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RESEARCH ARTICLES

Integrating Traditional Religio-Cultural Healing into Counselling and Psychotherapy with Punjabi Sikh Clients in North America

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Abstract

Because available counselling and psychotherapy services in India and abroad are predominantly based on Western approaches with little to no incorporation of Eastern philosophies, Indian cultural customs, and religious traditions, counselling and psychotherapy are not usually seen as a culturally consistent option for many Punjabi Sikhs, especially those born in India. What is most needed to increase fit and effectiveness is cultural and religious adaptation – a more flexible approach that allows for the integration of Sikh and Punjabi healing understandings and resources into counselling and psychotherapy. Without critical appreciation of religio-cultural influences, mental health professionals risk imposing Eurocentric principles to circumstances in which they are not

appropriate, which can result in making culturally disrespectful demands and countering traditional systems for healing. In addition, to neglect these indigenous assets that emerge out of Punjabi and Sikh thought is to overlook important and time-tested healing resources. This article seeks to provide mental health professionals with a collection of theoretical models and tangible strategies and interventions proposed to be more congruent to the traditional Punjabi Sikh worldview. It will be useful for mental health professionals with limited experience with Punjabi Sikhs, clinical supervisors overseeing trainees providing mental health services to Punjabi Sikhs, instructors teaching cross/multi-cultural counselling/psychotherapy classes, and those wishing to develop theories or models for providing counselling and psychotherapy services to this population.

Keywords: counselling with Punjabi Sikhs, psychotherapy with Punjabi Sikhs

The term "Punjabi Sikh" refers to an individual whose familial roots lie in the Punjab State of India and who follows the Sikh religion, the fifth largest religion in the world with over 25 million adherents (The Sikh Coalition, n.d). Although it may seem peculiar to amalgamate these two distinct identities (one geographical and one religious) into a unified sub-cultural group, there are justifiable reasons for doing so. The population of the state of Punjab is primarily composed of individuals who actively follow or were born into the Sikh religion, and the vast majority of individuals who subscribe to the Sikh religion still currently live in the State of Punjab* (Office of the Registrar General and Census Commissioner, India, 2011). Moreover, the intersecting identities of "Punjabi" and "Sikh" tend to be very central in how Punjabi individuals and Sikh individuals understand themselves and identify themselves to others (Dhillon, 2015; Sandhu, 2009). In addition, Sikh individuals, even those non-resident in Punjab, have frequently been encouraged to identify with the Punjabi regional

* But many also live abroad. For example, it is estimated that over 1.5 million Punjabi Sikhs reside in Canada, the United Kingdom, and the United States (Hart Research Associates, 2015; Office for National Statistics, 2011; Statistics Canada, 2011).

culture and often view it as an integral counterpart to their religion (Nayar, 2004). As a result, the relationship between the Punjabi regional culture and the Sikh religion is so interwoven that many Punjabi Sikh individuals are unable to identify what should be attributed to regional culture and what should be attributed to the Sikh religion (Sandhu, 2009).

While in India, Punjabi Sikh individuals are a religious and cultural minority, and when immigrating abroad, they often become a triple minority with the additional of visible (e.g., skin colour, ethnic dress) minority status. Therefore, they can and often do experience prejudice, discrimination, and hate-based violence on all three grounds, on top of expected acculturation issues (Ahluwalia & Alichandani, 2013; Ahluwalia & Pelletiere, 2010; Ahluwalia & Zaman, 2010). An increase in macro-aggressions and micro-aggressions against this cultural group has followed the September 11th, 2001 terrorist attacks in the United States, as many turbaned Sikhs have been mistaken for Muslims (or Muslim terrorists) in the United States (U.S., Ahluwalia & Zaman, 2010; for a list of hate-based crimes against Punjabi Sikhs in the U.S., please visit http://www.huffingtonpost.com/2012/08/07/history-of-hate-crimes-against-sikhs-since-911_n_1751841.html). Consequently, at least in the U.S., there has been an increase in psychological and emotional distress amongst Sikhs (Ahluwalia & Pelletiere, 2010). For example, 83% of American Sikhs said that they or someone they knew personally had experienced a hate crime or incident (Rajghatta, 2006).

