I feel I wanna say and have has happened to me since I | Talking without hesitation | Benefits from therapy | |
| 11. | previously saw them or why I am seeing them in the first place..I just feel | Update on situation | | |

*Phase 2:*


Some submerging themes
Benefits from therapy so were he to have issues again, he might consider it, more open to mental health issues
Witnessing and/ or experiencing a traumatic event which made them 'unwell'
Gains from therapy
Able to see support only from people very close to him
Lack of understanding from older generations
Self-perception, being weak opposed to being a man
Somebody else suggesting/putting into therapy
After therapy mental health issues put more into context – so not so scary or stigmatising
What can make a difference in raising awareness and influence understanding of mental health issues and thus the seeking of support
Engagement with therapy changes view of mental health and help-seeking style - in relation to the self
Having had therapy makes one more open to others in family/friends seeking help
Lack of teaching about therapy after education/Teaching of therapy limited to school years
View of therapy as only accessible for those in real need/battling through something severe
Those accessing therapy labelled as "crazy"
Aware of benefits from therapy and able to identify it could improve current lifestyle
Understanding of therapy in culture as going to solve problem over just going to talk
Views held within culture limited to medical model/lack of psychological understanding
Negative view of therapy in culture preventing help-seeking
The need for an increase in knowledge in culture to challenge negative connotations attached to therapy
Own decision influenced by negative view of therapy in culture – The need for external approval a barrier towards accessing help
Differences in teaching of mental health across generations playing a role in the understanding of help-seeking behaviour
Limited awareness of mental health in educational settings
No change in knowledge when migrating from east to west
Therapy regarded as an unfamiliar concept in India
JASMEEN KAUR BHANGU
Gains from therapy
Failing to manage alone
Keeping it and aiming to resolve it within the close circle
Difference in help-seeking style across generations impacting own decision e.g. east vs west
The Sikh warrior
Therapy regarded as the last option
Raised with no awareness or knowledge of mental health
What can improve help-seeking behaviour within the Sikh community
Therapy a foreign concept within Sikhism
Views held within culture limited to medical model/lack of psychological understanding
Parents/family comes first – importance of approval
Wary of what others may think (finding out/info leaking)
The positive role of religion in mental health
Opinion of therapy changing after interaction with services
Friends understanding and supportive of concept as exposed to it – the need to experience it to understand it
The role of Sikh male as breadwinner
External environment developing with more exposure to mental illness

*Phase 3:*

***The tendency to focus on the medical model/lack of psychological understanding***

- Views held within culture limited to medical model/lack of psychological understanding
- Perception of mental illness as "sickness" in society – put off accessing help
- Medical vs psychological understanding
- Asian reliance on medication and going to the GP

***The positive role/use of religion in mental health***

- Sikh scriptures do not prevent help-seeking
- Having therapist from same culture making a difference

- Religion impacting decision of whether to seek help- conforming to what one thinks others are doing
- Religion found helpful as help-seeking promoted via spiritual message within religion
- Sikhism as a religion promoting mental well-being within its own scriptures/teachings
- Understanding how religion can help via communication with other religious people
- Positive use of prayer in maintaining healthy mental state
- Understanding how religion can help via communication friends
- Actively engaging with religious material when feeling distressed – benefited by it so now a coping strategy
- Religion promoting help-seeking and not forbidding it
- Use of religious activity/spirituality as coping mechanism

***Raised with no awareness or knowledge of mental health***

- Asian parents lacking understanding of mental health
- Therapy unspoken of whilst growing up
- Lack of knowledge on therapy in religion
- Lack of understanding in others influencing own view

*Phase 4:*

***FURTHER DEVELOPMENT OF THEMES***

1. *Gains from therapy*
2. *What can improve help-seeking behaviour within the Sikh community*
3. *Culture developing due to changes in external environment thus, creating more exposure to mental illness*
4. *Viewed internally/externally as failing to manage on own*
5. *The cultural values and expectations for a male that result from the Sikh religions history as warriors*
6. *The expectation of a young Sikh male to take active role and eventually become the breadwinner*
7. *Parents and family come first*
8. *Keeping it within inner circle and aiming to resolve it within the close circle*
9. *IF problem severe enough to enter therapy as the last option*
10. *Difference in knowledge in east/west impacting help-seeking style across generations – this impacting own decision of whether to seek help or not*
11. *Raised with no awareness or knowledge of mental health*
12. *Therapy - a foreign concept within Sikhism*
13. *The tendency to focus on the medical model/lack of psychological understanding*
14. *Opinion of therapy changing after interaction with services*
15. *Friends understanding and supportive of concept as exposed to it – the need to experience it to understand it*
16. *Wary of what others may think (finding out/info leaking)*
17. *The positive role/use of religion in mental health*

