

Engaging Asian faith communities and counselling psychology perspectives in the development of older adult services.

Item Type	Thesis or dissertation
Authors	Thompson, Maria
Publisher	University of Wolverhampton
Download date	2026-04-14 11:44:33
Link to Item	http://hdl.handle.net/2436/123591

**ENGAGING ASIAN FAITH COMMUNITIES AND COUNSELLING
PSYCHOLOGY PERSPECTIVES IN THE DEVELOPMENT OF OLDER
ADULT SERVICES**

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A thesis submitted in fulfilment of the requirements of the University of
Wolverhampton for the degree of Doctor in Counselling Psychology.

February 2010

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Abstract

This mixed methods study investigates how counselling psychology perspectives can collaborate with the Sikh community in the development of Older Adult Psychology Services. 73 Sikh participants, aged 45-65 years contributed in English and Punjabi through interview, questionnaire or focus group at multiple community sites across 3 metropolitan boroughs in Sandwell. Qualitative data from validated scenarios and personal experience were analysed by a thematic approach informed by Interpretive Phenomenological Analysis. Master themes were identified for religion, quality of life and service development. The SF12v2 (Ware et al., 2005) is a measure of health and well-being which showed just below average population norms for physical and mental health components of well-being for the Sikh Community. The God Locus of Health Control Scale (Wallston et al., 1999) demonstrated religion's importance, and how karma is integral to Sikhs' understanding and management of health. 80.6% (N=31) prefer older adult service providers to account for their religious beliefs and counselling psychologists are recommended to address this request in their engagement with this community. Preferences in the modes of delivery, types of psychological intervention and aids to service uptake are provided with recommendations for clinical practice, training and future research.

KEYWORDS: Service development, Religion, Sikh, Older adults, Quality of life

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This research would not have been possible without the assistance and support of: Manjeet, Nav, Ruby, Dave, Dal, Raj and Deepak.

With thanks to the many Service Managers, Staff and Facilitators, Chartered and Trainee Counselling Psychologists, Community Leaders, and of course the local Sikh Community for their willingness to share their experience, ideas and thoughts in improving psychological service provision for the Sikh elderly.

Special thanks of course to Darren and Vicky – this is the last course, honest! My sincere thanks to Dr. Richard Darby (Director of Studies) who amongst the process of supervision and outside of it, kept my spirits up and Dr. Yvette Lewis (Research Supervisor) for being the voice of reason and keeping me on the right track.

Thanks also to those past: Julia McLeod, Dr. Elvidina Adamson-Macedo, Jackie Parrish and Mrs Walters and present: Dr. Nicky Hart for her consistent interest, warm understanding and constant encouragement to succeed and Anne Crawford-Docherty (Clinical Supervisor) who was incredibly supportive and inspirational in motivating me to commence this work. Lastly to those friends and colleagues who have encouraged me along with understanding and compassion, particularly Pat Lees, Dr. Martin Sharp, Dr. Lorna Fortune, Dr. Wendy Nicholls, Dr. Jane Carstairs and Ida Beasley.

In dedication to my Beloved, Victoria and Claire: The best portion of a good [person's] life, their little, nameless, unremembered acts of kindness and of love.
(William Wordsworth).

Section	Word Count
Abstract	193
Literature Review	7,493
Research Study	17,479
Critical Review	2,436
Overall Total	27,600
<i>Not including Tables & Graphs</i>	26,446

Summary of Portfolio

This work is presented in three sections. In Section One the Critical Review Paper outlines the relevant background and current issues for the Sikh Faith Community as it pertains to clinical practice and Older Adult Service development. This is presented in the format as prescribed by The Journal of Consulting and Clinical Psychology. Instructions to authors are located in Appendix 1. Section Two is the Research Report and Section Three is the Researcher's Critical Analysis of the Research Process. There are extensive General appendices which readers are appropriately referred to throughout the document (see pages v-x for a complete listing of appendices). All References can be viewed at the end of the report. Two Confidential Attachment Booklets 1 and 2 containing project administration, sensitive documentation and interview transcripts are also associated with this thesis, but not available for public viewing.

Literature Review Search Strategy

Throughout the completion of this work, literature searches have been conducted using the following databases and search engines: Psychinfo, WIRE, MEDline, British Medical Journal, Wiley Interscience Search Engine, RSS feeds, Zetoc alerts and the King's Fund reading lists.

Keywords include: Sikh, faith community, Older adults, counselling psychology, counselling, ethnicity, ethnic, multicultural, Quality of life in Older adults, Older Asian People, Quality of Life, Elders, religion, Phenomenology, Asian, Indian psychology, Indian philosophy, South Asian, Ethnic older adults.

Additional searches on known author names in this field have also been conducted. Examples include Silberman, Nazoo and Pargament. Journals deemed to be of particular relevance were also specifically selected for methodical searching of their articles published during the last 6 years. Examples include: The Journal of Clinical Psychology and Clinical Psychology Review.

There has also been consistent and extensive use of email alerts e.g. Healthcare Commission, and RSS streams for Journals whose titles included the above keywords such as religion and mental health, spirituality. The on-line bookstore Amazon and the British and University library resources have also been searched using the above keywords for texts classic and contemporary on the subjects. Finally, articles reference lists have been scrutinized for pertinent articles or those requiring further consideration.

SECTION 1

LITERATURE

REVIEW

Introduction

Counselling psychologists are required to '*respect the diversity of beliefs and values held within society and [to] continually review their practice with due regard to changing societal norms*' Professional Practice Guidelines (BPS, 2005, p.3). They are expected to '*make themselves knowledgeable about the diverse life experiences of the clients they work with [and] challenge the views of people who pathologise on the basis of such aspects as ... racial identity and religious and spiritual views*' Professional Practice Guidelines (BPS, 2005, p.7). This study intends to outline the issues and perspectives pertinent to the Sikh Community, with an emphasis on older adult issues and psychological services provision. The aim of this paper is two-fold. First, to evaluate the importance of religion in the Sikh Faith Community as it relates to identity, well-being and psychological health and secondly, how counselling psychologists can engage with this client group therapeutically and in service provision initiatives.

The decision was made to develop an applied focus to this work, so as to: improve the practical use of the research findings; increase the number of Asian clients accessing older adult psychological services; provide information that practitioners could apply within their clinical practice and which may assist older adult mental health service providers and commissioners in the provision of appropriate services. This has inevitably restricted theoretical and conceptual considerations that could have been explored further in basic/pure research (Drenth, 1996; 2008).

The review is presented in five sections: 1. The Perspectives (Counselling Psychology / The Sikh Community), 2. The Role of Religion, 3. Psychological Health & Quality of Life, 4. Older Adult, Ethnic Minority Service Provision and 5. Recommendations.

The Perspectives

Counselling Psychology Perspectives

Counselling psychologists, as part of their practice as ethical practitioners are encouraged to, as the Counselling Psychology Division of the British Psychological Society's (2005) *Professional Practice Guidelines* state:

... engage with subjectivity and intersubjectivity, values and beliefs [of clients] ... to know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing ... (p.1).

To this end the following section outlines the background and history to the UK Sikh community and the Sikh conceptualisation of self involving individual, social and religious identities.

The Sikh Community in the UK

Britain is the 'motherland' to the South Asian colonies which include India, Pakistan, and Bangladesh. South Asians residing in the UK are therefore a culturally diverse and heterogeneous population, with the Sikh, Indian-Punjabi being one of several distinct subgroups. These have their own languages, religions, diets, social practices and migration histories. Within each community variations exist in educational level, income, geographical area and level of acculturation (Anand & Cochrane, 2005).

Major events contributing to migration to Great Britain.

The first Sikh to enter Britain was Maharajah Duleep Singh in 1854, yet it was not until the 1920s after First World War service that Sikhs became traders in the UK (Bance, 2007). Invitations from Britain to relieve the labour shortage and escape from the political unrest following *The Partition in 1947*^{*} brought Sikh men from Bhatra during the mid-1950s (Kalathil, 2008). The first generation came before the 1963 ‘open door’ policy was closed and many had not intended to stay (see Bance, 2007; Mand, 2006). The Sikh Diaspora^{*1} is worldwide; the latest estimates suggest 19 million live in India with 61% in the Punjab and 500,000 in the UK. Almost two thirds of these reside in the West Midlands and London (Adherents, 2005; National Census, 2001).

The Self

South Asian views of the self: individual, social and religious identities.

Western psychologists maintain an individualist view of the person while in the Sikh community selfhood is indexical to the community (Mattis et al., 2006). For migrant groups, identity is influenced by the roles held; successful acculturation and adaptation at individual and community levels; and the national character of the host community; such as its secular stance (Bhagra, 2005; Vertovec 1997, 2000, 2004). Moreover, the impact of transnational, historic, socio-economic, political, biographical factors, changing family structures and social practices need to be acknowledged. For instance,

** This is when Britain relinquished its rule over the colonies (See Copeland, 2002; Singh, 1999) and was marked by civil war, resettlement and ethnic cleansing, across India, Pakistan and Bangladesh. The Indian sub-continent remains war torn and emotive for the Sikh Diaspora^{*1} who stay connected to the Punjab through perpetuating social, cultural and religious customs (Bruce, 1995; Shackle, 1988).*

**1 i.e. being a ‘dispersed people sharing a common religious and cultural heritage’ (Vertovec, 2000, p.3) whereby religion and culture occur at a social level without the confines of a physical location (Levitt, 1998).*

the influence of being raised in Britain, the British social life, changes in familial, personal, and professional roles and higher educational expectations of the Sikh younger generation has implications for their identity (Butt & Moriarty, 2004; Cole, 2004; Kalathil, 2008; Singh & Tatla, 2006).

In Sikhism, religion and identity are perceived to be intertwined from before birth due to the belief in reincarnation and 'old souls' (Mensching, 1976; Purdam et al., 2007; Smith, 2004). Religious development is linked to identity development and is most prominent within adolescence and old age. Religion offers stability across the lifespan in an environment that is consistent and supportive (Erikson, 1968; Klaassen et al., 2006; Marcia, 1980; Templeton & Eccles, 2006). Religion has a powerful role in the preservation and the perpetuation of cultural identity for migrant populations (Laungani, 2004). The 'little Punjabs' are found to be more religious than the host community (Bruce, 1995). Religion is central to cultural and social practices and engenders cohesion, social and emotional support for community members.

The caste system.

Religion impacts upon the social structure and daily experience of people who adhere to a hierarchical social and religious caste system (Mensching, 1976). A person's caste position is predetermined before birth and has major implications throughout each stage of life. Sikhism stipulates equality for all and is demonstrable within the daily practices of the Gurdwara and public kitchen, the *Langar* where everyone worships and eats together irrespective of status. The names Singh and Kaur (signs of Kalsha membership - the baptised within Sikhism) meaning lion and princess respectfully, are caste non-specific. Nonetheless there is a diversity of Sikh castes, groups and sects which can be

fragmented socially and politically (Singh & Tatla, 2006). They indicate status and exert influence upon marriage, occupancy and residency possibilities in the UK (Cole, 2004; Laungani, 2004) with differences evident in lifestyle, ritual practices, organisations and separate Gurdwaras.

A way of life.

The distinctions between Western and South Asian cultures have been described using various terminologies: individualistic verses collectivist or ego-centric verses socio-centric or individuals described as idiocentric or allocentric respectively (Bhugra, 2005; see Oyserman et al., 2002 for a critique). Through prior research (Laungani 1995; 1999^a; 1999^b; 2000; Laungani, Parkes, & Young, 1997^a; 1997^b; Triandis, 1994), Laungani (2004) devised a conceptual model to explain differences between British and Indian cultures based upon their value systems. He proposes four value continuums which mediate how individuals behave in private and public contexts: *individualism to communalism; cognitivism to emotionalism; freewill to determinism and materialism to spiritualism*. Sikhs tend towards communalism, emotionalism, determinism and spiritualism that influence cultural attitudes, values and beliefs in how they view themselves and interact with others (Laungani, 2004). Difficulties arise when there is a clash of values in adapting to the host community's cultural norms (Caldwell-Harris & Aycicegi, 2006). Laungani (2004) states the benefits of living in a communal society in that: 1) individuals more readily gain the support of family and community which can be drawn upon in old age; 2) their emotionalism enables them to express their emotions healthily; 3) their belief in Karma helps defend against guilt as these things are out of their control and they draw comfort from atoning for wrongdoing. Alternatively, the person may experience distress due to negative appraisals about being punished by God

(Phillips & Stein, 2007); 4) adherence to spiritualism provides religious coping resources. However, the effects on well-being are likely to be variable and dependent on the types of religious coping adopted (Pargament, 1997). Further, Laungani's model may only have significance for older Sikhs and new UK inhabitants. Beliefs in Karma may lead to a disinclination to change their fate, which has health implications.

The Role of Religion

This section considers the issues of religion, Sikhism, psychologists' religious research and beliefs and the religious coping literature.

Religion: History and Background

Defining Religion

Religion has been part of human existence since primitive times (Eliade, 1958). Western philosophical conceptualisations of religion separate the secular from the religious domains of life while other non-westernised communities consider psychological, physical, cognitive, social and political as a part of 'the sacred', i.e. of, or pertaining to religion (Singh, 2008). Many definitions for religion are based on views of the sacred and the nature, purpose and dimensions of religion (Chryssides, 1999; Mensching, 1976; Smart, 2000; Worthington & Aten, 2009). Religion also has its critics (e.g. Atran, 2002; Dawkins, 2006) but can be defined as 'the search for significance in ways related to the sacred' (Pargament, 1997, p. 32). It incorporates shared ritual practices; *liturgy* and a communal belief system; *dogma* (Richards & Bergin, 2005). Religions can include prayer, customs, celebrations, rituals, reading of scriptures, mediation and contemplation (Richards & Bergin, 2005). It is inherent

within all culture and is fundamental in the organisation of individual consciousness (Hefner, 1998) which influence the worldviews, rituals and morality of communities.