Punjabi Sikh men in North America and elsewhere are in greater need of support and, outside of religion and family, often have little elsewhere to turn due to the obvious lack of traditional Indian, Punjabi, or Sikh healing resources present outside of India (Sembhi & Dein, 1998). In the specific case of Punjabi Sikhs, they often prefer to turn to family, community, and their religion prior to seeking counselling or psychotherapy (Morjaria-Keval, 2006; Rana & Sihota, 2012); even then, usually only as a last resort or due to legal requirements. With continued immigration, as counselling and psychotherapy are mainstream indigenous healing practices in North America and Europe and legal courts can mandate such services, Punjabi Sikh individuals are logically seeking or at least receiving counselling and psychotherapy at higher rates than before and they can feel quite shameful about doing so (Shariff, 2009).

However, counselling and psychotherapy are not usually seen as a culturally consistent option for many Punjabi Sikhs, especially those born in India (Panganamala & Plummer, 1998; Syed, Baluch, Duffy, & Verma, 2012). As traditional healing methods indigenous to countries in Europe and North America, the theories and philosophies underlying conventional counselling and psychotherapy practices were developed primarily by Christian individuals of European descent to serve their local populace using culturally consistent values, norms, and objectives. As a result, it serves as no surprise that conventional practices have been slow to incorporate healing practices and principles endemic to other parts of the world (including the many rich traditions in India) or even judge them as equally meritorious. Religion is but one key example of a missed opportunity out of many as it is clearly differentiated from mainstream counselling and psychotherapy in relatively secular countries like the Unites States and Canada versus in highly religious countries like India (Gallup, 2009). Some even consider religion and counselling/psychotherapy as opposing or at least mutually exclusive options (Dhillon, 2015). In fact, mental health professionals in North America often shy away from including religion into the counselling and psychotherapy process despite appreciation from so many clients when they do so (Foskett, Marriot, & Wilson-Rudd, 2004; Hans, Lindgren & Courtsey, 1995).

As such, available counselling and psychotherapy services in India and abroad are predominantly based on Western approaches to psychology with little to no incorporation of Eastern philosophies, Indian cultural customs, and local religious traditions (Arulmani, 2007). What is most needed is cultural and religious sensitivity in adapting Western counselling and psychotherapy methods (Arulmani, 2009) – a more flexible approach that allows for the integration of Sikh and Punjabi healing understandings and resources. Without this, the potential for more effective counselling and psychotherapy with Punjabi Sikh individuals is not being realized.

In order for mental health professionals to demonstrate a greater respect for traditional healing systems as valid complements and integrate them into their work, greater familiarity with the Sikh religion and Punjabi culture is needed. Cultural knowledge is one of the key pillars for cross-cultural counselling competence (Sue et al., 1982). Primers about the Sikh religion and the Punjabi culture and its healing traditions geared specifically for mental health professionals are available, such as those provided by Nayar & Sandhu (2006), Sandhu

(2004, 2005, 2009); and Singh (2008). Basic information about prototypical differences between Indian worldviews and those of North America and Europe are also available (e.g., Arulmani, 2007, 2009; Jayakar, 1994; Neki, 1973). These articles are very important to consult as the average North American individual (and probably the average global citizen) knows very little about Punjabi Sikhs and holds much prejudicial misinformation (Hart Research Associates, 2015). Without critical appreciation of cultural influences, mental health professionals risk imposing principles of American and European psychology to circumstances in which they are not appropriate (Christopher, Wendt, Marecek, & Goodman, 2014). This can result in making culturally inappropriate demands and unintentionally disrespecting indigenous and cultural systems for healing, predictably resulting in less effective services (Sue & Sue, 2008). To neglect these indigenous assets that emerge out of Punjabi and Sikh thought is to overlook important and time-tested healing resources.

In sum, for counselling and psychotherapy to be most effective for Punjabi Sikhs, both those in India and for those who have relocated abroad, mental health professionals need to infuse religio-cultural understandings and utilize culturally appropriate strategies and interventions – that is, counselling/psychotherapy should be adapted to the Punjabi Sikh way of life and not vice versa. In the United States and Canada, the published case studies that exist seem to clearly support the incorporation of cultural and religious components (Bedi & Domene, 2015; Nayar & Sandhu, 2006; Sandhu, 2004; 2005; Singh, 2008).