*Phase 5:*

***Final draft of main concepts:***

*Theoretical concept 1: Gains from therapy*

*Theoretical concept 2: The Sikh warrior*

*Theoretical concept 3: To access existing means of support*

*Theoretical concept 4: Therapy an unfamiliar route for the "set minded" older generation*

*Theoretical concept 5: Therapy - a foreign concept within Sikhism*

*Theoretical concept 6: Lack of exposure*

*Theoretical concept 7: Importance of self-image*

*Theoretical concept 8: The positive role/use of religion in mental health*

*DRAFT TABLE 1*

| ***Theoretical concept 1: Gains from therapy*** | |
|---|---|
| ***Focused codes*** | ***Initial codes*** |
| 1. *What can improve help-seeking behaviour within the Sikh community* | • The need for an increase in knowledge in culture to challenge negative connotations attached to therapy<br>• Limited awareness of mental health in educational settings<br>• Sikhs potentially adapting to change if things are broken down |

***JASMEEN KAUR BHANGU***

BARRIERS FROM WITHIN

One -Barriers to therapy within the self, part of the process of seeking or not seeking MH support.

The Sikh warrior, importance of self-image

BARRIERS FROM THE OUTSIDE

Two- barriers to therapy as perceived from within the family and wider culture (including community and religion)- as part of seeking or not seeking MH support

Keeping it in the circle (existing means of support)
Unfamiliar route for the set minded older generation
Therapy a foreign concept in Sikhism,
Lack of exposure

OPENING UP THE BARRIERS

Three- having sought MH support or being open to it, what could help the process of seeking MH support

Gains from therapy
Need for exposure (in educational settings, GPs etc-see next comment)
The positive role/use of religion in mental health
Younger generation concept- hope