Sikhism

Sikhism emerged in 1469 from Hinduism and Islam with the first of the ten living Gurus, Guru Nanak Dev (Greenlees, 1994, provides a detailed explanation of the Sikh Holy Book, The Guru Granth Sahib; see Singh, 2004 for an overview of the life and contribution of each Guru). It is a monotheistic religion believing in one God who is considered the true teacher. Sikhism is a communal religion, not a personal one, where the importance of the collective through the *Panth* is fundamental in remembering God *Naam Simran*. This new religion emphasises peace, love and brotherhood and ranges along a continuum of inner devotion and adoration to militancy personified by the *Khalsa*. The word *Sikh* means disciple, and religion plays an important role in every aspect of life, especially in the main celebrations such as naming, birth, marriage and death (Cole, 2004; Shackle, 1988). Religious communal gatherings occur at the Gurdwara where religious ceremonies, daily worship involving singing of *ragas* and reading from the holy book the *Adi Granthi* (the living Guru) take place along with the opportunity to complete *seva* (voluntary service is a fundamental element of Sikhism). Sikhism has survived 17th century fighting; internal splintering and absorption into the Hindu faith (See Singh, 2003). Those baptised are recognisable by the '5 Ks' the comb, dagger, bangle, uncut hair, and shorts. Women may wear emblems such as a dagger necklace and turbans are worn by males. The removal of these items can cause distress and a lengthy religious reparation process (see glossary in Appendix 30).

Karma.

Karma (meaning ‘action’) destiny and fate are used interchangeably in relation to the law of karma (Bhangaokar & Kapadia, 2009). A belief in destiny acknowledges the ‘numinous (i.e. supernatural) powers in the background of human existence’ (Mensching, 1976, p.195). There are various types of karma linked to the past, present and future but in Karma law one repays for the deeds of this or a previous life. Karma is said to occur when accidental events appear to be necessary, purposeful and involve spiritual powers or beings such as God (Mensching, 1976, p.196). Destiny has different connotations but can mean suffering-destiny such as the repayment for past deeds or task-destiny, as signified by ‘all things are for the best.’ Karma is linked to reincarnation and transmigration of the soul in a perpetual cycle of rebirth until a reunion with God is achieved. The caste system depicts ones position in relation to rejoining God and also influences one’s roles and responsibilities in society. Good deeds and acceptable behaviour are required throughout a person’s human life, otherwise individuals return in any of the 8,400,000 forms of life (Bhangaokar & Kapadia, 2009; Raj & Singh, 1984).

Psychologists’ beliefs.

Religious studies are at the fringes of mainstream psychology/counselling psychology and almost dissipated entirely during the dominance of psychoanalysis and behaviourism in the 1930s to 1960s; despite some significant work (see Emmons & Paloutzian, 2003; Gorsuch, 1988; Haque, 2001; James, 1902). Several studies conclude that psychologists and mental health professionals are not usually religious (e.g. Connolly, 1999; Delaney, Miller, & Bisonso, 2007; Freud, 1963; Hayes & Cowie, 2005; Koenig, 1998; Pargament, 1997, 1998; Pargament & Brant, 1998; Worthington & Aten,

2009) and is thought partly responsible for the limited religious interventions in therapy and consideration within training programmes. Worthington & Aten (2009) advise that the world is more religious than professionals realise. In response to Pargament's (1996) claim, psychologists are encouraged to resist ignoring valuable coping resources in order to fully respect the value systems of ethnic clients. Psychologists' perspectives as researchers are found to influence the types of investigations undertaken, style of investigation, analysis and reporting of results (e.g. Coyle, 2008). Some will leave interpretation open to the possibility of God while others will refute Gods' existence (Connolly, 1999). Religious research has emerged from The Division of Counselling Psychology particularly from doctoral trainee investigations into practitioners' and clients' spiritual beliefs, and how religion and spirituality can be incorporated ethically within clinical practice e.g. Blaire (2010) and Jackson & Coyle (2009). These studies are predominantly qualitative and display the Discipline's preference for phenomenological models of practice and enquiry (BPS, 2005; Coyle, 2008). Quantitative studies are prevalent in the development and validation of religious scales (see Hill & Hood, 1999). Despite religion being an emotive topic, practitioners are encouraged to take clients' religious lives seriously (Goldstein, 2007; Hayes & Cowie, 2005; JCP (Special Issues), 2005, 2009; Post & Wade, 2009) since people increasingly turn to therapy for assistance in their search for purpose and meaning originally provided by religion (Hayes & Cowie, 2005).

Religious Coping

Religious coping is 'the search for significance in times of stress' (Pargament, 1997, p.90) and exceeds traditional coping as it assists when human competence, control and power appear exhausted (Koenig, 1998). It is as frequently utilised as non-religious

coping within diverse populations (Pargament, 1997) and is a strong predictor of adjustment to crisis, sometimes more so than non-religious coping (Gartner, 1996).

Functions and strategies of religious coping.

Religious coping addresses five functions according to Pargament et al. (2000) to find meaning in the unexplainable or adverse event; to gain control; to gain comfort by achieving closeness to God; to increase intimacy with God and others and to aid life transformation. Religion offers meaning and purpose to one's life (Park, 2005; Silberman, 2005) and different types of religious coping strategies exist. Helpful forms include spiritual support, collaborative religious coping and benevolent religious reframing while potentially harmful forms include negative religious reframing and discontent with God (Koenig, 1998; Pargament & Brant, 1998). Prayer and meditation are found to be helpful for older adults in enhancing well-being, psychological calmness, comfort and support (Koenig, 1998; Maltby, Lewis & Day, 1999; Maltby, Lewis & Day, 2008; Smith and Simmonds, 2006).

Religious agency.

Pargament (1997) identifies 4 types of religious agency: *self directing, collaborative, deferring* and *pleading*. Fabricatore et al. (2004) investigated whether religious coping mediates (i.e. translates religiousness into successful coping strategies) or moderates stressors, well-being and mental health. This investigation considered every day, unpredictable stressors on well-being and mental health rather than the life events and major traumas typically studied by Pargament (1997). They found that collaborative religious coping (i.e. sharing the responsibility for problem-solving with God) mediated for well-being and distress but failed to do so for stress and mental health. Those

adopting a deferring religious coping style, (i.e. passively deferring responsibility to solve difficulties to God), produced no effect on well-being and distress and worsened stress and mental health outcomes. However, the young adult participants were above average intelligence and did not reside in the UK, they were not British, or Asian and were two thirds female, of generally high social economic means. Their European beliefs do not mirror collectivist, South Asian religious culture and these limitations are in addition to those cited by the authors such as its cross-sectional nature and limited generalisability. Nonetheless, collaborative religious coping is consistently related to higher levels of well-being, self-esteem, mastery and sense of control whereas the deferring approach is linked to adverse affects (e.g. Klassen et al., 2006; Pieper, 2004).

Effectiveness of religious coping.

Findings are mixed on religion as a coping resource. It can be helpful, hurtful or have no effect but depends on several variables such as type of contextual factors, cognitive behavioural mechanisms, time-frame and type of religious coping adopted (i.e. positive or negative; generally associated with improvements or adverse outcomes respectively). Religious orientation, that is *intrinsic*, *extrinsic* or *religion as quest*^{*2} also determines outcomes (Allport & Ross, 1967; Ano & Vasconcelles, 2005; Batson & Ventis, 1982; James & Wells, 2003; Koenig, 1998). Several limitations exist within the religious coping literature including: confusion in the use of terminology; over use of uni-dimensional measures; excessive number of cross-sectional studies, sparse longitudinal studies and limited of samples e.g. fewer elderly studies and clinical samples and over reliance upon student participants.

^{*2} *intrinsic is associated with living a deeply religious life; extrinsic is where religion is used for personal gain; or religion as quest demonstrates a constant questioning without necessarily reaching resolution.*

Nonetheless, meta-analysis and reviews have drawn conclusions about the effectiveness of religious coping. Few find completely no effect as in Breslin & Lewis (2008) for distant intercessory prayer, or entirely positive effect e.g. Maltby, Lewis, & Day (2008) for meditative and ritual prayer on well-being. The majority of studies report mixed findings for the effectiveness of religious coping or commitment on health and well-being (Anand & Cochrane, 2005; Ano & Vasconcelles, 2005; Emmons & Paloutzian, 2003; Fabricatore et al., 2004; Gartner, 1996; Gorsuch, 1988; Hackney & Sanders, 2003; Koenig, 2009; Maltby, Lewis & Day, 1999; Shreve-Neiger & Edelstein, 2004).

Historical and contemporary reviews do indicate a positive relationship for elderly populations (e.g. Argyle & Beit-Hallahmi, 1975; Paukert et al., 2009). Gartner (1996) reviewed over 200 articles associated with religious commitment and psychopathology from 1979 to 1989. Her findings regarding the relationship between religion and mental health are consistent with Bergin's (1983) results that indicated 47% show a positive, 23% a negative and 30% no relationship, respectively. However Gartner's (1996) results may be due to 'methodological complexities' or the multidimensional nature of religiosity (James & Wells, 2003) and variation in conceptualisations and definitions of religion and mental health issues across studies (Hackney & Sanders, 2003; Shreve-Neiger, & Edelstein, 2004). A cross-cultural review of multicultural religious coping (Klaassen et al., 2006) supports Gartner's (1996) conclusions that religious coping is effective, but no effect and worsening outcomes in some studies do persist. King et al. (2006) found no difference in the prevalence of common mental health disorders between the religious that adhere to a religious framework such as Sikhism and non-religious ethnic groups. Spirituality without a formal framework is however associated with mental health disorders, including psychosis (see Clarke, 2001).

The Sikh community's style of religious agency and personal strategies of religious coping is unknown, which could be investigated to assess the impact on well-being and ensure helpful practitioner / service interventions. Findings are mixed for the effects of age and gender upon religious commitment and religious coping (Cohen & Koenig, 2003; Coleman, Ivani-Chalian & Robinson, 2004; Francis, 1997; Vaillant et al., 2008). Historically it was accepted that religiousness increased with age and women show greater religious attitude and observance than men (e.g. Argyle & Beit-Hallahmi, 1975). Future studies could determine the patterns of commitment and religious coping styles for Sikhs as it may differ from other communities.

Psychological Health and Quality of Life in Later Life

This section considers the impact of culture on conceptualisations of QoL and well-being, QoL in older adults particularly ethnic groups and South Asian experiences of mental health on QoL in old age, utilising Hwang et al.'s (2008) model of Cultural Influences on Mental Health.

The Impact of Culture on Conceptualisations of Quality of Life and Well-Being

Utsey et al. (2001) outline the difference between collectivist and individualist societies concerning QoL. Fundamental differences include the relative importance of existential and spiritual well-being and the role of cultural beliefs and practices. Authors highlight that most definitions focus on western assumptions of individualisation, choice, autonomy, wealth and life satisfaction which is at odds with the sublimation of personal desires for the betterment of the community evident within the Sikh community. Quality of life in mainstream psychology focuses upon personal happiness, self

actualisation, fulfilment and adaptive functioning as the ultimate in well-being. In collectivist cultures the emphasis is upon harmony between the mind and body and relational harmony on familial, social and spiritual levels. Social fulfilment with one's community and spiritual liberation are paramount to well-being. Such philosophical underpinnings of QOL need to be acknowledged, particularly ontologically, where the stance is not '*I think therefore I am*' but instead '*I am because we are, therefore I am; we are because I am.*' (See Utsey et al., 2001, pp.194-197). Most psychological models of QoL are founded on a psychologically, bodily bound self that will inevitably conflict with non-western perspectives (Rapley, 2003).

Quality of life is multidimensional, particularly for older people, involving objective and subjective aspects of life and is mediated by physical health, psychological well-being, personal beliefs, social relationships and environmental factors. For the elderly QoL includes managing declining ability, health, dying and death issues (Asadi-Lari, Tamburini, & Gray, 2004; Gilhooly, Gilhooly & Bowling, 2005; Netz et al., 2005; Smith et al., 2004; Utsey et al., 2001).

Quality of Life in Older Adult and Ethnic Older Adult Groups.

Quality of life investigations have been conducted with older adults and ethnic older adult populations (Moriarty & Butt, 2004). Gabriel and Bowling's (2004) research on national survey data of 999 older people determined the most important aspects of QoL for the UK elderly are: social relationships, homes and neighbourhoods, psychological well-being and outlook, activities and lone hobbies, health and functional ability and social roles and activities. Independence and finance were also consistently of concern. For Smith et al. (2004) QoL and life satisfaction are important for the discussions

around ageing 'well', and some researchers advocate that proactive coping and spirituality be included as factors for successful ageing (Crowther et al., 2002 see Ouwehand, De Ridder & Bensing's (2007) review which criticises psychological models of successful ageing for their unsuitability to the non-westernised elderly).

Bajekal et al. (2004) compared the *National House Survey* (2000) results with the *Fourth National Survey on Ethnic Minorities* (1997) to evaluate four QoL dimensions: neighbourhood quality, social networks and community participation, material conditions and health. Participants were older people from various ethnic backgrounds based on family origin, language and religion. Researchers found ethnic communities place value on QoL factors that the host community does not. The importance of social networks and social participation for the age group is well known, but they also identified frequent contact with family members and living within cohesive and supportive, high density communities as important, as is religious practice and its institutions. However, the sample did not include Sikhs, and over half of the respondents for the South Asian groups were below 55 years. The researchers utilized secondary data involving small sub-groups and could not determine causality from cross-sectional quantitative surveys. Neither can the influence of past life course trajectories on subsequent QoL be determined..