Plentiful academic and clinical literature exists that provides general cross-cultural and multi-cultural principles that can be generalized, to some extent, to most cultural groups including Punjabi Sikh individuals. In addition, there is growing literature that provides general guidance for counselling and psychotherapy with Asian-Americans, South Asian Americans, and Asian Indian individual in the United States (e.g., Jayakar, 1994). However, this article seeks to provide mental health professionals with a listing of theories/models and tangible strategies/interventions deemed more likely to be compatible specifically with the typical worldviews of their Punjabi Sikh clients. The provided information will be useful for mental health professionals with limited experience with Punjabi Sikhs, clinical supervisors overseeing trainees providing mental health services to Punjabi Sikhs, instructors teaching cross/multi-cultural

counselling/psychotherapy classes, and those wishing to develop theories or models for providing counselling and psychotherapy services to this population.

The reader needs to keep in mind that effective counselling and psychotherapy is as much an "art" as a science, as considerable clinical wisdom and intuition is needed (Levitt & Piazza-Bonin, 2016), as is timing. There is also much within-group variability within any cultural group. In addition, the professional needs to consider a plethora of variables that can mediate or moderate the information provided in this article. These variables include, but are not limited to: Ethnic minority identity development, religiousness, strength of cultural identification, nationality, acculturation level, personal values, and familial generation. Therefore, the reader is encouraged to treat the information presented below as a rich source of clinical hypotheses and guidance to be subject to clinical testing in their practice with Punjabi Sikh clients. Some basic familiarity with the Punjabi and Sikh cultures is needed to fully understand the connection between the material below and the underlying rationale for it. The unfamiliar reader is referred to first read one or more of the articles listed earlier prior to reviewing the below.

Theories and Models

Several conventional Western theories have been reported to be more likely to be effective and fitting with the typical Punjabi Sikh client, particularly one born and raised in India. These theories serve as a promising base from which to incorporate religio-cultural interventions and strategies. The preponderance of writers and published case studies seem to most support cognitive-behavioural (e.g., Nayar & Sandhu, 2006; Sandhu, 2009; Shariff, 2009), solution-focused (e.g., Bedi & Domene, 2015; Nayar & Sandhu, 2006), and spirituality-based existential approaches (e.g., Sandhu, 2004; 2005), particularly within family counselling/psychotherapy (e.g., Mani, 2005; Nayar & Sandhu, 2006) with minimization of affect-based interventions (e.g., Bedi & Domene, 2015; Nayar & Sandhu, 2006; Sandhu, 2009); and emphasis on psycho-education (e.g., Ahluwalia & Alimchandani, 2013) and direct problem-solving (e.g., Bedi & Domene, 2015; Rana & Sihota, 2012; Shariff, 2009).

Five specific and indigenous counselling/psychotherapy theoretical models exist that emerge directly from Punjabi Sikh thought to guide counselling and psychotherapy. Sandhu (2004) outlines the

Sikh's Guru Granth Sahib's (the Sikh holy book of scriptures) framework for conceptualizing the person, suffering, and healing. He works from Sikh cosmology and meta-physical understandings to analyze the key aspects of the person (spiritual self, consciousness, the hidden record, the mind, and the physical body), understand both internal and external sources of suffering, and implement spiritual and religious healing procedures within five spheres: righteousness, knowledge, effort, grace, and truth. The reader is referred here for more details as well as an application of this model with the counselling case of a 43-year-old, Indian-born, Punjabi Sikh woman experiencing work difficulties and depression with many somatic symptoms such as low energy, headaches, sleep disturbances, loss of appetite, and chronic pain.

Sandhu (2005) outlines the Sikh perspective on life stress based upon teachings of the Guru Granth Sahib and creates a life-stress model and concomitant psychoeducational activity that could be used to frame the counselling process. The model is premised on a cycle of suffering and the human ego's need to fulfill four core human needs: security, love, respect, and freedom simultaneously and seeks to assist the client in overcoming obstacles and achieving these needs in a culturally and religiously consistent manner. The four stages of this model are: Empathy, life-stress activity, further intervention, and post-life stress activity. The reader is referred here for more details as well as an application of this model with the counselling case of a 20-year-old, Canadian-born, Punjabi Sikh woman experiencing depression and academic difficulties.

Sandhu (2009) outlines the Sikh religious notion on the cause of alcohol and other drug use and how to apply scripture principles in light of powerful Punjabi cultural beliefs and historical and contextual factors. This counselling model guides substance-abusing clients through the corresponding two paths of human existence delineated by Sikh teachings: the Path of the Manmukh (understanding existential suffering as the root cause of addiction, drawing on the concept of excessive ego) and the Path of the Gurmukh (alleviating suffering, drawing on self-realizations and ways to unify with God). Counselling from this perspective is also centered around overcoming the five barriers to self-actualization (lust, anger, greed, attachment, and the ego). The reader is referred to this article for more details.

