Punjabi Sikh Parents' Beliefs about Suicide and Suicide-Related Behaviours.

by

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Abstract

This study is the first to describe first generation Canadian Punjabi Sikh parents' beliefs about suicide and suicide-related behaviours. Through an ethnographic approach the study sought to uncover the parents' beliefs about the causes and consequences of suicide, reaction and interventions utilized in response to adolescent suicide and suicide-related behaviours, barriers to seeking mental health services and current help seeking behaviours. Semi structured individual interviews were conducted with four groups of participants: first generation Canadian Punjabi Sikh parents of adolescents, second generation Canadian Punjabi Sikh young adults, South Asian mental health therapists and medical professionals, and a Punjabi Sikh community leader.

The findings of the study revealed the believed causes of suicide and suicide-related behaviours to be peer relations, lack of attention from parents, parental pressure to succeed, hormonal changes, and mental illness. Initially parents reported their emotional response to be shock and anger, followed by a range of other emotions. The interventions parents utilize in response to suicide and suicide-related behaviours are the Sikh religion, western health care, communication and monitoring of adolescent behaviour, and alternative healing methods. Barriers to accessing mental health services were identified to be a lack of comprehension of the concept of mental health, awareness of available services, and the Punjabi culture; the Sikh religion was identified not to be a barrier to seeking services. Although the help seeking behaviours of first generation Canadian Punjabi Sikh parents have changed in recent years, further education is needed to raise awareness of adolescent suicide and suicide-related behaviours. The findings of the study have important implications for the provision of culturally appropriate mental health services for adolescent suicide and suicide-related behaviours.

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Chapter One

Introduction

Youth suicide is a very serious concern in our society today. In 1991 the Canadian rate of suicide for youth, 13.8 per 100,000 surpassed that of the United States of America (Health Canada, 1994). At the national level, between the years 1989 and 1991, suicide became the second leading cause of death for youth between the ages of 15 and 19. This coincides with findings from the 2003 provincial statistics of British Columbia which identify suicide as the second leading cause of death for youth between the ages of 15 and 24 (British Columbia of Vital Statistics Agency, 2003; Health Canada, 1994). Furthermore, the 2008 British Columbia Adolescent Health Survey, in which 29,440 British Columbian secondary students participated, reported similar alarming results (Smith, Stewart, Peled, Poon, Saewyc, & the McCreary Centre Society, 2009). The survey revealed 12% of students had considered suicide, 5% had attempted suicide, and of those who had attempted suicide, 26% had required medical treatment. There is little doubt that adolescent suicide is a legitimate concern in British Columbia.

Despite numerous studies on the phenomenon of suicide in the Caucasian and Aboriginal populations of Canada, very little has been documented in regard to the mental health issues experienced by Punjabi Sikhs. South Asians, with origins in the Indian subcontinent, today form the second largest group of visible minorities, after Chinese, in British Columbia (Statistics Canada, 2001). Members of the Sikh religion are the largest religious group in B.C next to that of Christians (Statistics Canada, 2001). Most Sikhs have emigrated from Punjab, India and are concentrated in the Lower Mainland area of the province (Ley & Germain, 2000).

To understand the mental health issues experienced by Punjabi Sikhs in Canada, expressions of emotional distress and maladaptive cognitions, including suicide and suicide-related behaviours, must be viewed within a cultural context to be fully understood and treated (Burr, 2002; Bose, 1997; Fabrega, 1994; Kleinman & Good, 1985). Although similarities exist

across cultural and religious groups, Hines, Garcia-Preto, McGoldrick, Almeida, and Weltman (1992) noted the importance of recognizing and valuing the differences between groups and integrating the differences into our practice. Culture has been described as the "royal road to understanding a patient" and shapes the experiences and expressions of all human behaviour, including ordinary, everyday, personal, social, extraordinary, and abnormal (Aderibigbe & Pandurangi, 1995, p. 236; Bose, 1997; Fabrega, 1992; Kleinman & Good, 1985). Marsella (1993) defined culture to be a learned behaviour that is passed on from generation to generation with the purpose of individual and societal growth, adjustment, and adaptation. Furthermore, artifacts, roles and institutions are the external representations of culture, while internal representations include values, beliefs and attitudes (Marsella, 1993).

Beliefs about suicide in this population are affected by the process of acculturation, "the progressive adoption of elements of a foreign culture (ideas, words, values, norms, behavior, institutions) by persons, groups, or classes of a given culture" (International Organization of Migration, 2004, as cited in Sam, 2006, p. 11). When a cultural group immigrates it undergoes an acculturation process whereby behavioural changes occur within an individual cultural group as it interacts with a host culture (Berry, 2006). As a result of the acculturation process, the learned behaviours passed down through generations may be altered. This alteration necessitates a shift in the external and internal representations of the cultural group, including its own belief systems (Berry, 2006). The first generation Canadian Punjabi Sikh beliefs of suicide and suicide-related behaviours have undergone the process of acculturation and consequently must be interpreted within the context of Punjabi Sikh and Canadian culture.

First generation Canadian Punjabi Sikh beliefs about suicide do not only exist within a specific cultural context, but arise within a religious one as well. Religion, here defined as a belief in a superhuman power, can exert a strong influence upon our conscious and unconscious values, behaviours, emotions, and thoughts, just as culture does (Soanes, 2000). Together,

culture and religion exert a powerful influence upon communication patterns of distress, beliefs regarding the root of an issue, and how it is labeled, the preferred helpers in any given situation, as well as the preferred solutions (Hines, Garcia-Preto, McGoldrick, Almeida, & Weltman, 1992). Therefore, first generation Canadian Punjabi Sikh beliefs about suicide and suicide-related behaviours must be understood within the cultural and religious contexts in which they are embedded.

Despite comprising a large portion of the Canadian population, Punjabi Sikhs are underrepresented in mental health research. Thus, the broad purpose of the present study is to begin to address this gap in the literature, specifically, to enhance the understanding of beliefs about suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents of adolescent children.

Beliefs about suicide will determine what interventions are sought, and whether mental health services will be accessed. Although it may be schools, parents or adolescents themselves who initiate contact with mental health services, often therapy is pursued with the support of family members. Gaining an understanding of the parental beliefs about suicide and suicide-related behaviours provides insight into the perceived causes and consequences of suicide and suicide-related behaviour, and how parents react to, deal with, and intervene in suicide and suicide-related behaviours. Additionally, developing a better understanding of the beliefs held by first generation Canadian Punjabi Sikh parents assists in determining to what degree mental health practitioners may need to be sensitive to these beliefs.

1.1 Purpose of study

The purpose of this study is to describe the beliefs held by first generation Canadian Punjabi Sikh parents about adolescent suicide and suicide-related behaviours, using an ethnographic approach. For the purpose of this research, beliefs are generally defined as the

commonly held tenets of suicide and suicide-related behaviours held by the Punjabi culture and the Sikh religion.

1.2 Theoretical Perspective

Research in the area of suicide often begins with Durkheim's (1966) theory of integration and regulation. Durkheim identified two continua, social integration and social regulation, and four types of suicide: egoistic, altruistic, fatalistic, and anomie. On one end of the social integration continuum is egoistic and at the other end is altruistic and the social regulation continuum flows from fatalistic to anomie. Egoistic at one end of the social integration continuum represents an individual who does not identify with a group and as a result may feel lonely and isolated, while at the other end altruistic represents an individual who does identify with a group and as a result of which an individual identity may not exist or be dependent upon social ties. On the social regulation continuum fatalistic represents an individual who is highly socially regulated and may feel oppressed by the amount of social regulation, while anomie represents an individual who is not socially regulated and as a result may lack defined goals, such as religious and spiritual goals, or may prescribe to different goals than the majority of the group. Durkheim (1966) noted various groups to have varying rates of suicide and believed the social integration and regulation of a group to be key determinants of the level of risk for an individual. The current study addresses continua, social integration and social regulation, as they relate to the Punjabi culture and the Sikh religion.

The human ecological theory provides a multidimensional and an integrated approach to understanding suicide, one that views individual, environmental, and social systems as the context in which the phenomenon of suicide arises (Bronfenbrenner, 1979). The ecological model was first applied to adolescent suicide by Garbarino (1985). The first level of the approach is the organism, the individual. Suicide does not occur in isolation, as an individual event. Individuals exist within a set of microsystems that include family, peers, school and work. These

microsystems are interconnected, forming mesosystems, which arise within increasingly broader environments to the level of macrosystems; these include existing economic, social, educational, medical, legal, and political systems. Suicide as a phenomenon arises within this milieu (Garbarino, 1985).

Leenars (2008) suggests that suicide may be best understood within a multidimensional model which acknowledges the interpersonal and intrapsychic factors affecting any given individual. As Leenars (2008) states, "metaphorically speaking, suicide is an intrapsychic drama on an interpersonal stage" (p. 25). Within this dynamic interactional system, suicide is more likely when both intrapsychic and interpersonal factors are active; suicide occurs when individuals are unable to cope with pain and stress at the intrapsychic level, and also experience stressful interpersonal factors such as isolation from relationships, community, or society (Leenars, 2008).

1.3 Research Questions

The focus of my research is to investigate the beliefs about suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents of adolescent children. More specifically, I investigate the following research questions:

- What are the beliefs about suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents of adolescent children?
- What are the beliefs of first generation Canadian Punjabi Sikh parents of adolescents if they were to respond to a suicide attempt and suicide-related behaviours in their family?

The following are the subquestions for this study:

- What are the underlying themes that account for the beliefs about suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents of adolescent children?
- What are the believed causes of suicide and suicide-related behaviours?

- What are the consequences of suicide and suicide-related behaviours according to the Punjabi culture and Sikh religion?
- How do first generation Canadian Punjabi Sikh parents of adolescent children react to suicide and suicide-related behaviours?
- How do first generation Canadian Punjabi Sikh parents of adolescent children deal with suicide and suicide-related behaviours?
- What interventions do first generation Canadian Punjabi Sikh parents of adolescents utilize in response to suicide and suicide-related behaviours?
- Do first generation Canadian Punjabi Sikh parents seek help?
- What, if any, barriers do first generation Punjabi Sikh parents encounter in seeking help?

The following are the topical questions:

- How will the beliefs of first generation Canadian Sikh parents of adolescents be described by the data collected?
- What themes emerge from the data collected in relation to the literature?

1.4 Importance of Study

Currently, there exists a gap in the literature addressing mental health issues, particularly suicide and suicide-related behaviours experienced by Punjabi Sikhs. Duravasla and Mylavaganam (1994) noted this lack of literature for the South Asian population, that includes Punjabi Sikhs, and suggest that this may reflect mental health practitioners lack of expertise to confidently deal with mental health issues of this group, which is largely still the case today. To date, there has been a handful of studies that have examined suicide in the South Asian population around the world; that is, in England and Wales (Bhugra, Desai & Baldwin, 1999), Singapore (Kok, 1998; Kua & Tsoi, 1992), South Africa (Pillay, 1989), Fiji (Haynes, 1987), United States of America (Jha, 2001), and Canada (Wadhwani, 1999). These studies have revealed South Asians, particularly young women, to have higher rates of suicide in comparison

to other ethnic groups and to men of their own culture. Across Canada, only one study (Wadhwani, 1999) has examined youth suicide within the South Asian population. This study revealed 30% of the participants to have had suicide ideation and revealed family pressure to be the number one reason for the ideation. Furthermore, Sikhs in Toronto have expressed concerns that despite several youth suicides there has been no public dialogue in the community (O'Connel, 2000).

In British Columbia, the B.C. Mental Health Foundation extrapolated results from the 2008 B.C. Adolescent Health Survey and reported that 283 South Asian youth had considered suicide that year (B.C. Mental Health Foundation, 2010). Despite a lack of data regarding youth suicide among South Asians, B.C. mental health professionals have acknowledged a need to address the mental health issues of South Asian youth. This has led to the creation of the South Asian Youth Mental Health Fund (B.C. Mental Health Foundation, 2010).

The current project will be the first to discover the beliefs about suicide and suicide-related behaviour held by first generation Canadian Punjabi Sikh parents. It will assist to increase awareness and sensitivity of Punjabi Sikh views of suicide and suicide-related behaviour and to increase the success of mental health practitioner's interaction with Punjabi Sikhs of British Columbia. The need for cultural competence among mental health therapists has been well documented (Arthur & Stewart, 2001; Sue, Arredondo, & McDavis, 1992; Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982; Sue & Sue, 2008). A culturally competent counsellor is aware of their own assumptions, values, and biases, aware of their client's world-view, and will provide culturally appropriate services (Arthur & Stewart, 2001; Sue et al., 1982; Sue & Sue, 2008). Furthermore, this project may have implications for how suicide prevention and intervention might be undertaken by mental health therapists working with this population.

1.5 Definitions of Key Concepts

This section will discuss the key concepts that are examined in this study.

South Asian

The term South Asian is used in this study to describe those whose origins are from the Indian subcontinent.

Punjabi

The term Punjabi is used in this study to describe people whose origins are from the Province of Punjab in India.

Sikh

The term Sikh is used in this study to describe people who follow the Sikh religion founded in the 15th Century by Guru Nanak Dev Ji.

Suicide

The term suicide is defined in this study as the act of ending one's own life.

Suicide-related behaviour

The term suicide-related behaviour is defined in this study as potentially fatal self-harming behaviours and thoughts.

Beliefs

The term belief is defined in this study as the commonly held tenets by a group or an individual.

First Generation

The term first generation is defined in this study as Punjabi Sikhs who themselves immigrated to Canada from India.

Second Generation

The term second generation is defined in this study as Punjabi Sikhs who were born in Canada to first generation Canadian Punjabi Sikhs.

Chapter Two

Literature Review

In reviewing the literature on Punjabi Sikh mental health, specifically in the area of suicide and suicide-related behaviour, it is clear that little research has been conducted (Duravasla & Mylavaganam, 1994). The majority of the literature available is from the United Kingdom.

Punjabi Sikh beliefs about suicide are situated within a rich context of historical, social, cultural, religious, and familial beliefs. For this reason, it is crucial that examination of suicide within the Punjabi Sikh community considers the complexity of the Punjabi Sikh experience in Canada. It is important to take into account the traditional methods of healing within the framework of the western medical system. In addition, existing literature about suicide in regards to Punjabi Sikhs will be presented in this chapter.

2.1 Punjabi Sikhs – Background

History of India

India has always been ideal for trade and migration due to its location in the Arabian Sea and the Bay of Burma (Lee & Mock, 2005). It was first invaded in 1500 B.C. by the Aryans who inhabited northern India for approximately 700 years and laid the foundations for the Indian caste system and religions. From the eighth to eighteenth century northern India was invaded by the Arabs, Turks, and Afghans. However, it was the European colonization that began in 1500 that left a lasting impact. Great Britain conquered the sub continent and commanded control until 1947 when India won its independence (Lee & Mock, 2005).

Punjab: Homeland of the Sikhs

Punjab, the land of five rivers, is the homeland of the majority of Sikhs in Canada. It is located in the northwest of India and borders Pakistan on the west (Punjab at a Glance, 2007). Punjab has a population of 24 million of which 19 million are Sikh, and 16 million Sikhs call

rural Punjab home (Punjab at a Glance, 2007). The land of Punjab is flat and fertile for agriculture, which dominates the economy (Punjab at a Glance, 2007). Punjabi is the language spoken by the majority of the population; however, Hindi and English, the official languages of India, and Urdu are also spoken in the state (Singh, 2000).

Sikhism

Sikhism is one of the youngest major world religions today and it was founded by Guru Nanak Dev Ji, the first of ten Gurus, in the fifteenth century (Singh, 2000). Today, the Guru Granth Sahib, the compiled teachings of the ten Gurus is the presiding and eleventh Guru for all Sikhs (Singh, 1997). It carries the authority of God, Wahiguru and instructs Sikhs on moral conduct and attitudes (Krause, 1989; Singh, 1997). Although the Guru Granth Sahib emphasizes one's destiny, it also places importance on one's ability to effect one's own destiny. The Sikh Rehat Maryada, the official code of conduct and conventions for Sikhs also provides guidelines for religious and social practices (Shiromani Gurdwara Parbandhak Committee, 1994). Sikhs believe all humans to be equal despite social economic status and that women hold an equal status to men (Singh, 2000).

Punjabi Sikhs

For many Punjabi Sikhs religion is as much about culture as it is about religion. While not all Canadian Sikhs are Punjabi, most Canadian Sikhs who emigrated from Punjab, India are concentrated in the Lower Mainland area of British Columbia (Ley & Germain, 2000). Despite the appearance of a common cultural identity as a uniting force there are many differences between Punjabi Sikhs such as caste, region of Punjab, and those who have chosen to be baptized into the religion and those who have not. Ideally, being a Sikh would transcend caste, ethnicity, and gender; however in practice this is not the case (O'Connell, 2000).

Punjabi Sikh Immigration to Canada

The first wave of Indian immigrants from the state of Punjab, India to the west coast of Canada was seen during the years of 1904 to 1908 (Jagpal, 1994). This wave brought approximately 5,000 Punjabi Sikh males to British Columbia to provide labour for railway construction and the lumber industry (Jagpal, 1994). In the early years the majority of Indian immigrants were Punjabi Sikhs (Srivastava, 1983). In the years following there was a decrease in the number of Indians migrating to Canada due to the racially motivated Asiatic Exclusion League, the Oriental Riots of 1907, and the rule of the Dominion Government in British Columbia (Pravez, Siddique, & Wakil, 1981). A prime example of Canada's discriminatory and racist attitude and policy of the time is the denial of docking for the Komagata Maru in 1914. Over 300 Sikhs who defied the continuous journey policy of Canadian Immigration were forced to return to India where the British army awaited their arrival and opened fire upon those aboard (Basran & Bolaria, 2003; Boyd & Vickers, 2000; Walton-Roberts, 2003). In 1918, a resolution was passed at the Imperial Conference to allow children and spouses to immigrate to Canada; however, most Punjabi Sikh men did not have the necessary funds to finance the travel of these family members (Basran & Bolaria, 2003). In 1947 Punjabi Sikhs were given federal and provincial voting rights and municipal voting rights in 1948, which corresponds with India gaining independence from Great Britain in 1947 (Basran & Bolaria, 2003). However, immigration standards remained restricted by quotas of 150 in 1952 and 300 in 1957 (Basran & Bolaria, 2003).

It was in 1962 that the immigration policy of Canada was finally amended to permit immigration according to skills and merits (Pravez, Siddique, & Wakil, 1981). However, the new point system did not have much immediate effect on the rate of Indian immigration, but in the last decade Canada has seen an increase in the number of Indians immigrating in the Skilled Workers class. However, it was the Family Class immigration that had the greatest effect; in

1998, 80% of all of the applications were to reunite families from the Punjab (Walton-Roberts, 2003). The Refugee Class did not have as much effect either; however, after the Golden Temple, a holy Sikh shrine in Amritsar, Punjab, was invaded by the Indian army in 1984 Canada permitted over 1000 Sikhs to immigrate to Canada and escape the violent unrest. The number of Indian immigrants in the Business class remains insignificant in comparison to the other classes (Walton-Roberts, 2003).

According to the 2001 Canadian Census close to one million South Asians live in Canada. The term South Asian refers to those with origins in the Indian subcontinent, including Punjabi Sikhs. Of the one million South Asians in Canada, 74% reported themselves to be of East Indian cultural origin, which also includes Punjabi Sikhs, and eight percent reported themselves to be practicing the Sikh religion. Furthermore, eight percent of South Asians in Canada reside in Vancouver (Lindsay, 2001).

Punjabi Sikhs have come to Canada for various reasons. In Punjab, as the family farm for those belonging to the Jatt caste was divided among the brothers, land plots were increasingly smaller as generations evolved (Judge, 1994). This compelled many young Sikh men to immigrate to Canada to gain the necessary finances to purchase additional land. Going overseas was also considered prestigious as not many families could afford to send their sons abroad (Judge, 1994). Furthermore, immigration to Canada provided families with a higher quality of living and offered children better opportunities for education and career (Judge, 1994; Walton-Roberts, 2003).

2.2 Punjabi Sikhs and Mental Health

Culture and Mental Health

Having immigrated to Canada, Punjabi Sikhs brought with them their own set of beliefs and understandings of mental health, one that greatly differs from the western perspective. In western health care psychiatric disorders are historically and traditionally defined based upon

preconceived notions of distressing behaviour, a professional consensus, and a need for clinical attention to the distressing behaviour (Aderibigbe & Pandurangi, 1995). The mental disorder section of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), which is utilized to diagnose psychiatric disorders, is based upon the Anglo-European culture.

Generalization of diagnostic categories based upon the western perspective of the self, which is a highly individualized and mentalistic self that may be grasped objectively, is not possible for non western cultures that emphasize an interconnectedness of the mind, body, spirit, self, others, and the supernatural (Bose, 1997; Fabrega, 1994). For a category to be valid within a culture it must be credible to the people of the culture (Krause, 1989). Furthermore, it is possible for symptoms to be absent in certain cultures or to have different meanings in cultures where other traditions are influential (Borra, 2008; Krause, 1989). For instance, folk knowledge of mental health disorders in non-Anglo-European cultures may be expressed as causal explanations, which may be conveyed as metaphors, imagery, and narratives (Bose, 1997). However, at the root of diagnosing disorders lie judgments of abnormal behaviour, and there in exists the danger of stereotyping and stigmatizing psychiatric disorders as unique to specific cultures, and the challenge of incorporating cultural diversity into the DSM-IV-TR (Good, 1996; White Kress, Eriksen, Dixon Rayle, & Ford, 2005).

Although the lack of universality of cultural experiences limits the reliability and validity of the categorization of mental disorders included in the DSM-IV-TR, Appendix I of the DSM-IV-TR supplements the diagnostic assessment by outlining how to evaluate a client within their own cultural context (Fabrega, 1994; American Psychiatric Association, 2000). The appendix includes two sections, the first of which is the outline for cultural formulation that assists in addressing assessment difficulties that may arise in a multicultural context. The second section of the appendix is a glossary of culture-bound syndromes and idioms of distress that are defined as, "recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or

may not be linked to a particular DSM-IV diagnostic category" (American Psychiatric Association, 2000, p. 898). Despite the addition of the Appendix I to incorporate cultural diversity into the DSM-IV-TR, the focus tends to be upon individual disorders and does not address macro level issues, such as immigration, acculturation, and ethnic and racial identity confusion, which tend to be an issue for people of non-Anglo-European cultures residing in the west (White Kress, Eriksen, Dixon Rayle, & Ford, 2005).

Mental Health in India

Mental health issues do exist in India; however they must be seen with a unique cultural lens in order to fully comprehend the issue, the cause and the solution. For instance a similar pattern of illness of the western understanding of psychosis exists in India, but an episode tends to be short lasting and severe in comparison (Chakraborty, 1991). This pattern is similar to acute psychosis, but does not have a local name and is often explained to be the result of a spirit possession and is usually dealt with locally with a home remedy or a traditional healer (Chakraborty, 1991). On occasion when a doctor is consulted family members tend to dismiss previous episodes (Chakraborty, 1991).

Schizoaffective disorder is also found to affect Indians. However, it occurs more frequently than in western countries, and tends to have a better prognosis in India, which may be the result of an unidentified beneficial socio-cultural process (Chakraborty, 1991). On the other hand, anxiety is difficult to diagnose in India due to a cultural tendency to not distinguish between the mind, body, spirit, and community (Chakraborty, 1991). Conversely, the culture bound syndromes in the DSM-IV-TR do include a form of anxiety locally known as dhat.

In Appendix I of the DSM-IV-TR dhat, a diagnostic term utilized in India, refers to severe anxiety and hypochondriac concerns to do with the discharge of semen, discoloration of the urine, weakness and exhaustion (American Psychiatric Association, 2000). Possible explanations of dhat when diagnosed in men includes masturbatory and sexual guilt, and/or to

serve as a protective mechanism absolving one of feelings of failure and inadequacies (Chakraborty, 1991). On the other hand, leukorrhea, the term for the female experience of dhat is not included in the culture bound syndromes of the DSM-IV-TR. Although leukorrhea is quite common amongst South Asian women its biomedical symptoms often lead doctors to mistreat it as a reproductive tract infection, which are found to be rare amongst this group (Trollope-Kumar, 2001). Gynecologists explain leukorrhea to be a result of poor hygiene and poor diet, over work, and sexual anxieties, and tend to utilize a variety of treatments, such as Ayurvedic medicine, multivitamins, iron supplements, and suggestions of a nutritious diet and more rest (Trollope-Kumar, 2001). Often times the gynecologists will follow up with the husband and in-laws of the women to ensure a nutritious diet and rest, and thereby validating the women's distress (Trollope-Kumar, 2001). Thus, leukorrhea is thought to be an idiom of social distress for South Asians (Trollope-Kumar, 2001).

Overall, mental health illnesses in India are found to be mild in comparison to western countries, which may reflect a cultural tendency to either ignore or normalize symptoms (Chakraborty, 1991). There is also a cultural pattern of allowing people to recover without medication or medical attention and to utilize a more diverse range of healing practices (Chakraborty, 1991).

Recently, the relationship between post traumatic stress disorder (PTSD) and major depressive disorder was investigated amongst torture survivors of political persecution in the northern state of Punjab, India between the years of 1984 and 1995 (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). Indian security forces and the Indian police force tortured, "disappeared," executed and illegally cremated over 10,000 Punjabi Sikhs. Rasmussen, Rosenfeld, Reeves and Keller (2007) utilized a population of survivors of this torture to investigate the relationship between chronic injuries sustained as a result of the torture and the subsequent psychopathology.

The sample for this study was drawn from plaintiffs registered in a class action law suit against the Indian government (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). Government officials were able to identify 756 family members of decedents, of which every fourth decedent, 189, were chosen to participate in the study. However, contact information was not available for 29 family members, consequently, 160 immediate family members of decedents were invited to participate. However, only 130 family members attended appointments and a complete data set was available for 116.

The narratives of the abuse were recorded; if an injury prolonged, it was examined by a doctor for medical evidence (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). Three assessments were utilized for this study: CAPS (Clinician Administered PTSD Scale) to diagnose current PTSD, SCID (Structured Clinical Interview for DSM-IV) to diagnose current major depressive disorder, and the Dot Counting Test to identify individuals who may be exaggerating.

The results of the study revealed over half of the participants to have experienced some form of abuse at the hands of the Indian security forces and the Indian police and to have met the criteria for torture as set by the United Nations (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). A smaller number of women had been abused in comparison to men. One third of the sample reported chronic injures that were consistent with medical evidence. Furthermore, approximately one third of the sample was diagnosed with current PTSD and one fifth with PTSD in remission. Just over one third were diagnosed with current major depressive disorder and one third with major depressive disorder in remission. Injuries sustained from the torture were found to be a predictor of long-term psychopathology and a clear link to exist between the chronic injuries and the PTSD. If immediate medical attention had been provided after the torture, PTSD may have been avoided in many of the cases (Rasmussen, Rosenfeld, Reeves, & Keller, 2007).

South Asian Mental Health in Western Countries

Having immigrated to western countries South Asians have brought with them their own set of cultural and religious beliefs and understandings of mental health; one that emphasizes an integrated understanding of health to include the mind, body and spirit. As a result, there may be differing views of mental health disorders and symptoms of distress than that of the western perspective.

A study conducted with older adults who had been living with treated or untreated depression explored their conceptualization of it, more specifically their beliefs of its causes and how they deter or facilitate treatment (Lawrence, Murray, Banerjee, Turner, Sangha, Byng, Bhugra, Huxley, Tylee, & Macdonald, 2006). In-depth interviews were conducted with 110 older adults, of which 45 were White British, 33 South Asian, and 32 Black Caribbean. The study revealed White British and Black Caribbean older adults to define depression as a low mood and a sense of hopelessness. Whereas, South Asian older adults believed depression to be due to adverse personal and social circumstances that accrue in old age and defined depression to be a feeling of worry. Therefore, depression may be normalized for older adults of the South Asian culture, and the cultural group may not believe depression to affect young people (Lawrence, Murray, Banerjee, Turner, Sangha, Byng, Bhugra, Huxley, Tylee, & Macdonald, 2006).

Similarly, Adamson (2001) explored South Asians understanding of dementia through a Grounded theory approach. In-depth interviews were conducted with family members caring for an elderly diagnosed with dementia. The sample consisted of 18 African/Caribbean and 12 South Asian family members. The results of the study suggested dementia to not be widely known about or understood in the South Asian community. Despite the small sample size and the lack of generalizability, a need to raise awareness about dementia and to provide clear information for family members was identified in this study (Adamson, 2001).

Often times the mental health of men is either neglected or seen to be homogenous despite culture and age (Bhui, Chandran, & Sathyamoorthy, 2002). However, South Asian men have been noted to have lower rates of mental health issues, which may reflect cultural protective factors, differences in expression of distress, or issues of measuring distress (Bhui, Chandran, & Sathyamoorthy, 2002). A study was carried out by Bhui, Chandran, and Sathyamoorthy (2002) to gain an understanding of South Asian men's perception of mental health assessment, its value and importance upon their lives, and the quality of care. Semi structured interviews were conducted with eight South Asian men who had undergone a mental health assessment and three professionals who had completed such assessments. The study revealed cultural issues that were important to the men, such as religion, and coping styles influenced by the culture, to not be addressed by the medical professionals. Furthermore, the patients were not made aware of the nature of their illness, nor the rational for treatment, and viewed the assessment process to be authoritarian and disrespectful (Bhui, Chandran, & Sathyamoorthy, 2002). This study illustrated the importance of the cultural formulation process included in the DSM-IV-TR.

Karasz, Dempsey and Fallek (2007) conducted a study to explore the everyday somatic and psychological symptoms of distress amongst women of two diverse cultural groups, South Asian and European American. Semi structured interviews were conducted with 35 South Asian immigrant women residing in Queens, New York and 36 European American women of the upper middle class in New York. The study revealed the women of the two cultures to experience similar symptoms; however the origins of the illness and the explanatory models were found to be remarkably different (Karasz, Dempsey, & Fallek, 2007). The European American women utilized disease oriented labels, whereas the South Asian women were unable to do so, but instead spoke of hot and cold sensations and the desire to be left alone. Furthermore, the explanation model of psychological and bodily distress for South Asian women was rooted in the social context, but not for the European American women. A possible

explanation for the difference between the two cultural groups is that the careers of the European American women is a form of self expression and a failure to express themselves may lead to psychological distress. There may also be a difference in a social economic status and in literacy levels between the two groups of women. The European American women may have higher social economic status and a higher level of literacy than the South Asian women. The world of the South Asian women is regulated by their husbands and in-laws; when familial demands become too stressful, the women may experience physical debilitation and complain of physical distress. Consequently, South Asian women are more likely to consult a doctor for the physical symptoms than to access mental health services (Karasz, Dempsey, & Fallek, 2007).

Another case in example of a symptom of distress with a unique cultural meaning was presented by Krause (1989) who described a condition of the heart known as the "sinking heart" amongst Punjabi Sikhs in England. A patient suffering from a "sinking heart," also known as "dil ghirda hai" in Punjabi, experiences a physical sensation of the heart moving downwards or losing strength and may be accompanied by a dry mouth, faintness, a headache, and difficulty breathing. It is believed to be caused by a variety of issues ranging from, excessive heat, physical exhaustion, worry, to social failure. Thus, the "sinking heart" is based upon a culturally specific assumption that physical, emotional, and social symptoms are intertwined (Krause, 1989). Furthermore, the "sinking heart" is not a category included in the DSM-IV-TR, and thus the symptoms may be addressed as physical ailments and not as a mental health concern. Considering western medicine is not able to fully understand and address the health care needs of Punjabi Sikhs and other immigrants, it is not unusual for them to continue to hold onto their traditional beliefs and practices of health care.

Currently, there is little research available on the mental health needs of lesbian, gay, bisexual, transgender, intersex, and questioning (LGBTIQ) among the South Asian population. In Southern California the South Asian Network and Satrang completed a needs assessment for

South Asian LGBTIQ, with particular attention to issues of belonging and identity, and their impact upon their decision to access and to utilize mental health services (Choudhury, Badhan, Chand, Chhugani, Choksey, Husainy, Lui, & Wat, 2009). South Asian LGBTIQ face similar issues to heterosexual South Asians, however, the sexual identity adds an additional layer. Furthermore, many South Asians believe issues of sexual identity to be "western diseases," which may lead a LGBTIQ South Asian to feel torn between their culture and their sexual identity (Choudhury, Badhan, Chand, Chhugani, Choksey, Husainy, Lui, & Wat, 2009, p. 250).

An online survey was conducted with 94 LGBTIQ South Asians for this needs assessment. The results of the survey suggested South Asian LGBTIQ's are deterred from accessing mental health services due to cultural norms; shame and embarrassment were cited to be reasons for not accessing services. Not accessing services may also lead South Asian LGBTIQ to experience higher rates of mental health issues and to a higher frequency of engaging in risk taking behaviour, such as unprotected sex, drug use, and suicide thoughts. The study found a strong need for services to be sensitive to issues of sexual identity and ethnic identity (Choudhury, Badhan, Chand, Chhugani, Choksey, Husainy, Lui, & Wat, 2009).

Sikh Perspective of Mental Health

The Sikh scriptures provide an insightful understanding of the Sikh view of mental health. Sandhu (2004) through an analysis of primary and secondary sources offers a model to understand suffering and healing from a Sikh perspective. A person's spiritual self is multilayered; at its core lies the atma, which is part of the cosmic essence of Ek Onkar that unifies all diversity (Sandhu, 2004). The outer layers of the spiritual self include the consciousness (surti), the hidden record (chitr gupt), mind (antahkaran) and finally the body (sareer) (Sandhu, 2004). The source of all suffering (dukh) is related to transmigration, which is influenced by internal and external forces (Sandhu, 2004). A person's past karam, behavioural consequences, are imprinted upon the hidden record (chitr gupt) and determine the circumstances

a person is born into; while the external forces influencing birth are the familial and social environment (Sandhu, 2004). To suffer is to heal; suffering is believed to be curative as it serves to remind one of the inevitability of death and the importance of living in the moment (Sandhu, 2004). Since Sikh scriptures attest that one's suffering is a result of past behaviour, members of the Sikh religion may be less inclined to access mental health services available in their community.

Sandhu (2005) postulates the notion that suffering (dukhan ka chakar) is an existential reality whereby the ego motivates fulfillment of four core human needs: security, love, respect and freedom, all of which are interconnected and pursued simultaneously. Sandhu (2009) also suggests the Sikh view of addiction to be similar to existentialism in that the addiction is a symptom of deeper suffering. Sandhu (2005) suggests that recognition of the nature of suffering provides an understanding of the underlying causes of stress and allows for appropriate coping strategies.

Spirituality and Treatment

Immigrants are known to seek medical assistance outside the conventional western medical system in accordance to their own beliefs and values. As reported by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988) less than 20% of immigrants who need mental health services access them and it was the World Health Organization in 1989 which noted the importance of traditional healing methods for immigrants and recommended cooperation and respect between traditional and modern health to best meet the needs of all patients (Christie, 1991). Cultural and language barriers are believed to provide a partial explanation for the under utilization, but not a complete explanation.

Chiu, Ganesan, Clark, and Marrow (2005) completed a study to explore the effects of spirituality on treatment choices for 30 first generation Canadian women, of whom 15 were East Asian and 15 were South Asian, ranging in age from 26 to 67. All of the South Asian participants

were from Punjab, India and the East Asian participants were all Chinese, but varied in country of origin. Of the 15 East Asians, eight had been diagnosed with schizophrenia, four with major depression, and three with bipolar disorder. Of the 15 South Asians ten had been diagnosed with schizophrenia, two with depression, and one with major depressive disorder. Individual semi-structured interviews designed to understand the role of spirituality in treatment choices were utilized to obtain data for the study (Chiu, Ganesan, Clark, & Marrow, 2005).