South Asian Experiences of the Impact of Mental Health on Quality of Life in Old Age

Hwang et al. (2008) provide a conceptual framework "The Cultural Influences on Mental Health" (CIMH) model to assess how culture can influence six mental health domains: (a) the prevalence of mental illness, (b) aetiology of disease, (c) phenomenology of distress, (d) diagnostic and assessment issues, (e) coping styles and

help-seeking pathways, and (f) treatment and intervention issues. This model will prove useful in outlining the position for the Sikh community.

The prevalence of mental illness.

The prevalence of mental health issues for older adult South Asian minority groups illustrate that both men and women do experience psychological, psychosocial and psychiatric conditions above national average figures in most instances (e.g. Anand & Cochrane, 2005; Erens, Primatesta, & Prior, 2001; Hussain & Cochrane, 2003; Hwang et al., 2008; Nazroo, 1997, 2004; O'Connor & Nazroo, 2002; Sashidharan, 2003; Sproston & Nazroo, 2002). Such research reports higher rates of poor physical health and greater contact with GPs which is relevant given this community tends to somatise symptoms. However, of the 31,020 admitted to inpatient services across the UK in 2008, only 0.5% were Sikh (155 of the estimated 500,000 Sikhs in the UK) and these tended to discharge within short periods (Adherents, 2005; CHCAI, 2008).

Cultural issues on the aetiology of disease.

Hwang et al. (2008) and Nazroo (2004) finds that minority groups are likely to suffer from various forms of acculturative and migration stress, irrespective of period of residence. They also manage culturally specific issues such as linguistic difficulties, pressures to integrate with UK society; obtaining British citizenship, separation from subcontinent family, intergenerational conflict (e.g. see Sonugan-Barke & Mistry, 2000 on the interaction between mental health and women's position within families) and racism and discrimination (see Bowl, 2007; Nazroo, 2004). Poverty and isolation from supports like family, friends, health and social services tends to diminish psychological health and well-being (Butt & Moriarty, 2004). As outlined below, elderly Sikh people

may hold alternative beliefs for the cause of their illness which include numinous, paranormal, culturally-bound, somatic and psychosocial explanations (Hwang et al., 2008; Smith, & Simmonds, 2006).

Culture and the phenomenology of distress.

Stigma is not only an issue for ethnic minority groups when seeking help from psychological services (Clement, Brohan & Thornicroft, 2009; Vogel & Wade, 2009). In Asian communities, to be afflicted by mental health issues is shameful; *sharam* (see Glossary of Terms in Appendix 30) and stigmatising on the family's honour; *izzat* (see Appendix 30) illustrated by Bhagra's (2005) and Seabrooke & Milne's (2004) depression and dementia studies with Asian communities. Nesbitt (2005) writes mental illness is hidden from friends and neighbours for 'fear of gossip' (p.133) and openness on mental health matters is discouraged. There is the belief that God has the capacity to punish people with bad karma for wrong doing (Phillips & Stein, 2007; Pargament et al., 2000) which has implications for how the person and family are viewed and respected within the community. Family honour is important due to social, status, employment and marital consequences (*see* Gilbert, Gilbert & Sanghera, 2004).

Culture and diagnostic/assessment issues.

Many measures in clinical practice have not been adapted for ethnic groups. Those that have, with appropriate translated versions, are unlikely to have population norms to support them. Diagnosis and assessment are complicated by the cultural understanding, interpretation, manifestation and selective reporting of symptoms (Hwang et al., 2008). Somatisation of symptoms is common and socially acceptable in non-western communities and may be encouraged by health professionals who enquire about

physical symptoms that reinforce somatisation tendencies (Lam, Marra & Salzinger, 2005). They advise comprehensive assessments be completed irrespective of patient reporting, with a symptom checklist, in-vivo observation and interviews with others known to the patient.

One complexity is the issue of unfamiliarity with ill-health conditions on the part of the practitioner and client. Culturally-bound conditions of ill-health have specific cognitive, physiological and emotional components with social meanings not found in western psychiatry's constellation of symptoms. Awareness raising/training is necessary. Several culturally-bound examples appear in the appendices of the DSM 4-TR (APA, 2000) but also see Simons (2001) and Sproston & Nazroo (2002). Equally, elderly Sikhs are unlikely to recognise westernised mental health conditions. Dementia studies by Bowes & Wilkinson (2003); Seabrooke & Milne (2004) and Turner (2005) support this finding. Bhagra (2005) found that middle-aged women from the Punjab did not recognise depression, or would attribute ill-health to non-medical causes.

Reportedly, elderly Asians do not routinely accept the medical model as an explanation for their difficulties, but attribute ill-health (and treatment) to external psychosocial, physical or spiritual forces. For instance, people may suffer from bad Karma or be cursed with the evil eye, *Nazar*, that bestows human misfortune. People may become *Jinn* possessed, (this is similar to the western understanding of demonic possession) or rely on *Jadoo*, *i.e.* Black Magic to cure their ills. These are common place within the community (Howse, Ebrahim, & Gooberman-Hill, 2005; see Hussain & Cochrane, 2002). How these are managed is expanded upon below.

Culture, coping styles and help-seeking pathways

In Asian cultures, religion, psychology, medicine and ethics are integrated, in contrast to western approaches to psychological health; where the emphasis is on dichotomies of the mind and brain and the separation of religion from secular science. Indigenous mental healthcare involves individual, cosmic, physical, spiritual and environmental considerations. Healing requires a holistic approach involving psychology, medicine and religion where 'soul health recovery' and 'possessions' are normal (e.g. Fernando 2001; Lee et al., 2006). Kaassen et al. (2006) state communities have their own forms of communal and collective coping. For Sikhs this includes Seva (voluntary service), hospitality through food exchange and social and spiritual communal life at the Gurdwara. According to Laungani (2004) there are distinct Asian approaches to counselling and managing health including indigenous yoga therapies and religious counselling. Bhagra (2005) found that Asian women were more likely to utilise religious coping strategies such as reading scriptures and Hussain & Cochrane (2002) found that they would combine this with advice from healers. Elderly Asians are usually proactive in their healthcare and will seek support simultaneously from religious and spiritual experts (Laungani, 2004) which include faith healers, shamans or witch doctors, rather than mental health professionals (Clement, Brohan, & Thornicroft, 2009; Gartner, 1996; Nirmal, 2004; Smith & Simmonds, 2006; Snowden & Yamada, 2005). They are unlikely to inform professionals about this and are inclined to delay taking up non-indigenous assistance or will withdraw from treatment prematurely (Bhagra, 2005; Fernando, 2001; Hussain & Cochrane, 2002; Hwang et al., 2008). This could be to maintain family honour and the perceived lack of understanding by mental health professionals.

Several investigations into the avoidance of help and reduced uptake of services conclude that poor physical and mental health is considered a normal, accepted part of the ageing process by ethnic minority elderly (e.g. Howse, Ebrahim & Goberman-Hill, 2005). Sarkisian, Lee-Henderson, & Mangione (2003) found that older people were less likely to discuss their depression with GPs or seek help for it if they associated it with ageing rather than ill health. It would be valuable to determine how much of the variance in help seeking is attributable to this factor as this issue has relevance to all elderly groups and is usually clouded by reasons such as stigma, often associated with minorities. Additional non-culture-specific reasons include the preference for informal care, costs, appropriateness of services, knowledge gaps, guidance from family and social network, lack of hope that they can be helped and psychological disturbances such as depression (Howse, Ebrahim, & Goberman-Hill, 2005). McKevitt et al. (2005) conducted 203 interviews with Asian Indians, Pakistani, Bangladeshi and mixed heritage participants and the findings challenged stereotypical views, especially around the issue of caring. They found family support is preferred particularly as professional services fail to offer support at all. Hussain & Cochrane (2002) concluded that 'isolation' needed to be addressed by providing people with opportunities to talk to others. Suspicion appears prevalent around one-to-one work within the community. Structured/unstructured groups appear preferred because socialising, the exchange of experiences and emotional support occurs in contexts where cultural factors are accounted for. Cattan et al. (2005) in their systematic review of health promotion interventions in alleviating loneliness from 1970 to 2002 found that educational and social activity group interventions targeting specific groups were most effective. Interestingly, one-to-one support, advice, information and health needs assessments were ineffective interventions. Inadequate access to, and knowledge of, services

appears to be an on-going issue for Asian communities (e.g. Sashidharan, 2003; Snowden & Yamada, 2005). Butt & O'Neil (2004) and Kalathil (2008) confirm that these challenges are partly due to the communication barrier and cite the need for translators and assistance with comprehending psychiatric terminology. Nonetheless, the efforts of service providers to meet the needs of ethnic minority groups are generally unsatisfactory. Limited, unstable service provision and variations in the quality of services continue to exist. The Sikh Community's discontent remains evident in their limited uptake of older adult mental health and psychological services (e.g. (DoH, 2006; Dickson, 2007; Kalathil, 2008; Kings Fund, 2008).

Culturally relevant treatment and interventions

Laungani (2004) argues that a non-judgemental approach about the person's healthcare management is vital as cultural approaches are 'ingrained in the Indian psych' (Laungani, 2004, p.149). Smith & Simmonds' (2006) study supports previous research by Daleman & Nease (1994) who found that patients would like doctors to include spiritual aspects in relation to their illness. Recent findings indicate 70% of people would like their religiosity to be addressed when seeking support from counsellors, psychologists or other medical staff (Simmonds, 2006). Participants reported a tendency to seek support for serious, but non-psychiatric conditions from their friends or family (44.9%) before seeking external professional help. People ranked professionals in order of who they would be most willing to engage with. Counsellors were preferred, followed by psychologists, religious practitioners, and psychiatrists. Unfortunately, Sikh religious groups were not represented and only 0.5% of contributors were from the UK. Nonetheless, the authors suggest adopting a holistic approach to psychological care and practice which involves religious elements of the

person's life and substantiates this with best practice guidelines. Simons (2001) suggests combining several treatment options from western psychiatry and indigenous strategies. When determining whether to intervene if it is appropriate at all, Simons (2001) suggests identifying the problematic issues while retaining the social and cultural beliefs and practices when determining interventions.

Models of therapy specific to the needs of older adults and ethnic and religious orientated groups are now available (e.g. Singh, 2008). Their effectiveness and fit vary considerably. Knight's (1999) review of outcome studies supported the application and effectiveness of therapy for older people, although adaptations were necessary. He proposed the use of his trans-theoretical framework: the contextual, cohort-based, maturity, specific-challenge model (CCMSC) but unfortunately the model has relevance for western models of therapy only and is unlikely to be appropriate for the Sikh Community without further adaptation such as acknowledging their allocentric and philosophical values in order that interventions have salience for them.

Approaches that take into account culture, race, multicultural counselling competencies and racial identity theories have been developed with a proliferation of multicultural counselling models (e.g. Fuertes & Gretchen, 2001; Locke, 1998; Sue & Sue, 2003) as well as adaptations to traditionally western therapies e.g. Multi-model therapy (Lazarus, 1989), systemic and family therapy (see Jenkins, 2001; Lago, 2006; Natha & Craig, 1999). Models are available to improve cultural competence such as Hays' (2001 as cited in Hwang et al., 2008) 'ADDRESSING' framework which deals with cultural issues in formulation phases of treatment, and Hwang (2006) Psychotherapy Adaptation and Modification Framework (PAMF) that adapts psychotherapy for use with ethnic

groups. Gerstein, Roundtree & Ordonez (2007) identify two trends that can be adopted to avoid unhelpful, incompatible, oppressive or disrespectful interventions. In working with culture, one trend suggests cultivating an improved general awareness of cultural issues. The second trend espoused by Locke (1998) supports gaining an in-depth knowledge and competence for specific groups.

Some theorists are critical of multiculturalism and its implications for understanding the client and the therapeutic process. For instance, cultural assumptions underlying European/American models covertly permeate the therapeutic endeavour and perpetuate western belief systems like, individuals are predominantly scientific, rational and objective beings that have mastery over their own destiny; that they prefer being active as opposed to passive in achieving personal fulfilment; that their choices should meet their own ends and take precedence over others; and that people will dispense with or question parental, family and community influences that result in costly personal consequences (Lago, 2006). These assumptions are alien to Asian communities. Many models could be accused of being ethnocentric when cultural factors are ignored entirely (Blackwell, 2005; Laungani, 2004). The development and modernisation of models that become sufficiently flexible to encompass both eastern and western ideologies (on a continuum of application perhaps) may successfully curtail the ethnocentric argument. Moodley (2007) contends that multiculturalism has had a limited impact upon western ideologies and practices and argues that 'multiculturalism' and 'diversity' are 'fuzzy' concepts leading to professional confusion. He cites concerns about the baselines for the conceptualising and theorising of ethnic life experiences, and doubts the relevance of western approaches to ethnic groups, including whether talking therapies, (delivered traditionally by mental health professionals) have

utility for ethnic communities at all. He advocates for a 'third space' to tackle these issues and among others, proposes that social cultural diversity such as gender, sexual orientation, class, disability, age and religion be investigated for their influences.

Another proposal is to encourage indigenous healing practices in support of a holistic approach to client's health and well-being. These suggestions situate well with the ethos of counselling psychologists who aim to collaborate with clients whilst respecting their strengths and coping resources to manage challenges in improving QoL.