Singh (2008) outlines the Sikh scripture's spiritual model of mental health and organizes its psychological ideas around a hexagonal

structure comprised of: Ego, Self-Realization, Weaknesses (the five vices), Humility, Strengths (the five virtues), and Meditation/Spiritual Liberation. The client is assisted in working through each step of the six clockwise steps of the hexagon, starting with the Ego and in the order noted above. A lot of this working through is centred on education about Sikh principles, but it also includes learning how to keep vices (lust, anger, greediness, attachment, and pride) under control; how to be humble; and how to develop the virtues of truth, contentment, patience, perfect faith, and compassion. Upon completing these five steps and then meditating on God, the client is expected to achieve spiritual liberation and cure from psychological ailments. The reader is referred here for more details as well as an application of this counselling model with (a) a non-practicing Sikh male experiencing depression, alcohol abuse, and a suicide attempt, and (b) a conservative Indian-born but Canada-residing Sikh male referring for domestic violence incidents against his wife.

Nayar and Sandhu (2006) outline culturally-conditioned distinctive thought forms and communication patterns across three generations of Indians living in Canada (Indian-born grandparents, Indian-born parents, and Canadian-born children). They further examine inter-generation communication barriers and how to overcome them from the client point-of-view as well as communication trends needed for the counsellor to engage individuals for each of these family generations. These authors propose that the counsellor match the communication style of grandparents (collectivistic statements, concrete phases, limited affective and abstract language, discussing things in an impersonal manner, a concrete problem-solving approach, looking at them for their wisdom), parents (collectivistic statements, concrete phases, limited affective and abstract language, positioning individualistic desires within the family context, sharing objective facts, a problem-solving approach, a directive doctor-patient type of relationship), and children (promoting critical thinking in navigating their Indian and Canadian cultures, using abstract concepts). The reader is referred here for more details as well as vignettes demonstrating intergenerational communication in family counselling with a Canadian Punjabi Sikh family.

Interventions and Strategies

A host of psychotherapeutic interventions and strategies have been proposed and demonstrated useful for counselling and psychotherapy with Punjabi Sikh clients. These can and should be used in conjunction within the theories noted above and the traditional healing interventions noted later in this article. Sandhu (2004) proposes a more integrative stance in his theoretical guidance. Although he promotes an existential approach overall, he suggests the following elements taken from different theories as fitting:

1. Psychodynamic theory's emphasis on unconscious content as the cause of distress and a key influencer of present behaviour;
2. Cognitive theory's emphasis on identifying faulty thinking and beliefs that lead to distress;
3. Behavioural theory's emphasis on behaviour and environment as reciprocally influential on each other;
4. Family System theory's emphasis that individual behaviours are best conceptualized in context of the family environment;
5. Feminist theory's emphasis on power inequality as a key source of suffering;
6. Reality theory's emphasis on choices and taking responsibility for one's life within what is under one's control;
7. Humanistic theory's emphasis on receiving and providing empathy, regard and acceptance in order to self-actualize; and
8. Gestalt theory's emphasis on a holistic integration of thoughts, feelings, and behaviours.

Below is a list of more traditional religio-cultural strategies and interventions which can be used by a mental health professional providing counselling and psychotherapy to a Punjabi Sikh individual.

1. Utilizing the Sikh Life-Stress activity (Sandhu, 2005).
2. Utilizing the six-step hexagon model of Sikh Psychology (Singh, 2008).
3. Working within the assumptions of karma, fate, destiny, past lives, and reincarnation, which sometimes means not challenging client feelings of helplessness and pessimism about change (Ahluwalia &

Alimchandani, 2013; Dhillon, 2015; Horne & Arora, 2013; Mani, 2005; Sandhu, 2004).