***JASMEEN KAUR BHANGU***
Need for exposure- separate from Gain from therapy

Appendix N

*Extracts from reflective journal*

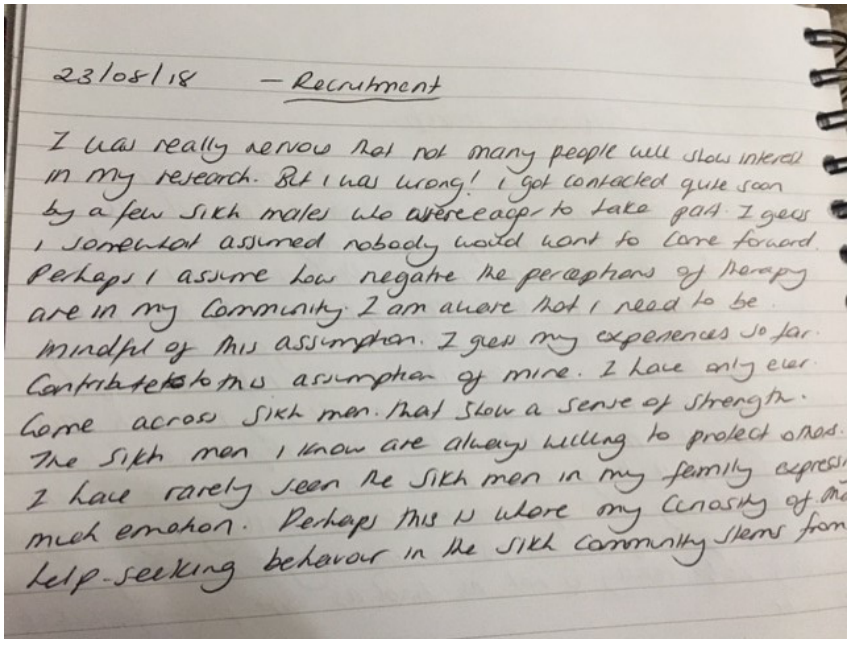
**Interview 1**

I was feeling very nervous about this interview as it was my first, and I was unsure how I would interact with the interview schedule throughout the interview. I was also anxious about the time frame as I am aware of how fast I speak. To deal with my nerves I turned up an hour early to have a quick rehearsal with myself and, to ensure I had all the paperwork ready. I felt a sense of excitement when going to collect the participant from the waiting room. I had no idea of how this Sikh male would present themselves appearance wise, *a modern Sikh or a traditional Sikh?* kept coming to mind. My mind wondered with curiosity. I had never sat in front of a Sikh male from the position of a trainee Counselling Psychologist. When I entered the waiting room in front of me stood a young Sikh male, wearing a turban and with a warm welcoming smile. I instantly felt at ease and this sense of comfort was due to the relaxed energy displayed by the participant. I somewhat had a predetermined assumption that I would have to urge my participants to talk. However, this participant gave me more information regarding his personal experiences than I expected. This was an eye-opening interview in the sense that the participant was very direct and open about their experiences. This developed a sense of resilience and motivation in me and urged me to stay connected with my thesis.

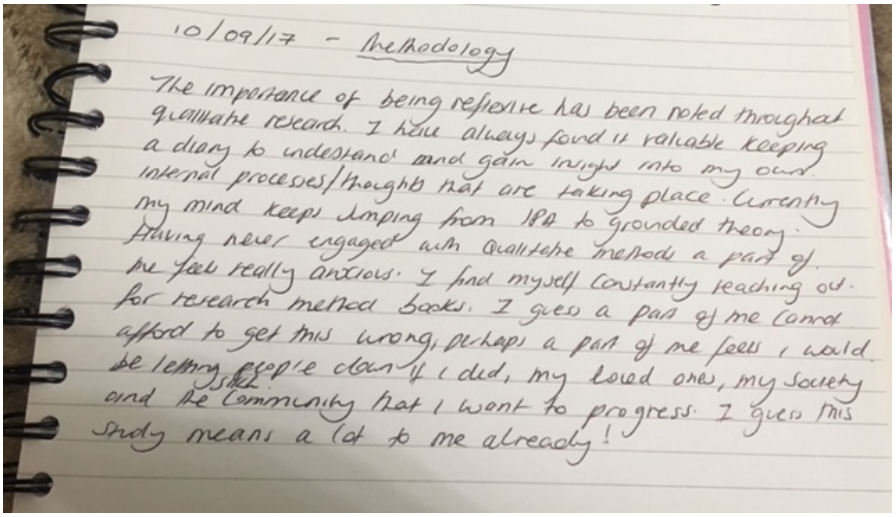
**Interview 4**

At this stage of my recruitment I was now proceeding to complete my fourth interview. I felt there were many patterns floating around from the last three interviews. I was eager to know more, and it felt as though this fourth interviewee could provide further insight into the previous information I had collected. I had developed and enhanced my interview skills and so, I felt calm and confident about the interview process. On arrival the participant seemed a little nervous and did not speak much. There were moments during the interview where he would pause and stare at me as if he was looking for answers himself. Although we finished the

interview earlier than expected, I had gathered enough material from the answers he had given. This participant had never approached any psychological services and he commented on how the interview made him feel as though it is okay to speak about things. I left the interview reflecting on how some of my participants may use my interviews as a valuable space to figure out their own thoughts and emotions. Perhaps these individuals were trying to seek a way in and these interviews were the first step. I was aware these were my assumptions and how important it was to continue reflecting on them through this interview process.


23/08/18 – Recruitment

I was really nervous that not many people will show interest in my research. But I was wrong! I got contacted quite soon by a few Sikh males who were eager to take part. I guess I somewhat assumed nobody would want to come forward. Perhaps I assume how negative the perceptions of therapy are in my community. I am aware that I need to be mindful of this assumption. I guess my experiences so far contributes to this assumption of mine. I have only ever come across Sikh men that show a sense of strength. The Sikh men I know are always willing to protect others. I have rarely seen the Sikh men in my family express much emotion. Perhaps this is where my curiosity of help-seeking behaviour in the Sikh community stems from.


10/09/17 - Methodology

The importance of being reflexive has been noted throughout qualitative research. I have always found it valuable keeping a diary to understand and gain insight into my own internal processes/thoughts that are taking place. Currently my mind keeps jumping from IPA to Grounded Theory. Having never engaged with qualitative methods a part of me feel really anxious. I find myself constantly reaching out for research method books. I guess a part of me cannot afford to get this wrong, perhaps a part of me feels I would be letting people down if I did, my loved ones, my society and the community that I want to progress. I guess this study means a lot to me already!