However, Moodley's propositions may generate models which are too general, thereby rendering them useless, but these discussions discourage complacency and ensure progress since calls for social action, change and advocacy continue within the literature (Gerstein, Roundtree & Ordonez, 2007).

Several authors suggest religious orientated therapies should be considered during assessment and intervention phases of therapy with attention to individual's religious involvement, beliefs, and practices and whether this impacts positively or negatively upon their mental health (Richards & Bergin, 2005; Paukert et al., 2009; Shafranske & Malony, 1996). Koenig & Pritchett (1998) suggest particular enquiries can be made during the assessment phase like "Is religious faith an important part of your life?" The benefits cited include greater concordance with interventions, congruence with clients' worldview and the ability to identify healthy, religious resources for additional comfort and support. Religious and spiritual transference and counter-transference issues have been considered in relation to therapy (see Koenig and Pritchett, 1998; Lannert, 1991). To avoid being misconstrued, practitioners could utilise Tan's (1998) guidance on implicit and explicit religious integration into traditional models of therapy.

Practitioners can choose either to be client-led on a continuum of covertly keeping in

mind religious aspects without them affecting the sessions. Alternatively practitioners may express religious aspects explicitly in the use of overt interventions, such as considering the client's religious coping resources. Assistance can be categorised as spiritual support, religious reframing, rituals and forgiveness (Koenig, 1998; Pargament, 1997). This might include prayer, readings or identifying religious coping resources. Singh (2008) focuses specifically on the therapeutic needs of the Sikh client while outlining their perceptions of spiritualism and mental health. Practitioners are encouraged to reflect on *their* cultural norms and he confirms that good mental health for Sikhs includes social, physical and spiritual components. He argues that religious and cultural models of therapy will reduce stress and somatic symptoms, but alone this seems idealistic given the numerous obstacles and considerations involved. McCullough's (1999) meta-analysis from 5 studies concludes that there is no benefit in religion-accommodative approaches in therapy and outcomes are potentially due to client preference, not differential efficacy. New research could test this.

Older Adult, Ethnic Minority Service Provision Initiatives and Preferences

2.3 million UK residents have cultural origins in the Indian subcontinent with the ethnic elderly predicted to rise 170% by 2012 (Anand & Cochrane, 2005; NoS, 2001; McIntosh, 2008). *The Patient Choice Survey* does indicate some progress in quality of care, but South Asian people, which include Sikhs, are less satisfied with NHS services, despite Government promises of person-centred care that caters for culture, linguistic needs and religious beliefs (DoH, 2006; Dickson, 2007; Kalathil, 2008; Kings Fund, 2008). Various recommendations have emerged which support the need for integrated, specialist mental health services with appropriately trained staff that maintain dignity,

age-equality and psychological well-being (Audit Commission, 2004; Healthcare Commission, 2006; 2009; SCIE, 2007). Hwang et al. (2008) and others (Bhagra, 2005; Bowl, 2007; Butt & O'Neil, 2004; Hussain & Cochrane, 2002; McIntosh, 2008; Milbourne, 2009; SCIE, 2008) provide numerous suggestions for how services can improve their accessibility for ethnic minority groups. These include increasing: public education, availability of educational brochures and sources of support; advocacy and community based services; cultural competence taking into consideration the effects of migration and acculturation for the person, family and community, and co-ordination of services with seamless referral systems. Advertising services' cultural sensitivity could lead to greater patient confidence, satisfaction and treatment engagement while reducing attrition rates. Client-therapist ethnic matching and culturally specific services are reported to be of benefit (Hwang et al., 2008) while other research finds less favourable outcomes due to cultural expectations and concerns regarding confidentiality within close-knit communities. Service providers are advised to learn from service users and the voluntary sector as well as to integrate religious aspects to the delivery of services (Hussain & Cochrane, 2002; Hwang et al., 2008; Nesbitt, 2005). Despite these findings, the implementation of such recommendations has been inconsistent across older adult services (Edwards, Temple, & Alexander, 2004; Gill & Bob, 1999; Sin, 2004^b).

Recommendations

Clinical Practice

This review informs practitioners of the little known religious, cultural, mental health and QoL issues which appear to influence the healthcare decisions of the elderly Sikh Community. It points to a number of multicultural and religious orientated therapies that can be drawn upon in therapeutic work and in the development and delivery of

services. Religion influences the Sikhs' understanding and management of mental health and well-being issues, and has a bearing on their support-seeking. Practitioners are encouraged to aid Asian clients' access to services by, 1) targeting information towards informal carers, family members and social peers as these hierarchal relationships influence decisions on accessing services; 2) offering clinical support within structures that maintain family honour; 3) working outside the usual mental health service structures to offer services in the community in liaison with statutory and non-statutory groups; 4) adaptation to and delivery of interventions focused at the community level - potentially into places of worship. Professional training courses could integrate religious and cultural diversity issues by offering placement experiences within culturally specific communities. Student research within these areas needs to be encouraged to fill the void and will only come about if there is greater support and acceptance by trainers. Ultimately psychologists need to accept that the world is inherently religious and that clients may have available to them additional resources for coping of the religious type.

Future Research

Researchers have found recruitment of Asian participants challenging and Sikhs often make up a small percentage of participants within the South Asian category (McLean & Campbell, 2003; Sin, 2004). Most research is based around South Asians being a homogenous group but avoidance of community specific studies will not challenge the stereotypes for these distinct groups. Further, most research delineates between homeland location rather than by faith community. Also the issue of costs of qualitative research when involving non-English speaking participants has been identified as a barrier to study inclusivity (Temple, Glenister & Raynes, 2002). A more flexible

approach in choosing between location and religious orientation is required and greater funding opportunities would assist in reducing inadvertent discrimination.

Internationally, counselling psychology purportedly leads the *multicultural movement* in psychology and is seen by some American colleagues (see D'Andrea, 2005; Delgado-Romero et al., 2005; Johannes, & Erwin, 2004; Wade, 2005) as saving the discipline's identity by upholding the developmental focus and emphasis on normality, uniqueness, prevention and well-being. Greater research with British ethnic minority groups is necessary, preferably by following Locke's (1998) focus upon particular groups within specific localities to amass a combination of theoretical papers and clinically relevant outcome studies. Practitioners are reminded of their lifespan orientation and are urged to engage with the older adult specialty while urgently contributing to research within QoL, multiculturalism and psychology of religion as these are relevant in Britain's ageing, religious, multicultural society.

Conclusions

The Sikh community have complex historical, religious social and cultural practices which influence their unique identity. Increasingly psychologists are investigating the potential role of religion in therapy and the mediating influence it may have in managing well-being and in coping with stress and distress. The literature generally reports mixed effects. As religion is an integral part of the Sikh community's identity and way of life; religious coping could potentially be an effective coping resource for Sikhs. Quality of life in older adults is multifaceted and research indicates ethnic communities place value on QoL factors that the host community do not, including religious practice and its institutions. The ever-increasing multicultural literature,

service providers' commitments to raise staff cultural awareness and meeting the needs of Asian communities, although improving, continue to have negligible effects on the number of Sikhs engaging with older adult psychology services. The Sikh community's preferences need to be delivered flexibly. This may involve increased multiagency working with community based and religious organisations. Psychologists practice within a religious, multicultural world and therefore need to consider religious beliefs, communal ways of life and philosophical differences. An awareness of multicultural guidelines and acceptable forms of engagement is essential in respecting the worldview and meeting the needs of older adult ethnic minority groups in therapeutic encounters.

SECTION 2

RESEARCH REPORT

This report adheres to the style of the British Journal of Counselling Psychology:

THE COUNSELLING PSYCHOLOGY REVIEW

Notes to contributors are available from:

<http://www.bps.org.uk/dcop/publications/cpr.cfm?templatetheme=default>

Abstract is available on page ii

Introduction and Overview

Fewer people from Asian backgrounds are accessing psychological services (CHCAI, 2008). This work investigates whether counselling psychologists as service providers should increase their understanding of Asian peoples' religious affiliations when developing and delivering services. This study outlines the preferences of those from the Sikh faith community within the West Midlands, Sandwell Metropolitan Borough.

In adhering to ethical and professional codes (BPS, 2005; 2009) and the principles of the NHS Constitution on healthcare for all (DH, 2009) the NHS and Counselling Psychologists are obligated to offer appropriate psychological services to the UK's multi-ethnic society of an estimated 59.6 million (NOS, 2003). Those which are poorly served compared to other populations are the elderly and Asian ethnic minority groups at 18.4% and 4.0% respectively. (NOS, 2003; Sandwell Headline Statistics, 2004).

Work has been conducted into the reasons why ethnic minorities are reluctant to access mental health services (see Snowden & Yamada, 2005) and knowledge already exists about the use of interpreters; the manifestations and alternative interpretations of psychological ill-health; the diagnostic pitfalls and multicultural models of therapy (Fernando, 2002; Laungani, 2004; Rack, 1993).

NHS service providers are aware of these and other problems and how they contribute to them (Beattie et al., 2005). These issues may also be related to the minimal work that has been conducted in determining how practitioners could devise culturally appropriate psychological services for elderly ethnic minority populations. Calls have been made for further research to be conducted; preferably qualitatively and in consultation with ethnic minority elderly, which emphasises the need for relevant, inclusive and culturally

sensitive services (e.g. Temple & Glenister, 2002). The National Service Framework for Older people and others make specific demands on behalf of the ethnic elderly for services and service user satisfaction that account for ethnic preferences, to eliminate wide-spread disparities (Duffy et al., 1996, DH, 2001).

The maintenance of mental health is more than a medical or psychological issue; along with culture, there are religious, ethical and spiritual dimensions (Fernado, 2002; Koenig, 2005). Several have found religion has a strong influence upon identity as well as permeating the individual's sense of nationality, ethnicity and class for example (Aldridge, 2005; Coleman & Collins, 2004). Ethnic minority populations are more likely to resort to religion and their ministers rather than their GP for mental health guidance in a bid to avoid stigma according to Ayalon & Young (2005) and Bhugra (2005). Although O'Connell, & Skevington (2005) found support for the relevance of spiritual and religious beliefs to health-related QoL in the UK, none of those participating within the focus groups were Sikh. Religious beliefs are found to have a major role in the healthcare decisions of American ethnic minority people (Felix, Levine & Burstin, 2003; Koenig, 2003; Koenig, 2005). It seems therefore plausible to consider the needs of British elderly Sikh people through their religious affiliations. The underlying assumption is that their religion is an integral part of the Sikh persons' identity which is embedded within a collectivist culture. The UK espouses an individualistic culture within a secular society. Consequently, Sikh's preferences in maintaining psychological health and QoL in old age may differ due to their religious affiliation and collectivist culture, and influence their willingness to engage with mental health services. Differences may also exist between middle and senior age groups and between genders.

The Current Study

The Aim of the Study

Sandwell's Mental Health Services have a highly populated and deprived catchment area with an Asian population of 39,592 (SHS, 2004). This research aims to discover that which Asian residents of Sikh faith require from Counselling Psychologists and NHS Older Adult Psychology services for their second generation elderly. This research promotes equity of service and respects the Sikh community's autonomy in informing practitioners/service providers of their future service-user preferences. The central phenomenon of this study is QoL and Sikhism. This emphasis will also assist to determine if practitioners and service providers should adapt service provision in view of this faith community's religious beliefs and practices.

Research Questions

Main Research Question:

1. What will second generation Asians of Sikh faith require from older adult psychological services to promote their psychological health and well-being?

Sub-Questions:

This study will also consider the following research sub-questions:

2. Should services take account of religion in the provision of their services?
3. In what areas of psychological health and well-being do Sikhs report they would like greater assistance?
4. How best can service providers engage Sikh service users in services?
5. Does religious affiliation influence the type of older adult psychology services and mode of delivery preferences of Sikhs?
6. Do Sikh people hold a significant belief in God's locus of control in managing their health concerns?
7. Is there a difference between Sikh males and females in their belief in God's locus of health control?

Method Section

This section outlines the research design, data collection methods, participants, materials and instruments and procedures, reflexivity and quality assurance, ethical considerations and analytic strategy.

Methodology

The relative new critical realist perspective addresses ontological and epistemological issues of reality and how knowledge is ascertained about reality respectively (e.g. Bhaskar, 2008; Danermark et al., 2002; Sayer, 2000; Raskin, 2008). This study adheres to several premises associated with critical realism:

Reality

Reality is external and independent, regardless of human knowledge about it and can be analysed through scientific endeavours; though not through empiricism alone, to obtain an acceptable understanding of it. Perceptions of reality change as it is filtered through language, theories and concepts that are relative to time, place and space. Critical realism accepts this knowledge is theory and concept dependent, but that these are invariably inaccurate as knowledge is not wholly determined by them. Unknown, generative mechanisms of objects (i.e. the ways things act) influence objects such as people and society's institutions. Objects are acted upon through causality that develops into events, additional action and consequences within the social world.

Experience

Critical realism maintains a distinction in human experience between the real, the actual and the empirical. The real is what exists and includes: natural or social objects/entities;

their structures - which includes structures within structures (i.e. internally related entities, processes, resources or practices inside the structure), their causal powers (i.e. their full range of potential and actual behaviour) and causal liabilities/passive powers (i.e. their susceptibility to particular types of change) (Danermark et al., 2002; Easton, 2010). Sayer (2000) states 'the world should not be conflated with our experience of it' (p.11) as reported experiences are incomplete. This empirical domain of experience does not provide the entire account of reality, or the processes that maybe associated with it, the event or outcome. What is gathered and interpreted through the senses is not the whole explanation. The actual refers to what happens when objects/entities are triggered to behave or change. Knowledge, experience, interpretation and understanding is context and geo-historically dependent. Human understanding of the world changes when theories are updated, but reality remains as it has been since time immemorial (Danermark et al., 2002; Easton, 2010; Sayer, 2000).