The study revealed the decision to seek medical attention for mental health concerns to be affected by psycho, social, cultural, and economic factors (Chiu, Ganesan, Clark, & Marrow, 2005). The decision-making process consisted of three non linear phases; identification of contributing factors, exploration of alternative resources and strategies, and living with the choices. Spiritual beliefs were discovered to be closely connected with the second phase of decision making – exploration of alternative resources and strategies. Thus, spirituality was found to have significant impact upon first generation Canadian women's decision to seek medical attention for psychiatric disorders. The limitations of the study included the small sample size, the possibility of the responses being biased and translation indeterminacy (Chiu, Ganesan, Clark, & Marrow, 2005).

To further illustrate the importance of spirituality in treatment choices, Hilton, Grewal, Popatia, Bottorff, Johnson, Clarke, Venables, Bilku, and Sumel (2001) conducted a study titled, Desi Ways, in British Columbia, to assess how South Asian women utilized traditional healing methods, which factors affected their decision to utilize traditional methods, and the importance of traditional methods in their daily lives. The study was conducted as a critical ethnography in which 50 individual interviews, 12 focus groups, community meetings, and phone-in radio shows were conducted to collect data. Participants ranged in age from 20 to 80 and their religious practices varied (Hilton et al., 2001).

The study revealed that South Asian women held an integrated understanding of health (consisting of mind, body, and spirit) and incorporated traditional healing practices into their daily lives (Hilton et al., 2001). The traditional healing methods, also known as desi ways, included auyrveda, homeopathic, and naturopathic remedies, and relied upon the intervention of other members of the community: baba ji's, respected and wise men in the community, pandit's and granthi's, holy men who prescribe rituals and or prayers for healing, and jyotshi's, who are fortune tellers and astrologers. The study also found that the family is an important factor in influencing South Asian women's decision to access medical care. The limitations of the study included the relatively small sample size and thereby the lack of generalizability of the results (Hilton et al., 2001).

The work of Grewal, Bottorff, and Hilton (2005) expanded on the Desi Ways study completed by Hilton et al (2001). A secondary analysis was conducted by utilizing the data collected for the Desi Ways study to specifically examine the influence of family upon South Asian women's health. Of the original 50 South Asian women who participated in the Desi Ways study, 47 participated in the secondary analysis; three women were eliminated because they were not immigrants to Canada. The participants, who ranged in age from 25 to 80, took part in individual open ended interviews in which they were asked to share their perceptions of health, self-care, and their experience with accessing and obtaining health care in British Columbia. It is important to note that participants were not directly asked to share their thoughts on the influence of their families upon their health (Grewal, Bottorff, & Hilton, 2005).

The study revealed three themes that influenced their decisions to access health services (Grewal, Bottorff, & Hilton, 2005). First, various family relationships heavily influenced the decision; the most significant relationships proved to be those of husband and wife, and mother and daughter. The second theme revealed the family's response to the women's health concerns to also have influenced the decision. South Asian women put family obligations and

responsibilities before their own health and when the health concerns could no longer be put off they shared their concerns with family members. With the support and encouragement of their family the women would seek medical attention. At times, women were reluctant to seek medical attention if it had not been sanctioned by the family. The third theme revealed fulfilling family expectations and obligations played an important role in health seeking behaviours. It was important for the South Asian women to fulfill their traditional roles as obedient wives, dutiful daughter-in-laws, nurturing mothers and to assist with the financial burdens of the family with either part time or full time employment. All these obligations tended to come before their own health. Therefore, as a result of the family being the center of life, the study revealed some South Asian women to be at risk of neglecting their own health. The limitations of the study include the small sample size, and therefore, the inability to generalize the results (Grewal, Bottorff, & Hilton, 2005).

Punjabi Sikhs have continued to practice traditional healing methods despite having immigrated to Canada and having access to free medical services. With their integrated understanding of health as mind, body and spirit, and the family playing a central role in influencing the decision to seek medical attention, it is no surprise that Punjabi Sikhs have been observed to have low access rates of psychiatric services.

South Asian Access Psychiatric Services

Brewin (1980) noted a lower rate of consultation with general practitioners (G.P.) among Asian immigrants to the U.K. Possible explanations for the trend were thought to be Asians being psychologically healthier than people of other cultures, utilization of lay referral networks, or concerns not being brought to the attention of G.P's. Brewin (1980) conducted a study in which it was hypothesized that the low rate of psychiatric treatment was due to differing referral practices by the general practitioners and that a low referral rate would be reflected in a low rate of consultation with general practitioners. Medical records for a random sample of 200 Asian

immigrants, specifically Indian and Pakistani immigrants, was compared to an English control group that was matched individually for gender and age (Brewin, 1980).

There was found to be no difference between the number of consults with general practitioners among the Asian group and the English control group (Brewin, 1980). Furthermore, Asians appeared to experience distress at a similar rate to other nationalities; however, the distress may not be as readily recognizable. Therefore, a lower rate of referral does not reflect the rate of consultation. As consultations are most likely to be conducted in English, Asian patients may not be comfortable with the language and may be unable to express their distress or may be unable to understand the medical and psychiatric terms. It is also possible that the use of interpreters during consultations may lead to patients filtering the information they share with their general practitioners. Furthermore, patients may express their psychiatric distress in culturally appropriate manners that the general practitioners may not be familiar with (Brewin, 1980). Therefore, due to the limited amount of information, general practitioners may treat the symptoms as physical ailments, rather than psychiatric illnesses, as in the case of the "sinking heart" and dhat (Brewin, 1980; Chakraborty, 1991; Krause, 1989).

Bhui, Strathdee and Sufraz (1993) also noted Asians in Britain to be underutilizing psychiatric services, and hoped to identify the reasons for underutilization by examining the routes taken into psychiatric care, as well as the sociodemographic and ethnic characteristics of those utilizing the services. The authors also identified the characteristics of psychopathology of Asian inpatients and attempted to determine any shortfalls of the current assessment process as a result of cultural differences. This retrospective study examined inpatient notes for 100 consecutive Asian inpatients in a psychiatric unit at the Greenwich District Hospital and selected cases based upon place of birth, parental origin, and predominant cultural factors. The sample consisted of approximately an equal sex ratio, and three fifths were between the ages of 21 and 40, 80% were Asian Indian, 43% Sikh, and 29% Hindu (Bhui, Strathdee, & Sufraz, 1993).

This study revealed 34% of Asian inpatients to have been referred by a general practitioner, 18% to have been self-referred, 14% to have been referred by a relative, and 27% to have been admitted during a hospital visit (Bhui, Strathdee, & Sufraz, 1993). While the majority of the sample were referred by a general practitioner a significant, but slightly lesser number were admitted during a hospital visit, which may have been the result of ineffective traditional and/or spiritual methods. Furthermore, just over half of the sample was admitted for suicidal risk or event and just under half were admitted for psychotic symptoms. Therefore, it is evident that suicide and suicide-related behaviours are prevalent and a cause for concern among the Punjabi Sikh community. Limitations of the study included possible data errors and omissions in case notes (Bhui, Strathdee, & Sufraz, 1993).

Shame may surface either as negative self-perceptions and feelings or as negative projections of how others see oneself. One's behaviour may bring shame to others or to oneself, particularly in collective cultures such as the South Asian. As shame and honour may be largely socially defined, it is important to note who has the power to define it. In South Asian culture this power typically rests with males (Gilbert, Gilbert, & Sanghera, 2004).

To explore women's view of shame and honour in connection with mental health and help seeking behaviours, Gilbert, Gilbert and Sanghera (2004) utilized a phenomenological approach to conduct three focus groups with South Asian women. Scenarios were utilized to discuss izzat – the term used to depict family honour, shame, subordination and entrapment. The results of the study revealed izzat to be related to family honour and reputation, while shame was found to be about personal identity and ability to fulfill roles. Also, the study found women preferred to stay in an abusive relationship to protect the family izzat. Furthermore, the study found that women were unaware of the services available in the community, but also feared accessing services due to a possible breach of confidentiality that would lead to a loss of izzat.

Thus, help seeking behaviours were seen to be closely linked to the notion of izzat (Gilbert, Gilbert, & Sanghera, 2004).

2.3 Punjabi Sikhs and Suicide

Suicide in India

India has a religious and social history of accepting suicide. It is only in recent times with the outlawing of suicide that it has become unacceptable. In the scriptures of the Vedic era, 1500 to 500 B.C., death by suicide was considered to be the best sacrifice to redeem oneself (Venkoba Rao, 1975). The Vedic era was juxtaposed by the Upanishadic era in 800 B.C. Its philosophy revolted against the Vedic era and deemed suicide to be a sin, except in the case of religious sacrifice. For instance, sati, widows cremating themselves with their husbands was an acceptable and expected ritual (Bhugra, 2005; Venkoba Rao, 1975). Prior to marriage women were the responsibility of their fathers and after marriage they were to serve the needs of their husbands as dutiful and obedient wives (Bhugra, 2005). By sacrificing themselves on their husband's funeral pyre, women were believed to purify themselves and their families and to gain reincarnation (Bhugra, 2005). Thus, sati was not just an act, but represented religious and cultural values as well (Bhugra, 2005).

Today, suicide is identified by the Hindu and Sikh religious scriptures to be a sin, and is believed to prevent a soul from being liberated (Bhatia, Khan, Mediratta, & Sharma, 1987). However, within the Indian cultures the acceptance of suicide as a means of protecting and preserving family honor has lingered until very recently. For instance, during the separation of India and Pakistan in 1947, young Sikh women committed suicide rather than to be left to the mercy of the Pakistani or Hindu men (Venkoba Rao, 1975). Thus, there is a complex discrepancy between the religious and cultural acceptance of suicide in India.

Despite suicide being an illegal act and no longer holding the same religious and cultural value as it had in the past, it continues to be an issue in India. Of the eight countries that

comprise the Indian subcontinent, three of them, India, Sri Lanka and Pakistan, together represent ten percent of the annual world wide suicides (Khan, 2002). The high rate of suicide in the eastern countries may be due to concentration of a large portion of the world's population, as well as a high rate of poverty in the developing countries. Furthermore, in the years 1994 to 1999, India held an average rate of suicide of 95 per 100,000 (Manoranjitham, Jayakaran, & Jacob, 2006). With such an alarmingly high rate of suicide, India is the second leading country with number of suicides, falling behind only China (Khan, 2002). Furthermore, suicide amongst India's farmers has been concerning in recent years. Between the years 1997 and 2005 approximately 150,000 farmers have chosen suicide as an option to escape the accumulated debts to private moneylenders who charge an interest rate of 50% to 60% (Aggarwal, 2008; Mittal, 2008). However, it has been noted that the number of suicides in India may be underrepresented due to the unreliable population counts, under reporting of suicides due to the social and cultural stigma that ostracizes families, and legal consequences (Joseph, Abraham, Muliyil, George, Prasad, Minz, Abraham, & Jacob, 2003; Khan, 2002; Mittal, 2008).

The Sikh View of Suicide

Sikhs believe life to be a gift bestowed upon them by God, Waheguru. One's birth and death are predetermined and, therefore, Sikhs reject suicide as an act against Waheguru's will (BBC, 2007; Bhinder, 2007). Sikhism also rejects the ritual of sati, the burning of widows on their husbands' funeral pyre (Venkoba Rao, 1975; Singh, 2000). The Sikh ceremony of death involves the cremation of the body and the release of ashes into moving water (Singh, 2000). One's karma determines the suffering and pain one faces in ones lifetime; Sikhs are taught to not only accept their lot in life, but also to make the best of their given situation by approaching life in a responsible manner (BBC, 2007; Bhinder, 2007). Sikhs offer daily prayers for the betterment of society; sincere prayers are believed never to go unheard. Such prayers provide hope that difficulties that may arise over the course of a lifetime may be overcome (Bhinder, 2007).

Suicide and Religion

The influence of religion upon beliefs related to suicide has a long history. Religions tend to vary considerably in regard to suicide as a means of ending pain and suffering. The Hindu religion, for instance, was fairly tolerant of suicide during the Vedic period and strongly opposed to suicide in the Upanishadic period; this change in doctrine may reflect the influence of Aryan beliefs and ideology in northern India (Kamal & Loewenthal, 2002; Venkoba Rao, 1975; Thapar, 1994). Islam, on the other hand, has been resolute in its view that suicide is a sin and has refused forgiveness and entry into heaven to those who suicide (Kamal & Loewenthal, 2002). It is interesting to note that suicide rates among Hindus have been observed to be generally higher than those among Muslims (Ineichen, 1998).

For members of the Sikh religion, suicide is rejected as a viable option to ending suffering; nonetheless, it has neither been documented nor proven that Sikh beliefs about suicide and suicide-related behaviours have deterred suicide or suicide-related behaviours (BBC, 2007; Bhinder, 2007). Although suicide is not seen as an acceptable option to dealing with emotional and physical pain, and is rejected as such, this may not act as a strong deterrent to suicide or suicide-related behaviours.

Kamal and Loewenthal (2002) sought to study how differences embedded in scriptures impact individual beliefs of suicide and suicide-related behaviours. This was accomplished by a snowball sample in the Greater London area of the United Kingdom with 40 Hindus (19 women and 21 men) and 60 Muslims (38 women and 22 men) with a mean age of 22.5 years and primarily a single marital status. Most participants were either born in the Indian subcontinent or had parents who had been born there. Participants completed a background questionnaire which included age, marital status, country of birth, number of years in the U.K., religion, and rated their frequency of religious activity. The Reasons for Living Inventory, which consists of six

categories of reasons for living when suicide is contemplated, was also completed by participants (Kamal & Loewenthal, 2002).

The results revealed the condemnation of suicide in Islam to be significantly represented in the beliefs of suicide and suicide-related behaviours among young Muslims (Kamal & Loewenthal, 2002). Also, women were found to endorse fewer reasons for living in comparison to men. Therefore, the religious condemnation of suicide as an option to end emotional pain is strongly related to individual beliefs of suicide and suicide-related behaviours. The limitations of the study include a sample that was predominantly young, single, and educated in the west, and therefore, a lack of generalizability of the results. Also, there exists a possibility that the measures may have been insufficiently sensitive for this sample size (Kamal & Loewenthal, 2002).

Another study that looked at the correlation between the degree of religiosity and vulnerability to suicide attempts and suicide plans was conducted by Jahangir, Rehman and Jan (1998). More specifically, the study sought to examine the degree of religiosity and vulnerability to suicide attempts and suicide plans amongst Afghan Muslims residing in refugee camps in Pakistan. Two clinical judges reviewed recorded information from clinical interviews conducted in the years 1979 to 1991 for 118 patients who had been treated for a depressive illness and assessed depressive symptoms and degree of religiosity. Based on the information available from the interviews, clinical judges rated patients on a four point scale to measure degree of religiosity, suicidal plans, suicidal attempts, and a wish for death (Jahangir, Rehman, & Jan, 1998).

The study revealed a high degree of religiosity to be related to a less likely probability of planning or attempting a suicide, and thereby proving religion to be a strong deterrent factor (Jahangir, Rehman, & Jan, 1998). The limitations of the study included a relatively small sample

size and the possible biases held by the clinical judges that may have influenced their rating of the variables being measured (Jahangir, Rehman, & Jan, 1998).

The Sikh religion strongly opposes suicide as an option to end emotional and physical pain (BBC, 2007; Bhinder, 2007). However, there currently is a lack of literature pertaining to Sikh beliefs of suicide. Nor is there any literature that establishes a correlation between the influence of the Sikh religion and the incidence of attempted or planned suicide. On the other hand, there does exist literature that suggests that South Asians, which includes Punjabi Sikhs, are at risk for suicide and suicide-related behaviours.

2.4 Punjabi Sikhs and Suicide and Suicide-related Behaviours

While there is a lack of research conducted in the area of suicide and suicide-related behaviours among the Punjabi Sikh population there is relevant literature regarding South Asians, which includes Punjabi Sikhs.

The United Kingdom leads the field in this area of research. A study conducted by Raleigh (1996) examined the suicide patterns and trends among migrants from the Indian subcontinent and the Caribbean. This was done by analyzing the Census data of England and Wales between 1988 and1992. In previous studies the author had reported suicide rates among migrants during the years 1970 - 1978 and 1979 - 1983, which noted young Asian women to be at high risk. The current study compared the latest mortality data from the 1991 Census to the baseline and target rates for suicide in the Health of the Nation Strategy, which aimed to lower the national suicide rate. The data was examined to determine if South Asian women continued to be at high risk of suicide. In addition, the study intended to highlight variations between ethnic groups and the need for ethnic specific interventions.

The Raleigh (1996) study revealed Indian men to have higher rates of suicide when compared to males of other ethnic groups, and young Indian women to have significantly

higher rates, two to three times higher between the ages of 15 to 34, in comparison to the baseline and target rates of the national suicide rate. Furthermore, Indian and Pakistani women had a rate of ten times in excess of the baseline and target rates of suicide by burning. Thus, the study identified Indians to be at high risk for suicide. Furthermore, the patterns and trends indicated young ethnic minority adults to be at high risk for mental distress and self-harming behaviours (Raleigh, 1996).

The one drawback of the study is that it is limited to first generation Indians of England and Wales. People of second generation were not and could not be included in this study due to the reliance on "country of birth" as a selective criterion for the study (Raleigh, 1996).

Other studies conducted in the United Kingdom include a study by Bhugra, Desai, and Baldwin (1999). This study investigated the suicide rate of South Asian women in comparison to Caucasian women and South Asian men. The authors hypothesized that the results would support previous studies in which South Asian women had a higher rate of attempting suicide when compared to that of Caucasian women. The study included 434 patients aged 16 to 64 who sought emergency health care in west London hospitals. It is also important to note that there were an equal number of South Asian and Caucasian participants in the study. Data for the study was collected through semi structured descriptive interviews (Bhugra, Desai, & Baldwin, 1999).

The study revealed South Asian woman to have a higher rate of attempted suicide: six times that of Caucasian women and five times that of South Asian men (Bhugra, Desai, & Baldwin, 1999). Furthermore, the study revealed younger South Asian women, aged 16 to 24, to be at most risk at a rate of five to seven times that of South Asian men. The limitations of the study include patient's self-assigning South Asian background, and the researchers not collecting information about previous suicide attempts or the precipitating events of the suicide attempt (Bhugra, Desai, & Baldwin, 1999).

One of the purposes of the study conducted by Hicks and Bhughra (2003) was to explore the perceived causes of suicide attempts by South Asian women in the United Kingdom. The authors hypothesized that social, cultural, and family issues are key factors in South Asian women attempting suicide. The study included 180 South Asian women recruited through the offices of nine general practitioners and 24 community agencies. The women ranged in age from 15 to 75 years and tended to have higher levels of education. The questionnaires were purposely written in English to attract younger women who were believed to be more comfortable with English as a written language and were therefore, believed to be at a higher risk of attempting suicide due to their identification with the mainstream culture. The questionnaire contained a list of perceived causes of attempting suicide, but the authors did note that the list was not exhaustive (Hicks & Bhugra, 2003).

The study revealed depression and being trapped in an unhappy situation to be among the top three perceived causes of attempting suicide. The authors noted the limitations of the study to include the relatively small sample size, the lack of random selection, the list of possible causes to possibly have left out perceived causes, and finally, that the perceived causes may not be the actual causes (Hicks & Bhugra, 2003).

To date there has been one study conducted in Canada on suicide ideation among South Asian youth. The Masters thesis completed by Wadhwani (1999) at McGill University is embedded in the work of Emile Durkheim, a French sociologist. Specifically, it was Durkheim's premise that although people have different reasons for attempting suicide, various groups of people do have different rates of suicide, and therefore, must have different reasons. Thus, Wadhwani attempted to identify the reasons South Asian youth in Canada consider suicide to be an option.

Wadhwani (1999) believed this study to be important for a number of reasons. Firstly, there had recently been a marked increase in completed suicides among South Asian youth in

eastern Canada leading to the formation of the Kesri Ribbon organization to raise awareness of suicide in the community. Secondly, despite the recent increase of South Asian youth suicide, there is no data available to analyze the rate of suicide among this population across Canada and hoped to address this gap in literature. Thirdly, the study hoped to provide mental health care workers with important information that would allow them to design and implement prevention and treatment programs that are specific to this ethnic group. A six-page survey was developed to address the goals of this research and 104 South Asian youth participated in this study. The findings of the study revealed 30% of the participants to have experienced suicide ideation. Furthermore, three significant variables, gender (80% of females), place of birth (Canada or the U.S.), and those with self-rating of depression, were correlated with suicide. Of those who reported having considered suicide as an option to suffering, family pressure was checked as the number one reason. Limitations of the study include a sample size of 104 participants, and lack of generalizability of the study. Furthermore, the author failed to include a definition for the term "family problems" (Wadhwani, 1999). However, the results do warrant further study in this population.

2.5 Punjabi Sikh Adolescents and Mental Health

Punjabi Sikh adolescent children of first generation Canadians are raised by parents who emigrated from India and brought with them an understanding of health that greatly differs from that of the western perspective; it is one that views mind, body, and spirit to be interconnected and that values traditional healing methods. Furthermore, first generation Punjabi Sikh Canadians have brought with them a strong sense of family values and a collective lifestyle, one that includes extended family members (Grewal, Bottorff, & Hilton, 2005; Hilton et al., 2001).

A Punjabi Sikh household consists of an extended family with the elders as the heads of the family (Assanand, Dias, Richardson, & Waxler-Morrison, 1990). The responsibility of parenting children is shared by the adults; however, mothers bear the majority of the burden.

When a child falls ill, decisions to seek medical attention are made by the elders or the male head of household; however, it is the mother's responsibility to follow through with the decision. Home remedies or traditional healing methods are likely to be attempted prior to consulting medical professionals, particularly in the case of mental illnesses, which are often believed to be caused by supernatural powers or spells cast by relatives (Assanand, Dias, Richardson, & Waxler-Morrison, 1990).

There have been a limited number of studies that have addressed the mental health issues experienced by children of Punjabi Sikh descent. Children in India tend to experience psychological issues at a similar rate to children in the west, perhaps at a higher rate in urban India (Harris, 2000). However, just as South Asian adults in the U.K. have been noted to be underrepresented in mental health clinics, so have South Asian children (Jawed, 1991; Stern, Cottrell, & Holmes, 1990). Although the reasons for underrepresentation are unclear; possible explanations include a lower rate of mental health disorders, cultural tendency to attempt to resolve issues within the family rather than seek medical attention, different meanings of emotional distress, and a lack of culturally appropriate mental health services (Harris, 2000). Despite the underrepresentation, South Asian parents view their children's' problematic behaviour to be difficult and distressing, but choose not to seek professional assistance (Nweth & Corbett, 1993). Mental health professionals have also noted South Asian children to be referred at a later stage for mental health concerns in comparison to children of other ethnicities (Harris, 2000). As male children have traditionally been shown preference, boys have been noted to be referred at an earlier stage than girls (Harris, 2000). Furthermore, South Asian children have been noted to be referred by specialists, instead of general practitioners, for child and adolescent mental health services in the London area (Daryanani, Hindley, Evans, Fahy, & Turk, 2001). This trend may be due to a display of psychosomatic symptoms, expression of distress in other

ways, such as self-harm and possibly parental preference for specialists (Daryanani, Hindley, Evans, Fahy, & Turk, 2001).

Given that Punjabi Sikhs under utilize mental health services, preferring to deal with health concerns within the family unit with the help of traditional healing methods, and their high risk for suicide and suicide-related behaviours, at least in western countries, it seems imperative that we learn more about Punjabi Sikh beliefs about suicide and suicide-related behaviours. Investigating the cultural interpretations of emotional distress, the warning signs of suicide and suicide-related behaviours, and how these are perceived by Punjabi Sikhs may reveal Punjabi Sikh youth to be a high risk group.

Chapter Three

Methodology

The purpose of this chapter is to provide an overview of the qualitative research design utilized for this study. The research questions addressed in this study and the factors which influenced the selection of methodology are explored within this chapter. The researcher's position in relation to the study is discussed and the method of data collection is presented with emphasis upon participant recruitment and interview methods. Finally, data analysis, ethical concerns, trustworthiness and limitations of the study are examined.

An ethnographical approach was taken to address the following research questions:

1. What are the beliefs about suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents of adolescent children?
2. What are the beliefs of first generation Canadian Punjabi Sikh parents of adolescents if they were to respond to a suicide attempt and suicide-related behaviours in their family?

Ethnography, which literally means "writing about groups of people," seems an ideal means by which to identify and describe the beliefs held by first generation Canadian Punjabi Sikh parents of adolescent children (Creswell, 2009; LeCompte & Schensul, 1999 b, p. 21). Ethnography is often utilized by researchers to study cultural groups in their natural settings and to discover a cultural group's explanation for behaviour, patterns of behaviour, customs, ways of life, language, and interactions (Creswell, 2007; LeCompte & Schensul, 1999 b). As the focus of this study is to describe the set of beliefs held by members of a particular cultural group (Canadian Punjabi Sikh), ethnography seems appropriate in helping to surface participants' thoughts, understandings, emotions, and perhaps most importantly, the meaning participants attribute to all of the former (Creswell, 2007; LeCompte & Schensul, 1999 b). An ethnographic approach offers rigorous data collection methods in order to avoid bias, and to accurately reflect a cultural groups' views and perspectives (LeCompte & Schensul, 1999 b).

The origins of ethnography lie in cultural anthropology. In the early 20th century anthropologists utilized this method to study comparative cultures (Creswell, 2007). It differed from the scientific approaches in that it relied upon first hand data collection and focused upon behaviour, language, and artifacts in various forms, all in hopes of uncovering cultural themes to provide insight into a culture. Thus, in essence, ethnography is a product of the research (Creswell, 2007).

While traditionally, ethnographers lived with a cultural group for an extended period of time to collect data using various methods, today the ethnographic approach may be compressed in terms of time if the researcher is familiar with the cultural context, able to speak the language, focused on one aspect of the culture, and able to work with cultural experts to ensure validity (LeCompte & Schensul, 1999 b).

As a researcher of Punjabi Sikh background I am familiar with the Punjabi culture and the Sikh religion. I speak fluent Punjabi and have cultural contacts to assist with this study. I have focused my study on one cultural aspect – first generation Canadian Punjabi Sikh parents' beliefs about suicide and suicide-related behaviours. I consider myself to be well positioned in order to engage in a research study of this nature.

3.1 Researcher's Position

I am a second generation Canadian Punjabi Sikh woman currently residing in the Greater Vancouver Area of British Columbia. My first generation Canadian Punjabi Sikh parents, who immigrated to Canada in the 1970s, raised the family in the Interior of British Columbia and we were educated in the public school system and post secondary institutions. Currently, I am employed by the Vancouver School Board as an Area Counsellor.

I am assigned to elementary schools to provide counselling services and to coordinate mental health programs with an emphasis upon prevention. My role as an Area Counsellor I have the responsibility to address emotional and behavioural issues before they significantly interfere

with a student's academic progress and emotional well being. A great deal of my role as an Area Counsellor includes working with individual students and groups, as well as with parents and families.

For five years now, I have been working in the South East area of Vancouver where there is a significant South Asian population. One of the issues I address with my students and their families is suicide and suicide-related behaviours. It has been my experience that mothers are the most likely family member to attend meetings with school officials when addressing mental health concerns. The decision to seek mental health services, however, tends to rest with the elders or the male head of households. I have noted a reluctance on the part of South Asian parents to access mental health services. There may be a number of reasons for this hesitancy, possibly language and cultural differences, and a fear of a breach of confidentiality. I have noted that some parents may minimize a presenting problem rather than seek professional help, choosing instead to address the issue within the family structure.

When working with South Asian parents my approach tends to be gentle and respectful of cultural and religious values. Also, I ensure confidentiality and normalize the situation, assuring parents they are not the first family to face such a situation. I find it is important to take the time to assist parents in understanding what treatment may look like and how they may participate and engage in the therapeutic process. Although parents may be reluctant at first, I do find parents are willing to listen and are eventually willing to access mental health services. As a counsellor with the Vancouver School Board I see a strong need for the current study.

On a personal level, the topic of suicide and suicide-related behaviours is close to my heart. Last summer my family and I acknowledged the ten year anniversary of a relative's death by suicide. It is my hope that by completing this study other families will be able to avoid the emotional pain and suffering our family has endured.

Before I began this study, I considered suicide to be culturally stigmatized and expected to encounter difficulty finding participants willing to share their beliefs about adolescent suicide and suicide-related behaviours. I thought it likely that Canadian Punjabi Sikh families' response to adolescent suicide and suicide-related behaviours might be initially one of denial. I expected that families might not be willing to speak about the issue in order to protect their family honor and to evade stigmatization. As much as I believed Punjabi Sikh parents to be appropriately concerned about their children experiencing suicide-related behaviours, I anticipated that Punjabi Sikh parents might not completely understand the issue and might comprehend neither the seriousness of the situation nor the importance of seeking mental health services. I expected Punjabi Sikh parents to encounter language and cultural barriers in seeking mental health services. The primary intervention I expected Punjabi Sikh parents to utilize was communication. I expected that parents might speak to their child to assist them in understanding that suicide is not an appropriate option and in resolving whatever issues that may have led them to consider suicide.

Prior to beginning the research I expected the second generation Canadian Punjabi Sikh young adults to be more willing to speak about the topic of adolescent suicide and suicide-related behaviours than the parents participating in the study. I also expected the young adults to have a better understanding of mental health issues than the parents. I anticipated the medical and mental health professionals to report a low access rate by Punjabi Sikh families, as well as difficulty in explaining mental health issues to parents and in engaging them in the therapeutic process. I had hoped the community leader participant would clarify the role of the Punjabi culture and the Sikh religion in the beliefs held Punjabi Sikhs about adolescent suicide and suicide-related behaviours.

3.2 Data Collection

Data was collected from multiple sources to provide a wide perspective to the study. Semi structured individual interviews were conducted with four groups of participants: first generation Canadian Punjabi Sikh parents (fathers and/or mothers) of adolescent children, second generation Canadian Punjabi Sikh young adults, South Asian mental health therapists and medical professionals, and a Punjabi Sikh community leader. The sample size of an ethnographic study is dependent upon available resources, as well as sufficiency and saturation of data (Ortiz, 2003). Sufficiency refers to the number of interviews required to reflect the breadth of experience with a cultural group, while saturation refers to the number of interviews it takes for there to be no new major themes arising (Ortiz, 2003; Suzuki, Mattis, Ahluwalia & Quizon, 2005). For the purpose of this study – to contribute to an understanding of first generation Canadian Punjabi Sikh parents' beliefs about suicide and suicide-related behaviours, a total of nine to 14 interviews were believed to provide an adequate data set. A total of ten interviews were conducted for this study and were found to provide an adequate data set, which did prove to be sufficient and further interviews were not required for sufficiency and saturation to be achieved. The community leader's interview assisted with triangulation of the data.

3.3 Participants

First Generation Punjabi Sikh Parents of Adolescent Children

Semi-structured interviews were conducted in the English language with a snowball sample of first generation Canadian Punjabi Sikh parents of adolescent children. Participants had the option of either joint parent or single parent participation in the interview. The selection criteria for participants included Punjabi Sikh cultural and religious background, parents of children who are currently adolescents and fluency in the English language. In an effort to avoid triggering any possible emotional distress and to focus upon the lay beliefs of Punjabi Sikhs, participants were not be permitted to take part in the study if they had experienced a death of a

family member or a close friend by suicide. Also, in an effort to prevent role confusion and a conflict of interest, family members or friends of the researcher, or participants who have children attending a school the researcher provides services for as an Area Counsellor were not be permitted to partake in the study.

Three first generation Canadian Punjabi Sikh parents participated in this study; one single mother, one mother of a two parent family, and a father and a mother of a two parent family. All parents had immigrated to Canada from India on an average of approximately 32 years ago. Of the two parent participants, the mother had immigrated to Canada from England. Although the participant's birth in England would have excluded this parent from the study, her husband, who did meet the criteria for participation, requested that his wife be permitted to participate. Parent participants had a mean age of 42 years, attended a Canadian College for post-secondary education, and had either two or three children, with at least one being an adolescent. See Table 3.1 for further details.

Table 3.1 First Generation Canadian Punjabi Sikh Parent Participants

	Parent 1	Parent 2	Parent 3
Mother and/or Father	Mother	Father & Mother	Mother
Age	42	43, 41	40
Birthplace	India	India, England	India
Number of years in Canada	29	37	29
Level of Education	College	College	College
Number of Children & Ages	2 - 13, 16	3 - 16, 16, 20	3 - 9, 11, 17
Household Composition	Single Parent	Nuclear	Extended

Second Generation Canadian Punjabi Sikh Young Adults

A snowball sample of second generation Canadian Punjabi Sikh young adults participated in semi-structured interviews. The selection criteria for participants included being of Punjabi Sikh cultural and religious background, having been born to first generation Canadian Punjabi Sikh parents, and being between the ages of 19 and 22. Participants in this age group, who had recently completed their adolescent years, were chosen as subjects as they were more

likely to provide insight into their parents' current beliefs about suicide and suicide-related behaviours.

In an effort to avoid triggering any possible emotional distress and to focus upon the lay beliefs of Punjabi Sikhs, participants were not be permitted to take part in the study if they had experienced a death of a family member or a close friend by suicide. Also, to prevent role confusion and a conflict of interest, participants were not be permitted to partake in the study if they were a family member or friend of the researcher or if the researcher had provided services for them as their high school counsellor.

Four second generation Canadian Punjabi Sikh young adults participated in this study; three females and one male participant. All were born in the Lower Mainland area of British Columbia, had a mean age of approximately 20 years, were currently attending a post-secondary institution, lived in either a nuclear or an extended family, and had at least one sibling. See Table 3.2 for further details.

Table 3.2 Second Generation Canadian Punjabi Sikh Young Adult Participants

	Young Adult 1	Young Adult 2	Young Adult 3	Young Adult 4
Gender	Female	Female	Male	Female
Age	19	22	19	19
Birthplace	Canada	Canada	Canada	Canada
Education	Post-Secondary	Post-Secondary	Post-Secondary	Post-Secondary
Siblings (Age(s))	4 (18, 16, 12, 3)	1 (20)	1 (25)	1 (18)
Household Composition	Nuclear	Nuclear	Nuclear	Extended

South Asian Mental Health Therapists and Medical Professionals

South Asian mental health therapists and medical professionals participated in semi-structured interviews. Many South Asians are able to speak and/or understand Punjabi and are likely to have been sought out by Punjabi Sikhs in need of services. These South Asian mental

health therapists and medical professionals were seen to have valuable insights into Punjabi Sikh beliefs about suicide and suicide-related behaviours.

The selection criteria for mental health therapists and medical professionals were that the individual be South Asian background and to be practicing within their professional field, with a minimum of five years experience. It was expected that by setting a minimum number of years of practice as a selection criterion it was expected that participants would have had sufficient experience working with the Punjabi Sikh population to offer insight into Punjabi Sikh beliefs of suicide and suicide-related behaviours. In an effort to avoid participant bias, participants were not permitted to partake in the study if they were a family member or a friend of the researcher.

Two South Asian mental health and medical professionals participated in the study. One of the participants is a Registered Clinical Counsellor and the other a Child and Adolescent Psychiatrist. Both of the participants are female, born in India, and practicing within their respective fields for an average of approximately 17 years. See Table 3.3 for further details.

Table 3.3 South Asian Mental Health and Medical Professional Participants

	Participant 1	Participant 2
Gender	Female	Female
Age	40	N/A
Place of Birth	India	India
Position	Registered Clinical Counsellor	Child & Adolescent Psychiatrist
Number of Years In Practice	18	15

Although two participant interviews were included in the analysis of this study, a third interview with a mental health professional took place, but was not included in the analysis. Despite the initial screening process, it became clear only afterward that the participant had not worked with Punjabi Sikh parents dealing with adolescent suicidal behaviour and was unable to comment about Punjabi Sikh beliefs about adolescent suicide; the participant admitted a lack of experience in working with this issue. Consequently, this interview was not included in the data analysis; the exclusion was discussed with the participant who agreed with the decision to

exclude the interview. While screening for participants for this portion of the study, general practitioner's contacted the researcher expressing interest in participating. However, all acknowledged they often referred parents to specialists, such as a child and adolescent psychiatrist, and that they themselves lacked experience in working with Punjabi Sikh parents regarding this issue.