4. Accepting and working with the tendency to somatize psychological symptoms, as is common in much of the non-Western world (Al Busaidi, 2010).
5. Working within the frame of prioritizing family's needs as much as feasible and highlighting the client's family/social identity (Bedi & Domene, 2015; Dhillon, 2015).
6. Using Punjabi cultural folklore stories (Nayar & Sandhu, 2006; Sandhu, 2004).
7. Learning more about the Sikh religion and/or strengthening one's commitment to it (Morjaria-Keval, 2006; Sandhu, 2009).
8. Reading Sikh scriptures (Ahluwalia & Alimchandani, 2013; Ahluwalia et al., 2015; Ahluwalia & Zaman, 2010; Morjaria-Keval, 2006; Sandhu, 2009).
9. Visiting the Sikh temple (Morjaria-Keval, 2006; Sandhu, 2004, Singh, 2008, Thandi, 2011).
10. Praying to God (Ahluwalia et al., 2015; Singh, 2008).
11. Becoming baptized as a Sikh (Morjaria-Keval, 2006).
12. Consulting a Sikh priest (Bedi & Domene, 2015; Morjaria-Keval, 2006).
13. Volunteering for society, especially at the Sikh temple or with a religious agenda (Ahluwalia & Alimchandani, 2013; Ahluwalia & Zaman, 2010; Bedi & Domene, 2015; Morjaria-Keval, 2006).
14. Meditating, especially on God's name (Ahluwalia & Alimchandani, 2013; Ahluwalia & Zaman, 2010; Singh, 2008).
15. Educating the community about Sikhism (Ahluwalia & Alimchandani, 2013; Ahluwalia & Zaman, 2010).
16. Normalizing suffering (Sandhu, 2005).
17. Exploring possible links between Punjabi Sikh religio-cultural expectations and the presenting issue (Ahluwalia & Zaman, 2010).
18. Sharing the professional's knowledge of Sikhism and the Punjabi culture and/or discussing similarities and differences between the practitioner's culture and the client's Punjabi Sikh culture (Ahluwalia & Alimchandani, 2013; Rana & Sihota, 2013).

19. Working foremost to elicit family support or compromises before an individual client enacts an individualistic change (Bedi & Domene, 2015; Dhillon, 2015; Mani, 2005 Shariff, 2009).
20. Strategizing how to help the family save "face" or increase/protect their family status and reputation in the surrounding Punjabi Sikh community when an individual client seeks to make an individualistic change (Bedi & Domene, 2015; Nayar & Sandhu, 2006).
21. Role-playing family scenarios, including through the Punjabi cultural folk dance of Giddha (Sandhu, 2005).
22. Framing/reframing strategies/interventions around strengthening the family, strengthening the community, gaining the strength to be a hero, or being a martyr (Ahluwalia & Alimchandani, 2013; Nayar & Sandhu, 2006; Thandi, 2011).
23. Discussing with the client or allowing the client to discuss personal issues with others in a non-personalized, somewhat detached and abstract/generalized manner (Bedi & Domene, 2015; Nayar & Sandhu, 2006; Sandhu, 2005).
24. Allowing the client to suppress feelings if doing so does not impair their functioning, as suppressing individual emotions has traditionally been seen as a strength and as a contributor to spiritual enlightenment (Dhillon, 2015).
25. Carefully asking questions that do not subtly assume or encourage an individualistic view of relating to others or personal independence (Dhillon, 2015; Horne & Arora, 2013).
26. Asking to involve parents into the counselling or psychotherapy (Bedi & Domene, 2015).
27. Talking with India-born elderly Punjabi Sikhs using familial and collectivistic proclamations, concrete phrases, limited abstract and affect-based terminology, biographical stories, personal life stories of others (especially of elders), an exploration of the client's own wisdom, a mystical/spiritual/religious theory of causality, and a concrete problem solving approach (Nayar & Sandhu, 2006).
28. Talking with Indian-born but emigrated Punjabi Sikhs using familial and collectivistic proclamations, concrete phrases, limited abstract and affect-based terminology, situating individualistic desires within a familial framework, discussion of other's life

experiences, sharing objective facts, and a medical doctor/patient style of relationship (Nayar & Sandhu, 2006).

29. Talking with foreign born Punjabi Sikhs using critical thinking about ethnic minority cultural identity development and abstract language.
30. Providing psycho-education about and normalizing common inter-generational issues upon emigration out of Punjab (Nayar & Sandhu, 2006; Shariff, 2009)

Conclusion

It is important that mental health professionals become more proficient at providing religio-culturally-sensitive services when working with Punjabi Sikh individuals. An essential component of cross-cultural competence in working with Punjabi Sikhs is an awareness and appreciation of the religion and the typical cultural values of Punjabi Sikhs. Through this appreciation of religion and culture, mental health professionals should be better equipped to respond empathically, respectfully, and in therapeutically beneficial ways as the Punjabi Sikh community's mental health needs can best be promoted by including elements of traditional religio-cultural healing into the counselling and psychotherapy services that they receive. Guidance for how to intervene with this highly ostracized cultural group in a religio-cultural manner has been provided in this article.

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