The analytic strategy of critical realism

The critical realist position values the exploration of causes of social phenomena to understand 'why things are as they are' (Easton, 2010, p.119). From this perspective, the research attempts to identify the powers and structures of objects. There is an emphasis on identifying what are the necessities, the essential and the nature of objects. The research aims to determine what objects, their structures and powers are related and what could transpire given the full range of behaviour of the objects. Also, it is interested in what is possible and what is the potential of objects and their internally and externally related objects (or entities) within the world. Critical realism considers that which can be inferred, that which exists although it may not be obvious or visible, and those causal and passive powers that could be activated, but are not (Sayer, 2000).

Critical realists are interested in events (i.e. outcomes) and what the interactions and relationships between objects and their causal powers and liabilities are. Particularly, what are and what could be the potential consequences and outcomes (Danermark et al., 2002; Easton, 2010). According to Easton (2010) case study research is ideal in achieving an in-depth, comprehensive understanding of these issues, especially by means of multiple data sources and an iterative research process.

Critical realism also accepts that a double hermeneutic exists when studying the social world where social phenomena are considered socially meaningful in ways which are descriptive and constitutive (i.e. essential to their nature and character) of social phenomena. The understanding of meaning is therefore a key enterprise and generates an interpretive and hermeneutic element to the research (Sayer, 2000). The double hermeneutic of understanding the participant's understanding of their experience – albeit critical realism argues reality is more than the researcher's understanding – is compatible with IPA's explanation of the researcher's sense making of the participant's sense making (Smith, 2009; Smith, Flowers & Larkin, 2009).

Critical realism advocates the use of research methodology which is relevant to the research question to understand relationships between, for instance concepts, meaning and practice through a process of conceptualisation by conceptual abstraction (see Lawson, 1998; Sayer, 1998) to be able to study the real, actual and empirical reality. Critical realism is said to have an 'emancipatory potential' (Sayer, 2000, p.18) when it identifies concepts, theories and understanding which are inaccurate so that these maybe altered to allow for social change.

Analysis technique

This study adopts a descriptive thematic approach informed by Interpretative Phenomenological Analysis as outlined by Willig (2001) and Smith & Osborn (2003). This approach is associated with phenomenology (e.g. see Smith & Osborn, 2003; Smith, 2009; Smith, Flowers & Larkin, 2009; Raskin, 2008) according to which the researcher's understanding influences the interpretation and reporting process. This is underpinned by hermeneutics and symbolic interactionism (Shaw, 2006). That is, to avoid purely subjective accounts, the researcher employs qualitative methods to comprehend and explain the participant's consciousness, psychological process or experience as derived through language. It involves a two-stage interpretation process or double hermeneutic where the participant tries to make sense of their world and the research is trying to make sense of the participants trying to make sense of the world. In this study there is the potential for a triple hermeneutic^{*3} due to the role of the interpreter within the interview and transcription process. IPA combines two interpretive stances involving an empathic hermeneutic with a questioning hermeneutic. An interpretive stance develops when critical questions are asked of the transcripts rather than just describing the participant's experience (the latter is however more prevalent in this thematic analysis). Experiences are interpreted differently by researchers because they make alternative links in, and assign different values to experience while reviewing relationships between phenomena (Ratner, 1997). This thematic analysis does deviate from IPA principles to address the perspectives of practitioners and service commissioners. Firstly, the analysis outlines the experience

^{*3} *That is, an additional stage within the interpretation process where the participant tries to make sense of their world, and the interpreter endeavours to make sense of the participant trying to make sense of the world followed by the researcher making sense of the interpreter's sense of the participant's sense of the world*

and meaning making of the participant as drawn from their reported experience, but also provides an additional layer of analysis in questioning that which a practitioner or service commissioner might need to know, from that interpretation of experience.

Secondly, the use of scenarios meant the person was not requested to speak about their own personal experience because of the socially sensitive nature of the research topic (i.e. mental health). In IPA the person's experience is fundamental to the analysis. It was anticipated however that participants may draw upon their personal or other's experiences and their cultural and religious knowledge base to answer the questions.

IPA can analyse data in several ways (Smith, 1996, Smith & Osborn, 2003). Here the idiographic method, followed by the integration of cases is appropriate due to its emphasis on the perception from the participant's subjective world, while acknowledging the interpretive function of the researcher. Although it is less interested in objective truth, it can reveal phenomena (from a critical realist perspective this would include objects, their structures, mechanisms and contrasts, the causal powers and outcomes) while accounting for the nature and quality of participant's social and cultural contexts (Shaw, 2001; Smith, Jarman & Osborn, 1999; Willig, 2001).

Limitations.

There are noted limitations to phenomenological research such as its reliance upon the explanation of experience through language (Willig, 2008) where richness is lost in translation when there are language barriers. Further, it may be that respondents are reticent to give a fuller account because of culturally similar interpreters and the expectation of them having to relay such information to a researcher outside the

community. The subtleties and nuances are likely to be missed and it is questionable whether brief survey answers are sufficient for analysis. Thoughts, feelings and behaviours are likely not to be outlined sufficiently and may lack clarity, accuracy and comprehensiveness. However, Ratner (1997) argues that qualitative research permits the assessment and understanding of meaning, context, individuality of experience, events and processes with the emphasis on the 'quality and nature' of psychological phenomena while accounting for the researcher's influence upon the collection, analysis and interpretation of the data. Quantitative analysis can quantify these phenomena's associations.

Reflexivity

IPA and Critical Realism acknowledge the influence of the researcher's 'vantage point' (Sayer, 1998, p.171).^{*4} Reflexivity permits assumptions and biases to be challenged and enriches practitioners' understanding and practice (Bartlett, 2003). To maintain research integrity it is important to make explicit that the researcher is a white, British, and Catholic (see Hornsby-Smith, 1991) female in her late 30s. The author has an ongoing interest in faith as it impacts upon others in their daily lives and during crises. It appears evident that some people find their faith provides a sense of security and guidance in an often unpredictable set of circumstances. Despite contradictions in the scientific philosophical perspectives mentioned herein, the author nevertheless holds

^{*4} That is, their past and current knowledge, interests, theories, understandings, values and experiences which influence the selection, analysis, interpretation and reporting of the participant's contributions. Critical realists state these will determine the phenomena or objects to be explained as well as the causal factors identified and the contrasts used to highlight these. The level of generality explored and the consideration of the extension of objects through time and space are also influenced by the researchers 'vantage point'. (Chamberlain, 1997; Hessian & Cochrane, 2002; Sayer, 1998).

some remnants of a belief in preordained destiny and that sometimes ‘things happen for a reason.’ It seems evident that religion is an important part of many people’s lived experience and is influential on their conduct in a variety of situations and circumstances throughout the lifespan.

The researcher became a chartered counselling psychologist in 2005 and has worked in various statutory and non-statutory organisations. The degree in psychology and social policy bias her attention and she aligns herself with humanistic traditions. This thesis stems from the researcher’s interest in religion and working with older adults and was an ideal means to study these areas in-depth. While working within an older adult psychology department it became evident that few Asian community members utilised the service. The researcher contended that the speciality needed to become aware of the preferences of Asian faith communities (rather than based on Indian subcontinent place of origin) to assist them in developing services relevant and amenable to them. Upon restriction to one faith group by the Research Board (see critique of research process) the Sikh faith community was selected for the opportunity to work with the high population within the locality.

The researcher’s interest in religion, working with older adults and egalitarian values (see Zalta, 2002) has determined the research topic and question. The interest in understanding the other’s perspective and subjective experience informed the methodology choice. An open mindedness to the possibility of preordained destiny, and the realisation that religion is important within some peoples’ lives will inevitably influence data interpretation and the reporting of results (Connelly, 1999).

Rationale for a Mixed Method Design

There has been a shift in view regarding the paradigm/method fit in mixed methods designs demonstrating broadly two positions. There are those that state there can be a fit and those that contend they cannot (e.g. Yeh & Inman, 2007; Creswell, 2003). This study adopts a pragmatic approach whereby the research question determines the best paradigm and method. Further, the paradigm and method do not have to fit to be able to produce valuable findings and that it is plausible to demonstrate 'representativeness and generalisability of quantitative findings and the in-depth contextual nature of qualitative findings' within the same study (Greene & Caracelli, 2003 as cited in Hanson et al., 2005, p.225). This study reflects the valuing of objective and subjective knowledge while accounting for the researcher's own interpretations and biases (Hanson et al., 2005). The advantages of adopting a mixed methods approach is the potential for greater understanding of the prospective elderly Sikh generation's experience of interpreting, managing and maintaining psychological health and well-being as well as their use of individual and social strategies to enhance these. There is the opportunity to consider the role and impact of religion upon health and well-being as individuals and as a community. Moreover there is an aim to understand at depth their reasoning and preferences for older adult psychology services which is relatively unknown and is possibly applicable to the wider UK Sikh community.

To provide a thorough exploration of religious, QoL and service development issues, a mixed methods concurrent triangulation design with qualitative data having greater priority than quantitative data^{*5} is employed (Creswell, 2003).

^{*5} *That is, data is collected, analysed and interpreted at the same time with greater emphasis placed upon the qualitative findings on service development issues.*

Triangulation in this study refers to a quality assurance method which can take several forms and is adopted to increase the validity and reliability of a study's findings

(Yardley, 2008). Thurmond (2001) states:

Triangulation is the combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods. The intent of using triangulation is to decrease, negate, or counterbalance the deficiency of a single strategy, thereby increasing the ability to interpret the findings. (Thurmond, 2001, p.253).

In this study there is a triangulation of data analysis method. In addition to qualitative analysis, quantitative analysis provides statistical findings for demographic variables, GLHC and SF12v2 results which includes between group analysis for gender and age. There is also a triangulation of data collection using a variety of methods, from various research sites, at different times, involving numerous co-researchers (i.e. interpreters) and participants. Yardley (2008) does indicate that in some qualitative research validity sought by triangulation is seen as enriching understanding from multiple perspectives.

Data Collection: preparation

The pilot study is outlined in Appendix 18. It demonstrates how this study has involved the guidance from community leaders and organisations working with the Sikh Community in how to work with Asian people and in the development of culturally appropriate questions and scenarios (Appendices 22, 27, 137-138). Specific open and closed questions were devised to provide pertinent information on service development issues, the maintenance of well-being and the role of religion in health and well-being.

Triangulation of data collection methods were employed in the form of interview, questionnaire and focus group to enhance validity and ensure results were not the

product of the data collection method (see Thurmond, 2001; Yardley, 2008). There are strengths and weaknesses associated with all three methods of data collection (e.g. see Stewart, Shamdasani & Rook, 2007, p.46 on focus groups benefits over interviews). In offering all three it was intended to gather sufficient data while engaging with individuals that are cautious when discussing 'sensitive' topics for them and their community. Interviews and focus groups are particularly acceptable forms of data collection for qualitative research and older people (Smith, Flowers & Larkin, 2009; Holland, 2005). The interview method involved viewing participants and interpreters as collaborative co-researchers (Gubrium & Holstein 2002). For example, they would assist in developing the researcher's understanding of their meaning and experience by providing additional clarification, information and personal examples. The interview process involved the researcher monitoring participants carefully for fatigue, comprehension and impact of the questions. Throughout the researcher relied upon her skills as a practitioner, such as the core conditions (Rogers, 1951, 1958) and listening, summarising and reflection to assist participants in expressing themselves throughout the interview process (see Coyle, 1998). The interview process is described further below (also see the context details surrounding each interview within the transcript appendices). These approaches were successful in eliciting comprehensive and often serendipitous data from ethnic minority participants (in the language of their choice) and allowed further insight into their experiences, as opposed to relying solely upon brief written survey responses. Successful data collection occurred from 15/07/07 to 14/09/07 across 26 sites (see Appendix 28) through interview (9.6%), questionnaire (57.5%) and focus group (32.9%).

Participants: Selection and Recruitment

678 requests to participate were made to 75 organisations and 603 individuals from February 2007 with an acceptance rate of 17.7%. There was no obvious pattern across the research sites, in those respondents that declined participation within this study. However, it was noted that members of informal social groups tended to defer the decision to assist in the research to the leader or spokesperson of the group. It was important to gain the support of these social-leaders.

Organisational recruitment.

Potential participant organisations were first contacted by letter which was followed up by a telephone call to discuss the possibility of a meeting to discuss the project, with a view to potentially recruiting their service users. Alternatively, it became possible for managers of services to recommend other contacts to speak to for the purpose of research participation. This snowball effect and word of mouth proved an invaluable means by which the researcher was made welcome to conduct the research within community based services. A copy of the letter is available in Appendices 23-25; over 75 organisations were contacted, 26 became research sites (Appendix 28). Several visits were often necessary to build a good relationship with services. Appendix 27 illustrates the researcher's experience in recruiting organisations.

Individual recruitment.

Upon agreement with the service provider, the researcher was then able to invite potential participants to contribute to the study through questionnaire, interview or focus group participation. The appropriate sample size for the Sikh population in Sandwell aged between 45–69 years was obtained from Census data where 3,979 Sikhs

were within this age range (NOS, 2001). The sample calculator (Creative Survey Systems, 2009) indicated a minimum of 42 participants would be required, with a confidence level of 95% and a confidence interval of 12. However, methodological complications like the sensitivity surrounding mental health, the perceived need to accept the life God has given without complaining, the accuracy of self-reporting, genuine understanding and the problems with missing data, for example, cannot be ignored. Findings are tentative and caution is necessary in generalising to the Sikh Diaspora.