Punjabi Sikh Community Leader

A Punjabi Sikh community leader participated in a semi-structured interview to share their understanding of Punjabi and Sikh beliefs of suicide and suicide-related behaviours. Since there are many elements of the Punjabi culture and the Sikh religion that overlap; the community leader was able to assist in deciphering a belief to be cultural and/or religious. One leader was invited to participate in the study based upon their contributions to the community and expertise in the culture and the religion; the participant had no relation to the researcher.

The following community leader interviewed for this portion of the study was Harinder Singh, the Executive Director of the Sikh Research Institute, a community development organization focusing on education through preservation, celebration and inspiration. An inter-disciplinary researcher and global orator, Harinder Singh is well known for his expertise on issues related to the Sikhs and the Punjab. Since 1997, he has developed, taught and supervised courses and projects in the Sikh Homeland and the Diaspora. He has lectured extensively at various forums in the United States, Canada, England Scotland, India, Pakistan, and South Africa. He envisioned the K-12 Sojhi curriculum in language arts and Sikh heritage. He has consulted on several films and documentaries including, *Ocean of Pearls, 35, The Widow Colony*, and *Jaswant Singh Khalra*. He contextualizes Sikh perspectives on genocide, theology, politics, culture, and linguistics. He is active with the Panjab Digital Library, Sikh Scholarship Foundation at Oxford & Harvard, the United Communities of San Antonio, and the Nanakshahi trust. His passion is to learn, interpret, and share intricacies of Sikh culture.

3.4 Recruitment

First generation Canadian Punjabi Sikh parents of adolescent children, second generation Canadian Punjabi Sikh young adults and South Asian mental health therapists and medical professionals were recruited through snowball samples (Berg, 1995). Recruitment letters addressing the parents, young adults, and therapists and medical professionals, written in the English language, informed and invited participants to partake in the study. See Appendices I, J and K for recruitment letters.

The recruitment letters were distributed via the Counselling Psychology student list serv of the University of British Columbia with a request to forward the email to those whom they believe may be interested in participating in the study. The letters were also distributed to South Asian members of the community via email. Due to the nature of the study with a specific target population and selection criteria, difficulty obtaining participants was anticipated. It was believed that the researcher's South Asian background would assist in gaining access to the target population. The researcher emailed family and friends with a request to forward the recruitment letters to those whom they believe may be interested in participating in the study and a request for them to forward the email to their family and friends, and so on, thereby creating a snowball effect (Berg, 1995). See Appendix H for the email message requesting the recruitment letters be forwarded to potentially interested participants. The recruitment letters requested potential participants to either email or call the researcher directly; contact information was included in the letters.

If a sufficient number of participants had not been recruited via email, the researcher was to approach local South Asian radio stations with a request to advertise for parental participants. Sufficient number of participants had been recruited without having to request assistance from local radio stations.

In a further effort to recruit mental health therapists and medical professional participants, the Directory of College of Physicians and Surgeons of B.C. and the Services and Resources Directory for the Punjabi speaking community in Metro Vancouver published by the Mood Disorders Association of B.C. was utilized to identify and mail recruitment letters to South Asian medical professionals. Although it was hoped that the recruitment letters sent via mail and email would be sufficient in obtaining participants for the study, it was necessary to send recruitment letters to Punjabi speaking professionals included in the Services and Resources Directory for the Punjabi speaking community in Metro Vancouver.

Telephone Interview Format

All recruitment letters requested potential participants to initiate contact with the researcher via email or telephone; the researcher's contact information was provided in the letters. Once initial contact had been made, the researcher conducted a brief telephone interview, which provided an opportunity to offer further details of the study, to determine if the participant met the selection criteria for the study, and to address any concerns or questions the participants might have. See Appendices L, M and N for the telephone interview formats.

At the end of the telephone interview, if a potential participant met the selection criteria they were invited to participate in the study. Participants were given a choice of going over the consent form at that time or of arranging another time to do so. The consent form was emailed, mailed, or hand delivered to participants - depending on the participants' preference. Once the participant had a copy of the consent form and the researcher had explained it in detail, the participants were given a minimum of three days to make a decision whether to participate or not. The researcher contacted the participants within the three-day time period to inquire about a decision. If a participant's decision was to participate, a date and time was set for the interview.

Prior to beginning the interviews, the researcher again explained the consent form to participants and checked their understanding of its contents. If the participant fully understood

and consented to participating in the study they then signed the consent form and were given a copy of the consent for their records. Participants' rights, privacy and confidentiality were respected throughout the study. See Appendices O, P, and Q for the consent forms.

Recruitment and Consent of the Punjabi Sikh Community Leader

Prior to beginning the study, the researcher approached Harinder Singh, outlined the study and requested for an interview. Harinder Singh accepted the invitation to participate and requested the researcher be in touch when prepared to interview.

The issue of confidentiality was discussed when the researcher invited Harinder Singh to participate in the study. It was agreed that information provided during the interview by the community leader would not be confidential as he would not be reflecting upon personal experiences and that any segments quoted in the final paper would identify the speaker. However, prior to the interview process, informed consent was obtained and the community leader's right to withdraw at any point from the study was respected. See Appendix R for the consent form.

3.5 Interview Procedure

All interviews were recorded and transcribed for analysis. Two digital audio recorders were utilized to prevent loss of data. The researcher recorded her thoughts from each interview in a journal, which aided the data analysis process.

Storage of Data

All data was stored in a secure locked filing cabinet at the researcher's home. The sole copy of documents which identified the participants was kept at the researcher's office in a locked cabinet. All other copies identifying the participants by a pseudonym were kept in a locked filing cabinet at the researcher's home.

Order of Interviews

The first generation Canadian Punjabi Sikh parents were interviewed prior to interviewing the second generation Canadian Punjabi Sikh young adults and the South Asian mental health therapists and medical professionals. This allowed for the data set collected from the parental participants to be checked by the second generation Canadian Punjabi Sikh young adults and the South Asian mental health therapists and medical professionals. A summary of the data collected from the parental interviews was presented at the conclusion of the young adult and medical and mental health participants' interviews and the young adults and medical and mental health professionals were requested to comment on the accuracy of the data based upon their experience of being raised by and working with first generation Canadian Punjabi Sikh parents.

First Generation Canadian Punjabi Sikh Parents

Participants were requested to complete a brief demographic survey prior to beginning the interview. The survey provided a brief sketch of the participants and their families by recording gender, age, birth place, number of years in Canada, level of education, number of children and their ages, and household composition. See Appendix A for the demographic survey.

The parental participants were presented two case studies of adolescents who have either completed suicide or are experiencing suicide-related behaviours. A series of questions were asked based upon the case studies to gain an understanding of their beliefs of suicide and suicide-related behaviours and how they would respond to a suicide or suicide-related behaviours in their family. The two case studies were adapted from Appendix four of the document titled, "Practice Principles: A Guide For Mental Health Clinicians Working With Suicidal Children and Youth" published by the Ministry of Children and Family Development of British Columbia (Ashworth, 2001). Both case studies were slightly altered to ensure comprehension of the situations by the

parental participants; medical and mental health terminology was simplified. The adaptations of the second of the two case studies included changing the name of the adolescent to reflect a Punjabi Sikh background. Traditionally, an ethnographic interview is free flowing with no pre set question schedule; however, due to the nature of the study, the case studies were utilized to contextualize the beliefs of suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents. See Appendix C for the case studies and the interview questions, which were pilot tested to check for understanding prior to conducting the interviews with the parental participants.

The interviews lasted approximately one hour and took place at the home of the participant; the researcher was accompanied by a companion to ensure safety, but the companion was not present during the interview. The interviews could also have taken place at the University of British Columbia, however, the participants preferred for them to take place at their home.

Upon completion of the interview participants were given information about the mental health services available in the community and the warning signs of suicide and suicide-related behaviours to take home. The handouts included two pocket sized cards for the Crisis Centre, which included local and long distance phone numbers, and email and website information for Youth In B.C. The cards also provided information of what a crisis and distress situation may look like, a stress ruler to judge the amount of stress one may be experiencing, the warning signs of suicide, and the steps to getting help for someone who may be suicidal. A third pocket sized card for 1-800-Suicide that also includes the warning signs of suicide was included with the handouts. In addition to the three pocket sized information cards, a Services and Resources Directory for the Punjabi speaking community in Metro Vancouver published by the Mood Disorders Association of B.C. in May of 2008 was also included in the handouts. The directory includes websites for publications on mental health disorders that have been translated into

Punjabi, contact information for mental health services for the Punjabi and Hindi speaking community, Punjabi and Hindi speaking psychiatrists and psychologists and mental health and addiction centers in Metro Vancouver and Fraser Valley. See Appendix D for the handouts.

Second Generation Canadian Punjabi Sikh Young Adults

The participants were requested to complete a brief demographic survey to provide a brief sketch of the participants and their families by recording their gender, age, birth place, level of education, and household composition. See Appendix B for the demographic survey.

The young adults were presented the same two case studies of adolescents who have either completed suicide or are experiencing suicide-related behaviours as the parental participants of the study. They were asked to respond to similar questions as the parental participants had, but with minor alterations to suit the change in participants. The interviews lasted approximately one hour and took place at the University of British Columbia. See Appendix C for the case studies and the interview questions.

Upon completion of the interview participants were given information about the mental health services available in the community and the warning signs of suicide and suicide-related behaviours to take home. The handouts were the same as those provided for the parental participants. See Appendix D for the handouts for the parental and young adult participants.

The researcher pilot tested the interview questions with a young adult who fits the selection criteria to check for understanding prior to conducting the interviews with young adults participating in the study.

South Asian Mental Health Therapists and Medical Professionals

Participants completed a brief demographic survey prior to the interview. The survey provided a brief sketch of the participants; it recorded participants' age, gender, place of birth, position held in medical community and the number of years of practice. See Appendix E for the demographic survey.

The semi-structured interviews, conducted in the English language, requested participants to answer all interview questions based upon their experience of working with first generation Canadian Punjabi Sikh parents of adolescent children. See Appendix F for a list of the interview questions, which were pilot tested to check for understanding prior to conducting the interviews. Interviews were scheduled for one hour to take place at the office of the participants. Although the interviews could also have taken place at the University of British Columbia, the participants preferred for them to take place at their office.

Punjabi Sikh Community Leader

Interview questions were provided prior to the interview to assist the participant to provide in-depth knowledge of the Punjabi Sikh beliefs of suicide and suicide-related behaviours. The interview was scheduled for one hour and took place at a location agreed upon by the researcher and participant. See Appendix G for a list of the interview questions.

As Harinder Singh does not reside in B.C. the second meeting, which was anticipated to be 30 minutes in length, was conducted via email, and allowed this participant an opportunity to perform a member check.

3.6 Data Analysis

All interviews were audio taped, transcribed, and analyzed at three stages: item, pattern, and structural, to co create themes of cultural and religious beliefs of suicide and suicide-related behaviours among first generation Canadian Punjabi Sikh parents of adolescents. After transcription, but prior to beginning the analysis of the data, the researcher met with the participants to provide an opportunity to perform a member check, in which they were asked to review a one page summary of the interview to check for accuracy (McLeod, 2001). See Appendix S for a sample of an interview summary. Although the second meeting was anticipated to be 30 minutes in length, in reality, the second meetings were approximately 15 to 20 minutes in length. This second meeting also provided an opportunity for the researcher to check in with

the participant and to offer the list of mental health services provided in the first meeting in the event that any distress may have occurred as a result of participation in the study. However, none of the participants of the study suggested that they required mental health services.

The data was analyzed through an inductive process, specifically an a priori content specific scheme; the categories were developed directly from the language of the research study (Schwandt, 1997). To begin the process of analysis, the data was explored by reviewing all transcripts and sketching notes, a process of writing reflections and memos in the margins (Creswell, 2007). A list of key concepts was developed from the reflections and memos and were narrowed down to 11 categories. Within each of the categories, codes were developed to identify items. Each of the codes was given a label, definition, description of when the theme occurs, qualifications or exclusions, and examples (LeCompte & Schensul, 1999 a). The coding system was then applied to all interview transcripts.

Once the data had been categorized and coded, the items were organized into higher order patterns (LeCompte & Schensul, 1999 a). This organization was executed by searching for the following criteria: frequency or omission of items, similarity, co-occurrence, or sequence of items, declaration by participants of an existing pattern and congruence with the researcher's expectations based upon experience and literature review (LeCompte & Schensul, 1999 a). The established patterns were then organized into themes by reviewing the research questions and viewing the results in a broader context.

The data analysis process was assisted with the XSight computer program, which was developed by QSR International. Features of the computer program include customizing the interface, capturing ideas visually, querying the data with a search engine, highlighting information, and working in all languages. The XSight program provided a sophisticated workplace that allowed the researcher to sort through the data and to develop meaningful interpretations.

All computer files were saved on a flash drive and password protected. A second flash drive was utilized to backup all files; the second flash drive was kept at a separate location in a locked filing cabinet.

The demographic survey completed by the parents, young adults and South Asian mental health therapists and medical professionals was analyzed for the means of the data. The computations were completed by hand.

3.7 Findings

Once the data analysis was complete, the results of the ethnographic study were presented in three aspects: description, analysis, and interpretation (Creswell, 2007). The description aspect presents the first generation Canadian Punjabi Sikh parents' beliefs of suicide and suicide-related behaviours without inference. The analysis of the data highlights specific findings and is presented in appropriate format(s), such as tables, charts, diagrams and figures. Interpretations of the Punjabi Sikh cultural and religious beliefs of suicide and suicide-related behaviours are presented while keeping the research questions, the experience of the researcher, and the literature review in mind. Quotes and excerpts from the participant interviews are utilized to illustrate the interpretations of the study.

3.8 Ethical Implications

For the purpose of this study, written and informed consent was obtained from all participants, who had the option of withdrawing from the study at any stage of the research. Any segments of the interviews presented in the final paper are submitted under a pseudonym to ensure confidentiality. The exception to the use of a pseudonym are any segments of the community leader's interview presented in the final paper. These identify the community leader as Mr. Singh. The community leader requested to edit each of his quotes for readability and grammar as a condition to his participation. Ethical approval for this study was obtained from the University of British Columbia's Research Ethics Board.

3.9 Trustworthiness

In qualitative research the criteria and the language utilized to determine the quality of a study differs from quantitative research (Creswell, 2007; Elliot, 2005; McLeod, 2001). To establish the quality or trustworthiness of this study, the following criteria was utilized: triangulation, member-checks of the interview contents, coherence, resonance with participants and peer readers, comprehension, pragmatic value, and peer reviews prior to the final defense of the thesis.

Triangulation is the process of looking at multiple sources of information to create a coherent justification of the themes (Creswell, 2007). In this study, data from four sets of participants, first generation Canadian Punjabi Sikh parents, second generation Canadian Punjabi Sikh young adults, South Asian mental health therapists and medical professionals, and a Punjabi Sikh community leader, were triangulated. As the data was collected, it was triangulated as each participant group reflected upon its accuracy in comparison to the experience of each participant. The second generation Canadian Punjabi Sikh young adults reflected upon the data set of the first generation Canadian Punjabi Sikh parents and the South Asian mental health professionals reflected upon the data set of both, the first generation Canadian Punjabi Sikh parents and the second generation Canadian Punjabi Sikh young adults.

Member checks are the series of actions taken to ensure the accuracy of the results (Creswell, 2007). In this study, member checks were performed by all four sets of participants. Once an interview was complete and had been transcribed, the researcher invited participants to read over, edit and offer feedback on a one page summary of the interview. Furthermore, in an effort to further ensure the credibility of the study, the second generation Canadian Punjabi Sikh young adults and the South Asian mental health therapists and medical professionals completed a check of the data set collected from the parental interviews. Therefore, member checks played a key role in ensuring the credibility of the study.

Comprehensiveness implies that the interpretations or analysis of the data be accurate and numerous quotations be provided as evidence (Lieblich, Tuval-Mashiach, & Zilber, 1998). The comprehensiveness of this study was achieved through in depth interviews with the participants, clustering and presenting thematic quotations from the interviews in the final paper.

For the study to have resonance with readers it must accurately reflect the topic of the research (McLeod, 2001). For this study, the findings resonated with the participants during the member checks, but also with the consumers of the research.

Coherence and pragmatic value of the study are also closely linked to the consumers of the research. Coherence of a study implies the findings of the research to offer emotional significance and to impart integrated information (Baerger & McAdams, 1999). While pragmatic value is defined as the extent to which the research instigates change (Kvale, 1996). It was the hope of the researcher that this study provide mental health and medical professionals with insight into Punjabi Sikh parents' beliefs of suicide and suicide-related behaviours, helping them to better meet the needs of their clients.

The thesis was peer reviewed prior to its final defense. Two peers were asked to review the thesis to provide feedback of the resonance, coherence, comprehensiveness, and pragmatic value of the research. The first of the two peers has 18 years of experience as a counsellor and holds an M. Ed. degree. He felt the final paper was well written, coherent and comprehensive. He further stated the study resonated with his experience of working with Punjabi Sikh families, and that he appreciated the pragmatic value of the study. The second of the two peers holds an M. Ed. degree in counselling psychology and has nine years of experience as a counsellor. Her comments on the resonance, coherence, comprehensiveness, and pragmatic value included:

> Iqbal Gill's thesis that explores suicide and suicide-related behaviours in Punjabi Sikh adolescents is such a significant contribution to adolescent mental health. As a school counsellor in the Lower Mainland, I am surprised to learn that very little research has

been conducted in this specific area and I am hopeful that the pragmatic value of this thesis is to ignite the very important conversation within the Punjabi Sikh community and beyond.

I found the thesis very engaging for its inherent interest and its coherence. The logical interconnection of ideas enhanced the overall understandability of the argument. The document is logically organized and well written.

What resonates with me in this work is the amount of education required to counter the negative attitudes concerning mental health. This study sheds light on the perception and stigma related to suicide within a particular community. In my experience, education and changing attitudes around mental health issues are required not only at a community level but a national one.

While this study utilizes a relatively small sample size, the significance and comprehensiveness of the topic warrants much more research and analysis. What excites me most about this thesis is the potential that it has to inspire a dialogue that is essential and timely.

3.10 Limitations

The limitations of the study are that beliefs may deter suicide and suicide-related behaviours, but may not prevent these behaviours from taking place. Also, conducting the interviews in the English language may have prevented the participants from fully conveying the cultural or religious beliefs of suicide and suicide-related behaviours due to a lack of transferability of concepts or phrases. Furthermore, making fluency in English as a selection criterion for the first generation Punjabi Sikh parents may have excluded a number of potential participants, and therefore, the cultural or religious beliefs recorded may not accurately reflect those of Punjabi Sikhs.

Chapter 4

Findings

This thesis proposed to describe the beliefs held by first generation Canadian Punjabi Sikh parents of adolescents about suicide and suicide-related behaviours. Besides describing parents' beliefs about suicide, the study proposed to describe parents' reactions to suicide-related behaviours, what services and interventions they might use when suicide-related behaviours occur, and the possible barriers they might encounter in accessing mental health services. Finally, the thesis proposed to describe the role the Punjabi culture and the Sikh religion might play in the formation of these beliefs held by first generation Canadian Punjabi Sikh parents. Through an ethnographical approach this study addressed the following two research questions:

1. What are the beliefs about suicide and suicide-related behaviours held by first generation Canadian Punjabi Sikh parents of adolescent children?
2. What are the beliefs of first generation Canadian Punjabi Sikh parents of adolescents if they were to respond to a suicide attempt and suicide-related behaviours in their family?

During the analysis of the ten interviews of the study, 11 categories emerged: Sikh religion, Punjabi culture, causes, honor, reaction, education, interventions, adolescence, help seeking behaviours, parenting, and barriers. These categories were organized into higher order patterns by searching for frequency or omission of items, similarity, co-occurrence, or sequence of items, declaration by participants of an existing pattern and congruence with the researcher's expectations based upon experience and literature review (LeCompte & Schensul, 1999 a). By reviewing the research questions these patterns were then organized into five themes to be presented in this thesis (see Table 4.1).

Table 4.1 Themes of Thesis

1. Causes of Suicide and Suicide-Related Behaviours

2. Reaction to Suicide and Suicide-Related Behaviours

Table 4.1 Themes of Thesis (continued)

3. Interventions Utilized in Response to Suicide and Suicide-Related Behaviours

4. Barriers to Accessing Mental Health Services

5. Help Seeking Behaviours

4.1 Causes of Suicide and Suicide-Related Behaviours

In order to understand first generation Canadian Punjabi Sikh parents' beliefs about the causes of adolescent suicide and suicide-related behaviours this study explored perceptions of the causes of this phenomenon. Interviews of parents, young adults, and mental health professionals who were participants in this study identified five generally held beliefs of the causes of suicide and suicide-related behaviours. These included peer relationships, lack of parental attention, pressure from parents to succeed, teenage hormonal changes, and mental illnesses. As a meta explanation, the Punjabi Sikh community leader, Mr. Singh considered a disconnect with the divine to be the underlying cause of all mental health issues, including suicide and suicide-related behaviours.

Peer Relationships

Peer relationships during adolescent years were identified to be the most frequently believed cause of adolescent suicide and suicide-related behaviours. Participants in the study acknowledged the complexities of peer relationships during adolescent years and the effect this may have upon adolescents' mental health. Mr. Grewal, a parent participant, noted the influence of peer relationships upon adolescents, "I think that growing up at that age is difficult enough, so maybe her friendships, her acceptance from other teenagers. I mean could be responsible for [her suicide]…"

The one commonality among parent interviews was the belief that adolescent relationships have significant impact upon adolescent mental health.

Although other peer issues were identified, the need to fit in and to conform to the expectations set by peers were identified to be the most believed cause of adolescent suicide and suicide-related behaviours. Amandeep, a young adult participant summed up the importance of fitting in and conforming to fit in:

> I've noticed throughout high school myself, for example, students who smoke cigarettes, you will see the group of students who do so at lunch time, or at the particular smoke pit may not have anything in common or might have other things in common, but what brings them together is the smoking right? That they all smoke. So this substance use could be way of him making more friends. Depends on if he's social or not. Did he have any friends before hand or not? It's a way of making an impression as 'I'm cool' as well.

All of the young adults participating in the study mentioned that fitting into their peer group held a high priority for adolescents. The mental health professionals participating in the study, like the parent and young adult participants, recognized the impact of peer relationships and saw romantic difficulties, in particular as a possible antecedent to suicide and suicide-related behaviours. As Dr. Brar, a mental health professional participant of the study noted that romantic relationships affect adolescents' emotional well being, "I think, quite a lot, it is the peer problems: boyfriend, girlfriend, break up, these kinds of things also trigger it."

Ms. Sandhu, also a mental health participant, conjectured as to the impact of sexual preference and romantic relationships upon adolescents:

> It could be that he is perhaps recognizing that he's recognizing that he's attracted to boys, or it could be he was in a serious relationship and it's ended and he doesn't want to talk to about, you know it could be really anything.

As much as the mental health professionals in the study acknowledged the importance of peer relations, there exists, as Ms. Sandhu noted, a wide variety of other issues that might

predispose adolescents to suicide and suicide-related behaviours. Nonetheless, the results of the study strongly suggest that peer relationships are believed to have a significant impact upon adolescents' mental health.

Attention from Parents

A lack of attention from parents was identified to be a cause of suicide and suicide-related behaviours amongst first generation Canadian Punjabi Sikh parents. Participants identified a possible cause of suicide and suicide-related behaviours to lie in early childhood, where lack of quality time spent with children and the failure to develop positive parental-child relationships had future catastrophic effects. As Mrs. Johal, one of the parent participants in the study, commented upon the effects of a lack of quality time spent with children, "the time is not spend [*sic*]…it all comes to time with the parents and quality time that is."

When speaking about time spent with children, participants in the study made a clear distinction between quality time and time spent on its own. Arjan, one of the young adult participants, articulated this distinction, "She might have been around but, she can be there but, also she cannot be there even if she's there."

Simply being physically present was not seen to foster strong parental-child connections. Participants in the study saw positive parental-child interactions as a necessary perquisite for the trust that is needed in order for adolescents to communicate openly about issues that are important to them. The mental health professionals in the study also cited the importance of strong ties adolescents share with their parents, and with other adults in the lives. Ms. Sandhu, a mental health participant, noted that in her experience parents often faced an enormous challenge when asked to examine how they may have contributed to adolescents' mental health issues:

> People may get frustrated because what they're hoping for isn't happening fast enough. And often when you want one behavior to change in the home, you also have to look at the other behaviors of other people and sometimes that can be a challenge, so you as a

parent with you relationship like with this child, you know, what does that look like? There are times where you do find yourself putting her down or saying things that you regret later or whatnot. Like you have to look at yourself sometimes, I think that can be difficult.

Ms. Sandhu further noted that despite being surrounded by people adolescents do not seem to form connections with adults who they can trust and talk to about their concerns:

> And for me, whatever I do here about the suicide of any child, the part that breaks me the most is that we are constantly surrounded by people, you know, our whole lives are surrounded by people and for this youth to not be attached or even close to even one person, an aunt, an uncle, a parent, a neighbor, a sibling who they could have reached out to before making that final decision…For me that's the part that breaks me the most because I think how is that possible? How is that possible that we allow these youths to grow up without those connections? And without those messages to say, you know, anything you need, anything at all, anytime, you can call me or you can let me know, or yeah, so, I think that message has to be made a little bit more clear for youth as well.

Thus, a lack of quality time and strong connections with parents and other adults in the adolescents' lives was identified to be a possible cause of suicide and suicide-related behaviours.

Parental Pressure

Adolescents often experience parental pressure to achieve academic success, to perform well in areas of sports or fine arts, or to subscribe to cultural or religious values. Participants in the study identified the pressure which parents place on adolescents to succeed to be a possible cause of suicide and suicide-related behaviours. A parent participant, Mrs. Johal, commented during her interview:

> There's a lot of parents I see, they, if the kids get B's, they are not satisfied, and they always want A's. That's wrong, I think you should take a look at the child as well. They should appreciate what they are getting.

Sukhdeep, one of the young adult participants, also suggested parental pressure on adolescents to succeed academically might be a possible cause of suicide:

> Or maybe even perhaps his education. Maybe he's not a very bright student and he is pressure from his family or friends to pull up his grades and he's just not able to do so. Maybe he just, he didn't have the right sources, to seek those sources and improve his grades. Or maybe he was a very intelligent student and his grades have dropped. And his family or parents have been questioning him about that and it's like a typical situation where his parents, where he might go up to his parents and say, "Mom I got 95% on my math test." And his mom might go, "what happened to the other 5%?" Right? Instead of being proud of her son, but hey he pulled 95%, she might be over concerned, "oh why did you make these mistakes?" And that might hurt him himself a lot more. And he might not know how to deal with it right?

Arjan, another young adult participant, also expressed frustration with the inconsistency of parental expectations:

> And even when they are like, "go to school, listen to what they are doing and get good grades" and you do that, and the ideas you bring back home, F--- that's stupid. Like you are telling me to do it, and then it's not good, but it's good to, like what do you want me to do?

Mental health participants agreed with parent and young adult participants as to how significantly parental expectations impact adolescent's mental health. Participants in the study held the common belief that incapability to achieve the standards set by parents may lead some adolescents to suicide and suicide-related behaviours.

Adolescent Hormonal Changes

First generation Canadian Punjabi Sikh parents interviewed in the study believed hormonal changes to be a cause of suicide and suicide-related behaviours. These participants said they believed changed in hormonal levels caused unpredictable swings in adolescents' moods and behaviour resulting in suicide and suicide-related behaviours. Mrs. Grewal, one of the mothers who participated in the study, identified the occurrence of mood swings among her daughters, "it's that age. 17 – Like my girls now, like I'd remember sometimes you'd pick them up from work and say 'what's wrong with you?' They're moody. And they'd say, 'What? I didn't say anything."

Parent participants saw a direct correlation between change in adolescent hormonal levels and the unpredictable mood swings experienced by some adolescents. These participants believed that adolescents experiencing such variation in mood were less likely to communicate about the challenges they were facing and were more vulnerable to suicide and suicide-related behaviours. However, during a data check of the parent interviews one mental health professional and one young adult participant challenged the notion that fluctuating hormone levels may lead to suicide and suicide-related behaviours. Sukhdeep, the young adult participant, suggested that attributing the cause of adolescent behaviour solely to changes in hormone levels was too easy of an answer:

> I don't know about the hormones part, because for me personally that just an excuse to be reckless. Like I understand kids want to be rebels and try something different, but I think not to that extent. I don't think it has anything to do with hormones.

This comment by Sukhdeep marks a notable difference between the parent interviews, and the young adult and mental health participants; the parents did believe hormonal changes could lead to suicide and suicide-related behaviours, whereas the young adult and mental health participants did not.

Mental Illness

Parent and young adult participants in the study also identified mental illness to play a role in adolescent suicide and suicide-related behaviours. However, the parent participants acknowledged that they had never experienced a mental illness themselves and consequently did not fully understand the full scope of mental illnesses. A parent participant, Ms. Sidhu, acknowledged her own lack of experience with mental illness, "I mean it is a serious depression, certainly. I've never experienced it, but I've heard of people, but I couldn't even imagine."

In contrast to the parents, the young adults appeared to understand the scope of mental illnesses to a greater extent. As Ranjit, correctly identified the mental health issue presented in the first case study of the interview, "probably her condition. Like, Bipolar or I'm just guessing."

During a data check of the parent and young adult interviews the mental health participants were pleased to see the parent and young adult participants having identified suicide and suicide-related behaviours to be a mental health issue. However, they did note the young adults to have a better understanding of the youth experiences in the case studies.

Sikhism's Believed Cause of Suicide

The community leader, Mr. Singh, interviewed as part of the study framed the issue of suicide and suicide-related behaviours in the context of Punjabi cultural and Sikh religious thought. This leader expressed the religious notion that disconnect with the divine is the root cause of suicide and suicide-related behaviours. According to Sikhism, those who lack a spiritual connection are less able to deal with stressors that may lead to suicide and suicide-related behaviours. As Mr. Singh stated:

> So, it is the lack of awareness, or ignorance is what causes the idea of suicide. So, again, [the] Sikh belief would be, that, really [people] should be working towards creating enlightenment, because when people are empowered and enlightened, then there is no room for even thinking of suicide.

Furthermore, Mr. Singh expressed that Gurbani, the Sikh scriptures, emphasize the need to eliminate one's ego, which is thought to prevent a connection with the divine:

> So killing your self, and Gurbani talks about that a lot, killing your self. So, metaphorically it talks about killing your ego, or killing the "I-ness" or killing things which, over power the individual. Or we can say things which disconnect the individual from the divine.

The consequences of not working towards eliminating one's ego is the inability to cope with stressors that may lead to suicide and suicide-related behaviours, "Gurbani is very big on that, individuals who do not kill their egos, they won't know how to deal with anything else, including suicide."

Although the other participants in the study did not suggest disconnect with the divine to be a possible cause of suicide and suicide-related behaviours, one parent participant did identify the role of karma in relation to suicide and suicide behaviour. Ms. Sidhu, one of the parent participants, suggested the suffering endured due to suicide and suicide-related behaviours to be directly related to one's karma, "I firmly believe that yes it is your Karam [*sic*], you do have to serve…"

The mental health participants acknowledged hearing parents speak of ones karma in relationship to adolescent suicide and suicide-related behaviours. These same professionals perceived the notion of karma as a means by which parents could make sense of adolescent suicide and suicide-related behaviours. Ms. Sandhu, a mental health participant, expressed parents' difficulty understanding why this may be occurring:

> Yeah, why is this happening to me? Why is my kid behaving like this? Oh well, maybe it's just what was written for me. You know maybe that I did something in a previous life and now I'm paying for it.

4.2 Reaction to Suicide and Suicide-Related Behaviours

Developing an understanding of first generation Canadian Punjabi Sikh parents' reaction to suicide and suicide-related behaviours is important to appreciating how they respond to the issues. The interviews of the parents in the study revealed a sequence of anticipated emotional reactions. The initial reactions are shock and anger, followed by a range of other emotions such as concern, helplessness, frustration, and fear.

Emotional Responses

The initial emotions which parents tend to exhibit in response to suicide and suicide-related behaviours are shock and anger. The emotional shock is experienced when parents first learn that their child is experiencing difficulty. The parent and young adult participants in the study believed parents' initial shock of learning about their child's suicide and suicide-related behaviours would be overwhelming and that parents would require time to process and to understand the situation completely. As Ms. Sidhu, a parent participant, commented on the second case study of the interview:

> It depends how he was behaving. Did they have a hint before? Then I guess they already saw it coming. But if they saw it all of a sudden then yeah I would be if I saw my son doing these things. I would go "Oh my God." That could happen too. I mean I hope I never have to see it, but I can't imagine though.

The parent and young adult participants' perceived shock to be the initial reaction of parents encountering suicidal behaviour. It seems likely that parents react with anger when they consider all that they have provided the child, and what the adolescent's behaviour indicates about their home life. Ms. Sandhu, a mental health participant of the study, identified anger to the initial reaction of parents to suicidal behaviour:

> I believe, again, besides the one I saw several number of years ago, the initial response was actually more around anger. Like how could my child make such a choice? What

were they thinking? How could they do this to us? Not just themselves, but it becomes a real family issue, how could they do this to us?

She further noted parents' difficulty understanding the motives of adolescent to suicide and suicide-related behaviours, "it's really difficult for parents and family to understand why someone would do that. And almost taking it personally I think. Personal, I think, yeah, the whole situation."

Although Dr. Brar, a mental health participant, did not note anger to be the initial parental reaction on learning about their child's suicide-related behaviour, she did express that parents often access her services after they have exhausted all other avenues of treatment. Consequently, she does not often witness the initial parental reaction.

The parent and young adult participants suggested that following their initial reactions on learning about their child's difficulties parents may exhibit a variety of emotional responses, such as concern, worry, helplessness, frustration, and fear for their child's well being. Although the mental health professionals agreed that while parents experience such a range of emotional responses and express concern about the emotional well being of their children, they had encountered parents who had minimized the situation. Ms. Sandhu, a mental health participant, commented on parents' tendency to minimize suicide and suicide-related behaviours among adolescents, "they did end up finding out because I have a duty to report that to them. And so it was later this stuff, so in that case, when I say that this was a family that totally minimized."

This study revealed a sequence and range of anticipated emotional responses exhibited by first generation Canadian Punjabi Sikh parents in reaction to adolescent suicide and suicide-related behaviours. The initial response tends to be an emotional shock followed by anger. After their initial reaction first generation Canadian Punjabi Sikh parents tend to experience a range of emotions, including concern, helplessness, frustration and fear.

4.3 Interventions Utilized in Response to Suicide and Suicide-Related Behaviours

Developing an understanding of the interventions first generation Canadian Punjabi Sikh parents might utilize when dealing with adolescent suicide and suicide-related behaviours assists medical and mental health professions to better meet their needs. Punjabi Sikh parents interviewed in the study identified a number of interventions they were most likely to access in response to suicide and suicide-related behaviours. These included seeking support and advice from the Gurdwara, the Sikh temple, accessing Western medical health care, an open line of communication and monitoring of adolescent behaviour, and obtaining support from family members. Parents interviewed gave mixed reviews for alternative healing methods.