In mixed methods designs it is possible to combined sampling strategies for the quantitative and qualitative aspects of the study (Patton, 2002). Participants of Sikh faith were recruited by purposive and, non-proportional quota sampling (and later snowballing) from non-clinical, second-generation Asian populations aged 45-65 years within the Borough. Asian faith communities are diverse and consequently recruitment continued until a minimum of 45 Sikh participants, consisting of both genders from the Borough was able to contribute.

120 South Asians of Sikh, Muslim and Hindu faith, aged 44 to 91 years participated in this study, of which 74 participants were second generation Sikhs residing within Sandwell aged between 45-65 years. A member of the Sikh Deaf community was removed as the consent form was not received which meant that 73 participants meeting this criteria were selected and assigned to groups on the basis of age, middle-aged (45-54 years) or senior-aged (55-65 years) age groups.

Description of Participants

Participants.

Contributions from forty-two Sikh women and thirty-one Sikh men were considered for analysis. Demographic questions (see Appendix 36) included age, sex, years in education, living arrangements, marital status, UK residency, whether an interpreter was required, name and number of spoken languages and religious belief. 52.1% of people within the target group required the use of an interpreter. In 30.1% of these cases there was no relationship between the participant and interpreter and in 15.1% of cases the relationship was professional. See Table 1 for additional demographic information.

Table 1 - Demographic information of participants

Sikh Participant Group					
	Percentage of Entire Sample (N=73) %	Mean	Median	SD	(N)
Age					
45-65* ¹	78.1	55.21	55	5.787	57
45-54* ²	38.4	50.18	50	2.667	28
55-65* ³	39.7	60.07	60	3.217	29
Male*⁴	42.5				31
45-65	27.4	56.70	59	5.573	20
45-54	9.6	50.14	50	1.952	7
55-65	17.8	60.23	60	2.948	13
Female*⁵	57.5				42
45-65	50.7	54.41	53	5.814	37
45-54	28.8	50.19	50	2.909	21
55-65	21.9	59.94	60	3.511	16
Residency Years in UK	72.6	37.83	39	10.942	53
Years of Education	39.7	13.62	15	5.493	29
Marital Status	74.0	n/a	74% indicated Married	n/a	54
Languages	84.9	n/a	66% indicated an ability to speak English	n/a	62
UK Literacy	75.3	n/a	80% indicated enough to excellent understanding of English	n/a	55
Living Situation	67.1	n/a	84% indicated living with partner &/or relatives	n/a	49
Living Environment	72.6	n/a	91% indicated House	n/a	53

*¹All Participants (45-65); *²Middle-aged Group (45-54); *³Senior aged Group (55-65).

*⁴ and *⁵ Results are based on available figures for age and gender.

Percentages are rounded up to one decimal place; further statistics are available in Appendices 58-66

Interpreters.

Blackwell (2005) advises that interpreters be drawn upon for their cultural knowledge and experience as a resource. The six (4 female and 2 male) interpreters assisted the researcher in avoiding faux pas, provided background cultural information, observations and opinions. Their involvement did introduce the issue of a triple hermeneutic in the process of interpreting the meaning and experience of participants. Literal translations were not obtained but this is accepted within the translation field (Bassnett, 2002; Pochhacker, 2004) and does not detract from the validity of the interpretation. Literal translations would have meant a laborious task for the interpreter and disjointed interaction between participant and researcher. As Blackwell (2005) confirms, non-verbal communication was vital in building up rapport and trust with participants.

The researcher debriefed with the interpreter after the interviews and had worked with four of the interpreters on more than one occasion. Their own insights, ideas, enthusiasm and sometimes frustration of the research process became evident during the research. They demonstrated a keenness to approach potential participants and suggested organisations and community leaders to contact. A co-researcher approach was encouraged with interpreters, to respect their knowledge and experience often as a member of the Sikh community themselves. Their insights often proved invaluable. Interpreters had to manage the attitudes and assumptions of participants as well as interpreting potentially embarrassing or culturally inappropriate information such as the elder's personal, social and religious practices (Lago, 2006).

Materials and Instruments

Hardware - Participant interviews were digitally recorded and uploaded directly to a password protected computer.

*Non-numerical Unstructured Data Indexing Searching and Theorizing, (Nud*ist 6)* is a computer assisted qualitative data analysis software developed by: QSR International Pty Ltd. This package assisted with the management and analysis of data (See Appendices 82 and 85 for thematic analysis process) and includes the ability to store, manipulate, search and query the text, themes and maintain memos for theorizing purposes. It also provides a variety of reports for analysis and audit trail purposes (Aubertin, 2002; Richards 2002). Nud*ist 6 predates the NVivo series of qualitative data analysis software. This issue is discussed further within the Critical Review.

Participant Pack Contents – consisted of the participant demographic sheet, a semi-structured interview consisting of Vignettes, a Service Needs Response Sheet, the God Locus of Health Control and the Health and Well-being SF12v2 measures. It combines open questions to elicit participant QoL experiences and closed questions to obtain specific information for service development purposes (see Appendices 31, 33-55).

The Consent Forms - Versions 1 and 2 were designed for those participating in a recorded interview or written contribution via survey, respectively (Appendix 34-35).

Participant Demographic Sheet provided the means to gather demographical information about the participant and included information on age, gender, level of education, marital status, for instance (Appendix 36).

Vignettes – The use of content scenarios is a valid approach to explore sensitive topics with participants which permits them to share their perceptions, opinions, beliefs and attitudes in a format that is less threatening. Vignettes can be applied within interview protocols and focus groups in written and verbal format (Barter & Renold, 1999; Stolte, 1994). Three vignettes were developed describing mild depression (dysthymic disorder), anxiety (social phobia with panic attacks) and dementia which reflect the most prevalent conditions found within elderly populations (see Copel, 1999; Jacoby & Oppenheimer, 2002). They demonstrate how someone with these conditions may present cognitively and behaviourally and are characteristic of symptoms as outlined within the DSM IV-TR (2000). Each narrative outlines how others may observe these difficulties within a typical Asian family setting and were adopted to provide insights into how these presentations might be interpreted and managed by those within the Sikh Community. They help to determine culturally appropriate coping strategies and approaches to improving access and uptake of older adult services.

Initial draft scenarios were forwarded to 67 chartered and training counselling and clinical psychologists to gain face validity on whether these were a reasonable account of Asian family life and how clients present with these difficulties. 16 responses assisted with the amendments (see Appendix 22). **Standardisation and validity become problematic when vignettes are founded on a limited number of responses. These may not represent the views and experiences of the Sikh community. See also the research caveats section.**

Short-Form 12 Health Survey, Standard, Version 2 (SF12v2) (see Ware et al., 2005) identified the well-being needs of potential service users within the Sikh Community.

It is a generic measure of physical and mental health with 12 questions and five choice response categories drawn from the SF36 Health survey (Ware, Kosinski & Keller, 1995, 1996). It consists of 8 subscales measuring eight domains of QoL (physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, mental health). This includes summary scores for mental health ($r=.86$) and physical components ($r=.89$). It has good internal consistency reliability ranging from .73 to .89; high test-retest reliability (Interclass Correlation Coefficient .60 to .78 and convergent validity ranging from $r>.56$ to $r>.38$ PCS and MCS respectively. It has been used extensively in clinical practice, service evaluation, research and with older adult populations (e.g. Cheak-Zamora, Wyrwich, & McBride, 2009; Lyons, Perry & Jenkinson et al., 1997; Littlepage, 1994; Pettit et al., 2001). The US population norms for the PCS and MCS summary scores have been developed to have a mean of 50 and SD of 10 for those under the age of 65 years. Research has been conducted to support the use of the standard scoring algorithms in various countries with high product moment correlations scores of 0.94 to 0.96 and is comparable across age groups (Gandek et al., 1998). A Punjabi SF12v2 version of the measure is not available but there is an interview script for interview administration in English (see Appendix 46). Nonetheless, standardisation has not been possible given the number of participants that needed interpreters, who would have read directly from the questionnaire. The Health Outcomes Scoring Software 2.0 calculated the results and addresses data quality and validity of data processing.

The God Locus of Health Control Scale (GLHC) Wallston et al. (1999) was used as a standalone measure to determine the extent that the local Asian elderly believe God is the locus of control in their health status. This is a 6 item measure with a 6-point Likert

scale ranging from 'strongly disagree' to 'strongly agree'. The Multi-dimensional health locus of control scale, of which the GLHC is a part, has moderate reliability with Cronbach alpha ranging from .60-.75 and test retest coefficients of between .60-.70. Generally validity is modest but varies dependent upon the statistical analysis adopted, theoretical context and target population. The convergent and discriminant validity is reported as $r=.28$ to $.31$ while the construct validity ranges from $r=.29$ to $r=.49$ (Wallston et al., 1999; Wallston, 2005) see also Chaplin et al. (2001); Masters, Wallston & DeBerard (2005); Masters & Wallston (2005) and Appendix 15. Many participants identified that the GLHC did not illustrate the collaborative effort of the person in conjunction with God, but agreed to indicate 3.5 on the scale to demonstrate this. The authors indicate that a different response scale is permissible if there is consistency. A high score demonstrates a strong belief in God's control over health (Appendix 41).

The Service Needs Response Sheet allowed participants to indicate sources of help required from psychological services and to highlight service issues such as appropriate access, delivery or developments they would like implemented (Appendix 40).

Debriefing sheet was provided to inform participants about the nature of the study, the principle research question and how their contribution would be utilised. It provided additional contacts if they had any queries about the study or if they wished to withdraw their contribution after participation (Appendix 48).

'Improve your Quality of Life' Booklet – was provided to all participants and organisations assisting with the research as part of the debriefing material. This and its 4 Asian translations were emailed to local organisations as a resource directory. It

identifies various sources of help for the ethnic minority elderly including voluntary, social and healthcare advice and support organisations in Sandwell (Appendices 51-55).

A Resource Sheet – was provided as part of the debriefing material for middle-aged participants listing contacts of where to seek help, psychological support and information, in case their participation raised concerns about their own predicaments (Appendix 49).

The Sandwell's Carer Information leaflet –provided as part of the debriefing material for those caring for elderly relatives (Appendix 50).

Procedures

For those participants associated with organisations, the researcher in discussion with service providers would offer the options of how data collection could be completed based on the most appropriate for their client group and setting. In most instances questionnaires and interviews were acceptable to the organisation, facilitator and the participants themselves. The researcher (and interpreter, if available) would usually agree a morning or afternoon to attend the organisation to request if individuals would be willing to complete either a questionnaire or interview. Sometimes the organisation/professional advocate would have particular people in mind with whom they would assist in completing the survey in their own time. I would then return to collect completed forms. On other occasions, particularly when the emphasis was upon group activities within community groups, the group organisers would actively request a focus group be convened. For this report 3 Focus Group's contributions were analysed. FG1F consisted of 9 female participants from an Asian Women's Group. 7 were of Sikh faith aged between 45–65 years. FG4F consisted of 10 female participants from a Women's Drop-In Centre. 6 were of Sikh faith aged 45-65 years and FG6M consisted of 10 Sikh male participants from a Day Centre aged 45–65. Further details about how these groups were convened can be found with the interview transcripts in Appendices 126, 127 and 128. Also see Appendices 57, 83 to 84 for further details about the participants within each focus group. The arrangement of these focus groups involved considerable preparation, where the organisations themselves would make the appropriate arrangements in convening willing participants and providing a room and refreshments, in most cases without charge. The researcher, interpreter and professional advocates would then talk through the information/consent forms and assist participants in completing the consent forms. Focus group questions were developed from the

protocol to cover the 3 areas of study: religion, QoL and service development. These were adapted throughout the research to fill the gaps in knowledge and to follow-up on points previous made (See Appendix 81 for focus group questions). Focus groups were conducted in line with the suggestions of Krueger & Casey (2000). Service users were asked if they would be willing to participate in research to “help find out the type of help you or your generation would like from older adult services?” If agreeable, participants then read the appropriate Participant Information /Consent Form (with assistance from the researcher or interpreter if needed) before providing signed consent. Some participants may have read the poster information devised during the pilot study (Appendix 25). Participants would first be invited to complete the Demographic form, before their views were elicited through the questionnaire, semi-structured interview or focus group, depending upon their choice of participation. They would then complete the SF12v2 and GLHC, comment on the Service Needs Response Sheet and one of the scenarios (depicting depression, anxiety or dementia presentations) and the questions associated with service development, QoL and religion. All forms were completed randomly, except for the demographic sheet. At completion, respondents were talked through the Debriefing Sheet, received the Resource Sheet for middle-aged participants, a copy of Sandwell’s Carer Information leaflet and the ‘Improve your QoL Booklet.’

Qualitative data was entered into a Word document for each participant and quantitative data was added to a data collection form in Excel and SPSS v12 (Appendices 57, 70) for analysis in SPSS and Nud*ist 6. Following transcription, Interview and focus group transcripts were forwarded to Participants: P5F, P10M, P27F, 102M, FG 2 and FG4 for amendments and comments as they had agreed that they were contactable to provide feedback on their transcripts. No additional comments or amendments were received.

Analytic Strategy

Thematic analysis selection criteria.

Participants (Appendices 83-84 for selection decisions) were chosen to represent 6 participants for each middle-aged and senior-aged group, within the 45-54 and 55-65 age ranges respectively. All participants followed the protocol although they may not have completed all sections. Each age group included recorded participant interviews in English and Punjabi and both groups consisted of 6 questionnaire contributions from 3 female and 3 male participants. Middle-aged and Senior-aged groups contained no more than two participants from the same venue and the contributions range from extensive to limited as quantity and relevance do not equate to the size of contribution. Focus groups 1, 4 and 6 are included to reflect the views of Sikh males and females across the entire age range of 45-65 years.