Sikh Religion

Findings of the study indicated seeking support and advice from the Gurdwara, the Sikh temple, would be utilized as an intervention by Punjabi Sikh parents when dealing with adolescent suicide and suicide-related behaviours. Participants in the study acknowledged that Punjabi Sikh parents considered their religion to play a supportive role and at these times for Gurdwaras, to provide a sense of peace, community, and hope. Mrs. Grewal, a parent participant, shared that attending services at the Gurdwara had helped her son to cope with the loss of his cousin, "…like I think my son was upset once, he lost, well I lost my nephew, he would want to go to the Gurdwara because it brings him peace. So it helped him heal that way."

Sukhdeep, one of the young adult participants, made the astute observation that the effectiveness of attending a Gurdwara was dependent upon the adolescent and family's level of religiosity. Those who do not subscribe to Sikh values may not find it a useful resource for intervention:

> I guess it kind of just, it would be something that might have helped Paula, but it's not something that's guaranteed to help her because obviously at the end of the day you know it's each person's perspective on it, right?

The mental health professionals and community leader in the study confirmed that many parents hold prayer services when dealing with adolescent suicide and suicide-related behaviours. Parent and one of the young adult participants expressed frustration with the lack of youth programs in local Gurdwaras, with one notable exception. Sukhdeep, the young adult, further noted that the youth programs are not widely advertised; if an adolescent is not already involved in Sikh youth activities it is difficult for him/her to learn of the programs available in the community:

> Like, there are, because I know one of my close family they're really religious so I know. My little cousin, she's in high school. She is involved, she's in a public school but she is involved in a lot of religious camps and whatnot and I think that could have helped Paula. But I think it's just you don't really know about it unless you're already really religious I think maybe.

Although seeking support from Gurdwaras was identified as an important intervention that first generation Canadian Punjabi Sikh parents utilize when dealing with adolescent suicide and suicide-related behaviours, it was recognized that those in the Sikh community who were not affiliated with the Gurdwaras were less likely to access it as a resource. On a practical note, the likelihood of adolescents accessing the Gurdwara as a resource might be diminished depending upon availability of youth programs, and information about them.

Western Health Care

Western health care services were identified to be an important intervention utilized by first generation Canadian Punjabi Sikh parents when dealing with adolescent suicide and suicide-related behaviours. Discussing any medical and mental health concerns with a doctor was suggested by participants to be a good starting point to assist parents in understanding and treating the phenomenon. Also, every participant in the study identified counselling to be an

effective intervention. As Mrs. Johal, a parent participant, suggested, “counselling for sure. Talking about your problems does help.”

However, Ms. Sidhu, also a parent participant, suggested that as much as counselling is an effective intervention, it requires a time commitment, which can be taxing on energy levels, particularly for single parents:

> But I tried bad [sic] to go to the psychiatrist. They are telling you things as well, it doesn’t matter which way you wanna go. I know lately, things going okay and I am going to give up on the counselling. It was taking too much time and I think we were putting more stress, like sometimes I had to take him to Vancouver for a psychiatrist appointment, and then it was after work, and I’m a single mom and I thought some days it was more stress.

Although all the parent and young adult participants said they believed counselling to be an effective intervention, one of the young adults identified one drawback: whether parents accessed counselling services may or might not be dependent upon the parents’ level of education; parents with a lower level of education may be reluctant to access counselling services. However, during a data check of the parent and young adult interviews conducted by the mental health professionals both suggested this is a common stereotype of Punjabi Sikh parents. Dr. Brar commented that despite the level of education of first generation Canadian Punjabi Sikh parents are very much in tune with their adolescents’ needs. Also Ms. Sandhu noted another common stereotype of Punjabi Sikh parents:

> I think there is this assumption sometimes that parents are just way too busy working all the time and not involved in their kids’ lives. I think that happens in some families, but I’m very aware that doesn’t happen in all families. But there seems to be this sort of thing going around that you know, both parents are working and no one is watching the kids,

the kids are doing whatever they want, I think there seems to be a bit of a stereotype around South Asian parents doing that.

Despite the stereotypes of Punjabi Sikh parents not being available to meet their children's needs, the study did reveal that Punjabi Sikh parents would seek professional medical and mental health assistance when dealing with adolescent suicide and suicide-related behaviours.

Communication

Communicating with their child was identified as an intervention first generation Punjabi Sikh parents of adolescents would utilize when dealing with suicide and suicide-related behaviours. By communicating with adolescents, parents would hope adolescents would articulate what had led them to suicide-related behaviours. Mrs. Johal, a parent participant, noted the importance of listening to adolescents, "talking to them, asking how their school is and listening to them, what they have to say."

Also, Mrs. Grewal noted, her experience with her adolescent daughters, opening lines of communication is crucial to building a strong relationship:

> Like everybody who has a child, I would put 100% effort into having a strong relationship and communicating with the child. I think it is so important to communicate. With my girls now, even though their attitude and their moodiness, I'll take them for a coffee and we'll have a three hour coffee, but then so much comes out. They talk, it's so important. A lot of people in that community should do.

Although the participants in the study acknowledged communication to be an important intervention, the young adults noted the challenges they faced in attempting to openly communicate with their parents during their adolescent years. Young adult participants reported that their parents had difficultly understanding their point of view, particularly when it came to topics such as alcohol and drugs use, or premarital sex. The young adults shared that when they

had attempted to engage their parents in such conversations often their parents would respond with a simple no, and were unable to provide any further explanation of why alcohol and drug use and premarital sex are forbidden. As Ranjit shared:

> And that's as far as it goes. There's no in-depth thought into like why is sex before marriage is bad. Why are drugs bad? There's no actual thought as to why. Their thought, her thought, I'm telling you straight forward her thought is just that. Look, my mom said that they're bad, they're bad.

Although the parent and young adult participants acknowledged communication to be a useful intervention, it is evident that individual experiences may differ. While the mental health professionals cautioned that generalizations could not be made, they suggested many parents understand their children's needs and try to meet their emotional and physical needs.

Monitoring Adolescent Behaviour

Participants in the study identified monitoring adolescent behaviour and setting boundaries and guidelines for expected behaviour as one intervention they were likely to use when responding to adolescent suicide and suicide-related behaviours. Parent participants, in particular, noted the importance of monitoring adolescent's peer relationships and setting guidelines for behavioural expectations. As Mr. Grewal noted a need to monitor adolescent behaviour and interaction with peers, "yeah, more counselling and monitoring on who he is hanging around with, who his peers are, because if he's doing dope, his friends are doing it, so, try to guide him away from those types of people."

Young adult participants noted that in their experience Punjabi Sikh parents had difficulty maintaining the set guidelines and boundaries; these tended to be either too rigid or too flexible. Sukhdeep, a young adult participant, commented on parents struggling with setting and maintaining guidelines:

Like there's no, there's no set guidelines. Like there's no strict guidelines you could say. Like they set guidelines, but if they're broken, there's really no consequence is what I'm trying to say. Like they might get yelled at for 5 minutes but then after that you know it's kind of like, over and done with. It's the way they smell first of all is like the one thing that they do after they blaze is put on 20 pounds of cologne before they go home. You know like that's suspicious. Like if your son comes home with Axe all over him, that's what he reeks like, there's a problem right? It's just like, little things that they don't notice or pick up on. And I guess it's, again it's cultural because they don't expect their son to do that, and everyone looks down at their own child as in you know, like, and it's not even just us, it's everyone and everyone looks at their child as if they can't do something wrong. And I think it's just not being willing to accept those little facts could be a problem. Is what kind of makes it bigger. Like, and also their friends, parents have, like you know, a lot, I find a lot of Sikh Punjabi parents they don't keep track of their children's friends. And that's huge, because who they hang out with is what's going to influence them. And you know what, if you don't even know who your son's hanging out with, you're not going to know where they are. And I'm not saying like all of the people who don't know who their kids are hanging out with, they're doing something wrong. But it's just you know one of those little steps that they don't take. Does that make sense?

Some of the study's participants, young adults and mental health professionals, noted that many parents tended to lecture their adolescent children in hopes of changing their behaviour and thought patterns. Ms. Sandhu, a mental health participant, described the parent's tendency to lecture:

> Really, what does that child need at that time besides lectures, and get your act together and something's got to change or you're lazy or whatever the parent might say because they don't really know of the other issues, which is the mental health.

In an effort to monitor adolescent peer relationships, participants suggested parents seek to remove the child from what they may perceive to be a negative environment. Parents often attempt to monitor whom their adolescent children are spending time with and the activities they are engaged in. One of the mental health professionals further noted that some parents choose to remove their children entirely from what they perceive to be a negative environment, sending them to stay with family in India. Ms Sandhu, a mental health professional, noted parents' tendency to remove children from negative environments:

> But they actually think just removing one setting and replacing it with another and somehow all of India is never like oh let's take our kid from here and send him to Spain. No it's always you're land of origin that they think that he's going to somehow change and kind of feel like that way.

Although participants in the study identified monitoring adolescent behaviour and setting boundaries and guidelines for behavioural expectations to be an intervention that first generation Canadian Punjabi Sikh parents utilize, the young adult and mental health participants noted some Punjabi Sikh parents' struggle with this.

Family Members

Participants identified seeking advice from family members and close family friends on how to handle adolescent suicide or suicide-related behaviours to be an intervention first generation Canadian Punjabi Sikh parents utilize. By discussing their concerns about the adolescents with family members, particularly elder family members, parents hope to resolve the issues within the family and thereby, protect the family honor in the larger Punjabi Sikh community. Parents may also call on older siblings or cousins of the adolescent and request they

intervene on their behalf. Arjan, a young adult participant, noted that should his parents ever have needed to deal with adolescent suicide or suicide-related behaviours it is likely he would have been called upon to deal with the situation:

> I know my mom a lot of times, she told me, to take care of your brother. She's like, 'Why don't you do it? I can't do this.' And she would walk away. And he had a lot of his own, like not the ADD type of thing, like she wanted me to deal with that. So, I could see that happening, like they would probably be like, they would probably rely on me more.

The other young adults confirmed it was very likely their parents would request their assistance when needing to deal with a sibling's mental health issue, including suicide and suicide-related behaviours.

The mental health professionals reported that parents sought professional help as a last resort, and depended upon other interventions, including seeking assistance from family members. As Ms. Sandhu, a mental health participant, noted parents' tendency to resolve the issues within the family:

> I know that when there are issues in the home, whether it's a child with suicide ideation or whatnot there are other means that people use, though therapy is kind of like the very bottom of the list. And mental health intervention is at the bottom of the list. But you know consulting with other family members or having a prayer or trying to find something kind of within their own toolbox to assist in the issue prior to coming to mental health services. And by the time they come to us, they have pretty much tried a lot of other things.

This study found that an intervention commonly used by parents was to seek assistance from family members when dealing with adolescent suicide and suicide-related behaviours.

Alternative Healing Methods

Participants were divided in their opinions as to the degree to which alternative healing methods are used as an intervention for suicide and suicide-related behaviours. Parent participants reported using alternative health methods such as a homeopathic or naturopathic doctor for physical ailments to avoid the side effects of western medications. However, the parent and three of the young adult participants reported parents to not utilize alternative healing methods for mental health issues, such as suicide and suicide-related behaviours. As Mrs. Grewal noted:

> We would probably agree to this, like going to the temple, going to the Gurdwara because I do find it peaceful and you know I don't think that they educate people, with these people. If you go to a Baba or a Pandit, they just tell you stuff. You know the only help I would get is professional help. That's the help I think is important. It's important to take them to the Gurdwara and where they, listen to patth (prayers).

In contrast to the parent and the three of the young adult participants, one of the young adults, the mental health professionals and the community leader suggested parents do utilize alternative healers, such as pandit's and jyothsi's. Amandeep, the young adult, said she believed her parents would seek the services of an alternative healer:

> I'd say they would not refer to a granthi in itself because that individual would be considered not to have any power to heal. Yes they might set aside a prayer, in which a granthi would be involved. I'd say the only times they would refer to a baba ji or a pandit or even a jyotshi is if that individual was perhaps in a near vicinity and perhaps there were individuals having discussions with my parents saying yes, go to this person. He solved all my problems or he can tell you certain aspects about your life, your future, you present, what's going on. I'm sure they will go to him and would just want to see what's up and hey if this person's able to help then why not. The more the help the better to

resolve the situation right? Because they would be a little bit confused in terms of how to deal with the situation and if someone can provide insight then they would, I'm certain of that.

The mental health professionals reported that it was quite common for parents to have tried alternative healing methods prior to seeking professional help. Dr. Brar, a mental health participant, described parents seeking alternative healers, such as pandit's and jyotshi's, "this is very common. And they think, 'oh that's what happened, so that's the time it may have happened, and this is what they did.' And there is not concrete thing in it, but this goes on a lot."

Participants were divided in their opinion as to the extent to which alternative healing methods were used by first generation Canadian Punjabi Sikh parents when dealing with suicide and suicide-related behaviours.

4.4 Barriers to Accessing Mental Health Services

The study identified particular barriers to first generation Canadian Punjabi Sikh parents in accessing mental health services when dealing with adolescent suicide and suicide-related behaviours. These identified barriers were a lack of understanding about mental health, and a lack of awareness about mental health services available in the community. Those interviewed for the study identified mental illness as having a strong social stigma within Punjabi culture. Consequently, membership in Punjabi culture was identified as a barrier to parents seeking medical and mental health assistance in the case of suicide and suicide-related behaviours. Participants did not consider Sikh religious affiliation as a barrier to utilizing mental health services. To the contrary, participants perceived the Sikh religion to be a proponent of mental health services, encouraging its religious members to seek professional help when it was needed.

Understanding the Concept of Mental Health

Participants in the study identified a lack of comprehension of the concept of mental health by first generation Canadian Punjabi Sikh parents to be the greatest barrier to accessing

mental health services. This lack of comprehension may prevent the parents from seeking help from medical and mental health professionals to address concerns of adolescent suicide and suicide-related behaviours. Participants noted a lack of exposure to the concept of mental health and mental health illnesses in India, which may prevent many first generation Canadian Punjabi Sikh parents from understanding mental health issues, such as suicide and suicide-related behaviours. The young adult participants in the study reported difficulty in discussing mental health with their parents. Ranjit, one of the young adult participants, noted her difficulties in discussing mental health with her parents:

> But I don't think they understand it to be, like it seems like overall in our community it's not a concept. Like mental health until you, until they've been taught that look there's something separate. It's your mental, like it's an actual, like it could go wrong. Sometimes it's not even a concept. Like when you're discussing it with your parents, like normally, like regularly. Say if I were to discuss mental health with my parents, they wouldn't really understand. They would look at me and go what? Like when I told them I wanted to be a psychologist, they didn't understand.

Young adult participants further reported that parents often view situations in black and white and do not have the background or mindset required to fully understand mental health issues. Ranjit, a young adult participant, expanded upon her mother's understanding of mental health and emotions, "sometimes I think it's just because the lack of understanding. And my mom, she's never talked about learning psychology in India. It's like you're either happy, unhappy, you're good, you're bad. There's no grey area."

The young adult participants in particular noted the abstractness of emotions and mental health; they cannot be seen whereas physical illnesses often are visible. The abstractness of the concepts can make them more difficult for parents to grasp, and therefore, the importance of seeking mental health services or continuing medication, if necessary, may also be difficult for

parents to process. Sukhdeep, one of the young adult participants, commented in regards to parents not understanding the importance of continuing medication:

> So it could have been a Punjabi Sikh family. But it just, I think with Punjabi Sikh parents, they're really ignorant about some things. And this could be one of those things where they think that you know like she's already been treated, she's out now and she took her medication and you know maybe she feels fine now that's she's not taking anymore or whatever, right?

Parent participants noted many first generation Canadian Punjabi Sikh parents to not acknowledge suicide and suicide-related behaviours to be an issue that affects them. It was suggested that many parents in the community may deny their adolescent child is experiencing suicide-related behaviours. They may hope that the issue will go away without needing to address it or enlist the help of a professional. Mr. and Mrs. Grewal commented upon parents' tendency to deny and not seek professional help:

> Mrs. Grewal: Because they are in denial. They don't want to admit that their kids have a problem because of the embarrassment, like geez, not realizing that you are worried about what everybody else thinks, or are you worried about saving your child? They're worried about what everybody else thinks.
>
> Mr. Grewal: They just hope it will go away.

Amandeep, a young adult participant, also commented on parents' tendency to be in denial of a problem existing:

> Yes if the parents did ignore it, they wouldn't be so helpful. They could be in denial if they're being a problem. They could just think that their child is being childish or stupid in a sense that way they might term it like that and just think "oh it's just, it's not a big deal."

The mental health professionals identified challenges in explaining mental health concepts to Punjabi Sikh parents. They noted that first generation Canadian Punjabi Sikh parents tend to minimize the issue of suicide-related behaviours or desired a quick fix to the situation. Ms. Sandhu, a mental health participant, commented upon the challenges she faces in working with first generation Canadian Punjabi Sikh parents:

> I'm challenged by this question actually almost everyday. First of all, just not being able to define or understand mental health in our community is a real challenge. People in general are looking for very quick solutions. I met with the young boy last week, and his mom is basically saying "he's doing this, this, this and this, now fix him." And so not realizing that they also need to engage in the process.
>
> Ms. Sandhu further noted the extent to which parents may deny adolescent suicide:
>
> Yes, I am just reminded of the family who wasn't able to even name the suicide, and so they named it something else, and put it on a different behavior, such as sleepwalking, because the young person apparently used to sleep walk before. And so, they couldn't even come to terms, with say the name, or even labeling it as a suicide.

Awareness of Mental Health Services

Participants identified a lack of awareness of the mental health services that are available in the community and how to access them to be barriers to accessing professional help. As the mental health professionals and the community leader pointed out, children of Punjabi Sikh parents are often aware of the mental health issues and the services available as a result of exposure in the school system and in the media. However, the parents of adolescents, immigrants to Canada, most often are not aware of the services available or how to access them. The parent and young adult participants also noted that many Punjabi Sikh parents are not aware of the services available or how to access them. As Ms. Sidhu, a parent participant of the study noted many parents lack of awareness of the services available, "and maybe sometimes parents don't

realize, I see these with other parents too, especially in our culture, I don't know too much about Canadian culture though. They don't know there is help available as well."

However, one of the parent participants, Mrs. Grewal, proved to be an exception to the parent participants in this regard in that she was aware of Alcohol Anonymous:

> I know that there is Punjabi AA in Canada. It's a really good thing, because some people are here from India and they don't have the second language. And you want them to go to AA meetings; well they don't understand what the people are saying. We do have that in our community.

The young adult participants in the study also perceived that many parents may not be aware of the mental health services available in the community or aware of how to access the services. Ranjit, a young adult participant, noted this lack of awareness, "so they don't know what type of help to get even sometimes. Even if they were kind of aware of it, they wouldn't know where to start. Most of the time especially Indian families."

The mental health professionals confirmed that parents were unaware of the available services. Ms. Sandhu, a mental health participant, commented that parents are often unaware of services and medical care benefits:

> I think first of all just lack of knowledge. In terms of what is available out there and then once you know what's available, how do you access it, and become a part of it and you know engage in it. For example I know a lot of families have a mom or a dad who work in jobs where they do have extended health and could access you know the resources of a counselor or a psychologist or a mental health professional, but it is something that they never think of or consider, or in some cases aren't even aware of – that they have that within their extended health that they could use.

Punjabi Cultural Stigma

The study identified a cultural stigma towards mental health illnesses as a barrier to seeking mental health services. Participants in the study further identified protection of family honor and family reputation to be of great importance in the Punjabi Sikh community and accessing mental health services for an adolescent child experiencing suicide and suicide-related behaviours may negatively influence the community's perception of the family. The community leader interviewed in this study reported he believes parents often feel ashamed when an adolescent child has been involved in suicide and suicide-related behaviours. One of the parent participants, Mr. Grewal, also commented on the cultural stigma of suicide:

> I think the Sikh community as a whole; I don't think they really acknowledge suicide as being a major problem. They don't – probably looked upon as – if somebody is suicidal they're looked upon as being weak and don't try to understand the reasons. I don't think there is support for that. Because I think that people that look for help from the Sikh community – I think they find it too shameful. They think it's too shameful and so embarrassing, so they are not going to do that.

Many first generation Canadian Punjabi Sikh parents may experience shame, and embarrassment, and may be afraid of gossip among community members. Amandeep, one of the young adult participants, also suggested that parents' primary concern may be about protecting family honor, which may consequently lead them to try to resolve issues within the family:

> I'd say also it's a matter of honor of the family, regardless of whether Paula was a member of the Punjabi Sikh community and Manjit saying that he is one. Let's just say in general that if both of them weren't, I'd say that within any family situation you would consider this to be a personal matter to be dealt within closed doors. Not something that you would openly talk about in front of others because it's not something to be proud of. It's not something you want people to discuss out loud about you, in terms of people

> gossiping. In terms of let's say both of them are from the Punjabi Sikh community, it's something that's considered a disgrace for someone to want to commit suicide. It's just something that you would want to resort within the family. You think that your family is going to be able to overcome this.

The mental health professionals noted that the cultural stigma, in part, results from the cultural tradition of children's behaviour and achievement reflecting upon the parents' and the family's reputation in the Punjabi Sikh community, thereby, impacting the family honor. Dr. Brar, a mental health participant, commented on the children's behaviour impacting the family reputation:

> It's not, it's considered something very negative in terms of stigmatism, it's if somebody tells somebody or somebody's child is doing that, you know they feel it's negative impression of them or their…because in our culture the parents feel what that their children are reflects on them a lot, more than other groups, ethnic groups.

The community leader interviewed for the study, Mr. Singh, noted that despite the strong cultural stigma currently surrounding mental illnesses, there have been instances in Punjabi history when suicide has been considered an acceptable decision. In 1947, India and Pakistan gained independence from Britain and split into two countries and during this partition many Sikh women chose to die by suicide to avoid being raped and to protect the family honor. The community leader mentioned that this historical acceptance of suicide, "is not talked about much, but, in the larger Punjabi community, yes it was accepted as being, perhaps the right thing to do." Protecting the honor of the family, even when it meant the loss of a human life, was considered within Punjabi culture to be reason enough for suicide. However, as the community leader pointed out, the acceptance of suicide during this time reflects an exceptional period in Punjabi history; prior to the partition of India and Pakistan, Sikhs did not consider suicide an acceptable practice.

Sikh Religion

In contrast to the Punjabi culture, participants in the study identified the Sikh religion not to be a barrier to seeking mental health services. The community leader stated that the Sikh religion does not forbid seeking medical or mental health assistance; rather it encourages all to seek professional help. The community leader, Mr. Singh, described the Sikh religions' stance on mental health issues, "Gurbani says, 'we are all sick.' So, we all need help." He further stated that the Sikh religion suggests Sikhs seek the best help available for mental illnesses.

Seeking mental health services is not forbidden or seen negatively within the Sikh religion, but encourages Sikhs to seek the best possible assistance available to deal with a mental health issue, such as suicide and suicide-related behaviours.

4.5 Help Seeking Behaviours

Participants agreed first generation Canadian Punjabi Sikh parents are accessing mental health services more readily than they have in the past and identified a positive change in help seeking behaviours.

Positive Changes in Help Seeking Behaviours

Participants identified positive changes in the help-seeking behaviours of first generation Canadian Punjabi Sikh parents dealing with adolescent suicide or suicide-related behaviours; in recent years parents are accessing professional help more readily. Participants also agreed that the Punjabi Sikh community has accepted mental health illnesses to affect people of the Punjabi Sikh background and are more open to receiving professional help in dealing with the illnesses. Participants in the study perceived a positive change in the way mental health illnesses are viewed within the Punjabi community. There is less of a cultural stigma attached to mental illness than in the past, and mental illness does not bring the dishonor to a family to the degree it once did. Consequently, parents are more willing to access mental health services. The

community leader, noted this shift in help seeking behaviours, and a decrease of a cultural stigma and loss of honor:

> So I think there is this whole idea of honor, this whole idea of who you are as an individual. It's changing; it's more dynamic. In the Diaspora, you are beginning to have families, beginning to talk about this. So it's not considered dishonor, they are still hiding it, but it's not as much of a bad thing if you talk about it [mental health] as it was earlier.

The mental health professional participants in the study agreed with the community leader that the Punjabi Sikh community is beginning to access mental health services and is less inclined to be concerned with being dishonored in the eyes of community members. The mental health professional participants, in particular, have observed this shift in their practices. Dr. Brar, one of the mental health participants, commented on her observation of parents seeking mental health services for their adolescent children:

> I have seen it lately, not many years ago. But I would say the last few years, two to three years or so, a lot of parents have adolescents with the first generation, I can count it, still my patient at this point. Some of the parents are very, very in tune with that, okay?

Ms. Sandhu, also a mental health participant, too commented on this trend towards accessing services:

> So we should be able to solve this you know, if I go there people will know that I have a problem. That is getting a lot better actually within the last little while anyways. I've had people who come here and say, you know what? I'm not doing this for anyone else; I'm doing this for me. I don't care who I run into in the hall or the elevator. I'm even telling people that I have a therapist and this is what I'm working on.

Parent participants noted that they would seek professional mental health services if they needed to deal with adolescent suicide or suicide-related behaviours, and thereby confirming the trend the community leader and mental health professional participants identified.

The young adult participants each held hope that if the parents were truly to understand the concept of mental health, the importance of professional help, and where and how they can access services they would seek mental health support services for their adolescent children if they were to experience suicide and suicide-related behaviours.

Need for Further Changes in Help Seeking Behaviours

In spite of the recent changes in help seeking behaviours, first generation Canadian Punjabi Sikh parents more readily accessing professional help, each of the participants in the study did note a need to continue educating parents about adolescent suicide and suicide-related behaviours. Dr. Brar, a mental health professional participant, noted there to be new immigrants arriving in Canada from Punjab, India each year, and therefore, a need to continue educating parents about mental health issues, including suicide and suicide-related behaviours. In addition to educating parents about mental health issues, participants also suggested parents develop an understanding of adolescent experiences in Canada. As Dr. Brar, a mental health participant, noted the importance of understanding adolescent behaviour:

> But I think the key things are the prevention, education, in parents to educate in mental health and also educate how to deal with adolescent behavior and what is within normal limits, what is not, depending on the family values and communicating with your child. I think it's very, very important.

Ms. Sandhu, a mental health participant, also noted a need to educate parents about adolescent developmental issues in addition to mental health issues:

> And just to give you an example, the incident was, he had a friend over, in his room, and I guess he had gone somewhere where they had been given free condoms. South Asian family, and the 15 year old boy and his friend were in his room and so they blew them up, and like tied them into balloons, and were throwing them at each other. And I guess at one point, the mom walked into the room, and she was just horrified. She knew what

they were, and she was like, 'what is going on?' Turned around and left the room. And then when the friend left, she totally reamed the young boy out, like what are you doing? What are you thinking? You have sisters, blah blah blah. And it's kind of, it's kind of funny right? To us, when we hear the story, but to her she just thought it was the most disrespectful thing her son could do is to be playing with these condoms in his room with this boy. And she taking it to places where I thought okay we really need to explore that thing. Well, is he gay? Like why does he have the boy in his room? Why is he doing it? And just like, instead of just looking at the behavior and just taking it for what it is, like these are boys, they're being silly. They're curious about sex and sexuality. They come across these free condoms this is what they do. Instead of being able to look at it like that, she's just taking it over the top and thinking of like worst case scenario, and what about this? And what about that? And so just getting away from the question a little bit, but it's around how do you engage it with parents whether it's around parenting issues or developmental issues or mental health issues.

Participants also identified a variety of means to educate first generation Canadian Punjabi Sikh parents; the media, public schools, community centers, and Gurdwaras. The Punjabi speaking radio stations and the television shows were suggested by participants in the study as a means of continuing the education, which would allow parents to overcome the language and cultural barriers. They also suggested public schools and community centers host educational seminars to help Punjabi Sikh parents understand mental health issues and other relevant topics to their children's well being.

Local Gurdwaras were identified by participants to play potentially a large role in educating parents as well. Participants suggested that since many first generation Canadian Punjabi Sikh parents attend the Gurdwara for guidance in many aspects of their lives, and therefore, the Gurdwaras might be a suitable resource for educating parents about mental health

issues. The advantage of using Gurdwaras for education about mental health issues is that the obstacle of language and cultural barriers would be removed. However, one of the mental health professionals and the community leader challenged the viability of such an idea, noting that officials at Gurdwaras are not trained to educate or assist parents to deal with adolescent suicide and suicide-related behaviours. Ms. Sandhu, the mental health participant, challenged the practicality of Gurdwaras:

> I have a reaction when people say that the Gurdwaras are somehow responsible in creating more programs. I personally have never seen that as their role; have never expected that from the Sikh temple. I don't think that there would be (inaudible 41:02) or setup to work in the same way as local churches. I think it's just a completely different format in terms of what's available there … For example, for years I heard people saying around the domestic violence issues, oh why aren't the temples doing anything? Why don't they take these women in? Why don't they give them a place to stay? And I'd say well our temples, hypothetically a woman could go there and I'm sure she could spend a night or two; I don't know how comfortable she would feel with her children and whatnot. I don't think anyone would say to her you know what you need to go; I think they would try to assist her. So it's just not set up for that. Right? It's not set up to do that, and really honestly at the end of the day, do I want her coming there and do I want the people in charge to be doing the social services work which they're not trained to do and to give this women advice. And what if the advice that they are giving her is like going back would be alright, just go home, he promises he'll change and he'll never do this again. And then she ends up getting killed. I don't want that, I don't think they're set up to do that. And I don't think they should be expected to do that, so that's what I mean by, and I know I've had lots of long discussions with people who completely disagree with me who say all the temples get all this money, they get lots of donations, that they

should be doing more, I'm not saying that they shouldn't be doing more, I'm sure they should be doing more, but we need to assist them, in showing them how to do more, and how to do it better.

The community leader participant, Mr. Singh, also acknowledged the lack of expertise in mental health issues by officials at Gurdwaras, and a need for training professionals to understand the Sikh values, "what we need are people who are trained to deal with the issues in a Sikh way. Someone who understands Sikhi, as well as counselling techniques."

Therefore, in addition to continuing to educate first generation Canadian Punjabi Sikh parents about mental health issues, including suicide and suicide-related behaviours, it is important for mental health therapists to recognize the Punjabi Sikh cultural and religious values in regard to mental illness, and more specifically suicide and suicide-related behaviours. Familiarity on the part of mental health therapists with Punjabi Sikh values will be crucial to the success of mental health services for the members of this community.

4.6 Conclusion

This study is the first to describe first generation Canadian Punjabi Sikh parents' beliefs of adolescent suicide and suicide-related behaviours and the resulting consequences of the beliefs. More specifically, this study describes in what ways parents would react, and intervene, when encountering suicidal behaviour, what services they would utilize and what barriers they are likely to encounter in accessing mental health services for an adolescent experiencing suicidal behaviour.

First generation Canadian Punjabi Sikh parents believe peer pressure, lack of parental attention, pressure to succeed, teenage hormonal changes and mental illnesses to be possible causes of adolescent suicide. The community leader participant of the study presented the Sikh view that disconnect with the divine is the cause of suicidal behaviour.

Punjabi Sikh parents' initial reactions to adolescent suicidal behaviour tend to be shock and anger, followed by a range of emotions such as concern, helplessness, and fear. The interventions the parents utilize include seeking support from the Gurdwara, accessing western health care services, keeping an open line of communication between themselves and their offspring, monitoring adolescent behaviour, and obtaining support from family members. Alternative healing methods may or may not be utilized by Punjabi Sikh parents when dealing with adolescent suicide-related behaviours.

Identified barriers to seeking mental health services included a lack of understanding about mental health, a lack of awareness about mental health services available in the community and a cultural stigma attached to mental illnesses. The Sikh religion was identified as supporting mental health services. Currently, first generation Canadian Punjabi Sikh parent's access mental health services more readily than in the past. Still, there is a need to continue to educating parents about adolescent suicide and suicide-related behaviours.

Chapter 5

Discussion

"Suicide is a topic that is discussed in a whisper; but should be discussed openly to determine what role society plays in this dilemma and more importantly, what society can do to learn more about it" (Wolff, 2008, p. 9). The current study is an attempt to initiate a dialogue about adolescent children of first generation Canadian Punjabi Sikh parents and their vulnerability to suicide and suicide-related behaviours. This study also increases awareness and sensitivity of Punjabi Sikh beliefs of suicide and to increase the success of mental health practitioners working with Punjabi Sikh families with an adolescent experiencing suicide-related behaviour.

5.1 Comparison of Findings with Literature

There are many findings within this research study that are consistent with current literature regarding adolescent suicide and suicide-related behaviours. This study reflects the findings of other research in regard to the causes of suicidal behaviour, the emotional reactions that occur as a result of these behaviours, possible interventions that might be considered in the circumstance of suicidal behaviour, and the possible barriers that might be encountered in accessing professional health care services. Despite the many consistencies with literature, there are some inconsistencies. Specific inconsistencies lie in the areas of believed cause of adolescent suicide and suicide-related behaviours, interventions parents would utilize, and the help seeking behaviours.

Causes of Suicide and Suicide-Related Behaviours

The findings of this study revealed that first generation Canadian Punjabi Sikh parents seek answers to adolescent suicide and suicide-related behaviours in a diverse range of contexts: social, familial, biological, and medical. The beliefs of first generation Canadian Punjabi Sikh parents about adolescent suicide and suicide-related behaviours may be contextualized in terms

of the social integration and social regulation theory (Durkheim, 1966), the ecological risk factor model (Garbarino, 1985), or the action theory view of suicide (Michel & Valach, 1997).

Peer Relationships

All participants in the study situated adolescent suicide within the social context of peer relationships, specifically the manner in which adolescents fit into and are accepted by their peer group. Locating the phenomenon of suicide within the context of social peer relationships is reflective of Durkheim's theory of social integration and social regulation (1966). Adolescents who are unable to identify with their peer group may feel isolated; such isolation may make contribute to suicide or suicide-related behaviours. On the other hand, adolescents who do identify with their peer group to a high level may not develop an individual identity or may become dependent upon their peers for an identity. This overreliance on peers for identity formation may eventually lead to suicide and suicide-related behaviours. Similarly, the human ecological theory views interactions with peer groups, which occur at the microsystem level, to be a factor in suicide and suicide-related behaviours (Garbarino, 1985). In relation to the action theory view of suicide, peer relations may be seen as a suicide career, project, or action and as either top-down or bottom-up processes (Valach, Michel, Dey, & Young, 2006; Valach, Michel, Young, & Dey, 2006). Participants' responses in this study reflected the belief that suicide could be goal-oriented or dynamic systems, precipitated by specific events such as a difficulty with a peer or a breakup with a romantic party (Valach, Michel, Young, & Dey, 2006).

The current research study has confirmed that first generation Punjabi Sikh parents view peer relationships to have significant impact upon the mental health of an adolescent. A number of other studies have identified peer connectedness to be a protective factor against suicide (Anteghini, Fonseca, Ireland, & Blum, 2001; DeWilde, Kienhorst, Diekstra, & Wolters, 1993; Rubenstein, Heeren, Housman, Rubin, & Stechler, 1989). Similarly, other research has correlated poor peer relations with suicide-related behaviours (Bearman & Moody, 2004; Field, Diego, &

Sanders, 2001; Prinstein, Boergers, Spirito, Little, & Grapentine, 2000). By acknowledging the impact of peer relationships upon adolescents' mental health, particularly suicide and suicide-related behaviours, first generation Canadian Punjabi Sikh parents are in a position to reduce the possibility of adolescent suicide and suicide-related behaviours. To ensure a healthy mindset for their adolescent children the parents may monitor and help foster positive peer relationships.

Parent-Child Relationship

All participants in this study identified positive parent-child relationship as a protective factor against suicide. A lack of parent-child connection, insufficient quality time with parents, and parental pressure to succeed, were identified as possible causes of adolescent suicide and suicide-related behaviours. These beliefs are congruent with Durkheim's theory (1966) and the ecological theory (Garbarino, 1985). As per the theory of integration and regulation (Durkheim, 1966), a lack of parental attention can be a contributing factor to egoistic suicide. Adolescents who do not experience a strong sense of connection to their parents may feel less integrated into the family, and may be more vulnerable to suicide or suicide-related behaviours. Parental pressure to succeed may be experienced as a high level of regulation and may lead the distressed adolescent to fatalistic suicide. The ecological theory perceives familial interactions to occur at the microsystem level, and to be a factor in suicide and suicide-related behaviours (Gabarino, 1985).

In correlation with action theory view, the findings of the current study did not reveal Punjabi Sikh parents to view suicide processes necessarily as goal directed processes, but instead to take a more causal view of suicide (Valach, Michel, Dey, & Young, 2006; Valach, Michel, Young, & Dey, 2006).

Positive parental connections have been identified to be a protective factor against suicide (Kidd, Henrich, Brookmeyer, Davidson, King, & Shahar, 2006). A positive-parent adolescent relationship is characterized by a strong, functional, and caring connection (Seguin, Lynch,

Labelle, & Gagnon, 2004). Adolescence is a time of change not only for the youth, but also for the family. Adolescents who perceive their parents to be controlling by setting high standards for either achievement or behaviour, or to be overprotective, may perceive that others do not respect their personal autonomy (Seguin, Lynch, Labelle, & Gagnon, 2004). On the other hand, adolescents who feel supported by their parents during this time of change tend to be at lower risk of suicide (Rutter & Behrendt, 2004). This study suggests that first generation Canadian Punjabi Sikh parents are aware of the implications of a strong and healthy parent adolescent relationship.

For the most part the participants in the study situated suicide and suicide-related behaviors within a social context: particularly in the domain of peer and parental relationships. It is to be noted that the parents located the possible cause of suicidal behaviour in context of the family structure. Insufficient quality time spent with children, poor parent-child connection and parental pressure upon the adolescent to succeed were seen to be contributing factors to adolescent suicide. These beliefs are congruent with the findings of a study conducted by Wadhwani (1999) in which South Asian youth identified family pressure and difficulty with relationships as being the most pressing reasons for considering suicide. By recognizing the significance of parent-child connection, the value of spending quality time and the impact of pressure upon adolescents' first generation Canadian Punjabi Sikh parents are able to help lower the risk of adolescent suicide and suicide-related behaviours.

Teenage Hormones

The findings of the current study revealed that first generation Canadian Punjabi Sikh parents believe teenage hormones, particularly the fluctuating hormone levels are a cause of adolescent suicide and suicide-related behaviours. Durkheim's (1966) theory of integration and regulation does not specifically address biological factors, such as hormone levels, as contributing factors to suicidal behaviour. The ecological theory does identify biological causes

of suicide and suicide-related behaviour and suggests that they occur at the level of the organism (Garbarino, 1985). The action theory view may see fluctuating teenage hormones as bottom-up suicide action (Valach, Michel, Dey, & Young, 2006; Valach, Michel, Young, & Dey, 2006). As hormones fluctuate they may elicit sudden feelings or thoughts of suicide (Valach, Michel, Dey, & Young, 2006).

Although the neurobiology of suicide and suicide-related behaviours has been investigated, there has been little research completed with adolescents as subjects (Bridge, Goldstein, & Brent, 2006). While adolescent hormonal changes have not been identified as a cause of suicide and suicide-related behaviours, the serotonin system, cell signaling and modulation have been implicated in suicide-related behaviours (Pandey, Dwivedi, Rizavi, Ren, & Conley, 2004). Participants in the study suggested parents do not have a complex understanding of adolescent development, which may lead parents to identify hormonal changes to be a cause of adolescent suicide and suicide-related behaviours. They may be unaware to what degree mood changes may be caused by hormonal changes. This lack of awareness may render the adolescent children of first generation Canadian Punjabi Sikh more vulnerable to suicide and suicide-related behaviour. However, it is possible the parents may mistake changes in the serotonin system to be causes for the adolescent mood swings. If parents were to seek medical or mental health help in dealing with the mood swings, the adolescent might be diagnosed and avoid possible suicide and suicide-related behaviours.

Mental Health

Although the participants in the study did not specify particular mental illnesses as causes of adolescent suicide and suicide-related behaviours, they identified mental illness to be a contributing factor to adolescent suicide and suicide-related behaviours. Participants' beliefs about the psychological bases of suicidal behaviour are congruent with recent research findings. Psychological issues such as depression, feeling of hopelessness, low self-esteem and psychiatric

disorders have been linked to suicide and suicide-related behaviours (Goldston, Daniel, Reboussin, Reboussin, Frazier, & Harris, 2001; Overholser, Adams, Lenert, & Brinkman, 1995). Extensive research has shown psychological factors increase the risk of suicide and suicide-related behaviours among adolescents (Marttunen, Aro, Henriksson, & Lonnqvist, 1991). Psychological issues are not specifically addressed by Durkheim's theory (1966). The ecological theory (Garbarino, 1985) places psychological issues at the level of the organism. The action theory view of suicide suggests mental health may be seen as a suicide career, project, or action and as either top-down or bottom-up processes (Valach, Michel, Dey, & Young, 2006; Valach, Michel, Young, & Dey, 2006). Mental illnesses may be long term issues that may lead to a suicide career, or a short term issue that may cause a suicide project, or an immediate reaction that may lead to suicide action (Valach, Michel, Young, & Dey, 2006).

While the possibility of there being biological, as well as psychological, causes to suicidal behaviour was a theme that emerged in this study, it seems that first generation Canadian Punjabi Sikh parents do not have a complex grasp of how these biological and psychological factors may contribute to suicide and suicide-related behaviours. However, a complex grasp of biological and psychological factors is not required to avert adolescent suicide and suicide-related behaviours. By understanding that biological and psychological factors play a key role in adolescent suicide and suicide-related behaviours first generation Canadian Punjabi Sikh parents may be able to assist their child be less vulnerable to adolescent suicide and suicide-related behaviours. Nevertheless, a deeper understanding of the biological and psychological factors contributing to adolescent suicide and suicide-related behaviours may assist parents in knowing when to seek professional help.

Sikhism's Believed Cause of Suicide

The community leader participant of the study suggested that connection with the divine, no matter what one's life circumstances may be, is key in overcoming pain and suffering. Sikhs

are encouraged to seek help when in distress; the Sikh religion does not view pain and suffering as obligatory experiences or as prerequisites for a spiritual life. Sandhu (2004) suggests the pain and suffering one experiences are due to karam, which are the behavioural consequences of a past life; Sikhs may be less inclined to seek help if they believe they are destined to experience pain and suffering in this lifetime. Despite what one's destiny may be, Sikh scriptures encourage Sikhs to make the best of every situation and to seek help in order to overcome life's challenges (BBC, 2007; Bhinder, 2007).

The parent, young adult and mental health participants in the study did not specifically identify a disconnect with the divine as a possible cause of adolescent suicide and suicide-related behaviours. However, these same participants considered the Sikh religion, specifically attending the Gurdwara, as an effective intervention. Attending the Gurdwara could be a way of establishing or strengthening a connection with the divine. Participants may not have identified a spiritual cause for adolescent suicide and suicide-related behaviours because they do not situate suicide within a spiritual context. It may also be the case that participants did not consider this study an appropriate forum for a spiritual discussion.

Reaction to Suicide and Suicide-Related Behaviours

A range of parental emotional responses to adolescent suicide and suicide-related behaviours were reported in this study. The parent and young adult participants all reported shock and anger to be their likely initial reactions to adolescent suicide and suicide-related behaviours. According to Raphael, Clarke, and Kumar (2006) the initial shock experienced by parents on first learning of their child's difficulties is associated with grief, which may subsequently manifest as anger. Although half of the mothers participating in a study completed by Wagner, Aiken, Mullaley, and Tobin (2000) reported experiencing feelings of hostility, they also reported it was unlikely they would verbalize their hostility in fear of the consequences it might have for their child. The young adult and mental health participants suggested first

generation Canadian Punjabi Sikh parents may express their anger. It seems likely that parents experience anger because they consider their child's behaviour to be a slight against themselves and to reflect a lack of appreciation for all that they have provided. Parents may also experience anger because they may fear how their child's behaviour reflects upon the family; protecting the family honour (izzat) has been found to be of the utmost importance in South Asian families (Gilbert, Gilbert, & Sanghera, 2004).

A study conducted by Raphael, Clarke, and Kumar (2006) found deliberate self harm on the part of adolescents to be a traumatic experience for parents. Parents of that study reported feeling confusion, hurt, rejection and helplessness. Another study found adolescent suicide attempts increased parents' feelings of caring, sadness, and anxiety when compared to their feelings prior to the attempts (Wagner, Aiken, Mullaley, & Tobin, 2000). The findings of the current study confirm that first generation Canadian Punjabi Sikh parents also experience a variety of emotions, including concern, worry, helplessness, frustration and fear for the adolescent's well being. The emotional responses to adolescent suicide and suicide-related behaviours may not be determined by culture and religion. First generation Canadian Punjabi Sikh parents respond emotionally to suicide and suicidal behaviour in exactly the same fashion as other parents do. However, culture may determine which emotions are appropriate to express; first generation Canadian Punjabi Sikh parents may not view anger to be an inappropriate reaction to adolescent suicide and suicide-related behaviours.

Interventions Utilized in Response to Suicide and Suicide-Related Behaviours

The current study found first generation Canadian Punjabi Sikh parents consider a variety of interventions in response to adolescent suicide-related behaviours. The Sikh religion, western health care services, communication and monitoring of adolescent behaviour were all interventions that parents reported they were likely to utilize. Parents are also likely to seek the

support of family members. This could potentially be a great support system for the adolescent or have significant consequences for the adolescent.

Sikh Religion

The current study revealed first generation Canadian Punjabi Sikh parents are likely to seek support from the Gurdwara; participants identified the Sikh religion as providing a supportive role in dealing with adolescent suicide and suicide-related behaviours. Research suggests that religious affiliation may be a protective factor against suicidal behaviour. A study conducted by Walker and Bishop (2005) identified youth who held onto religious beliefs to be less likely to experience suicide ideation. In another study, adolescents who believed religion to be an important part of their lives had lower incidences of suicide ideation (Elliott, Colangelo, & Gelles, 2005). A study of adolescent males found that those involved or active in religious groups were less at risk for suicide ideation (Hilton, Fellingham, & Lyon, 2002). Attending the Gurdwara may foster adolescents' religiosity. Religious affiliation has been determined to be a protective factor against suicide and suicide-related behaviours.

Access Western Health Care

The current study found first generation Canadian Punjabi Sikh parents are willing to access western health care services, including counselling services. These findings are in contrast to those of previous studies that have investigated the utilization rate of western medical services. These studies have shown children of South Asian background to be underrepresented in western health care (Bhui, Strathdee, & Sufraz, 1993; Brewin, 1980; Stern, Cottrell, & Holmes, 1990; Harris, 2000; Jawed, 1991). Findings of the current study suggest first generation Canadian Punjabi Sikh parents are likely to seek help from Western health care providers. This trend on the part of Punjabi Sikh parents in accessing services may reflect that mental health professionals are beginning to provide culturally sensitive services. By being open to seeking

assistance from mental health care workers, first generation Canadian Punjabi Sikh parents are potentially able to prevent adolescent suicide and suicide-related behaviours.

Communication and Monitoring of Behaviour

The current study revealed that first generation Canadian Punjabi Sikh parents believe open communication and monitoring of behaviour are useful interventions when dealing with adolescent suicide and suicide-related behaviours. A positive connection between parent and child is a prerequisite for open communication between adolescent and parent; such a connection has been identified to be a protective factor against suicide (Kidd, Henrich, Brookmeyer, Davidson, King, & Shahar, 2006). The quality of parent child relationship and the degree of communication, particularly between fathers and older adolescents, has been proven to be a determining factor in adolescent suicide and suicide-related behaviours (Wagner, Cole, & Schwartzman, 1995; Gould, Fisher, Parides, Flory, & Shaffer, 1996; Tousignant, Bastien, & Hamel, 1993). Therefore, by being aware of the significance of creating strong connections with adolescents early in childhood, first generation Canadian Punjabi Sikh parents are able to potentially lower the risk of adolescent suicide and suicide-related behaviours.

Family Support and Alternative Healing Methods

It was the World Health Organization in 1989 that recognized the importance of traditional healing and the need for cooperation between modern and traditional health care systems. Punjabi Sikh households often consist of extended family members whose home remedies are often tried prior to seeking medical care (Assanand, Dias, Richardson, & Waxler-Morrison, 1990). Choosing to access medical health care services is often a family decision with the elders or the male head of household casting the determining vote. (Assanand, Dias, Richardson, & Waxler-Morrison, 1990). Harris (2000) noted South Asian families to attempt to resolve issues within the family structure. The current study revealed that first generation Canadian Punjabi Sikh parents are likely to seek assistance from family members when dealing

with adolescent suicide and suicide-related behaviours. Although family members could serve as an excellent support system for the parents and for an adolescent experiencing suicide-related behaviours, it is possible that receiving assistance from family members could delay medical and mental health treatment of the adolescent. Unfortunately, the study did not determine at what point the parents are likely to seek professional help, or from whom parents might seek help first: family members, or professionals.

The findings of the current study were inconclusive in regards to the use of alternative healing methods. The parent and some of the young adult participants suggested first generation Canadian Punjabi Sikh parents would not utilize alternative healing methods, while a young adult, mental health, and community leader participants disagreed. In spite of the inconclusive findings of the current study, previous studies have shown South Asians, including Punjabi Sikhs, to utilize alternative healing methods.

With an integrated understanding of health: mind, body and spirit, Punjabi Sikhs seek alternative healing methods (Grewal, Bottorff, & Hilton, 2005; Hilton, Grewal, Popatia, Bottorff, Johnson, Clarke, Venables, Bilku, & Sumel, 2001). However, there may be a number of reasons that the findings of the current study as to the use of alternative healing methods may have been inconclusive. It is possible parent participants in the study no longer hold an integrated understanding of health to the degree which they did when they first arrived in Canada. The extended amount of time they have resided in Canada may have resulted in a higher level of acculturation, making them less amenable to historic methods of healing. It is also possible that parents were unwilling to admit they had utilized alternative healing methods: they may have felt embarrassed in disclosing the use of alternative healing methods, particularly if these had proven ineffective.

Barriers to Accessing Mental Health Services

The findings of the current study identified three barriers to accessing mental health services: misunderstanding of the concept of mental health, lack of awareness of services available, and the cultural stigma of mental illness. To assist first generation Canadian Punjabi Sikh parents to overcome these barriers, mental health care providers may need to work with within their clients' framework of mental health, to assist them in accessing services, and to ensure confidentiality.

Traditionally, South Asians hold an integrated understanding of health which includes, mind, body and spirit (Hilton, Grewal, Popatia, Bottorff, Johnson, Clarke, Venables, Bilku, & Sumel, 2001). The findings of the current study found first generation Canadian Punjabi Sikh parents encounter difficulty in understanding western mental health concepts, including those having to do with adolescent suicide and suicide-related behaviours. Previous studies have shown South Asians to experience difficulty in understanding medical and mental health concepts, particularly dementia and depression (Adamson, 2001; Lawrence, Murray, Banerjee, Turner, Sangha, Byng, Bhugra, Huxley, Tylee, & Macdonald, 2006). Participants in the study thought this lack of understanding may be due to a lack of exposure to western concepts of mental health. It may be that parents hold to an integrated understanding of health over one that splits the self into parts.

It may not be vital for first generation Canadian Punjabi Sikh parents to have a complex understanding of mental health concepts in order to help their children be less vulnerable to suicide. Medical and mental health professionals have a responsibility to explore their clients' point of view of mental health, to work within their framework of understanding, and to offer an integrated perspective when addressing adolescent suicide and suicide-related behaviours. Such a perspective would take into account the context in which the clients situate suicide, which contributing factors they identify, and which interventions they are likely to embrace.

The current study found first generation Canadian Punjabi Sikh parents to likely be unaware of the mental health care services available in the community or how to access these services. The consequences of not being aware of the services are potentially fatal for an adolescent experiencing suicide-related behaviours. Medical and mental health care service providers need to reach out to the parents to help them to access necessary services for their adolescent children. Furthermore, the participants in this study have identified key areas to preventing vulnerability to adolescent suicide and suicide-related behaviours: peer relations, parent-child relationships and pressure to succeed, which mental health care workers could utilize as part of a guideline to developing an educational seminars.

The cultural stigma of mental illness was also identified in the current study as a barrier to accessing mental health care services. Participants suggested protection of family honor and family reputation to be of great importance in the Punjabi Sikh community. Participants stated that first generation Canadian Punjabi Sikh parents may fear that accessing mental health services for an adolescent child experiencing suicide and suicide-related behaviours might negatively influence the community's perception of the family. It has been suggested that Punjabi Sikhs may not seek Western health care services in fear of undergoing stigmatization and of isolating their families from their community (Gilbert, Gilbert, & Sanghera, 2004; Joseph, Abraham, Muliyil, George, Prasad, Minz, Abraham, & Jacob, 2003; Khan, 2002; Mittal, 2008). If first generation Canadian Punjabi Sikh parents allow the cultural stigma to prevent them from seeking medical and mental health help for an adolescent experiencing suicide-related behaviours they may leave their children vulnerable to suicide and suicidal behaviours. In an attempt to avoid the possible cultural stigmatization of their clients, medical and mental health care providers need to assure first generation Canadian Punjabi Sikh parents of confidentiality. This may make clients more receptive and open to engaging in medical and mental health care services when dealing with adolescent suicide and suicide-related behaviours.

Help Seeking Behaviours

The current study found first generation Canadian Punjabi Sikh parents willing to seek mental health care services when dealing with adolescent suicide and suicide-related behaviours. Previous studies have shown South Asians to be underrepresented in the western medical health care system (Daryanani, Hindley, Evans, Fahy, & Turk, 2001; Jawed, 1991; Nweth & Corbett, 1993; Stern, Cottrell, & Holmes, 1990). Despite the current study's findings of parents' willingness to seek help, participants also acknowledged a need to continue to educate parents about mental health disorders, including suicide and suicide-related behaviours, as well as adolescent development. Participants were able to identify modes of educating first generation Canadian Punjabi Sikh parents: via Punjabi media, schools, and Gurdwaras; there exists an opportunity for mental health professionals to respond to this need. Professionals need to raise awareness about adolescent suicide and suicide-related behaviours, and provide public information about mental health care services available in the community.

As Gurdwaras were identified to be a means of providing information about health issues for Punjabi Sikhs, there exists an opportunity for Gurdwaras to become more actively involved in disseminating this information. Traditionally, the Gurdwara is seen to be an institution for education; the function of the Gurdwara is to provide education, worship, and social justice (Singh & Singh, 2006). Recently the Sikh community has questioned whether Gurdwaras are fulfilling these purposes as well as they might; this particular issue was acknowledged by a mental health and community leader participant of this study. The findings of the current study suggest that some Sikhs continue to regard the Gurdwara as a place of education. This suggests that local Gurdwaras might be appropriate institutions to provide educational workshops about mental health issues, such as adolescent suicide and suicide-related behaviors.

5.2 Significance of Study

The purpose of the study was to describe the beliefs held by first generation Canadian Punjabi Sikh parents of adolescents about suicide and suicide-related behaviours. With an ethnographic approach semi-structured interviews were conducted with four groups of participants: first generation Canadian Punjabi Sikh parents of adolescents, second generation Canadian Punjabi Sikh young adults, South Asian mental health therapists and medical professionals, and a Punjabi Sikh community leader. The ten interviews conducted were audio-taped, transcribed and analyzed through an inductive process, an a priori content specific scheme (Schwandt, 1997). The ethnographic approach was an appropriate method for this study; it allowed for the Punjabi Sikh community's beliefs to be most accurately reflected. Excerpts of the ethnographic interviews provided deeper understanding of the themes presented in the thesis.

This is the first study to describe first generation Canadian Punjabi Sikh parents' beliefs about adolescent suicide and suicide-related behaviours, and to identify how they contextualize adolescent suicide and suicide-related behaviours. The study found that this group of first generation Canadian Punjabi Sikh parents' are aware of many protective factors against suicide and are able to help reduce the risk of adolescent suicide and suicide-related behaviours. The study identifies beliefs held by first generation Canadian Punjabi Sikh parents as to the probable causes of adolescent suicide and suicide-related behaviours, which included poor parent-child relationship, parental pressure to succeed, teenage hormonal activity, mental illness, and difficulty with adolescent peer relationships. Although the parents identified possible causes of suicide and suicide-related behaviours, they acknowledged that many parents lacked a satisfactory understanding of these causes. Parents would benefit from learning more about the causes and warning signs of suicide, the protective and risk factors for suicide, and available professional help. The mental health participants of the study identified mental health clinicians are in the best position to develop and deliver such programs.

By understanding the reaction first generation Canadian Punjabi Sikh parents have towards adolescent suicide and suicide-related behaviours, mental health professionals may be able to normalize their reaction, helping them to understand that many parents would react in a similar fashion. Also, developing a deeper understanding of how the parents react to suicidal behaviour would help mental health professionals be better prepared to deal with their reactions.

By knowing the interventions parents utilize when dealing with adolescent suicide and suicide-related behaviours mental health professionals may be able to integrate the support elements into therapy. Furthermore, by discussing the therapeutic process with parents, specifically the prospective interventions to be utilized, professionals may broaden parents' understanding of adolescent suicidal behaviour. An opportunity exists for professionals to assist parents in understanding how therapy works and what it may look like. As well, professionals have a responsibility to broaden their understanding of how adolescent suicide and suicide-related behaviours may be contextualized by first generation Canadian Punjabi Sikh families.

Although there has been a shift in first generation Canadian Punjabi Sikh parents seeking mental health services, barriers to accessing mental health services persist. It would be helpful for the community to be acknowledged and commended on their efforts on this recent shift towards accessing services. Such acknowledgment would provide the Punjabi Sikh community an opportunity to recognize the progress it has made in addressing the issue of suicide and suicide-related behaviour.

5.3 Limitations of Study

There are a number of limitations of this study: recruitment of the parent, and the medical and mental health participants, participant self-reporting, possibly the extended period of time the first generation Canadian Punjabi Sikh parent participants had been in Canada at the time of the interviews, and the study's small sample size.

Recruitment of participants, particularly first generation Canadian Punjabi Sikh parents and South Asian medical and mental health professionals, was a challenge. Recruitment of parent participants was expected to be a challenge due to the cultural stigma surrounding mental illnesses in the Punjabi Sikh culture. Three parent participants were recruited for the study. Given the large Punjabi Sikh population in the metro Vancouver area, it was expected that recruitment would not be difficult and that a larger sample of participants would be easily gathered. This was not the case. The cultural stigma of mental illnesses, particularly around suicide and suicide-related behaviours, may have prevented parents from participating in the study. Upon reflection, future studies may encounter more success recruiting participants via the Punjabi media, particularly Punjabi radio stations. This would allow the researcher to cast a wider net for participants.

This researcher had not anticipated the difficulty that was encountered in recruiting medical and mental health professionals. Although many South Asian medical and mental health professionals expressed an interest in the topic of the study and in participating, upon hearing the details of the study many medical professionals, particularly general practitioners, responded by saying that they did not believe they had the experience necessary to participate in the study. The general practitioners explained that they often referred parents to other service providers and consequently could not comment on the parents' beliefs about adolescent suicide and suicide-related behaviours.

The parent and young adult participants' responses were based upon hypothetical case studies, which provided the participants with a context and a means to focus upon the topic. However, determining the accuracy of participants' responses to the case studies may be difficult; consequently, self reporting by participants may be a limitation. In addition, it is recognized that participants' responses to hypothetical case studies may not reflect how participants might react when confronted with adolescent suicide and suicide-related behaviours

in real life situations. Furthermore, although the parent participants reported recognizing the significance of peer and parent-child relationships and the need to avoid pressuring adolescents to succeed, this study was not able to determine to what degree participants' actions reflect their beliefs.

The reflections of the ten participants in this study cannot be generalized to reflect the Punjabi Sikh community's view of adolescent suicide and suicide-related behaviours. Despite a multi-dimensional approach taken by interviewing four participant groups to provide a wide perspective to the study, the study was not designed for the purpose of generalization. Further study would be required with a larger sample size to explore the various themes of this thesis.

It must be noted that the parent participants in the study have been residents of Canada for an extended period of time (20 years on average) and have received at least a partial college education. As a result, the opinions held by participants in the study may reflect a higher level of acculturation and a greater exposure to mental health issues than those of more recent immigrants to Canada. Therefore, parent participants' reflections in the study may not accurately reflect the beliefs of recent immigrants to Canada.

5.4 Implications for Counselling Practice

The findings of this study have direct implications for counselling practice. To increase their effectiveness, mental health professionals should become familiar with first generation Canadian Punjabi Sikh parents' beliefs regarding adolescent suicide and suicide-related behaviours. Parents, on the other hand, will benefit from opportunities to learn more about protective and risk factors, warning signs and the interventions utilized by mental health professionals. Participants in the study suggest information through multicultural newspapers, radio, and television, with a Punjabi Sikh audience in mind, could focus on education regarding protective and risk factors for suicide, the warning signs of suicide, and when and where to access professional help.

The findings of the study suggest many Punjabi Sikh parents are unaware of mental health issues, the services available, and how to access and engage in services. Public schools were identified to be a mode to assist parents in understanding mental illnesses and accessing services. However, in the experience of the researcher mental health informational sessions held at schools attract few parent attendees. There may be a variety of reasons for the low attendance. The cultural stigma of mental illnesses may prevent parents from attending such a public forum; informational sessions may not be the ideal mode of communication with parents for schools. School officials may choose a more discreet manner of disseminating the information. For instance, schools may send home informational brochures about mental illnesses and how and where to access services; these documents may be translated into Punjabi so that parents are not dependent upon their children to translate the material. In regards to raising awareness of youth suicide schools may send home informational brochures during the week of Suicide Awareness held each May, or during the national Suicide Prevention week in September, or the World Suicide Prevention Day on September 10th.

Gurdwaras may be more of an ideal location for the informational sessions. Mental health care workers may hold informational sessions as part of the services on a regular basis. The potential to reach masses of people is greater as attendance may be in the hundreds. Also, hearing the information in such a public forum offers anonymity to a cultural group to whom confidentiality is essential and the cultural stigma of mental illnesses may be avoided.

The Punjabi media may also be an ideal mode of providing information to the Punjabi Sikh community. Mental health care workers may write newspaper or magazine articles, hold radio talk shows, or appear on television shows to raise awareness of youth suicide. The anonymity of this mode of communication assists parents and families to avoid the cultural stigma of mental illnesses.

Medical and mental health care workers can be helpful in identifying particular treatments and therapy for suicide-related behaviours, as well as describing how parents can contribute positively in the therapeutic process. Parents also need to be made aware of the services available in the community and how to access them. Discussing their concerns with a family doctor was identified to be a starting point to understanding the phenomenon of suicide and accessing services. Family doctors may play a key role in assisting parents to develop an understanding of the interventions mental health professionals may employ, and assisting parents in understanding the phenomenon of adolescent suicide and suicide-related behaviours from a western perspective. The family doctors may also play a role in ensuring parents follow through with the services they may have referred the youth to.

The findings of this study empower mental health professionals to work within first generation Canadian Punjabi Sikh parents' framework and to provide culturally sensitive and appropriate services for parents with adolescents experiencing suicide-related behaviours. Confidentiality was identified to be particularly important to Punjabi Sikh parents when dealing with adolescent suicide and suicidal behaviours due to the cultural stigma attached to mental illnesses. Mental health therapists need to be aware of the essentiality of confidentiality to Punjabi Sikh families and avoid a reaction of suspicion when parents request the mental health care workers not contact the family via the home telephone number. The study identified Punjabi Sikh parents' willingness to utilize mental health services provided their rights to confidentiality are honored.

Developing a strong therapeutic connection with parents may provide parents an opportunity to be more open in sharing their experiences and engaging in the therapeutic process. Parents are likely to feel more comfortable sharing information about alternative resources they may have accessed, and the degree to which they had found these interventions successful. By ensuring confidentiality and building a strong therapeutic alliance with Punjabi Sikh parents

mental health professionals may more effective when working with Punjabi Sikh parents and their adolescent children.

5.5 Implications for Future Research

The broad range of this thesis prevented in depth investigation into any one theme presented in this paper. Future studies could explore any given theme deeper to provide a more comprehensive view of first generation Canadian Punjabi Sikh beliefs about adolescent suicide and suicide-related behaviour. In particular, the use of alternative healing methods may be important to explore further as the findings of the current study were inconclusive in this regard. It may be worthwhile to explore if the amount of time spent in Canada may influence the decision to utilize alternative healing methods. Living in Canada for an extended period of time may lead to a higher level of acculturation, which may coincide with a decline in the use of alternative healing methods.

This study suggests that future studies on this topic include Punjabi Sikh adolescents who have experienced suicide-related behaviours. It would further our knowledge to determine whether adolescents' experiences reflect the findings of the current study. The qualitative method of action theory could be utilized to investigate Punjabi Sikh adolescent suicides to be goal-directed or dynamic systems views (Valach, Young, & Lynam, 2002). Hearing the stories of adolescents who have experienced suicide-related behaviours would provide a more in-depth view of what leads a Punjabi Sikh adolescent to view suicide to be an option. However, locating second generation Canadian Punjabi Sikh adolescents who have experienced suicide-related behaviours and are willing to reflect upon their experiences may be a challenge. Also, gaining parental permission for participation of the adolescents may be a challenge due to the cultural stigma of mental health illnesses.

References

Adamson, J. (2001). Awareness and understanding of dementia in African/Caribbean and South Asian families. *Health and Social Care in the Community*, 9, 6, 391-396.

Aderibigbe, Y., & Pandurangi, A. (1995). Comment: The neglect of culture in psychiatric nosology. The case of culture bound syndromes. *International Journal of Social Psychiatry*, 41, 4, 235-241.

Aggarwal, N. (2008). Editorial: Farmer suicides in India: The role of psychiatry and anthropology. *International Journal of Social Psychiatry*, 54, 4, 291-292.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

Anteghini, M., Fonseca, H., Ireland, M., & Blum, R. W. (2001). Health risk behaviours and associated risk and protective factors among Brazilian adolescents in Santos, Brazil. *Journal of Adolescent Health*, 28, 295-302.

Arthur, N., & Stewart, J. (2001). Multicultural counselling in the new millennium: Introduction to the special theme issue. *Canadian Journal of Counselling*, 35, 1, 3-14.

Ashworth, J. (2001). *Practice principles: A guide for mental health clinicians working with suicidal children and youth*. British Columbia: Ministry of Children and Family Development.

Assanand, S., Dias, M., Richardson, E., & Waxler-Morrison, N. (1990). The South Asians. In N. Waxler-Morrison, J. Anderson, & E. Richardson (Eds.), *Cross cultural caring. A handbook for health professionals in western Canada* (141-180). Vancouver, B.C.: The University of British Columbia Press.

Baerger, D. & McAdams, D. P. (1999). Life story coherence and its relation to psychological well-being. *Narrative Inquiry*, 9, 69-96.

Basran, G. S., & Bolaria, B. S. (2003). *The Sikhs in Canada: Migration, race, class, and gender.* New Delhi, India: Oxford University Press.

BBC Team. (2004). *Euthanasia and suicide*. Retrieved September 17, 2007 from http://www.bbc.co.uk/religion/religions/sikhism/sikhethics/euthanasia.html.

B.C. Mental Health Foundation. (2010). *South Asian youth mental health fund*. Retrieved April 3, 2010 from http://www.bcmhf.ca/news/news-article/mar-17-2010/south-asian-youth-mental-health-fund.

Bearman, P. S., & Moody, J. (2004). Suicide and friendships among American adolescents. *American Journal of Public Health*, 94, 89-95.

Berg, B. L. (1995). *Qualitative research methods for the social sciences* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Berry, J. W. (2006). Contexts of acculturation. In D. L. Sam, and J. W. Berry (Eds.), *The Cambridge handbook of acculturation psychology* (27-42), Cambridge, NY: Cambridge University Press.

Bhatia, S.C., Khan, M. H., Mediratta, R. P., & Sharma, A. (1987). High risk suicide factors across cultures. *The International Journal of Social Psychiatry*, 33, 3, 226-236.

Bhinder, K. K. (2007, August 23). *The Ottawa citizen*. Retrieved September 17, 2007 from http://www.canada.com/components/print.aspx?id=6d3c0761-28eb-4.

Bhugra, D. (2005). Sati - A type of nonpsychiatric suicide. *Crisis*, 26, 2, 73-77.

Bhugra, D. (2002). Suicidal behavior in South Asians in the UK. *Crisis*, 23, 3, 108-113.

Bhugra, D., Desai, M., & Baldwin, D. S. (1999). Attempted suicide in west London, I rates across ethnic communities. *Psychological Medicine*, 29, 1125-1130.

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

Bhui, K., Strathdee, G., & Sufraz, R. (1993). Asian inpatients in a district psychiatric unit: An

examination of presenting features and routes into care. *The International Journal of Social Psychiatry*, 39, 3, 208-220.

Boldt, M. (1989). Defining suicide: Implications for suicidal behaviour and for suicide prevention. In R. Diekstra, R. Maris, S. Platt, A. Schmidtke, & G. Sonneck (Eds.), *Suicide and it's Prevention: The Role of Attitude and Imitation* (5-13). Leiden, Netherlands: E. J. Brill.

Borra, R. (2008). Working with the cultural formulation in therapy. *European Psychiatry*, 23, 43-48.

Bose, R. (1997). Psychiatry and the conception of possession among the Bangladeshis in London. *International Journal of Social Psychiatry*, 43, 1, 1-15.

Boyd, M., & Vickers, M. (2000). 100 years of immigration in Canada. *Canadian Social Trends*, Autumn, 2-12.

Brewin, C. (1980). Explaining the lower rates of psychiatric treatment among Asian immigrants to the United Kingdom: A preliminary study. *Social Psychiatry*, 15, 17-19.

Bridge, J. A., Goldstein, T. R., & Brent, D. A. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry*, 47, 3, 4, 372-394.

British Columbia of Vital Statistics Agency. (2003). Table 23: Leading causes of death by age and gender. Retrieved October 31, 2008 from http://www.vs.gov.bc.ca/stats/annual/2003/xl/tab23.xls.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

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

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. (1988). *After*

the door has been opened. Ottawa: Minister of Supply and Services.

Chakraborty, A. (1991). Culture, colonialism, and psychiatry. *Lancet*, 337, 8751, 1204-1208.

Chiu, L., Ganesan, S., Clark, N., & Marrow, M. (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. *Transcultural Psychiatry*, 42, 4, 630-656.

Choudhury, P. P., Badhan, N. S., Chand, J., Chhugani, S., Choksey, R., Husainy, S., Lui, C., & Wat, E. C. (2009). Community alienation and its impact on help-seeking behavior among LGBTIQ South Asians in Southern California. *Journal of Gay & Lesbian Social Services*, 21, 247-266.

Christie, V. M. (1991). A dialogue between practitioners of alternative (traditional) medicine and modern (western) medicine in Norway. *Social Science and Medicine*, 32, 549-552.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches*. Thousand Oaks, California: Sage Publications Inc.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, California: Sage Publications Inc.

Daryanani, R., Hindley, P., Evans, C., Fahy, P., & Turk, J. (2001). Ethnicity and use of child and adolescent mental health service. *Child Psychology & Psychiatry Review*, 6, 3, 127-132.

DeWilde, E., Kienhorst, E., Diekstra, R., & Wolters, W. (1993). The specificity of psychological characteristics of adolescent suicide attempters. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 51-58.

Durkheim, E. (1966). *Suicide: A study in sociology*. New York, NY: The Free Press.

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

Elliott, G. C., Colangelo, M. F., & Gelles, R. J. (2005). Mattering and suicide ideation: Establishing and elaborating a relationship. *Social Psychology Quarterly*, 68, 223-239.