Steps within the analysis process.

Audio recordings were transcribed by the researcher or by professional translators where necessary. For quality assurance and validity purposes several transcripts have been transcribed and translated by professional translators from Punjabi to English then from English to Punjabi then back to English. All English versions are on one final transcript for comparative purposes. When analysing, the researcher analysed all translation versions as these are of equal merit according to translation literature (e.g. Pochhacker, 2004). Some transcripts contain just the English sections of the recording and include the researcher's and the translator's comments. Transcripts begin by outlining the background of the interview and the researcher's experience to demonstrate reflexivity.

Individual case analysis.

The 14 transcripts were then analysed qualitatively both manually (Appendices 114-130) and in Nud*st 6 (Appendices 107-112). The researcher followed the guidance for IPA analysis as outlined in Appendix 82, as informed by Willig (2001) and Smith & Osborn (2003). For manual analysis the process involved listing the researcher's initial encounter with text comments on the left hand side of the margin on each transcript and included for example observations, summary statements and initial thoughts. On the right hand side the researcher identified the initial themes (in purple pencil) which included psychological terms, concepts and the essential quality of the section. Analysis then transferred to Nud*ist 6 where participant folders were created for individual case analysis. Within these, folders were created to store their initial encounter with text comments, with the relevant text attached to each comment (or node as it is known within Nud*st 6). These in turn were then grouped under the relevant initial themes. These in turn were then grouped under a relevant but provisional cluster of themes heading due to a shared meaning, state or similar reference point. These in turn were then organised for explanatory purposes to show hierarchical relationships where appropriate and grouped under official super-ordinates titles. These were then used to develop the individual case tables which demonstrate the super-ordinate themes and sub-themes for each participant with supporting evidence from the text for the super-ordinate themes existence.

Integration of cases analysis.

Analysis of cases began at the individual case level which was then integrated to build the master themes for the Sikh community in concordance with the integration of cases approach one as outlined by Willig (2001) and Smith & Osborn (2003). The integration

of cases analysis involved the creation of a new folder for the Sikh Community where all the Super-ordinate themes from across the individual cases were placed into tentative Master theme clusters. Within these master clusters, the sub-themes of each super-ordinate's were merged into one list. Duplicate sub-ordinate themes or those that were manifestations of the same theme were removed. Themes that were found not to fit within their allocated master themes were transferred into a more appropriate Master theme cluster. New Master theme clusters were created as they emerged and were still grounded within the transcripts. Analysis continued until all reported experience was evident within the master themes and a full integration of themes had been achieved. Sub-ordinate, Super-ordinate and Master Themes that were not the main focus of this study or those that were not well supported were removed. In reality, very few themes were removed as a comprehensive overview was developed of the participant's experience. It is likely that the specific nature of many of the questions meant that little of the data needed to be discarded during analysis. See Appendix 85 for further details of the stages and phases of the analysis process.

Quality Assurance

Evaluation criteria depend upon the epistemological framework of the research. In mixed methods research it includes those associated with quantitative methods i.e. reliability, representativeness, validity, generalisation and objectivity and qualitative methods, i.e. creditability criteria such as trustworthiness, validity, reliability and replicable (Creswell, 2003; Lincoln & Guba, 1985; Willig, 2008).

Interpreters where possible were matched for gender*⁶ and religion, but not age (Temple, Glenister & Raynes, 2002) The younger age of the translators worked well in relation to the issue of respect and being able to communicate between the British culture of which the younger Sikh generation are more attuned. Also, despite costs, this study engaged with ethnic minority participants in their own language. Obstacles in communication can prevent participant inclusivity within research as English speaking participants are usually recruited (Temple, Glenister & Raynes, 2002).

The validity of the qualitative research may be queried when not all participants contribute to the master theme. In this research, this can be explained as an artefact of this study due to the unique challenges of working with an elderly, ethnic minority participant group using a variety of data collection methods. For instance, researchers can expect to gain less data from people who are cautious about what they divulge about the emotive topics of mental health and religion to a researcher whose origins and cultural practices are that of the host community. Participants generally tend to divulge less due to the different data collection methods when more elaboration can be expected

*⁶ *Interpreters were of the same gender as the participants they were interviewing and of Sikh faith. In relationships between Sikh men and women, there is a strict social etiquette. The gender matching of interpreters to participants is in keeping with the social norms of the Sikh community.*

during interviews than from the completion of questionnaires. Many participants did not complete all the questions or focused on only a few of them. Reasons include the researcher monitoring for participant fatigue, which was often exacerbated by the language barrier and the time involved in repeating all information through an interpreter. It is therefore less surprising to find not all master themes have been mentioned or as fully outlined by all participants.^{*7}

Ideally the themes require validation by participants. These checks have not been completed due to the length of time since data collection and the sensitivity and permission needed to contact previous participants. Validity is assessable by other criteria (e.g. Elliot et al., 1999; Yardley, 2000; 2008) and this report includes a comprehensive audit trail (Yin, 1989). Alternatively, validity checks can be completed before publication with co-researchers. However, by limiting the theoretical and interpretive nature of the analysis and retaining findings that remain close to participants' self-reports, there is no cause for them to disagree on the themes identified.

^{*7} *A broad overview of the community's experience within the fields of QoL, religion and service development has been achieved and is consistent with the researcher's aims. However, the limited level of scrutiny in presenting a broad analysis reduces the quality, validity and confidence in the research findings. Studies on specific elements outlined within this thesis are needed to substantiate these findings.*

Ethical Issues

Several ethical issues were addressed throughout this study:

- a) Research approval and ethical clearance was sought from various committees and granted by the University's Behavioural Sciences Ethics Committee and School of Applied Sciences Ethics Committee (Appendices 6-11).
- b) The Information sheet/consent form and debriefing sheets are COREC compliant (Appendices 34-35, 48).
- c) Accredited, professional translation services and advocate translators undertook the interpreter/transcription tasks.
- d) The welfare of participants remained paramount while adhering to guidelines as outlined by the NHS, BPS and Division of Counselling Psychology (BPS, 2009; Cooper et al., 2005; DCoP, 2005) and those relevant in the conduct of research with older ethnic people (e.g. APA, 1990; 2004; Gill & Bob, 1999; Hanley et al., 2003; Wenger, 2002).
- e) Elliott et al. (1999) guidelines have been adhered to in representing the study's qualitative findings.
- f) Ensuring informed consent – some deferred signing the consent form until after their participation or only marked their initials to avoid identification.
- g) Participant distress and fatigue were monitored and avoided.
- h) Vignettes were introduced to enable the expression of views and preferences in an indirect manner to protect participants from psychological and social harm.
- i) The *'Improve your Quality of Life' Guide* supported the psychological welfare of participants in a language of their preference.
- j) Participants could withdraw their contribution and had access to the clinical and research Supervisors should they have subsequent concerns.

Results Section

Structure

Qualitative results are presented first, followed by the quantitative descriptive and inferential statistics. There are a variety of tables, matrices, diagrams and quotations which outline the experience of participants while addressing the research questions and hypothesis.

Integration procedures

A complementary method of analysis has been applied where qualitative findings inform the quantitative analysis of variables to gain a deeper appreciation of the community's experience and preferences (Hanson et al., 2005; Goodyear et al., 2005; Beck, 2005). This approach assists in exploring further those variables or experiences that are identified as essential in answering the research questions and provides further validation and interpretation of psychological, social and clinical findings (Ratner, 1997). The integration of the quantitative and qualitative findings is considered within the discussion which includes a single page conclusion.

Qualitative Analysis Results

Analysis Summary

Eight Master themes were identified from the data: 1. Cultural and contextual background; 2. The significance of religion in health and healthcare; 3. Individual strategies for managing distress; 4. Individual strategies for enhancing QoL; 5. Challenges to QoL in old age; 6. Limited service provision; 7. All psychological services are potentially useful for this generation /community and 8. Service delivery considerations for the Sikh community. Word length criteria confine the combined analysis and discussion to the essential themes to answer the research questions.

Themes highlighted in lilac on the Master Theme Tables depict those addressed in this report. The Audit Trail (Appendices 107-113) comprehensively demonstrates the analytic process and thorough analysis of the data with a range of theme reports, exemplar memos and diary extracts for example.

Presentation of Findings

Table 2 provides the structural overview of the Master and Constituent themes for the Sikh community which are organised under 3 sections: Religion (Master Theme 2), Quality of Life (Master Themes 3, 4 & 5) and Service Development (Master Themes 6, 7 & 8) to demonstrate the Sikh community experience, their preferences for older adult services and implications for practitioners' clinical practice with this client group. Each section begins with Master Theme Table(s) which outline the constituent themes and who of the 14 participants have contributed to their construction through independent case analysis (Appendix 93-106 for individual case tables). Each data set has been assigned a code which signifies an individual (P) or focus group (FG) contribution. This is followed by a participant number in chronological order of data collection (1–120) and an affix of (F) or (M) to indicate the gender of participant. P3F refers to an

individual female participant who contributed to the research in the very early stages of data collection. FG6M indicates one of the last focus groups consisted of males.

Participants' quotations are identified below by their participant, appendix, page and line numbers from the original transcripts, e.g. *P3F [A114, p.8: 408-411]*. The notation guide adapted from Pope-Davis et al. (2002) illustrates grammatically the number of participants that supported the existence of each master theme. Adjectives describe a majority (70% of respondents) e.g. *most, often, usually, typically, these respondents, the majority, the participants in this sample, generally*; moderate support, (40%-49% of respondents) e.g. *some, several, a number* and less support, (30%-39% of respondents) e.g. *a few*. Specific words e.g. *all* or *one* is used when appropriate (See Appendix 86).

Table 2: Structural Overview of The Master and Constituent Themes for the Sikh Community

Only Themes highlighted in lilac are discussed in this report due to word length limitations, but further analysis on Quality of life (master themes 3, 4, 5) and Limited Service Provision (master theme 6) is available in Appendices 87-92.

1. CULTURAL AND CONTEXTUAL BACKGROUND	2. THE SIGNIFICANCE OF RELIGION IN HEALTH AND HEALTHCARE	3. INDIVIDUAL'S STRATEGIES FOR MANAGING DISTRESS	4. INDIVIDUAL'S STRATEGIES FOR ENHANCING QUALITY OF LIFE	5. CHALLENGES TO QUALITY OF LIFE IN OLD AGE	6. LIMITED SERVICE PROVISION	7. ALL PSYCHOLOGICAL SERVICES ARE POTENTIALLY USEFUL FOR THIS GENERATION /COMMUNITY	8. SERVICE DELIVERY CONSIDERATIONS FOR THE SIKH COMMUNITY
Ethnic origin and Religion	Karma, Kismet, Destiny	Managing health concerns	Adopt life goals to be remembered, productive and enjoy life	Challenges of old age for the mind	Provide permanent public services	All services could potentially be utilised	Opening hours and refreshments
Long term UK residency	Generational differences in the reliance upon religion	Children held responsible for the care and well-being of parents	Adopt an active lifestyle involving physical activity and mental stimulation	Challenges of old age for the body	Call for specific multi-purpose centre to enhance mental and physical activity levels	Greater assistance with depression, anger, addiction, relationships, ageing, loneliness, isolation	Account for religious beliefs
Fluent in several languages	Good health is a shared responsibility between God, the person and service providers	Managing depression	Maintains a healthy diet to remain active and healthy	The impact of physical health on Quality of Life	Requests for activities that promote socialisation, relaxation and physical health	Reduced demand for assistance with psychosis, addiction and life long behavioural problems	Preference towards Integration with the English culture
Difficulty understanding those from other communities	Religion provides strength, guidance, support and comfort	Managing anxiety	Maintaining well-being - keeps busy especially with enjoyable activities	Worries about ageing	Provide variety and choice of where to go and what to do	Design services for groups	Challenges to the uptake of services
Asian living arrangements	Religion influences views of burden and motivation for change	Seeking advice and support	Maintaining well-being by socialising with others outside the home	Stigma and Family influence well-being	Provide separate places for men and women	Design services for the individual	Fear of gossip, importance of confidentiality
Social norms – differ for men and women	Experience of religion in healthcare - knowledge first, faith last		Advice suitable for both sexes		Preferred service locations		Qualities valued by service users
Meaningful life - relationships with family and friends					Community support in adapting to old age		Aids to support seeking - support, publicity, familiarity and encouragement
					Service users experience of research		

TABLE 3 - Master and constitute themes table for the Sikh Community illustrating the significance of religion in health and healthcare

Only one example for a super-ordinate theme is indicated within the Table. Super-ordinate numbers from the participant's Table of Super-ordinate and Sub-ordinate Themes are indicated in bold, where associated themes and in vivo quotes can be viewed. The Nodes Report comprehensively lists all themes associated with each Master Theme (see Appendix 112)

Master Theme	FG1F	FG4F	FG6M	P3F	P5F	P7M	P10M	P11M	P14M	P27F	P35F	P41M	P77F	P86F
Constitute Themes	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:
	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
2. THE SIGNIFICANCE OF RELIGION IN HEALTH AND HEALTHCARE														
Karma, Kismet, Destiny	1-89: 148-149	10-97: 385	2-128: 439											
Generational differences in the reliance upon religion		12-102: 636-638 1-103: 707												
Good health is a shared responsibility between God, the person and service providers	1-89: 153		2-127: 380-382	2-8: 377-378	2-13: 246-247	3-41: 286	2-53: 354-356		1-60: 103-104	1-74: 598				
Religion provides strength, guidance, support and comfort		3-100: 537		2-8: 377-378										
Religion influences views of burden and motivation for change		11-110: 1078-1081												
Experience of religion in healthcare - knowledge first, faith last			2-122: 180-181		2-23: 736-737									

Religion

2. The significance of religion in health and healthcare

The importance of *karma, kismet and destiny* were mentioned interchangeably by a few contributors. There is a belief that life is a learning process and religion was used to explain the unexplainable. There was a fear of God's punishment and a belief that faith, destiny, kismet and God has a controlling influence over health and death, but this is not to be confused with responsibility.