Elliot, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches.* London: Sage Publications Inc.

Fabrega, H. Jr. (1992). The role of culture in a theory of psychiatric illness. *Social Science and Medicine*, 35, 91-103.

Fabrega, H. Jr. (1994). International systems of diagnosis in psychiatry. *Journal of Nervous and Mental Disease*, 182, 256-259.

Field, T., Diego, M., & Sanders, C. E. (2001). Adolescent suicidal ideation. *Adolescence*, 36, 241-248.

Garbarino, J. (1985). *Adolescent development: An ecological approach*. Columbus, OH: Charles E. Merrill.

Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion & Culture*, 7, 2, 109-130.

Goldston, D. B., Daniel, S. S., Reboussin, B.A., Reboussin, D. M., Frazier, P. H., & Harris, A. E. (2001). Cognitive risk factors and suicide attempts among formerly hospitalized adolescents: A prospective naturalistic study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 91-99.

Good, B. J. (1996). Culture and DSM-IV: Diagnosis, knowledge, and power. *Culture, Medicine, & Psychiatry*, 20, 127-132.

Gould, M. S., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicide. *Archives of General Psychiatry*, 53, 1155-1162.

Grewal, S., Bottorff, J. L., & Hilton, B. A. (2005). The influence of family on immigrant South Asian women's health. *Journal of Family Nursing*, 11, 3, 242-263.

Harris, Q. (2000). Psychological problems in Asian children. In A. Lau (Ed.), *South*

Asian children and adolescents in Britain (195-216). London, U.K.: Whurr Publishers Ltd.

Haynes, R. M. (1984). Suicide in Fiji: A preliminary study. *British Journal of Psychiatry*, 145, 433-438.

Health Canada. (1994). *Suicide in Canada. Update of the report of the National Task Force on suicide in Canada*. Ottawa, Canada: Health and Welfare Canada.

Hicks, M., & Bhugra, D. (2003). Perceived causes of suicide attempts by U.K. South Asian women. *American Journal of Orthopsychiatry*, 73, 4, 455-462.

Hilton, B. A., Grewal, S., Popatia, N., Bottorff, J. L., Johnson, J. L., Clarke, H., Venables, L. J., Bilkhi, S., & Sumel, P. (2001). The desi ways: Traditional health practices of South Asian women in Canada. *Health Care of Women International*, 22, 553-567.

Hilton, S. C., Fellingham, G. F., & Lyon, J. A. (2002). Suicide rates and religious commitment in young adult males in Utah. *American Journal of Epidemiology*, 155, 413-419.

Hines, P., Garcia-Preto, N., McGoldrick, M., Almeida, R., & Weltman, S. (1992). Intergenerational relationships across cultures. *Families in Society: The Journal of Contemporary Human Services*, 23, 323-338.

Hirakata, P., & Arvay, M. J. (2005). Into the fire: Using therapeutic enactments to bridge early traumatic memories of childhood sexual abuse. *International Journal for the Advancement of Counselling*, 27, 3, 445-455.

Ineichen, B. (1998). The influence of religion on the suicide rate: Islam and Hinduism compared. *Mental Health, Religion and Culture*, 1, 1, 31-36.

Jagpal, S. (1994). *Becoming Canadians: Pioneer Sikhs in their own worlds*. Vancouver, BC: Harbour Publishing.

Jahangir, F., Rehman, H., & Jan, T. (1998). Degree of religiosity and vulnerability to suicidal

attempt plans in depressive patients among Afghan refugees. *The International Journal for the Psychology of Religion*, 8, 4, 265-269.

Jawed, S. H. (1991). A survey of psychiatrically ill Asian children. *British Journal of Psychiatry*, 158, 268-270.

Jha, A. (2001). Depression and suicidality in Asian Indian students. Dissertation Abstracts International, 62/03. (UMI No. 3007999).

Joseph, A., Abraham, S., Muliyil, J. P., George, K., Prasad, J., Minz, S., Abraham, V. J., & Jacob, K. S. (2003). Evaluation of suicide rates in rural India using verbal autopsies, 1994-1999. *British Medical Journal*, 326, 1121-1122.

Judge, P. S. (1994). *Punjabi's in Canada: A study of formation of an ethnic community.* New Delhi, India: Chankya Publications.

Kamal, Z., & Loewenthal, K. M. (2002). Suicide beliefs and behaviour among young Muslims and Hindus in the UK. *Mental Health, Religion & Culture*, 5, 2, 111-118.

Karasz, A., Dempsey, K., & Fallek, R. (2007). Cultural differences in the experience of everyday symptoms: A comparative study of South Asian and European American women. *Culture, Medicine,& Psychiatry*, 31, 4, 473-497.

Khan, M. M. (2002). Suicide on the Indian subcontinent. *Crisis*, 23, 3, 104-107.

Kidd, S., Henrich, C. C., Brookmeyer, K. A., Davidson, L., King, R. A., & Shahar, G. (2006). The social context of adolescent suicide attempts: Interactive effects of parent, peer, and school social relations. *Suicide and Life-Threatening Behavior*, 36, 4, 386-395.

Kleinman, A., & Good, B. (1985). *Culture and depression*. Berkeley: University of California Press.

Kok, L. P. (1988). Race, religion and female suicide attempters in Singapore. *Social Psychiatry & Psychiatric Epidemiology*, 23, 236-239.

Krause, I. (1989). Sinking heart: A Punjabi communication of distress. *Social Science and Medicine*, 29, 4, 563-575.

Kua, E. H., & Tsoi, W. F. (1985). Suicide in the island of Singapore. *Acta Psychiatrica Scandinavica*, 71, 227-229.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage Publications Inc.

Lawrence, V., Murray, J., Banerjee, S., Turner, S., Sangha, K., Byng, R., Bhugra, D., Huxley, P., Tylee, A., & Macdonald, A. (2006). Concepts and causation of depression: A cross cultural study of beliefs of older adults. *The Gerontologist*, 46, 1, 23-32.

LeCompte, M. D., & Schensul, J. J. (1999 a). *Analyzing and interpreting ethnographic data*. Walnut Creek, CA: AltaMira Press.

LeCompte, M. D., & Schensul, J. J. (1999 b). *Designing and conducting ethnographic research*. Walnut Creek, CA: AltaMira Press.

Lee, E., & Mock, M. (2005). Asian families: An overview. In M. Goldrick, J. Giordano, & N. Garcia-Preto (Eds.), *Ethnicity and family therapy* (269-289). New York: Guildford Press.

Leenars, A. A. (2008). Suicide: A cross-cultural theory. In F. T. L. Leong, and M. M. Leach (Eds.), *Suicide among racial and ethnic groups* (13-38). New York, NY: Routledge.

Lester, D., & Bean, J. (2001). Attributions of causes to suicide. *The Journal of Social Psychology*, 132, 5, 679-680.

Ley, D., & Germain, A. (2000). Immigration and the changing social geography of large Canadian cities. *Plan Canada*, 40, 4, 29-32.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation.* Thousand Oaks, CA: Sage Publications Inc.

Lindsay, C. (2001). Profiles of ethnic communities in Canada: The South Asian community in Canada. *Statistics Canada*. Retrieved September 19, 2007 from http://www.statcan.ca/english/freepub/89-621-XIE/89-621-XIE2007006.pdf.

McLeod, J. (2001). *Qualitative research in counseling and psychotherapy.* Thousand Oaks, CA: Sage.

Madison, S. D. (2005). *Critical ethnography: Method, ethics, and performance*. Thousand Oaks, CA: Sage Publications Inc.

Manoranjitham, S. D., Jayakaran, R., & Jacob, K. S. (2006). Suicide in India. *British Journal of Psychiatry*, 188, 86.

Marsella, A. J. (1993). Sociocultural foundations of psychopathology: An historical overview of concepts, events and pioneers prior to 1970. *Transcultural Psychiatric Research Review*, 30, 97-141.

Marttunen, M. J., Aro, H. M., Henriksson, M. M., & Lonnqvist, J. K. (1991). Mental disorders in adolescent suicide. DSM-III-R axes I and II diagnoses in suicides among 13- to 19-year olds in Finland. *Archives of General Psychiatry*, 48, 834-839.

Michel, K., & Valach, L. (1997). Suicide as goal directed action. *Archives of Suicide Research*, 3, 213-221.

Mittal, A. (2008). Harvest of suicides: How global trade rules are driving Indian farmers to despair. *Earth Island Journal*, 23, 1, 55-57.

Murphy, J. M. (1976). Psychiatric labeling in cross cultural perspectives. *Science*, 191, 1019-1028.

Newth, S. J., & Corbett, J. (1993). Behaviour and emotional problems in three-year old children of Asian parentage. *Journal of Child Psychology and Psychiatry*, 34, 3, 333-352.

O'Connell, J. (2000). Sikh religion - Ethnic experience in Canada. In H. Coward, J. Hinnells, and

R. Williams (Eds.), *The South Asian religious diaspora in Britain, Canada, and the United States* (191-209). Albany, NY: State University of New York Press.

Ortiz, A. M. (2003). The ethnographic interview. In F. K. Stage, and K. Manning (Eds.), *Research in the college context: Approaches and methods* (35-48). New York, NY: Brunner-Routledge.

Overholser, J. C., Adams, D. M., Lenert, K. L., & Brinkman, D. C. (1995). Self-esteem and suicidal tendencies among adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 919-928.

Pandey, G. N., Dwivedi, Y., Rizavi, H. S., Ren, X., & Conley, R. R. (2004). Decreased catalytic activity and expression of protein kinases C isozymes in teenage suicide victims: A postmortem brain study. *Archives of General Psychiatry*, 61, 685-693.

Parvez Wakil, S., Siddique, C. M., & Wakil, F. A. (1981). Between two cultures: A study in socialization of children of immigrants. *Journal of Marriage and Family*, 43, 4 929, 940.

Pillay, A. L. (1987). Factors precipitating parasuicide among young South African Indians. *Psychological Reports*, 61, 545-546.

Prinstein, M. J., Boergers, J., Spirito, A., Little, T. D., & Grapentine, W. L. (2000). Peer functioning, family dysfunction, and psychological symptoms in a risk factor model for adolescent inpatients' suicidal ideation severity. *Journal of Clinical Child Psychology*, 29, 392-405.

Punjab at a glance. Retrieved September 12, 2007 from http://punjabgovt.nic.in/punjabataglance/SomeFacts.htm.

Raleigh, S. V. (1996). Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales. *Ethnicity and Health*, 1, 1, 55-63.

Raphael, H., Clarke, G., & Kumar, S. (2006). Exploring parents' responses to their child's deliberate self-harm. *Health Education*, 106, 1, 9-20.

Rasmussen, A., Rosenfeld, B., Reeves, K., & Keller, A. S. (2007). The effects of torture-related injuries on long-term psychological distress in a Punjabi Sikh sample. *Journal of Abnormal Psychology*, 116, 4, 734-740.

Rubenstein, J. L., Heeren, T., Housman, D., Rubin, C., & Stechler, G. (1989). Suicidal behaviour in "normal" adolescents: Risk and protective factors. *American Journal of Orthopsychiatry*, 59, 59-71.

Sahin, N., Sahin, N. H., & Tumer, S. (1994). Stereotypes of suicide causes for three age/gender cohorts. *International Journal of Psychology*, 29, 2, 213-232.

Sam, D. L. (2006). Acculturation: Conceptual background and core components. In D. L. Sam, and J. W. Berry (Eds.), *The Cambridge handbook of acculturation psychology* (11-26), Cambridge, NY: Cambridge University Press.

Sandhu, J. (2005). A Sikh perspective on life-stress: Implications for counselling. *Canadian Journal of Counselling*, 39, 1, 40-51.

Sandhu, J. (2004). The Sikh model of the person, suffering, and healing: Implications for counsellors. *International Journal for the Advancement of Counselling*, 26, 1, 33-46.

Sandhu, J. (2009). The Sikh perspective on alcohol and drugs: Implications for the treatment of Punjabi-Sikh patients. *Sikh Formations*, 5, 1, 23-37.

Schwandt, T. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, CA: Sage Publications Inc.

Seguin, M., Lynch, J., Labelle, R., & Gagnon, A. (2004). Personal and family risk factors for adolescent suicidal ideation and attempts. *Archives of Suicide Research*, 8, 227-238.

Shiromani Gurdwara Parbandhak Committee. (1994). Retrieved Oct. 31, 2008 from http://www.sgpc.net/sikhism/sikh-dharma-manual.asp.

Singh, G. (1997). *The Sikh faith: Questions & answers*. Amritsar, India: Dharam Parchar Committee Shiromani Gurdwara Parbandhak Committee.

Singh, H., & Singh, S. (2006). Sikh leadership: Established ideals and diasporic reality. *Teaching Theology and Religion*, 9, 2, 133-138.

Singh, R. (2000). Religious beliefs and practices among Sikh families in Britain. In A. Lau (Ed.), *South Asian children and adolescents in Britain* (107-120). London, U.K.: Whurr Publishers.

Smith, A., Stewart, D., Peled, M., Poon, C., Saewyc, E., & the McCreary Centre Society. (2009). *A picture of health: Highlights from the 2008 B.C. Adolescent Health Survey*. Vancouver, B.C.: McCreary Centre Society.

Soanes, C. (Ed.). (2000). *The Oxford compact English dictionary*. New York: Oxford University Press.

Srivastava, R. P. (1983). The evolution of adaptive strategies: East Indians in Canada. In G. Kurian and R. P. Srivastava (Eds.), *Overseas Indians: A study in adaptation* (30-40). New Delhi: Vikas Publishing House PVT Ltd.

Statistics Canada. (2001). Ethnocultural portrait of Canada. *2001 Census of Population*. Retrieved October 18, 2005 from http://www40.statcan.ca/l01/cst01/demo52c.htm.

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

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, 70, 477-486.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counselling competencies. *Counseling Psychologist*, 10, 45-52.

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice*. Hoboken, NJ: John Wiley & Sons.

Suzuki, L., Mattis, J., Ahluwalia, M., & Quizon, C. (2005). Ethnography in counseling psychology research: Possibilities for application. *Journal of Counseling Psychology*, 52, 2, 206-214.

Thapar, R. (1994). Sacrifice, surplus and the soul. *History of Religions*, 33, 4, 305-324.

Tousignant, M., Bastien, M. F., & Hamel, S. (1993). Suicidal attempts and ideations among adolescents and young adults: The contribution of the father's and mother's care and personal separations. *Social Psychiatry Epidemiology*, 28, 256-261.

Trollope-Kumar, K. (2001). Cultural and biomedical meanings of the complaint of leukorrhea in South Asian women. *Tropical Medicine & International Health*, 6, 4, 260-266.

Valach, L., Michel, K., Dey, P., & Young, R. A. (2006). Linking life- and suicide-related goal directed processes: A qualitative study. *Journal of Mental Health Counseling*, 28, 4, 353-372.

Valach, L., Michel, K., Young, R. A., & Dey, P. (2006). Suicide attempts as social goal-directed systems of joint careers, projects, and actions. *Suicide and Life-Threatening Behaviour*, 36, 6, 651-660.

Valach, L., Young, R. A., & Lynam, M. J. (2002). *Action theory: A primer for applied research in the social sciences*. Westport, CT: Praeger.

Venkoba Rao, A. (1975). Suicide in India. In N. L. Farberow (Ed.), *Suicide in different cultures* (231- 238). Baltimore, Maryland: University Park Press.

Wadhwani, Z. B. (1999). To be or not to be: Suicidal ideation in South Asian youth. *Masters Abstracts International*, 39, 03, 935. (UMI No. MQ55116).

Wagner, B., Aiken, C., Mullaley, P. M., & Tobin, J. (2000). Parents' reactions to adolescents' suicide attempts. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 4, 429-436.

Wagner, B. M., Cole, R. E., & Schwartzman, P. (1995). Psychosocial correlates of suicide attempts among junior and senior high school youth. *Suicide & Life-Threatening Behavior*, 25, 358-372.

Walker, R. L., & Bishop, S. (2005). Examining a model of the relation between religiosity and suicidal ideation in a sample of African American and White college students. *Suicide & Life Threatening Behavior*, 35, 630-639.

Walton-Roberts, M. (2003). Transnational geographies: Indian immigration to Canada. *The Canadian Geographer*, 47, 3, 235-250.

White, G. M. (1982). Ethnographic study of cultural knowledge of "mental disorder." In A. J. Marsella & G. M. White (Eds.), *Cultural conceptions of mental health and therapy* (69-95). Boston, MA: D. Reidel Publishing Company.

White Kress, V. E., Eriksen, K. P., Dixon Rayle, A., & Ford, S. J. W. (2005). The DSM-IV-TR and culture: Considerations for counsellors. *Journal of Counseling & Development*, 83, 97-104.

Wolff, E. (2008). Adolescent suicide and societal pressure. *College of Saint Elizabeth Journal of the Behavioural Sciences*, 2, 9-16.

Appendix A

Demographic Survey for Punjabi Sikh Parents.

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Faculty of Education

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Vancouver, BC, Canada V6T 1Z4
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Demographic Survey for Punjabi Sikh Parents.

Date of Interview: _____
Time of Interview: _____
Place of Interview: _____
Interviewee(s): _____

1. Mother _____ &/or Father _____

2. Age(s): _____

3. Birth Place(s): _____

4. Number of years in Canada: _____

5. Level(s) of education: _____

6. Number of children and ages: _____

7. Household composition – Please place an X next to one of the choices below:

_____ Nuclear family (two parents and children)
_____ Extended family (nuclear plus other family members, such as grandparents)
_____ Single parent (i.e. not married, divorced, or separated)
_____ Other (please specify) _____

Appendix B

Demographic Survey for Punjabi Sikh Young Adults.

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Demographic Survey for Punjabi Sikh Young Adults.

Date of Interview: _____
Time of Interview: _____
Place of Interview: _____
Interviewee(s): _____

1. Gender: Male _____ Female _____

2. Age: _____

3. Birth Place: _____

4. Level of education: _____

5. Number of siblings and ages: _____

6. Household composition – Please place an X next to one of the choices below:

_____ Nuclear family (two parents and children)
_____ Extended family (nuclear plus other family members, such as grandparents)
_____ Single parent (i.e. not married, divorced, or separated)
_____ Other (please specify) _____

2/12/2009

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Appendix C

Case Studies and Interview Questions for Punjabi Sikh Parents and Young Adults.

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Case Studies and Interview Questions for Punjabi Sikh Parents and Young Adults.

Date of Interview: _____
Time of Interview: _____
Place of Interview: _____
Interviewee(s): _____

Interview questions:

1. Have you had any personal experience with suicide? If so, could you tell me about it? (Interviewer shares personal experience with suicide and the purpose of the research and interview)

Read Case Study #1 – Paula

Questions for Case Study #1:

1. What do you think of this story?

2. How do you think Paula's parent's reacted to her suicide?

3. What kind of support might Paula's parents have provided to her?

4. How might Paula's parents not have been helpful to her?

5. What do you think may have led to Paula experiencing such mood swings and to be involved in such reckless behaviour?

6. Do you think Paula's suicide could have been prevented? If so, how?

7. From Paula's story does it sound as if she could be part of the Punjabi Sikh community? Why or why not?

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Faculty of Education

8. If Paula was a member of the Punjabi Sikh community, do you see a role for the Punjabi Sikh community to play in helping Paula? If so, what do you see that role being?

9. If you were the parent/sibling of Paula, what would you or your spouse/your parents do?

10. How do you think Paula's family dealt with her passing away?

Read Case Study #2 - Manjit

Questions for Case Study #2 – Manjit:

1. What do you think of this story?

2. How do you think Manjit's parents may have reacted to Manjit using alcohol and marijuana?

3. How do you think Manjit's parents may have reacted to Manjit having thoughts of wanting to kill himself?

4. What kind of support might Manjit's parents have provided to him?

4. How might Manjit's parents not have been helpful to him?

5. What do you think may have led Manjit to substance use and experiencing thoughts about suicide?

6. Do you see a role for the Punjabi Sikh community to play in helping Manjit? If so, what do you see that role being?

7. If you were the parent/sibling of Manjit, what would you or your spouse/your parents do?

8. Why do you think sometimes families like Paula and Manjit's don't ask for help?

9. In your view is suicide a crime, sin, sacrifice, mental health issue, something that happens due to circumstances, or a combination of these?

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For Parents:

10. If you were a parent of Manjit would you use alternative healing methods, such as auyrveda, homeopathic, naturopathic, baba ji's, pandit's and granthi's or jyotshi's? If so, which one and why?

For Young Adults:

10. If you were a sibling of Manjit do you believe your parents may use alternative healing methods, such as auyrveda, homeopathic, naturopathic, baba ji's, pandit's and granthi's or jyotshi's? If so which one and why?

11. Please take a look at the summary of the interviews conducted with first generation Canadian Punjabi Sikh parents and comment on whether or not you believe it accurately reflects your experience of being raised by first generation Canadian Punjabi Sikh parents.

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Faculty of Education

Case Study #1

Paula was 17 years old when she was admitted to the psychiatric unit of the local general hospital by her family doctor. Admitting problems included mood swings, refusal to eat or come out of her bedroom, experiencing thoughts about suicide, refusal to talk to anyone, and obsession with her appearance. After a full psychiatric workup she was diagnosed with a mental health illness, as well as depression. She spent one month in hospital. Upon discharge she was referred to community based mental health services where she was treated by a child and youth mental health team and a psychiatrist. Because she had recently been discharged from hospital, outpatient treatment began immediately.

Six months later Paula was involved in a series of incidents involving reckless behaviour, including shoplifting and public drunkenness. She was readmitted to hospital and treated with a number of medications. However, upon leaving the hospital she discontinued taking the medication regularly. She was again referred for community mental health follow-up where she began to attend regularly. At the urging of her mental health clinician and psychiatrist, she began to take her medication on a regular basis.

Paula and her family were provided with educational materials concerning her mental health illness that included information about the risk for Paula becoming ill again. After three to four months however, she refused to continue at the mental health centre as she thought her problem was cured. She stopped taking her medication regularly. Six months later she died by suicide at the age of 18.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Case Study #2

Manjit is a 15 year old son of a Punjabi Sikh family who has been using alcohol and marijuana regularly. His substance use combined with his obsession (his word) with hard rock music often makes him feel like he wants to kill himself. Based upon his thoughts of wanting to end his life, substance use, and impulsive behaviour, in addition to other risk factors, his high school counselor determined his risk for suicide to be high and referred him to a mental health clinician.

Manjit appeared quite willing to attend counselling sessions. Concerned about his immediate safety his mental health clinician developed a plan to ensure his safety and scheduled treatment sessions three times a week for the next three weeks. Manjit also agreed to check in with her by phone daily. His mental health clinician determined that Manjit needed to address his substance use problem – which was significantly contributing to his current thoughts of wanting to suicide – she inquired into the availability of outpatient drug and alcohol counselling services, but it would be several weeks before he could get in to see a drug and alcohol counsellor. In the meantime, Manjit's mental health clinician continued with the counselling sessions.

Appendix D

Handouts for Punjabi Sikh Parents and Young Adults.

- **Hopelessness**
  A negative outlook with no positive future. "What's the point? It won't change."
- **Changes in Mood**
  crying easily; depressed; frequently agitated or anxious
- **Warnings**
  saying "life isn't worth it" or "things would be better if I were gone"; jokes, poems and art about suicide
- **Preparations for Death**
  saying goodbye; making a will; giving away prized possessions; talking about going away
- **Impulsiveness**
  actions without thought of risks or consequences; out bursts or aggressive behaviour
- **Previous Attempts**
  recent intentional self-harm or suicide attempt

WHAT CAN I DO IF SOMEONE IS SUICIDAL?

Talking can help

- **Reach out** and let them know you care.
- **Ask directly** "Are you considering suicide?"
- **Be a supportive listener;** accept their feelings.
- **Offer help.** Find out whom they can talk to...

a counsellor, partner, teacher, relative, clergy member, doctor, nurse or crisis centre. Never promise to keep a suicide plan secret.

- **Take them to help**, like a hospital, mental health clinic, or suicide prevention counsellor, if they can't assure their own safety.

WHAT IF I'M THINKING ABOUT SUICIDE?

Seek out help instead of keeping problems to yourself and feeling alone. Talk with someone you trust or call your local crisis centre.

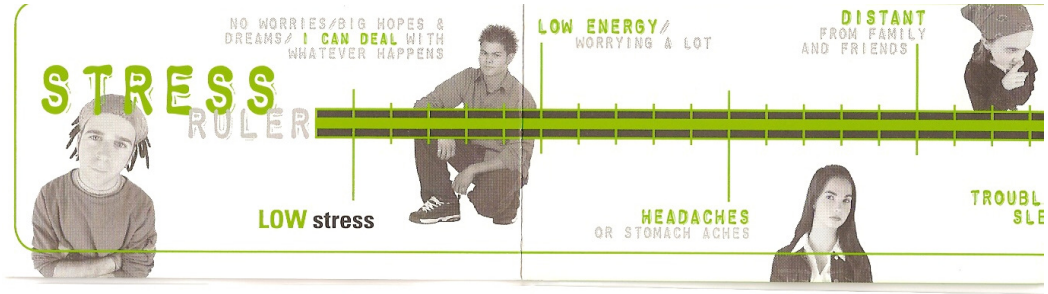
1-800-SUICIDE
1-800-784-2433

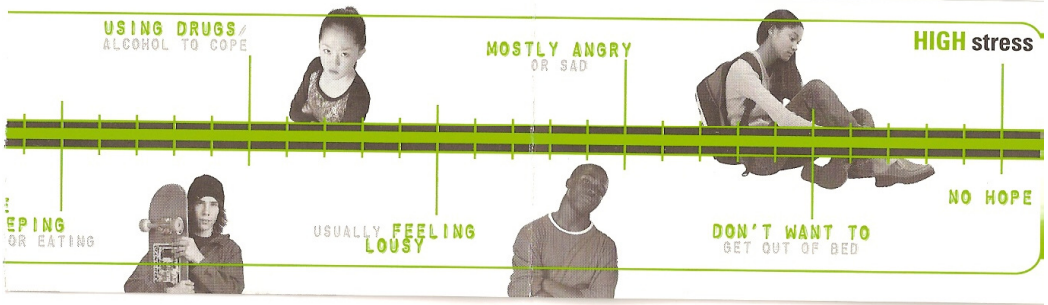
1-800-SUICIDE
1-800-784-2433

SIGNALS OF SUICIDE

A person who is suicidal feels trapped, hopeless and alone. They feel their only choice is to die by suicide. Some possible signs are:

- **Changes in Behaviour**
  increased use of alcohol or other drugs; increased or decreased sleeping or eating; decreased self-care



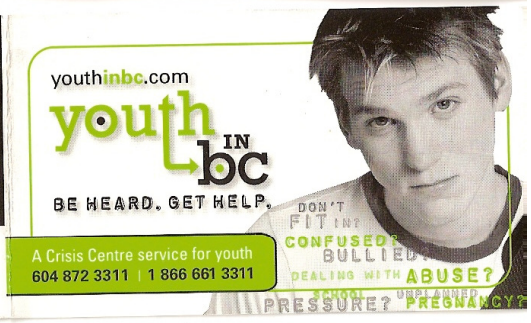


It's ok and possible to reach out for support. There are a lot of trustworthy people who want to help. If you aren't comfortable talking to anyone you know personally, get in touch with us!

- Chat live with a trained volunteer between 2pm-midnight
- Email us anytime you need to (we'll respond within 48 hours)
- Call our Distress Line 24-hours a day
- All our services are private and confidential.

CrisisCentre

Web: www.YouthInBC.com
Email: youthinbc@crisiscentre.bc.ca
Distress Line: 604.872.3311 or 1.866.661.3311



What does it mean to be in crisis or distress?

A person might feel	A person might think	A person's behaviour might change
• overwhelmed	• i can't take it anymore	• sleeping more or less
• depressed	• i'm a failure	• eating more or less
• agitated	• nobody can help me	• getting angry more quickly
• exhausted	• i'm going crazy	• misusing drugs and/ or alcohol
• scared	• i'm all alone	• crying easily
• confused		• thinking the same thoughts over and over
• alone		

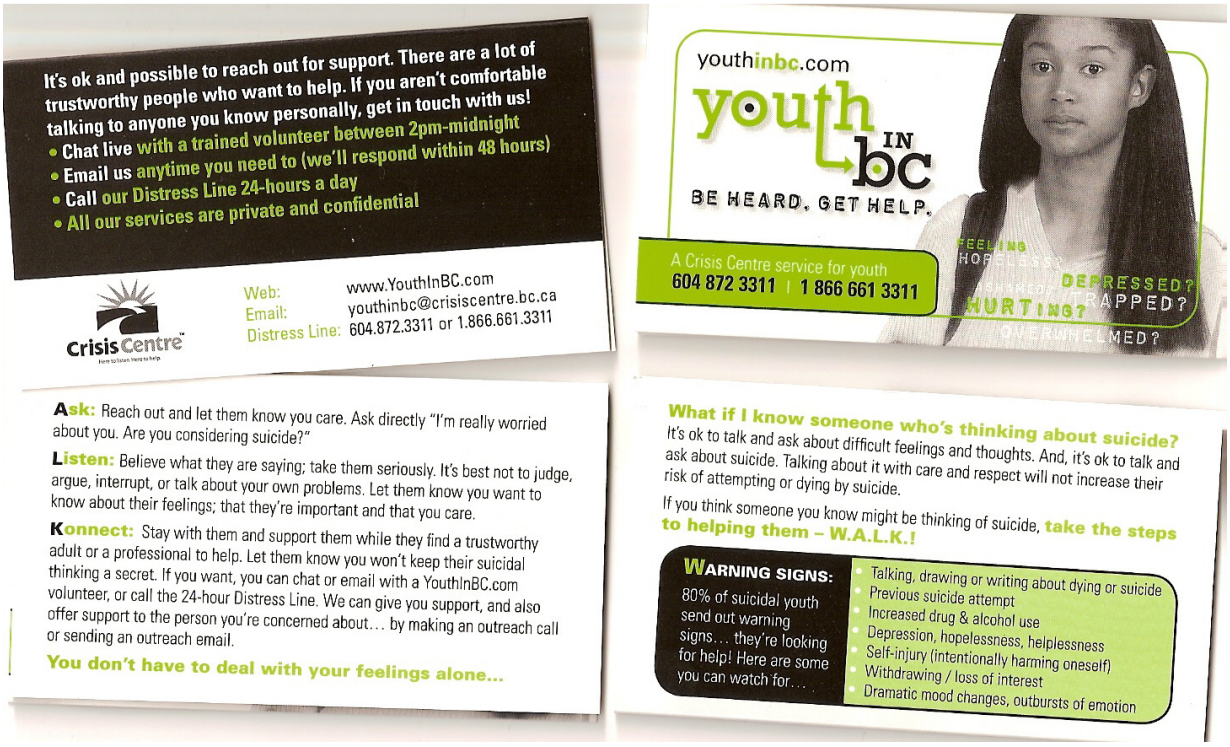
What Can I do if I'm in Crisis or Distress?

Talk to someone: a friend, family member, counsellor or someone else you can trust. You can also contact YouthInBC.com or the Distress Line.

Remember self care: be good to yourself! Get lots of rest; eat healthy meals & snacks, exercise, and do things you enjoy!

Think of your successes: Is there anything you could do now that has helped you cope in the past?

Take one step at a time: Wait until your emotions are less intense and your thoughts are clearer. Plan what you can do to make things better for yourself and take action little by little.



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CrisisCentre

Web: www.YouthInBC.com
Email: youthinbc@crisiscentre.bc.ca
Distress Line: 604.872.3311 or 1.866.661.3311

youthinbc.com

youth IN bc

BE HEARD. GET HELP.

A Crisis Centre service for youth
604 872 3311 | 1 866 661 3311

FEELING HOPELESS? ASHAMED? DEPRESSED? TRAPPED? HURTING? OVERWHELMED?

Ask: Reach out and let them know you care. Ask directly "I'm really worried about you. Are you considering suicide?"

Listen: Believe what they are saying; take them seriously. It's best not to judge, argue, interrupt, or talk about your own problems. Let them know you want to know about their feelings; that they're important and that you care.

Konnect: Stay with them and support them while they find a trustworthy adult or a professional to help. Let them know you won't keep their suicidal thinking a secret. If you want, you can chat or email with a YouthInBC.com volunteer, or call the 24-hour Distress Line. We can give you support, and also offer support to the person you're concerned about… by making an outreach call or sending an outreach email.

You don't have to deal with your feelings alone...

What if I know someone who's thinking about suicide?

It's ok to talk and ask about difficult feelings and thoughts. And, it's ok to talk and ask about suicide. Talking about it with care and respect will not increase their risk of attempting or dying by suicide.

If you think someone you know might be thinking of suicide, **take the steps to helping them – W.A.L.K.!**

WARNING SIGNS:

80% of suicidal youth send out warning signs… they're looking for help! Here are some you can watch for…

- Talking, drawing or writing about dying or suicide
- Previous suicide attempt
- Increased drug & alcohol use
- Depression, hopelessness, helplessness
- Self-injury (intentionally harming oneself)
- Withdrawing / loss of interest
- Dramatic mood changes, outbursts of emotion

MOOD DISORDERS ASSOCIATION
of British Columbia (MDA)

SERVICES *and* RESOURCES DIRECTORY

For the Punjabi-speaking Community in Metro Vancouver

May 2008

MDA
MOOD DISORDERS ASSOCIATION OF BRITISH COLUMBIA

BC Partners for Mental Health and Addictions Information
EMPOWERMENT THROUGH INFORMATION

MOOD DISORDERS ASSOCIATION
of British Columbia (MDA)

ਮੂਡ ਡਿਸਆਰਡਰ ਏਸੋਸੀਏਸ਼ਨ ਆਫ ਬ੍ਰਿਟਿਸ਼ ਕੋਲੰਬੀਆ

Mood Disorders Association of British Columbia
Mission

To provide support and education for people with a mood disorder, their families and friends, as we build an understanding community.

The Mood Disorders Association of British Columbia has a vision of seeing people with a mood disorder living a healthy and active life.

Goals

- Provide support and friendship for those with the illness, their family and friends
- Educate the community - providing information and sharing experiences about mood disorders
- Encourage the development of effective self-help models
- Encourage research into mood disorders and self-help models
- Encourage the development of resources and services necessary for recovery
- Link with national and international mood disorder associations
- Reduce the sense of disgrace experienced by people with mood disorders

For more information contact Mood Disorders Association at 604-873-0103. If you would like to speak with someone in Punjabi or Hindi, you can leave your name and number with the reception and you will contacted you as soon as possible.

ਵਧੇਰੇ ਜਾਣਕਾਰੀ ਲਈ ਮੂਡ ਡਿਸਆਰਡਰ ਏਸੋਸੀਏਸ਼ਨ ਨਾਲ ਸੰਪਰਕ ਕਰੋ 604-873-0103। ਪੰਜਾਬੀ ਜਾਂ ਹਿੰਦੀ ਵਿਚ ਜਾਣਕਾਰੀ ਲੈਣ ਲਈ ਆਪਣਾ ਨਾਂ ਅਤੇ ਨੰਬਰ ਰੀਸੈਪਸ਼ਨ ਨੂੰ ਲਿਖਾ ਦਿਓ; ਛੇਤੀ ਹੀ ਤੁਹਾਨੂੰ ਵਾਪਸ ਫੋਨ ਕੀਤਾ ਜਾਵੇਗਾ

Mood Disorders Association of British Columbia (MDA)

Address
202 - 2250 Commercial Drive
Vancouver, B.C., V5N 5P9
Phone: 604-873-0103
Fax: 604-873-3095
E-Mail: info@mdabc.net
Website: www.mdabc.ca

Mood Disorders Association of BC
Services and Resources Directory for Punjabi-Speaking Community

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The information in the Directory has been prepared from the best information available at the time. Please contact Mood Disorders of British Columbia (MDA) if you wish to add, update or remove your contact information from this Directory.

Publications Translated in Punjabi and Available Online

Anxiety and Stress

Anxiety
ਬੇਚੈਨੀ ਦੇ ਵਿਗਾੜ **Anxiety Disorders** http://heretohelp.bc.ca/sites/default/files/images/punjabi_anx.pdf
BC Partners for Mental Health and Addictions Information
Website www.heretohelp.bc.ca

Stress
ਸਦਮੇ-ਪਿੱਛੋਂ ਸਟਰੈਸ ਦਾ ਵਿਗਾੜ **Post-traumatic Stress Disorder** http://heretohelp.bc.ca/sites/default/files/images/punjabi_ptsd.pdf
BC Partners for Mental Health and Addictions Information
Website www.heretohelp.bc.ca

Depression and Other Mood Disorders

Depression
ਉਦਾਸੀ-ਰੋਗ **Depression** http://heretohelp.bc.ca/sites/default/files/images/punjabi_dep.pdf ਜਣੇਪੇ-ਪਿੱਛੋਂ ਦਾ ਉਦਾਸੀ-ਰੋਗ **Postpartum Depression** http://heretohelp.bc.ca/sites/default/files/images/punjabi_partum.pdf
BC Partners for Mental Health and Addictions Information
Website www.heretohelp.bc.ca

Mental Disorders (Schizophrenia and Psychosis)

Mental Disorders
ਮਾਨਸਿਕ ਵਿਗਾੜ ਕੀ ਹਨ? **What are Mental Disorders**? http://heretohelp.bc.ca/sites/default/files/images/punjabi_whatmd.pdf
ਮਾਨਸਿਕ ਵਿਗਾੜ: ਪਰਿਵਾਰ ਅਤੇ ਦੋਸਤ ਸਹਾਇਤਾ ਕਰਨ ਲਈ ਕੀ ਕਰ ਸਕਦੇ ਹਨ? **Mental Disorders: What Families and Friends Can Do to Help** http://heretohelp.bc.ca/sites/default/files/images/punjabi_families.pdf
ਮਾਨਸਿਕ ਵਿਗਾੜ ਵਾਸਤੇ ਸਹਾਇਤਾ ਲੈਣੀ **Getting Help for Mental Disorders** http://heretohelp.bc.ca/sites/default/files/images/punjabi_gettinghelp.pdf
ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ **Schizophrenia** http://www.bcss.org/a_documents/pdf/multilingual/FactSheetPunj.pdf
ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ ਬਾਰੇ ਸਹੀ ਤੱਥ: Facts About Schizophrenia
ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ ਦੇ ਲਛਣ: Symptoms of Schizophrenia
ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ ਕਿਉਂ ਹੁੰਦਾ ਹੈ?: What Causes Schizophrenia?
ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ ਦੇ ਰੋਗ ਦਾ ਇਲਾਜ ਕਿਵੇਂ ਹੁੰਦਾ ਹੈ? How is Schizophrenia Treated?
ਦਵਾਈ ਬਾਰੇ ਆਧੁਨਿਕ ਜਾਣਕਾਰੀ: Medication Update
ਕੁਝ ਸਵਾਲ ਜਿਹੜੇ ਸਾਈਕਿਐਟਰਿਸਟ ਤੋਂ ਪੁੱਛ ਸਕਦੇ ਹੋ: Questions to Ask the Psychiatrist
ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ ਦਾ ਪਰਿਵਾਰ ਤੇ ਕੀ ਅਸਰ ਹੁੰਦਾ ਹੈ?: How Schizophrenia Affects Families
ਪਰਿਵਾਰ ਕਿਵੇਂ ਸਹਾਈ ਹੋ ਸਕਦਾ ਹੈ: How Families Can Help
ਸਾਈਕੋਸਿਸ ਰੋਗ ਕੀ ਹੈ?: What is Psychosis?
ਨਸ਼ੇ (ਡਰਾਗਾਂ), ਸ਼ਰਾਬ ਅਤੇ ਸਕਿਟਜ਼ੋਫਰੀਨੀਆ: **Drugs, Alcohol and Schizophrenia**

BC Partners for Mental Health and Addictions Information	
Website	http://heretohelp.bc.ca/other-languages#punjabi

Psychosis

ਨਿਭਾਅ ਕਰਨਾ: ਜਦ ਪਰਿਵਾਰ ਦੇ ਕਿਸੇ ਮੈਂਬਰ ਨੂੰ ਸਾਈਕੋਸਿਸ ਹੋਵੇ
EPI Family Coping Booklet: Information on how to cope with a loved one experiencing episodes of psychosis.
http://www.psychosissucks.ca/epi/pdf/trans/02-EPI-Coping_Booklet_Punjabi.pdf

ਸਾਈਕੋਸਿਸ ਰੋਗ ਕੀ ਹੈ?
http://www.psychosissucks.ca/epi/pdf/trans/03-What_is_Psychosis-3_col.pdf

ਸਾਈਕੋਸਿਸ ਰੋਗ ਦੇ ਕਾਰਨ
Causes of Psychosis
http://www.psychosissucks.ca/epi/pdf/trans/04-Causes_of_Psychosis_3_col.pdf

ਡ੍ਰਗਜ਼ (ਨਸ਼ੇ) ਅਤੇ ਸ਼ਰਾਬ
Drugs and Alcohol: Speaks about the relationship of drugs and alcohol to psychosis
http://www.psychosissucks.ca/epi/pdf/trans/05-Drugs_And_Alcohol-3_Col.pdf

ਅਗੇਤਾ ਉਪਾਅ
Early Intervention: A flyer regarding the benefits of early intervention and how it relates to long-term treatment.
http://www.psychosissucks.ca/epi/pdf/trans/06-Early_Intervention-3_col.pdf

ਟੀਚੇ ਮਿਥਣਾ
Goal Setting: How to improve your quality of life through goal setting
http://www.psychosissucks.ca/epi/pdf/trans/07-Goal_Setting-3_col.pdf

ਜੀਵਨ-ਢੰਗ
Lifestyles: An outline of how your quality of life can be improved through lifestyle choices.
http://www.psychosissucks.ca/epi/pdf/trans/08-Lifestyle-3_col.pdf

ਦਵਾਈ
Medication: A guide to medications used in the early treatment of psychosis.
http://www.psychosissucks.ca/epi/pdf/trans/09-Medication-3_col.pdf

ਲੰਮੇ ਸਮੇਂ ਤਕ ਰਹਿਣ ਵਾਲੇ ਲਛਣ (ਨਿਰੰਤਰ ਲੱਛਣ)
Persistent Symptoms: What to do if you continue to experience persistent symptoms
http://www.psychosissucks.ca/epi/pdf/trans/10-Persistent_Symptoms-3_col.pdf

ਸਮੱਸਿਆ ਹੱਲ ਕਰਨੀ
Problem Solving: A guide on strategies to assist in problem solving.
http://www.psychosissucks.ca/epi/pdf/trans/11-Problem_Solving-3_col.pdf

Psychosis (continued)
ਮਨੋ-ਸਮਾਜੀ ਉਪਾਅ **Psychosocial Treatments:** A guide to different methods of treatment http://www.psychosissucks.ca/epi/pdf/trans/12-Psychosocial_Treatments-3_col.pdf
ਰੀਲੈਪਸ ਦੀ ਰੋਕਥਾਮ (ਮੁੜ ਰੋਗੀ ਹੋਣ ਤੋਂ ਬਚਣਾ) **Relapse Prevention** http://www.psychosissucks.ca/epi/pdf/trans/13-Relapse_Prevention-3_col.pdf
ਮੁੜ ਰੋਗੀ ਹੋਣ ਤੋਂ ਬਚਣ ਦੀ ਪਲੈਨ **Relapse Prevention Planning:** A relapse prevention worksheet. http://www.psychosissucks.ca/epi/pdf/trans/14-Relapse_Prevention_Plan-1_col.pdf
ਸਮਾਜੀ ਸਹਾਰੇ: ਤੁਹਾਡੇ ਸਮਾਜੀ ਰਿਸ਼ਤੇ ਤੇ ਸਮਾਜੀ ਮੇਲ-ਮਿਲਾਪ **Social Support:** How your social support network affects treatment. http://www.psychosissucks.ca/epi/pdf/trans/15-Social_Supports-3_col.pdf
ਤਣਾਅ ਤੇ ਕਾਬੂ ਰੱਖਣਾ: ਹਿੱਸਾ ਪਹਿਲਾ **Stress Management Part 1:** Stress and how it relates to Psychosis. Some strategies to deal with stress. http://www.psychosissucks.ca/epi/pdf/trans/16-Stress_management_Part_1-3_col.pdf
ਤਣਾਅ ਤੇ ਕਾਬੂ ਰਖਣਾ: ਹਿੱਸਾ ਦੂਜਾ **Stress Management Part 2:** More strategies to help with stress. http://www.psychosissucks.ca/epi/pdf/trans/17-Stress_Management_Part_2-3_col.pdf
Fraser Health: Fraser South Early Psychosis Intervention (EPI) Program
Website http://www.psychosissucks.ca/epi/
ਸਾਈਕੋਸਿਸ ਦੀ ਸ਼ੁਰੂ ਵਿਚ ਪਛਾਣ ਕਰਨ ਬਾਰੇ ਮੁਢਲੀ ਜਾਣਕਾਰੀ **Early Identification of Psychosis: *A Primer*** http://www.mheccu.ubc.ca/documents/publications/GPPrimer_Punjabi.pdf
ਸਵੈ-ਸੰਭਾਲ ਡਿਪਰੈਸ਼ਨ ਪ੍ਰੋਗਰਾਮ: ਪੇਸ਼ੈਂਟ ਗਾਈਡ **Self-help Depression Program: Patient Guide** http://www.carmha.ca/publications/resources/asw/SCDP-Punjabi.pdf
Centre for Applied Research in Mental Health and Addiction (CARMHA)

Appendix D (cont'd)

Website	http://www.carmha.ca/

Miscellaneous

ਆਤਮਘਾਤ: ਖ਼ਤਰੇ ਦੇ ਚਿੰਨ੍ਹਾ ਦੀ ਪੈਰਵੀ ਕਰੋ
Suicide: Follow the Warning Signs
http://heretohelp.bc.ca/sites/default/files/images/punjabi_suicide.pdf

ਅਮਲ ਕੀ ਹੈ?
What is Addiction?
http://heretohelp.bc.ca/sites/default/files/images/punjabi_whatad.pdf

ਕਮਿਊਨਿਟੀ ਚਾਇਲਡ ਐਂਡ ਯੂਥ ਮੈਂਟਲ ਹੈਲਥ ਸਰਵਿਸਿਜ਼ ਤੋਂ ਕੀ ਉਮੀਦ ਰੱਖੀਏ
What to Expect From Community Child & Youth Mental Health Services
http://heretohelp.bc.ca/sites/default/files/images/cymh_community_punjabi.pdf

ਬੱਚਿਆਂ ਦੀ ਮਾਨਸਿਕ ਸਿਹਤ ਦੇ ਸੰਬੰਧ ਵਿੱਚ ਆਪਣੇ ਬੱਚੇ ਦੇ ਸਕੂਲ ਤੋਂ ਕੀ ਉਮੀਦ ਰੱਖੀਏ
What to Expect From Your Child's School in Children's Mental Health
http://heretohelp.bc.ca/sites/default/files/images/cymh_school_punjabi.pdf

ਬੱਚਿਆਂ ਦੀ ਮਾਨਸਿਕ ਸਿਹਤ ਦੇ ਮਾਮਲੇ ਵਿੱਚ ਆਪਣੇ ਪਰਿਵਾਰਕ ਡਾਕਟਰ ਤੋਂ ਕੀ ਉਮੀਦ ਰੱਖੀਏ
What to Expect From Your Family Physician in Children's Mental Health
http://heretohelp.bc.ca/sites/default/files/images/cymh_physician_punjabi.pdf

ਜਵਾਨੀ ਅਤੇ ਨਸ਼ੀਲੇ ਪਦਾਰਥਾਂ ਦੀ ਵਰਤੋਂ
Youth and substance abuse
http://heretohelp.bc.ca/sites/default/files/images/punjabi_ysubstance.pdf

BC Partners for Mental Health and Addictions Information	
Website	http://heretohelp.bc.ca/

Miscellaneous (continued)

ਮਾਨਸਿਕ ਸਿਹਤ ਅਤੇ ਮਾਨਸਿਕ ਸਿਹਤ ਸੰਬੰਧਤ ਸਮੱਸਿਆਵਾਂ ਬਾਰੇ (ਤੱਥ ਪੱਤਰ):
ਮਾਨਸਿਕ ਸਿਹਤ ਕਿਸ ਨੂੰ ਕਹਿੰਦੇ ਹਨ?; ਮਾਨਸਿਕ ਸਿਹਤ ਸਮੱਸਿਆਵਾਂ ਦੇ ਕੀ ਕਾਰਣ ਹੈ ਸਕਦੇ ਹਨ?; ਮਾਨਸਿਕ ਸਿਹਤ ਸਮੱਸਿਆਵਾਂ ਦੀਆਂ ਕਿਸਮਾਂ; ਜ਼ਿਆਦਾ ਜਾਣਕਾਰੀ ਜਾਂ ਸਹਾਇਤਾ ਕਿੱਥੇ ਲਈ ਜਾਵੇ:

About mental health (fact sheet)
What is mental health; What contributes to mental health problems; Types of mental health problems; Where to get help?
http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/punjabi_about_mentalhealth.pdf

ਤੱਥ ਪੱਤਰ: ਹਾਲਾਤ ਠੀਕ ਨਾਂ ਹੋਣ ਦੀ ਸੂਰਤ ਵਿੱਚ ਸਹਾਇਤਾ ਮੰਗਣਾ
Asking for help when things are not right (Fact Sheet): What is part of the normal reaction to living in a new country; When it is a good idea to ask for help and where.
http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/punjabi_asking_help.pdf

ਆਦਤ ਪੈਣ ਨੂੰ ਸਮਝਣਾ: ਵੈਬ ਆਰਟੀਕਲ
ਆਦਤ ਪੈਣਾ ਕੀ ਹੈ?
Understanding Addiction (Fact Sheet)
What is addiction; What are the signs and symptoms of an addiction; How are family members affected; Will treatment help; When is it necessary to get help; Where to get help.
http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/punjabi_understand_addiction.pdf

ਤਨਾਵ ਨਾਲ ਸਫਲਤਾ ਪੂਰਵਕ ਨਿੱਬੜਨਾਂ (ਤੱਥ ਪੱਤਰ):
Coping with Stress (Fact Sheet)
Tips on dealing with stress; Where to get help
http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/punjabi_coping_stress.pdf

Centre for Addiction and Mental Health	
Website	http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/index.html

Miscellaneous (continued)

ਕੀ ਹਨ ਬਾਲ ਅਤੇ ਨੌਜਵਾਨ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਵਾਂ? **What are Child and Youth Mental Health Services?** http://www.mcf.gov.bc.ca/mental_health/mh_publications/punjabi_cymh_youth.pdf

Ministry of Children and Family Development	
Website	http://www.mcf.gov.bc.ca/mental_health/mh_publications/cymh_youth_brochure.pdf

Mental Health Services for Punjabi and Hindi-Speaking Community in Metro Vancouver and Fraser Valley

Mood Disorders Association of British Columbia (MDA)		
Address	202 - 2250 Commercial Drive, Vancouver, BC, V5N 5P9	
Program	Punjabi-speaking Support Groups for Men and Women	
Service Provider	Dr. Rajpal Singh (Psychologist)	**Phone:** 604.875.0103
Description Provides support groups and information meetings for people living with depression or bipolar mood disorders, and for their families and friends including: - Punjabi-speaking Support Group for Men and Their Family Members: Group meets Sunday evenings from @ 6.30PM - 8:00 PM on Sunday evenings @ Diverse*City* Community Resources Society, located at #1113-7330, 137 Street, Surrey, BC. - Punjabi-speaking Support Group for Women and Their Family Members: Group meets Sunday evenings from @ 4:30PM - 6:00 PM @ Diverse*City* Community Resources Society, located at #1113-7330, 137 Street, Surrey, BC.		
Language(s)	Punjabi	

Fraser Health: Burnaby Mental Health and Addictions	
Address	#2-4603 Kingsway, Burnaby, BC, V5H 4M4
Program	Community Mental Health & Addictions Liaison (MEIA/FHA)
Service Provider	Kala Singh (MBBS): Clinician
Phone	604 664 0139
Language(s)	Punjabi, Hindi, Urdu

DiverseCity Community Resources Society	
Address	1107-7330 -137th Street, Surrey, BC
Program	Child and Youth Mental Health Program
Service Provider	Nidhi Sharma: Child and Youth Mental Health Therapist
Phone	604.597.0205 – Local 280
Description The Child and Youth Mental Health Program provides: ▪ Professional counselling services to children and youth (from immigrant and refugee families) experiencing mental health issues through individual, family and group therapy. Issues dealt with are varied and include: depression, anxiety, suicide, PTSD, ADHD, and psychosis ▪ Outreach and education services to immigrant communities with the hope of raising awareness and increasing knowledge regarding mental illness as it pertains to children and adolescents. Topics addressed include: warning signs and symptoms and early detection of illness, dispelling myths, dealing with shame, client and his/her family's right to access medical and counselling services ▪ Short-term counselling and support to clients and makes subsequent referrals to Child and Youth Mental Health teams for long-term counselling.	
Language(s)	Punjabi, Hindi, Urdu

Abbotsford Addiction Centre (Multicultural Services)		
Address	Abbotsford Addiction Centre, 2420 Montrose Avenue, Abbotsford, BC	Phone: 604.850.5106
Program	Addiction counselling and referral services	
Service Provider	Multicultural Therapist Dalbir Randhawa	Phone 604.850-5106: Ext.: 500
Description A Punjabi-speaking therapist ○ Provides addictions counselling and referral services to drug and alcohol users and affected family members ○ Facilitates a support group for South Asian men in recovery (the support group meets every week on Wednesdays from 6p.m. to 7:30 p.m.) ○ Makes appropriate referrals to a Treatment Center. No referrals are needed for these services. Services are FREE and provided in a confidential and safe environment. Individuals interested in the above services must attend an orientation session held on Thursday at 4:00pm at the Addiction Centre.		
Program	Multicultural School Based Prevention Program	
Service Provider	Devinder Dherari-Sidhu	**Phone:** 604.850.5106: Ext.: #224 604. 613.1557
Description A multicultural Prevention Worker provides education and support to local middle and high school youth around about substance use.		
Language(s)	English, Punjabi and Hindi	

Progressive Intercultural Community Services Society (PICS)		
Address	Surrey Settlement Office #211, 8556 – 120 Street, Surrey	**Phone:** 604.596.7525
Program	Drug & Alcohol Counselling Services	
Service Provider	Maninder Bajwa	**Cell #:** 778.996.6250
Description PICS culturally sensitive and appropriate counselling services assist individuals to deal with anger, conflict, drug and/or alcohol dependency. A Certified Counsellor provides anger management, conflict resolution, and addictions counselling (fee for service) to alcohol/drug addicts and their family members. A bio-psycho-social-spiritual, client centered, and holistic approach is used to enable the Counsellor to deal with other troublesome aspects of the individual's life. The counsellor encourages the 12-Step Program with prevention through education and anger management workshops. This program also includes a thorough follow-up and after care program. Services are provided to everyone irrespective of age and financial and cultural background.		
Language(s)	English, Punjabi and Hindi	

Punjabi and Hindi-speaking Psychiatrists in Metro Vancouver and Fraser Valley

Abbotsford

No.	Name	Address	Telephone	Language(s)
1	**Dr. Sidhu** Paramjit K.	2309 McCallum Road, Abbotsford, BC	604.854.2001	Punjabi

Burnaby

No.	Name	Address	Telephone	Language(s)
1	**Dr. Kang** Nirmal S. Geriatrics	**Fraser Health** Burnaby Mental Health & Addiction Services	604.453.1900	Punjabi, Hindi, Urdu
2	**Dr. Rana** Babra Mumtaz	**Kensington Medical Clinic** 6548 Hastings Street Burnaby, BC	604.299.9769	Punjabi, Hindi, Urdu

Coquitlam

No.	Name	Address	Telephone	Language(s)
1	**Dr. Kang** Arvind Geriatrics	Riverview Hospital 2601 Lougheed Highway, Coquitlam, BC	604.524.7174	Punjabi, Hindi, Urdu

Delta

No.	Name	Address	Telephone	Language(s)
1	**Dr. Gandhi** Amita	**Private Practice** 101- 6935 120 Street, Delta, BC	604.599.4373	Hindi, Punjabi

Langley

No.	Name	Address	Telephone	Language(s)
1	**Dr. Pande** Suniti	**Private Practice** 22190 - 48 Avenue, Langley, BC	604 534.8151	Hindi

Maple Ridge

No.	Name	Address	Telephone	Language(s)
1	Dr. Venkataram Gopinath, Hirekatur	**Ridge Meadows Hospital** Maple Ridge, BC **Private Practice** 105-11743 - 224 Street, Maple Ridge, BC	604.467.4042	Hindi

New Westminster

No.	Name	Address	Telephone	Language(s)
1	Dr. Phaterpekar Hem Madhukar	**Royal Columbian Hospital** New Westminster, BC	604.520.4662	Hindi

Richmond

No.	Name	Address	Telephone	Language(s)
1	Dr. Bhopal Jaswant Singh	**Richmond Hospital** Richmond, BC **Private Practice** 160B-8279 Saba Road, Richmond, BC	604.273.6641	Punjabi & Hindi
2	Dr. Katta Balaraju Bhagavan	**Richmond Hospital** Richmond, BC	604 244.5534	Hindi

Surrey

No.	Name	Address	Telephone	Language(s)
1	**Dr. Harrad** Upninderjit Singh	**Private Practice** #201, 7110-120th Street, Surrey, BC	604.592.6660	Punjabi, Hindi
2	**Dr. Harinath** Mallavarappu	**Private Practice** #207-13710 - 94A Avenue, Surrey	604.581.0576	Hindi, Telugu
3	**Dr. Lamba** Rakesh	**Private Practice** 10022 King George Hwy, Surrey, BC	604.586.4048	Punjabi, Hindi
4	**Dr. Manjunath** Chinnapalli Veeraiah	**Surrey Memorial Hospital** (Kensington Building) 13750-96 Ave., Surrey, BC	604.585.5666 Ext. 8720	Hindi, Kannada, Tamil, Telugu
5	**Dr. Narang** Satinder Pal Singh	**Surrey Memorial Hospital,** Surrey, BC **Private Practice** 301-9656 King George Highway, Surrey, BC	604.581.2003	Punjabi, Hindi, Urdu
6	**Dr. Pole** Chakrabarty L.	**Private Practice** 108-14914 104 Avenue, Surrey, BC	604.589.2426	Hindi
7	**Dr. Sandhu** Jatinder Singh	**Private Practice** 201-7110-120th Street, Surrey	604.572.0195	Punjabi & Hindi

Vancouver

No.	Name	Address	Telephone	Language(s)
1	**Dr. Jokhani** Veena ADHD: Child & Adolescent Psychiatry	**Children's & Women's Health Centre** 4500 Oak Street, Vancouver, BC	604.875.2424	Punjabi, Hindi
2	**Dr. Kang** Shimi Addictions	**BC Women and Children's Hospital** Vancouver, BC	604.875.2025	Punjabi
3	**Dr. Madhani** Kurban Jafferali	1503-805 Broadway W. Vancouver, BC	604.879.1503	Hindi
4	**Dr. Misri** Shaila (SR) Reproductive Psychiatry	**St Paul's Hospital & BC Women and Children's Hospital** Vancouver, BC	604 806-8589	Hindi
5	**Dr. Raina** Raj. B.	**Cross-cultural Outpatient Clinic** Vancouver General Hospital, BC	604 875.4115	Punjabi, Hindi, Urdu
6	**Dr. Randhawa** Ramandeep Singh Sleep &Anxiety Disorders	**University Hospital (UBC)** Koerner Pavilion, Vancouver, BC	604.733.2329	Punjabi
7	**Dr. Riar** Kulwant Forensic Psychiatry	**Private Practice** 305 -1245 West Broadway, Vancouver, BC	604 733-5722	Punjabi
8	**Dr. Singh** Kulbir Indar	**Vancouver General Hospital** Vancouver, BC	604.875.4634	Punjabi

Punjabi and Hindi-Speaking Psychologists in Metro Vancouver and Fraser Valley

Delta

No.	Name	Address	Telephone	Language(s)
1	**Dr. Sidhu** Kamaljit Adults, Adolescents, Children	Suite 205 – 6905 - 120 Street Delta, BC	604.502.7175	Punjabi, Hindi

Port Coquitlam

No.	Name	Address	Telephone	Language(s)
1	**Dr. Sohi** Bali K Adult & Geriatric Psychotherapy	2300 - 2850 Shaughnessy Street Port Coquitlam, BC	604.552.4368	Punjabi, Hindi

Surrey

No.	Name	Address	Telephone	Language(s)
1	**Dr. Shergill** Amritpal	Suite 286 - 8128 - 128 Street Surrey, BC	604.597.8330 604 603.4745	Punjabi
2	**Dr. Thinda** Sundeep Clinician	**Back in Motion** 206 - 5500 - 152nd Street (Executive Plaza Hotel), Surrey, BC	604.575.2262	Punjabi

Fraser Health
Mental Health and Addiction Centres

No	Centre	Address	Phone
1	Abbotsford Mental Health Centre	11-32700 Dahlstrom Avenue, Abbotsford, BC	604.870.7800
2	Burnaby Central Mental Health Centre	3935 Kincaid Street Burnaby, BC	604.453.1900
3	Burnaby North Mental Health Centre	206-3900 East Hastings Street, Burnaby, BC	604.949.7730
4	Burnaby South Mental Health Centre	320-7155 Kingsway, Burnaby, BC	604.777.6870
5	Chilliwack Mental Health Centre	45470 Menholm Road Chilliwack, BC	604.702.4860
6	Delta Mental Health Centre - North	129 - 6345 120th Street, Delta, BC	604.592.3700
7	Delta Mental Health Centre - South	15-1835 56 Street Delta, BC	604.948.7010
8	Fraser Valley/West Coast Mental Health Support Teams	207-2248 Elgin Avenue, Port Coquitlam	604.777.8475
9	Hope Mental Health Centre	1275A-7th Avenue, Hope	604.860.7733
10	Langley Mental Health Centre	305-20300 Fraser Highway, Langley	604.514.7940
11	Maple Ridge Mental Health Centre	500-22470 Dewdney Trunk Road, Maple Ridge	604.476.7165
12	Mission Mental Health Centre	101-33070 5th Avenue, Mission	604.814.5600
13	New Westminster Mental Health Centre	2nd Floor 403 Sixth Street, New Westminster	604.777.6800
14	Surrey Mental Health & Addictions	#1100 13401 108th Avenue, Surrey	604.953.4900
15	Tri-Cities Mental Health Centre	1-2232 Elgin Avenue, Port Coquitlam	604.777.8400
16	White Rock/South Surrey Mental Health & Addictions	Peace Arch Hospital, Russell Unit, 15521 Russell Avenue, White Rock	604.541.6844

Fraser Health	
Website	http://www.fraserhealth.ca/Services/MentalHealthandAddictions/Pages/MentalHealthCentres.aspx

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Vancouver Coastal Health
Mental Health Teams

No.	Mental Health Team	Address	Telephone
1	Grandview Woodlands Mental Health Team	300-2250 Commercial Dr. Vancouver, BC V5N 5P9	604.251.2264
2	Kitsilano Mental Health Team	400-1212 West. Broadway Vancouver, BC V6H 3V1	604.736.2881
3	Midtown Mental Health Team	3rd Floor – 2450 Ontario Street, Vancouver, BC V5T 4T7	604.872.8441
4	Northeast Mental Health Team	2610 Victoria Drive Vancouver, BC V5N 4L2	604.253.5353
5	South Mental Health Team	220-1200 West 73rd Avenue Vancouver, BC V6P 6G5	604.266.6124
6	Strathcona Mental Health Team	330 Heatley Avenue Vancouver, BC V6A 3G3	604.253.4401
7	West End Mental Health Team	1555 Robson Street Vancouver, BC V6G 1C3	604.687.7994
8	West End Geriatrics	1555 Robson Street Vancouver, BC V6G 1C3	604.688.0738
9	West Side Mental Health Team	200-4088 Cambie Street Vancouver, BC V5Z 2X8	604.873.6733
Vancouver Coastal Health: Vancouver Community Mental Health			
Website	http://www.mcf.gov.bc.ca/mental_health/mh_publications/cymh_youth_brochure.pdf		

This Directory is a product of the Mood Disorders Association's Punjabi- Speaking Community Outreach Project Winter/Spring 2008. The intention of this directory is to give service-providers resources and information for their Punjabi-speaking clients and patients.

If you are aware of any resources and services that should be listed in this Directory, please forward your information to mdabc@telus.net

This Directory was made possible through project funding provided by:
The Provincial Health Services Authority (PHSA)
4500 Oak Street, Room C3, Box 104
Vancouver, BC
V6H 3N1

Mood Disorders Association of British Columbia (MDA)
202 - 2250 Commercial Drive
Vancouver, BC,
V5N 5P9

Appendix E

Demographic Survey for South Asian Mental Health Therapists and Medical Professionals.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4
Tel: 604-822-6380 Fax: 604-822-2328
richard.young@ubc.ca

Demographic Survey for South Asian Mental Health Therapists and Medical Professionals.

Date of Interview: _____
Time of Interview: _____
Place of Interview: _____
Interviewee: _____

1. Gender: Male _____ Female _____

2. Age: _____

3. Place of birth: _____

4. Position held within the medical community: _____

5. Number of years in practice: _____

2/12/2009

1 of 1

Appendix F

Interview Questions for South Asian Mental Health Therapists and Medical Professionals.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4
Tel: 604-822-6380 Fax: 604-822-2328
richard.young@ubc.ca

Interview Questions for South Asian Mental Health Therapists and Medical Professionals.

Date of Interview: _____
Time of Interview: _____
Place of Interview: _____
Interviewee: _____

1. In your experience have you dealt with the Punjabi Sikh community in regards to suicide and suicide related behaviours?

2. Have you had experience with first generation Canadian Punjabi Sikh parents whose adolescent children are exhibiting suicide related behaviours?

3. In your experience, how do first generation Canadian Punjabi Sikh parents respond to their adolescent's suicide and/or suicide related behaviours?

4. In your experience, what have the first generation Canadian Punjabi Sikh parents perceived to be the causes of the suicide and/or suicide related behaviours?

5. In your experience, what is the willingness of first generation Canadian Punjabi Sikh parents to engage mental health services?

6. What were the successful interventions utilized in response to suicide related behaviours in adolescents of first generation Canadian Punjabi Sikh parents?

7. In your experience, how does the Punjabi culture and Sikh religion factor into the views of suicide and suicide related behaviours held by first generation Canadian Punjabi Sikh parents, if at all?

2/12/2009

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

8. In your experience, have first generation Canadian Punjabi Sikh parents refused mental health intervention for their adolescent who is experiencing suicide related behaviours? What methods of treatment did they choose instead, if any?

9. As a mental health practitioner (medical professional), what are the ways in which the medical community could improve services to better meet the needs of first generation Punjabi Sikh parents who are raising adolescent children?

10. In your experience, what are the barriers to accessing mental health services for first generation Canadian Punjabi Sikh parents, if any?

11. Please take a look at a summary of interviews conducted with first generation Canadian Punjabi Sikh parents and comment on whether or not you believe it accurately reflects your experience of working with this population.

Appendix G

Interview Questions for the Punjabi Sikh Community Leader.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380 Fax: 604-822-2328
richard.young@ubc.ca

Interview Questions for the Punjabi Sikh Community Leader.

Date of Interview: _____
Time of Interview: _____
Place of Interview: _____
Interviewee(s): _____

1. What are the Punjabi cultural beliefs of suicide and suicide related behaviours?

2. What are the Sikh religious beliefs of suicide and suicide related behaviours?

3. According to the Punjabi culture what are the consequences of suicide and suicide related behaviours?

4. According to the Sikh religion what are the consequences of suicide and suicide related behaviours?

5. How do the Punjabi culture and Sikh religion merge to form the Punjabi Sikh community view of suicide and suicide related behaviours?

6. What is the Punjabi Sikh view of mental health?

7. What is the likelihood of the Punjabi Sikh community to access mental health services? Why or why not?

8. What is the likelihood of Punjabi Sikh parents to access mental health services for their adolescent children? Why or why not?

9. What are the perceived barriers/obstacles to accessing or utilizing mental health services from a Punjabi Sikh perspective?

10. What can be done to better meet the mental health needs of the Punjabi Sikh community?

2/12/2009

Appendix H

Email Message.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380 Fax: 604-822-2328

richard.young@ubc.ca

Message To Be Sent Via Email

Subject Line: Participants Required for Study of Punjabi Sikh Beliefs

Message: Dear CNPS students,

Research participants are being sought for a study entitled *Punjabi Sikh Parent's Beliefs of Suicide and Suicide Related Behaviours*. The study requires three to five first generation Punjabi Sikh parents of adolescents, three to five second generation Punjabi Sikh young adults between the ages of 19 and 22, and two to three South Asian Mental Health Therapists and Medical Professionals. The data collection will begin in March 2009 and will require participants to participate in two interviews. Please see the letters of invitation for further details.

This study is part of Iqbal Kaur Gill's master's research, supervised by Dr. Richard Young, Professor in Counselling Psychology at UBC, and has been approved by UBC's Behavioural Research Ethics Board. I would appreciate you forwarding this email to those whom you believe may be interested in participating in this study.

Kind Regards,
Miss Iqbal Kaur Gill

1 of 1

2/12/2009

Appendix I

Recruitment Letter – Punjabi Sikh Parents.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

February 11, 2009

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

To Whom It May Concern:

I am an Area Counsellor presently working for a local school district. I am also an M.A. student at the University of British Columbia, in the Faculty of Education, Department of Counselling Psychology and Special Education, preparing my thesis under the supervision of Dr. Richard Young, my thesis advisor.

To fulfill the requirements of my qualitative research, I am seeking 3 to 5 Punjabi Sikh parents willing to participate in an interview for my study of Punjabi Sikh parent's beliefs about suicide and suicide related behaviours. During the interview I will present 2 case studies in which an adolescent did suicide or experienced potentially fatal self harming behaviours. A series of questions will follow each of the case studies. Upon completion of the interview participants will be given information about the mental health services available in the community and the warning signs of suicide. Also, prior to beginning the interview participants will complete a very brief demographic survey. I anticipate the interview to be approximately 1 hour in length. A few weeks after the interview, a second meeting will be scheduled to provide participants an opportunity to offer feedback on the accuracy of a one page summary of the interview. The second meeting is anticipated to be approximately 30 minutes in length. The initial interview and the follow up meeting will take place either at the home of the participant or at the University of British Columbia during the month of March or April 2009. Please note, any and all identifying information regarding participants will be kept completely confidential. Following the defense of my thesis in the summer of 2009, upon request you will receive a copy of the final document with my sincere thanks.

To partake in this study a participant must be:
- First generation Canadian Punjabi Sikh – first generation is defined for the purpose of this study as Punjabi Sikhs who themselves immigrated to Canada from India.
- Parents of children currently between the ages of 13 to 18.
- Fluent in the English language – the interview will be conducted entirely in English.
- Not have experienced a death of a family member or close friend by suicide.

Please contact me via telephone or email if you are willing to participate in this research study. If you know of a potentially interested participant, I would be pleased to contact these individuals directly.

Sincerely,

Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl.Ed., M.A. Student

Appendix J

Recruitment Letter – Punjabi Sikh Young Adults.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

February 11, 2009

To Whom It May Concern:

I am an Area Counsellor presently working for a local school district. I am also an M.A. student at the University of British Columbia, in the Faculty of Education, Department of Counselling Psychology and Special Education, preparing my thesis under the supervision of Dr. Richard Young, my thesis advisor.

To fulfill the requirements of my qualitative research, I am seeking 3 to 5 Punjabi Sikh young adults willing to participate in an interview for my study of Punjabi Sikh parent's beliefs about suicide and suicide related behaviours. During the interview I will present 2 case studies in which an adolescent did suicide or experienced potentially fatal self harming behaviours. A series of questions will follow each of the case studies. Upon completion of the interview participants will be given information about the mental health services available in the community and the warning signs of suicide. Also, prior to beginning the interview participants will complete a very brief demographic survey. I anticipate the interview to be approximately 1 hour in length. A few weeks after the interview, a second meeting will be scheduled to provide participants an opportunity to offer feedback on the accuracy of a one page summary of the interview. The second meeting is anticipated to be approximately 30 minutes in length. The initial interview and the follow up meeting will take place at the University of British Columbia during the months of March or April 2009. Please note, any and all identifying information regarding participants will be kept completely confidential. Following the defense of my thesis in the summer of 2009, upon request you will receive a copy of the final document with my sincere thanks.

To partake in this study a participant must be:
- A second generation Canadian Punjabi Sikh – second generation is defined for the purpose of this study as a young adult who was born in Canada to immigrant parents.
- Born to first generation Canadian Punjabi Sikh parents – first generation is defined for the purpose of this study as those who immigrated to Canada themselves.
- Between the ages of 19 and 22.
- Not have experienced a death of a family member or close friend by suicide.

Please contact me via telephone or email if you are willing to participate in this research study. If you know of a potentially interested participant, I would be pleased to contact these individuals directly.

Sincerely,
Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl.Ed., M.A. Student

Appendix K

Recruitment Letter – South Asian Mental Health Therapists and Medical Professionals.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

February 11, 2009

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

To Whom It May Concern:

I am an Area Counsellor presently working for a local school district. I am also an M.A. student at the University of British Columbia, in the Faculty of Education, Department of Counselling Psychology and Special Education, preparing my thesis under the supervision of Dr. Richard Young, my thesis advisor.

To fulfill the requirements of my qualitative research, I am seeking 2 to 3 South Asian mental health therapists and medical professionals willing to participate in an interview for my study of Punjabi Sikh parent's beliefs about suicide and suicide related behaviours. During the interview I will ask a series of questions in relation to Punjabi Sikh parent's beliefs of suicide and potentially fatal self-harming behaviours based upon the participants' experience of working with the Punjabi Sikh community. Prior to beginning the interview participants will complete a very brief demographic survey. I anticipate the interview to be approximately 1 hour in length. A few weeks after the interview, a second meeting will be scheduled to provide an opportunity for participants to offer feedback on the accuracy of a one page summary of the interview. The second meeting is anticipated to be approximately 30 minutes in length. The initial interview and follow up meeting will take place either at the office of the participant or at the University of British Columbia during the months of March or April 2009. Please note, any and all identifying information regarding your name will be kept completely confidential. Following the defense of my thesis in the summer of 2009, upon request you will receive a copy of the final document with my sincere thanks.

To partake in this study a participant must be:
- Of South Asian background.
- Practicing as a mental health therapist or medical professional (i.e. Pediatrician, General Practitioner and Psychiatrist) for a minimum of 5 years.

Please contact me via telephone (or email (if you are willing to participate in this research study. If you know of a potentially interested participant, I would be pleased to contact these individuals directly.

Sincerely,

Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl.Ed., M.A. Student

Appendix L

Telephone Interview Format for Punjabi Sikh Parents.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380 Fax: 604-822-2328
richard.young@ubc.ca

Telephone Interview Format
Punjabi Sikh Parents

Hello, may I speak to (respondent's name). Hi, my name is Iqbal and I am calling in regards to your email/phone message expressing interest to participate in the study titled, *Punjabi Sikh Parent's Beliefs About Suicide and Suicide Related Behaviours*. I wonder if now would be an appropriate time for me to provide you with details of the study and what participating in this study would look like for you? (If answer yes, continue. If no, ask what would be a better time to call back).

This is a study I am conducting in partial fulfillment of an M.A. through UBC in Counselling Psychology. To give you a better understanding of the study I'd like to start by discussing the purpose of the project. Punjabi Sikhs make up a large portion of the Canadian population, particularly in the Great Vancouver area of B.C., but they are underrepresented in mental health research. So the broad purpose of the study is to address this gap in the literature. Specifically, the intention of this study is to describe the beliefs about suicide and potentially fatal self-harming behaviours held by first generation Canadian Punjabi Sikh parents.

Do you have any questions for me thus far? (If yes, answer questions prior to continuing the conversation. If no, continue with conversation)

I would like to interview 3 to 5 first generation Canadian Punjabi Sikh parents of children who are between the ages of 13 to 18. You may choose to participate alone or you and your husband/wife may choose to do the interview together. The interview would be scheduled for an hour at a time that is convenient for you and I and will take place at your home or at UBC. (Check for understanding).

During the interview I will present two case studies of adolescents who either did suicide or are experiencing suicide related behaviours and a series of questions. By participating in this study you will have an opportunity to assist medical and health professionals to better meet the mental health needs of the Punjabi Sikh community. Do you have any questions for me at this point? (If yes, answer questions prior to continuing the conversation. If no, continue with conversation)

2/12/2009

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Faculty of Education

Talking about suicide can at times be emotional, and if distress about this process is evident I will refer you for appropriate counselling. Also, at the end of our interview I will provide you with information about the mental health services available in your community.

A few weeks after the interview I will schedule a second meeting in which you will be able to offer feedback on the accuracy of a one page summary of the interview. Any information that identifies you will be strictly confidential and any segments of the interview that may be presented in the final paper will not identify you as the speaker. Do you have questions you would like me to address at this point? Are you still interested in participating?

To better determine if you would be an appropriate candidate for this study I'd like to ask you some questions. There are 6 questions and for the most part they only require either a yes or no answer. Are you ready for the 1st question? (If yes, continue with the questions).

1. Are you first generation Canadian Punjabi Sikh? By first generation I mean did you yourself immigrate to Canada?
2. Do you have children who are currently between the ages of 13 and 18?
3. Are you of Punjabi Sikh background?
4. Are you fluent in English? I ask because the interviews will be conducted in English.
5. Have you experienced a death of a family member or close friend by suicide?
6. Do you have children attending an elementary school in Vancouver, if so, which schools are they attending?

If not an appropriate candidate for the study:

Thank you so much for answering the questions. However, unfortunately you do not meet the selection criteria for the study. But please know that I truly appreciate you contacting me and taking an interest in my research. Thanks again and take care.

If an appropriate candidate for the study:

Thank you for answering my questions. Having determined you would be an appropriate candidate for this study, are you still interested in volunteering to participate in this study? Please note that you have the right to refuse to participate at any time.

If answer is no:

Thank you for taking the time to contact me and inquire about the study. Please let me know if you do decide to participate or if you have any further questions. Thank you and good bye.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

If answer is yes: Thank you so much for volunteering to participate in this study; I appreciate your willingness to do so. I do need to discuss the consent form with you to ensure you fully understand your rights. Would you like to do this now or would it be best for me to call another time. Also, would you like me to email/mail/deliver a copy of the consent form to you so that you have time to read it over and make an informed decision? (If participant agrees to do this now – explain the consent form. If asked to call again – arrange a time. Once the participant has a copy of the consent and understands their rights they will have three days to make a decision to participate in the study or not.)

Before ending the conversation:

Please know that if at any time you have questions or concerns about participating in this study, you are welcome to contact either myself at or Dr. Richard Young, at 604-822-6380.

2nd Telephone conversation (three days after receiving and understanding the consent form):

Hi there, it's Iqbal calling. How are you? I wondered if you had any questions or concerns about your participation in the study? (Answer any questions/concerns they may have) Have you made a decision to participate in the study? (If yes - set a date and time for the interview. If no – thank them for their time.

Appendix M

Telephone Interview Format for Punjabi Sikh Young Adults.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380 Fax: 604-822-2328
richard.young@ubc.ca

Telephone Interview Format
Punjabi Sikh Young Adults

Hello, may I speak to (respondent's name). Hi, my name is Iqbal and I am calling in regards to your email/phone message expressing interest to participate in the study titled, *Punjabi Sikh Parent's Beliefs About Suicide and Suicide Related Behaviours*. I wonder if now would be an appropriate time for me to provide you with details of the study and what participating in this study would look like for you? (If answer yes, continue. If no, ask what would be a better time to call back).

This is a study I am conducting in partial fulfillment of an M.A. through UBC in Counselling Psychology. To give you a better understanding of the study I'd like to start by discussing the purpose of the project. Punjabi Sikhs make up a large portion of the Canadian population, particularly in the Great Vancouver area of B.C., but they are underrepresented in mental health research. So the broad purpose of the study is to address this gap in the literature. Specifically, the intention of this study is to describe the beliefs about suicide and potentially fatal self-harming behaviours held by first generation Canadian Punjabi Sikh parents.

Do you have any questions for me thus far? (If yes, answer questions prior to continuing the conversation. If no, continue with conversation)

I would like to interview 3 to 5 second generation Canadian Punjabi Sikh young adults who are between the ages of 19 to 22. The interview would be scheduled for an hour at a time that is convenient for you and I and will take place at UBC. (Check for understanding).

During the interview I will present two case studies of adolescents who either did suicide or are experiencing suicide related behaviours and a series of questions. By participating in this study you will have an opportunity to assist medical and health professionals to better meet the mental health needs of the Punjabi Sikh community. Do you have any questions for me at this point? (If yes, answer questions prior to continuing the conversation. If no, continue with conversation)

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Talking about suicide can at times be emotional, and if distress about this process is evident I will refer you for appropriate counselling. Also, at the end of our interview I will provide you with information about the mental health services available in your community.

A few weeks after the interview I will schedule a second meeting in which you will be able to offer feedback on the accuracy of a one page summary of the interview. Any information that identifies you will be strictly confidential and any segments of the interview that may be presented in the final paper will not identify you as the speaker. Do you have questions you would like me to address at this point? Are you still interested in participating?

To better determine if you would be an appropriate candidate for this study I'd like to ask you some questions. There are 5 questions and for the most part they only require either a yes or no answer. Are you ready for the 1st question? (If yes, continue with the questions).

1. Are you a second generation Canadian Punjabi Sikh? By second generation I mean where you born in Canada?
2. Are you between the ages of 19 and 22?
3. Are you of Punjabi Sikh background?
4. Have you experienced a death of a family member or close friend by suicide?
5. Have you attended a Vancouver high school in the last five years, if so which one?

If not an appropriate candidate for the study:

Thank you so much for answering the questions. However, unfortunately you do not meet the selection criteria for the study. But please know that I truly appreciate you contacting me and taking an interest in my research. Thanks again and take care.

If an appropriate candidate for the study:

Thank you for answering my questions. Having determined you would be an appropriate candidate for this study, are you willing to volunteer to participate in this study? Please note that you have the right to refuse to participate at any time.

If answer is no:

Thank you for taking the time to contact me and inquire about the study. Please let me know if you do decide to participate or if you have any further questions. Thank you and good bye.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

If answer is yes: Thank you so much for volunteering to participate in this study; I appreciate your willingness to do so. I do need to discuss the consent form with you to ensure you fully understand your rights. Would you like to do this now or would it be best for me to call another time. Also, would you like me to email/mail/deliver a copy of the consent form to you so that you have time to read it over and make an informed decision? (If participant agrees to do this now – explain the consent form. If asked to call again – arrange a time. Once the participant has a copy of the consent and understands their rights they will have three days to make a decision to participate in the study or not.)

Before ending the conversation:

Please know that if at any time you have questions or concerns about participating in this study, you are welcome to contact either myself at or Dr. Richard Young, at 604-822-6380.

2nd Telephone conversation (three days after receiving and understanding the consent form):

Hi there, it's Iqbal calling. How are you? I wondered if you had any questions or concerns about your participation in the study? (Answer any questions/concerns they may have) Have you made a decision to participate in the study? (If yes - set a date and time for the interview. If no – thank them for their time.

Appendix N

Telephone Interview Format for
South Asian Mental Health Therapists and Medical Professionals.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380 Fax: 604-822-2328
richard.young@ubc.ca

Telephone Interview Format
South Asian Mental Health Therapists and Medical Professionals

Hello, may I speak to (respondent's name). Hi, my name is Iqbal and I am calling in regards to your email/phone message expressing interest to participate in the study titled, *Punjabi Sikh Parent's Beliefs About Suicide and Suicide Related Behaviours*. I wonder if now would be an appropriate time for me to provide you with details of the study and what participation in this study would look like for you? (If answer yes, continue. If no, ask what would be a better time to call back).

This is a study I am conducting in partial fulfillment of an M.A. through UBC in Counselling Psychology. To give you a better understanding of the study I'd like to start by discussing the purpose of the project. Punjabi Sikhs make up a large portion of the Canadian population, particularly in the Great Vancouver area of B.C., but they are underrepresented in mental health research. So the broad purpose of the study is to address this gap in the literature. Specifically, the intention of this study is to describe the beliefs about suicide and suicide related behaviours held by first generation Canadian Punjabi Sikh parents.

Do you have any questions for me thus far? (If yes, answer questions prior to continuing the conversation. If no, continue with conversation)

For this study I would like to interview 2 to 3 South Asian mental health therapists and medical professionals. The interview would be scheduled for an hour at a time that is convenient for the both of us and will take place either at your office or at UBC. During the interview I will ask you a series of questions in relation to Punjabi Sikh beliefs of suicide and suicide related behaviours based upon your experience of working with Punjabi Sikhs. Do you have any questions for me at this point? (If yes, answer questions prior to continuing the conversation. If no, continue with conversation)

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

A few weeks after the interview I will schedule a second meeting in which you will be able to offer feedback on the accuracy of a one page summary of the interview. Any information that identifies you will be strictly confidential and any segments of the interview that may be presented in the final paper will not identify you as the speaker.

Do you have questions or concerns you would like me to address at this point?

To better determine if you would be an appropriate candidate for this study I'd like to ask you some questions. There are 3 questions and for the most part they only require a yes or no answer. Are you ready for the 1st question? (If yes, continue with the questions).

1. Are you of South Asian background?
2. Are you a mental health therapist or a medical professional? Please specify.
3. Have you been practicing within this field for a minimum of five years?

If not an appropriate candidate for the study:

Thank you so much for answering the questions. However, unfortunately you do not meet the selection criteria for the study. But please know that I truly appreciate you contacting me and taking an interest in my research. Thanks again and take care.

If an appropriate candidate for the study:

Thank you for answering my questions. Having determined you would be an appropriate candidate for this study, are you willing to volunteer to participate in this study? Please note that you have the right to refuse to participate at any time.

If answer is no:

Thank you for taking the time to contact me and inquire about the study. Please let me know if you do decide to participate or if you have any further questions. Thank you and good bye.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

If answer is yes: Thank you so much for volunteering to participate in this study; I appreciate your willingness to do so. I do need to discuss the consent form with you to ensure you fully understand your rights. Would you like to do this now or would it be best for me to call another time. Also, would you like me to email/mail/deliver a copy of the consent form to you so that you have time to read it over and make an informed decision? (If participant agrees to do this now – explain the consent form. If asked to call again – arrange a time. Once the participant has a copy of the consent and understands their rights they will have three days to make a decision to participate in the study or not.)

Before ending the conversation:

Please know that if at any time you have questions or concerns about participating in this study, you are welcome to contact either myself at or Dr. Richard Young, at 604-822-6380.

2nd Telephone conversation (three days after receiving and understanding the consent form):

Hi there, it's Iqbal calling. How are you? I wondered if you had any questions or concerns about your participation in the study? (Answer any questions/concerns they may have) Have you made a decision to participate in the study? (If yes - set a date and time for the interview. If no – thank them for their time.

Appendix O

Consent Form – Punjabi Sikh Parents.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

February 11, 2009

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

Consent Form
Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours.
Punjabi Sikh Parents.

Introduction

Miss Iqbal Kaur Gill, a Masters student in the Department of Educational Psychology, Counselling Psychology, and Special Education, is seeking research participants for her thesis entitled Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours. The purpose of this thesis is to describe the beliefs about suicide and potentially fatal self harming behaviours held by first generation Canadian Punjabi Sikh parents, using an ethnographic approach. Once complete, this thesis will be available for public review and reading through the UBC Library. Segments of this thesis may also appear in educational peer-reviewed journals.

Study Procedures

Miss Gill hopes to interview 3 to 5 first generation Canadian Punjabi Sikh parents (fathers and/or mothers) of adolescent children. The interviews will be approximately 1 hour in length and will begin with a very brief demographic survey. A series of questions will then be asked based upon two case studies of adolescents who either did suicide or are experiencing suicide related behaviours. During a second meeting, which will be 30 minutes in length, participants will have an opportunity to offer feedback on the accuracy of a one page summary of the interview. At any time participants have the right to refuse to participate further and may withdraw from the study.

Confidentiality

Any identifying information related to subjects participating in this study will be strictly confidential. Audiotapes and written materials derived from the interviews will not identify individuals. Audiotapes and any written materials will be kept in a locked filing cabinet to which only Miss Gill and her advisor have access, and will be held securely for five years before being destroyed, as required by UBC regulations. Any segments of these interviews that may be quoted in the final paper will not identify speakers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

Potential Risks

Talking about beliefs of suicide and suicide related behaviours may at times be emotional, and if distress about this process is evident, Miss Gill will refer participants for appropriate counselling.

Potential Benefits

Participation in this study will provide an opportunity to offer insight into the Punjabi Sikh parent's beliefs about suicide and suicide related behaviours that will assist medical and health professionals to better meet their needs.

Contact Information About This Study

If at any time you have any comments or concerns about participating in this study, you are welcome to contact either Iqbal K. Gill, ', or her thesis advisor and Principal Investigator, Dr. Richard Young, Professor, Faculty of Education, Department of Educational and Counselling Psychology, and Special Education, 604-822-6380. If you would prefer not to discuss concerns with the researcher for some reason, you may also contact UBC's Research Subject Information Line, RISL@ors.ubc.ca or 604-822-8598, which is concerned with the protection of research volunteers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

Consent

Your participation in this study is completely voluntary. You may refuse to participate or withdraw from this study at anytime.

Your signature below indicates you have received a copy of this consent form for your own records.

Your signature indicates you consent to participate in this study.

Subject Signature Date

If you wish to receive a printed copy of this thesis upon its completion, please record your address below:

Address City Postal Code

Thank you for your interest and participation in this research.

Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl. Ed., M.A. Student

Appendix P

Consent Form – Punjabi Sikh Young Adults.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

February 11, 2009

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

Consent Form
Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours.
Punjabi Sikh Young Adults.

Introduction

Miss Iqbal Kaur Gill, a Masters student in the Department of Educational Psychology, Counselling Psychology, and Special Education, is seeking research participants for her thesis entitled Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours. The purpose of this thesis is to describe the beliefs about suicide and potentially fatal self harming behaviours held by first generation Canadian Punjabi Sikh parents, using an ethnographic approach. Once complete, this thesis will be available for public review and reading through the UBC Library. Segments of this thesis may also appear in educational peer-reviewed journals.

Study Procedures

Miss Gill hopes to interview 3 to 5 second generation Canadian Punjabi Sikh young adults. The interviews will be approximately 1 hour in length and will begin with a very brief demographic survey. A series of questions will then be asked based upon two case studies of adolescents who either did suicide or are experiencing suicide related behaviours. During a second meeting, which will be 30 minutes in length, participants will have an opportunity to offer feedback on the accuracy of a one page summary of the interview. At any time participants have the right to refuse to participate further and may withdraw from the study.

Confidentiality

Any identifying information related to subjects participating in this study will be strictly confidential. Audiotapes and written materials derived from the interviews will not identify individuals. Audiotapes and any written materials will be kept in a locked filing cabinet to which only Miss Gill and her advisor have access, and will be held securely for five years before being destroyed, as required by UBC regulations. Any segments of these interviews that may be quoted in the final paper will not identify speakers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

Potential Risks

Talking about beliefs of suicide and suicide related behaviours may at times be emotional, and if distress about this process is evident, Miss Gill will refer participants for appropriate counselling.

Potential Benefits

Participation in this study will provide an opportunity to offer insight into the Punjabi Sikh parent's beliefs about suicide and suicide related behaviours that will assist medical and health professionals to better meet their needs.

Contact Information About This Study

If at any time you have any comments or concerns about participating in this study, you are welcome to contact either Iqbal K. Gill, ', or her thesis advisor and Principal Investigator, Dr. Richard Young, Professor, Faculty of Education, Department of Educational and Counselling Psychology, and Special Education, 604-822-6380. If you would prefer not to discuss concerns with the researcher for some reason, you may also contact UBC's Research Subject Information Line, RISL@ors.ubc.ca or 604-822-8598, which is concerned with the protection of research volunteers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

Consent

Your participation in this study is completely voluntary. You may refuse to participate or withdraw from this study at anytime.

Your signature below indicates you have received a copy of this consent form for your own records.

Your signature indicates you consent to participate in this study.

Subject Signature Date

If you wish to receive a printed copy of this thesis upon its completion, please record your address below:

Address City Postal Code

Thank you for your interest and participation in this research.

Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl. Ed., M.A. Student

Appendix Q

Consent Form – South Asian Mental Health Therapists and Medical Professionals.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

February 11, 2009

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

Consent Form
Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours.
South Asian Mental Health Therapists and Medical Professionals.

Introduction

Miss Iqbal Kaur Gill, a Masters student in the Department of Educational Psychology, Counselling Psychology, and Special Education, is seeking research participants for her thesis entitled Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours. The purpose of this thesis is to describe the beliefs about suicide and potentially fatal self harming behaviours held by first generation Canadian Punjabi Sikh parents, using an ethnographic approach. Once complete, this thesis will be available for public review and reading through the UBC Library. Segments of this thesis may also appear in educational peer-reviewed journals.

Study Procedures

Miss Gill hopes to interview 2 to 3 South Asian mental health therapists or medical professionals. The interviews will begin with a very brief demographic survey, which will be followed by a series of questions based upon professional experience to gain an understanding of Punjabi Sikh parent's beliefs of suicide and suicide related behaviours. This first meeting will be approximately 1 hour in length. During a second meeting, which will be 30 minutes in length, participants will have an opportunity to offer feedback on the accuracy of a one page summary of the interview. At any time participants have the right to refuse to participate further and may withdraw from the study.

Confidentiality

Any identifying information related to subjects participating in this study will be strictly confidential. Audiotapes and written materials derived from the interviews will not identify individuals. Audiotapes and any written materials will be kept in a locked filing cabinet to which only Miss Gill and her advisor have access, and will be held securely for five years before being destroyed, as required by UBC regulations. Any segments of these interviews that may be quoted in the final paper will not identify speakers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

Potential Risks

Talking about beliefs of suicide and suicide related behaviours may at times be emotional, and if distress about this process is evident, Miss Gill will refer participants for appropriate counselling.

Potential Benefits

Participation in this study will provide an opportunity to offer insight into the Punjabi Sikh parent's beliefs about suicide and suicide related behaviours that will assist medical and health professionals to better meet their needs.

Contact Information About This Study

If at any time you have any comments or concerns about participating in this study, you are welcome to contact either Iqbal K. Gill, , or her thesis advisor and Principal Investigator, Dr. Richard Young, Professor, Faculty of Education, Department of Educational and Counselling Psychology, and Special Education, 604-822-6380. If you would prefer not to discuss concerns with the researcher for some reason, you may also contact UBC's Research Subject Information Line, RISL@ors.ubc.ca or 604-822-8598, which is concerned with the protection of research volunteers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Consent

Your participation in this study is completely voluntary. You may refuse to participate or withdraw from this study at anytime.

Your signature below indicates you have received a copy of this consent form for your own records.

Your signature indicates you consent to participate in this study.

Subject Signature Date

If you wish to receive a printed copy of this thesis upon its completion, please record your address below:

Address City Postal Code

Thank you for your interest and participation in this research.

Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl. Ed., M.A. Student

Appendix R

Consent Form – Punjabi Sikh Community Leader.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

February 11, 2009

Dept. of Educational and Counselling Psychology and
Special Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: 604-822-6380
Fax: 604-822-2328
Email: richard.young@ubc.ca

Consent Form
Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours.
Punjabi Sikh Community Leader.

Introduction

Miss Iqbal Kaur Gill, a Masters student in the Department of Educational Psychology, Counselling Psychology, and Special Education, is seeking research participants for her thesis entitled Punjabi Sikh Parent's Beliefs about Suicide and Suicide Related Behaviours. The purpose of this thesis is to describe the beliefs about suicide and potentially fatal self harming behaviours held by first generation Canadian Punjabi Sikh parents, using an ethnographic approach. Once complete, this thesis will be available for public review and reading through the UBC Library. Segments of this thesis may also appear in educational peer-reviewed journals.

Study Procedures

Miss Gill hopes to interview 1 community leader of the Punjabi Sikh community. The interview will be approximately 1 hour in length. During a second meeting, which will be 30 minutes the participant will have an opportunity to offer feedback on the accuracy of a one page summary of the interview. At any time the participant has the right to refuse to participate further and may withdraw from the study.

Confidentiality

Any information provided during the interview process will not be confidential. Any segments of the interview that may be quoted in the final paper will identity the speaker. Audiotapes and any written materials will be kept in a locked filing cabinet to which only Miss Gill and her advisor have access, and will be held securely for five years before being destroyed, as required by UBC regulations.

Potential Risks

Talking about beliefs about suicide and suicide related behaviours may at times be emotional, and if distress about this process is evident, Miss Gill will refer participants for appropriate counselling.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty *of* Education

Potential Benefits

Participation in this study will provide an opportunity to offer insight into the Punjabi Sikh parent's beliefs about suicide and suicide related behaviours that will assist medical and health professionals to better meet their needs.

Contact Information About This Study

If at any time you have any comments or concerns about participating in this study, you are welcome to contact either Iqbal K. Gill, , or her thesis advisor and Principal Investigator, Dr. Richard Young, Professor, Faculty of Education, Department of Educational and Counselling Psychology, and Special Education, 604-822-6380. If you would prefer not to discuss concerns with the researcher for some reason, you may also contact UBC's Research Subject Information Line, RISL@ors.ubc.ca or 604-822-8598, which is concerned with the protection of research volunteers.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Consent

Your participation in this study is completely voluntary. You may refuse to participate or withdraw from this study at anytime.

Your signature below indicates you have received a copy of this consent form for your own records.

Your signature indicates you consent to participate in this study.

Subject Signature Date

If you wish to receive a printed copy of this thesis upon its completion, please record your address below:

Address City Postal Code

Thank you for your interest and participation in this research.

Miss Iqbal Kaur Gill, B.A., B.Ed., Dipl. Ed., M.A. Student

Appendix S

Sample Summary of a South Asian Mental Health Professional Interview.

Summary of South Asian Mental Health Professional

1. In your experience have you dealt with the Punjabi Sikh community in regards to suicide and suicide related behaviours?

- Yes, there was one particular case that came to mind – a young woman of approx. 14 years of age whose parents had a great deal of difficulty believing she would have attempted suicide and felt that the situation had been exaggerated. This case stands out because it was not the reaction the professionals working with the family had hoped for - for them to come to terms with the attempt and to address the situation. There have been other similar experiences to this case.

2. Have you had experience with first generation Canadian Punjabi Sikh parents whose adolescent children are exhibiting suicide related behaviours?

- Two other recent cases of suicide came to mind. Both of adolescents who were thought to be talented and outgoing. You were concerned about the services they had received either prior to the suicide or after in assisting them to come to terms with it. Although you've offered your services, the families have not made contact as of yet. One of the families is not calling it a suicide, but blaming it on an outside force; the youth was sleeping walking when they committed suicide.

3. In your experience, how do first generation Canadian Punjabi Sikh parents respond to their adolescent's suicide and/or suicide related behaviours?

- Suicide is a strange phenomenon for all parents to understand and every culture and religion has its own set of beliefs around suicide. In the Punjabi Sikh culture suicide is not acceptable. Human life is highly valued and thought to be in the hands of a greater power. The initial reaction of parents tends to be of anger – how could the youth have made such a choice and done this to not only themselves, but the family. Parents also tend to be in disbelief, shock.

4. In your experience, what have the first generation Canadian Punjabi Sikh parents perceived to be the causes of the suicide and/or suicide related behaviours?

- You could perceive the parents suggesting that children these days are too self-focused. Parents tend to lack an understanding of mental health, i.e. what does it mean for a child or adult to be experiencing depression. The piece that lingers with you is that it is difficult to understand why children are not able to establish at least one connection whether it be with a parent, sibling, aunt, uncle, etc whom they could reach out to for help before they make the choice of suicide.

5. In your experience, what is the willingness of first generation Canadian Punjabi Sikh parents to engage mental health services?

- You are challenged by this question on a daily basis. The first challenge is defining and understanding mental health in the Punjabi Sikh community. Parents tend to look for a quick fix without having to engage in the process of therapy themselves. It can also be a challenge to engage parents in conversations about developmental issues, mental health or parenting issues.

6. What were the successful interventions utilized in response to suicide related behaviours in adolescents of first generation Canadian Punjabi Sikh parents?

- Going back to the first case mentioned of the young woman who had attempted suicide – her parents minimized the attempts - perhaps because this was just one more thing in a long string of behaviours they had been dealing with. They were at a point where they no longer felt they could deal with her and sought other family members to raise her, however, there were no other family members who could do this and she did not go into foster care. The approach utilized with these parents was a heavy handed approach where they were told that it was their responsibility to raise her and care for her. This was an approach they understood and it worked.

7. In your experience, how does the Punjabi culture and Sikh religion factor into the views of suicide and suicide related behaviours held by first generation Canadian Punjabi Sikh parents, if at all?

- Life is sacred and suicide is not an acceptable choice. Some fear that the soul is in limbo after a suicide – neither here nor there – not having a final resting place. It is very difficult for them to understand why someone would make a choice to suicide.

8. In your experience, have first generation Canadian Punjabi Sikh parents refused mental health intervention for their adolescent who is experiencing suicide related behaviours? What methods of treatment did they choose instead, if any?

- In my experience parents have not full out refused mental health services. Usually by this point parents are at their wits end and willing to try anything that will help. However, they do not fully understand what a mental health intervention would look like and engaging parents in therapy and looking at their part in the situation can be difficult. Often parents will try all resources in their own tool box prior to seeking help, such as consulting with family members or elders, holding prayers either at home or in the temple to remove any possible negative energies, or taking the child away from the situation to India for a few months or to be raised their by their grandparents. It is always the land of origin, India, rather than another country. Separating the children from the parents leaves concerns of attachment, but luckily this does not happen so often anymore. However, we may see this trend re-emerge with the new schools in India that are a part of the Canadian schooling system.

9. As a mental health practitioner (medical professional), what are the ways in which the medical community could improve services to better meet the needs of first generation Punjabi Sikh parents who are raising adolescent children?

- To educate the Punjabi Sikh community about mental health and developmental issues, and also the experiences of youth in Canadian society. The youth don't seem to be sharing this with their parent's – some parent's have some what of an idea, but many do not; there is a lack of communication between parents and youth. And to normalize the experiences of the youth.

10. In your experience, what are the barriers to accessing mental health services for first generation Canadian Punjabi Sikh parents, if any?

- There appears to be a lack of knowledge of what is available in the community, and how to access and engage the services. For example, many parents have extended health care benefits, but would not consider utilizing them for counselling services. There is also a stigma of asking an outside person for help; we should be able to solve our problems within the home. And the stigma of people knowing they are accessing mental health services because it reflects upon their parenting. However, this is getting better; people are accessing services and are less afraid of who will know.

11. Please take a look at a summary of interviews conducted with first generation Canadian Punjabi Sikh parents and comment on whether or not you believe it accurately reflects your experience of working with this population.

Punjabi Sikh Parents Summary:

- Some of the responses are black and white. For instance, if Paula had continued her medication her suicide could have been prevented. However, it is not as simple as that.
- Concerns around stereotypes of Punjabi Sikh parents
- Disagree that the Gurdwaras should play an active role in educating the community about mental health issues. They are not set up to do this.
- Overall, the parent's responses matched your experience of working with the Punjabi Sikh community.

Punjabi Sikh Young Adults Summary:

- Concerns around stereotypes of Punjabi Sikh parents – i.e. parents who are not educated are not able to meet the needs of their children. This is not true.
- From the youth's responses it becomes apparent that the Punjabi Sikh culture is a mix – they are impacted by other belief systems and it becomes a challenge for them to separate that from the Punjabi culture and Sikh religion.
- They are not able to see a division between religion and mental health – i.e. wanting the Gurdwaras to play a bigger role in educating the community about mental health issues.
- The youth seemed to have a better grasp of what the youth in the case studies were experiencing than the parents.

Appendix T

UBC Behavioural Research Ethics Board – Certificate of Approval.

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - FULL BOARD

PRINCIPAL INVESTIGATOR:	INSTITUTION / DEPARTMENT:	UBC BREB NUMBER:
Richard A. Young	UBC/Education/Educational & Counselling Psychology, and Special Education	H09-00452

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

Institution	Site
UBC	Vancouver (excludes UBC Hospital)

Other locations where the research will be conducted:
Punjabi Sikh parents will be interviewed either at UBC or in their homes. If the interview is at their home, the researcher will be accompanied by a companion who will not be a part of the interview to ensure confidentiality. Punjabi Sikh young adults will be interviewed at UBC. South Asian Mental Health Therapists and Medical Professionals will be interviewed at their office or at UBC. The Punjabi Sikh Community Leader will be interviewed either at UBC or a mutually agreed upon location as he is not a local resident.

CO-INVESTIGATOR(S):

Iqbal Kaur Gill

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Punjabi Sikh Parent's Beliefs of Suicide and Suicide Related Behaviours.

REB MEETING DATE:	CERTIFICATE EXPIRY DATE:
February 26, 2009	**February 26, 2010**

DOCUMENTS INCLUDED IN THIS APPROVAL: **DATE APPROVED: March 2, 2009**

Document Name	Version	Date
Protocol:		
Thesis Proposal	N/A	February 12, 2009
Consent Forms:		
Punjabi Sikh Parent's Consent Form	N/A	February 11, 2009
Punjabi Sikh Young Adults Consent Form	N/A	February 11, 2009
Punjabi Sikh Community Leader Consent Form	N/A	February 11, 2009
South Asian Mental Health Therapists and Medical Professionals Consent Form	N/A	February 11, 2009
Advertisements:		
Email Message	N/A	February 12, 2009
Questionnaire, Questionnaire Cover Letter, Tests:		
Telephone Interview Format for South Asian Mental Health Professionals and Medical Professionals	N/A	February 12, 2009
Interview Questions for South Asian Mental Health Therapists and Medical Professionals	N/A	February 12, 2009
Demographic Survey for Punjabi Sikh Parents	N/A	February 12, 2009
Demographic Survey for South Asian Mental Health Therapists and Medical Professionals	N/A	February 12, 2009
Telephone Interview Format for Punjabi Sikh Young Adults	N/A	February 12, 2009
Case Studies and Interview Questions for Punjabi Sikh Parents and Young Adults	N/A	February 12, 2009
Telephone Interview Format for Punjabi Sikh Parents	N/A	February 12, 2009
Interview Questions for the Punjabi Sikh Community Leader	N/A	February 12, 2009
Demographic Survey for Punjabi Sikh Young Adults	N/A	February 12, 2009

Letter of Initial Contact:		
Recruitment Letter - Punjabi Sikh Young Adults	N/A	February 11, 2009
Recruitment Letter - South Asian Mental Health Therapists and Medical Professionals	N/A	February 11, 2009
Recruitment Letter - Punjabi Sikh Parents	N/A	February 11, 2009

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Anita Ho, Associate Chair