... If you are sitting there and you are eating and eating and eating and you are getting fatter and fatter, God's not going to turn around and tell you to not eat, and he's not going to come and stand in front of you and say 'don't eat' It's up to us to do something about that [*P3F, A114, p.8: 408-411*].

Several people confirmed that *good health is a shared responsibility between God, the person and service providers*. There was a strong belief that the well-being of the person is in the 'hands of God', although they should not intentionally place themselves in harm's way. Ill health was attributable to the person or God but individuals are expected to take some responsibility for their health and recovery, especially from self-derived illness. God is unlikely to intervene unless they help themselves proactively in adopting healthy habits for instance. Notably, accidents or sudden illness were associated with God and karma. (e.g. see P5F transcript). This suggests that Sikhs are expected to adopt a collaborative religious coping style often associated with improved well-being (Pargament, 1997; Phillips & Stein, 2007; Fabricatore, et al., 2004).

One focus group mentioned the *generational differences in the reliance upon religion*.

FG4P: You same as, *name of daughter*, two alike. FG4P: Scientific way.
FG4P: You think to be a scientist, but your destiny or religion you want to be. ... FG4P: Why you chose to be a scientist? FG4P: No, some people like the kind of things, my son he's do[ing a] degree, he hasn't finished, but he's got maths and science ... because he likes to do the new things. He likes to find out the things [FG4P:A127, p.99:480-501].

This demonstrates religious verses scientific thinking between the older and young generation and raises questions for practitioners such as the importance of understanding your own religious convictions. Consistent with Argyle & Beit-Hallahmi's (1975) findings, participants reported that religiosity increased with age, particularly in the 30 to 40 age range and in response to a personal crisis or when individuals become aware of their own mortality and proximity to death.

FG4P: That's the call when you are getting older, you pray more. FG4P: You start believing. FG4P: You know the time is going. [A127, p.113:1221-1225]

A few highlighted how *Religion provides strength, guidance, support and comfort*. It has a positive influence and can be a non-dogmatic resource in times of distress, when fearful, alone and low or when facing mortality issues. Participants confirmed that religion informs their conscience by influencing thoughts and behaviour around wrongdoing, consequences and coping strategies. The Temple, hymns and prayers assist in accessing religious coping resources:

FG4P: I always like go to the Temple, ... if I'm scared, I just pray in Punjabi.
FG4P: It helps me, yes. P: It calms you down, yes. FG4P: And you think twice ... it's in our mind, ... FG4P: if we sort of have any fear or anything that we can't confide in, at least we've got that power, the same God. ... they put me into isolation, and there was nobody there at that time, to talk to me, to anything, I was on my own, and that's when prayers, only once I used to listening to hymns on tape and so on, and that is what bought me out. I was very, very low. ... I was put into a section, where I was locked up, ... FG4P: Then you can pray there. FG4P: You've got something to do. FG4P: So people [are] left with faith in their religion. [A127, pp.101-102:580-636].

Religion influences views of burden and motivation for change. For some, they pray not to be a burden and for good health FG4F[A127, p.110:1067-1081]. Burden was reported as being linked to karma:

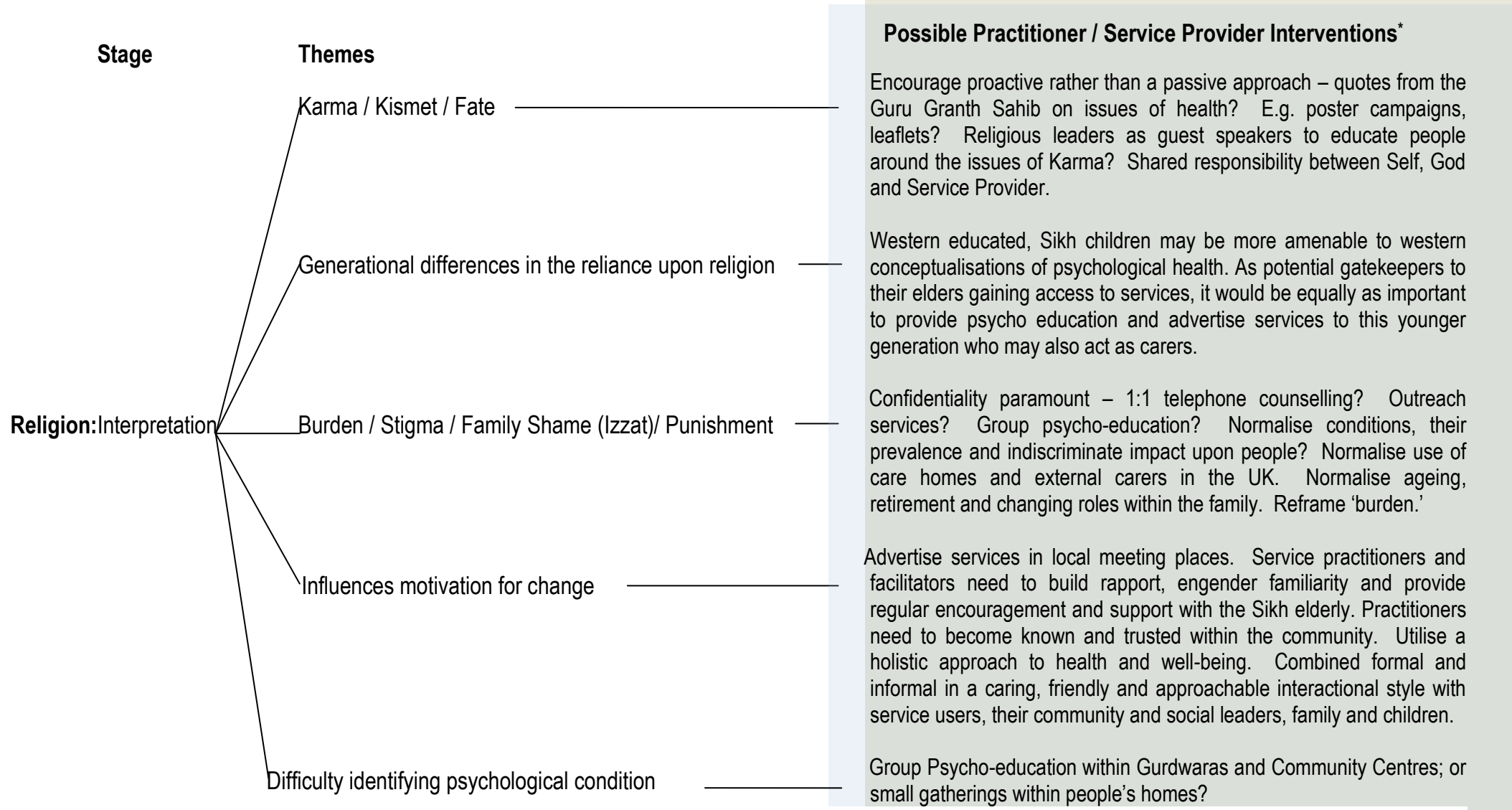
FG4P: ... And if somebody dies quickly, and we think oh he did good Karma. FG4P: He going quickly. FG4P: ... that's why he went quickly and whoever suffers we think, may be he did something wrong, that's why he's burden. FG4P: Yes, he's having punishment. [A127, p.110-111:1083-1091]

This finding is consistent with religious meaning making associated with a punishing God reappraisal which has negative outcomes on well-being and mental health status (Phillips & Stein, 2007). Families may feel punished and associate it with bad karma, especially if caring for those with mental health issues. Low motivation for change appears linked to strong, generationally ingrained beliefs in karma and fate.

FG4P: Because in Hindu and Sikh religion people believe in last birth, ... FG4P: yes, reincarnation, so sometimes we believe that whatever we did wrong in last life, it will affect our, this life. FG4P: And this is the learning process that perhaps what we didn't learn in the last one, we're meant to learn here now, so it is our destiny, whatever we are supposed to be going through, it is a learning process for us through life. FG4P: Some people don't make an effort because they think it is in their destiny so, it won't change anything ... [A127, p.97:389-401].

To motivate service users, services could emphasise that true destiny can be influenced and is uncertain and that they can choose to make good health decisions and adopt healthy behaviours in the belief that God may intervene. A few expressed their experience of *religion in healthcare as being knowledge first and faith last* when it came to GP guidance in managing their health concerns. Faith usually enters the final phase of treatment, if there was little that medicine could do. They identified the differences between themselves and health professionals as one of religious mindsets which they viewed as the impact of education and the less religious beliefs of service providers (e.g. see FG6M, P3F, FG4F transcripts).

Figure 1 Religion in the interpretation of health concerns with potential practitioner/service provider interventions



**The intervention suggested are drawn from the researcher's experience, observations and discussions with service providers, community leaders and carers throughout this research project, but are predominantly from the analysis of participant contributions.*

TABLE 4 - Master and Constitute Themes Table for the Sikh Faith Community: 7. All psychological services are potentially useful for this generation/community

Only one example for a super-ordinate theme is indicated within the table. Super-ordinate numbers from the participant's Table of Superordinate and Subordinate Themes are indicated in bold, where associated themes and in vivo quotes can be viewed. The Nodes Report comprehensively lists all themes associated with each Master Theme (see Appendix 112)

Master Theme	FG1F	FG4F	FG6M	P3F	P5F	P7M	P10M	P11M	P14M	P27F	P35F	P41M	P77F	P86F
Constitute Themes	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line	Page: Line
7. ALL PSYCHOLOGICAL SERVICES ARE POTENTIALLY USEFUL FOR THIS GENERATION/COMMUNITY														
All services could potentially be utilised								4-57: 77	1-60: 89	6-73: 536-539		1-80: 77-80	4-82: 77	
Greater assistance with depression, anger, addiction, relationships, ageing, loneliness, isolation					6-25: 804-805		5-49: 150							1-83: 8 19-21
Reduced demand for assistance with psychosis, addiction and life long behavioural problems							5-53: 312-313			7-73: 552-554				
Design services for groups		8-109: 998-999	1-125: 323-325		6-29: 1042-1045		5-53: 346	4-57: 86	1-60: 57-58	6-74: 591			4-82: 99	1-83: 31
Design services for the individual									1-60: 92-94			1-80: 89		

Service Development

7. All psychological services are potentially useful for this generation/community

A number of participants indicated all *services could potentially be utilised* by the community: P14M aptly stated ‘All of these things you can come across every day!’ and P77F clarified:

P77F: I feel all the above services are beneficial. The Asian community do not recognize mental health as an issue and that there is help and this needs to be addressed. [A124, p.82:77-78]

Three participants indicated *greater assistance with depression, anger, addiction, relationships, ageing, loneliness and isolation.*

P5F stated:

P: As there is an increase in age, sometimes people think that they are still young. So, it’s always good to discuss about this. [A116, p.25:804-812]

P86F highlighted the need to alleviate loneliness which suggests there may be limited social and emotional support for some elderly. She wanted ‘Someone to talk to, to have a cup of tea with and someone to visit me’ [A125, p.83:8]. An outreach service for the elderly is likely to be appreciated (see Thompson & Packwood, 2005). Additional help was asked for:

P86: Relationships – a lot of the health problems are related to family problems and arguments feelings of sadness, anger and loneliness – people don’t care anymore, too many problems of their own. [A125, p.83:19-21]

Certainly, there is an acknowledgment that people do have emotional, interpersonal and relational problems to deal with which counselling psychologists could address.

Another two participants indicated that there could be a *reduced demand for assistance with psychosis, addiction and lifelong behavioural problems:*

P27F: Arh, they don’t believe [in psychosis]; I think these things. Because ... my own kid ... says no, we don’t believe these things. ... I think younger generation, maybe they don’t believe it. [A121, pp.73-74:552-581]

Practitioners could offer psycho-education and involve children as they may be fundamental to the older generation accessing services for psychosis symptoms. One participant proposed that addiction and behaviour problems will not be amenable to change in later life especially if they have been lifelong:

P10M: ... because any addictions I think they would have had them earlier in their life. ... the same with the behaviour problems ... by the time you reach old age, ... your habits or your behaviour is sort of set, yes? Unless that's an illness, obviously, that's different. [A118, p.52-53:308-319]

It is worth investigating if this view is prevalent across the community as alcohol addiction is a concern (Johnson et al., 2006; Orford, Johnson, & Purser, 2004) and could be addressed with Sikh preferences in mind (e.g. Morjaria-Keval, 2006).

Many participants indicated that service providers would do better to *design services for groups* as there is a preference for open and inclusive groups. Participants preferred non-restrictive attendance in terms of time, group membership (open to everyone irrespective of place of birth, language or religion) and being able to come and go as they pleased. This suggests adopting a 'drop in' approach to attendance. It was felt that group attendance breaks the sense of isolation and loneliness and offers support to those with dissimilar challenges but services should guard against:

FG4P: ... there are one or two that will ask you certain questions constantly, the same harping question, 'what tablets are you on, I've been worse off than you' or something, compare. And that only makes us even lower. So we try not to discuss our problems. [A127, p.106:877-880]

Group attendance distracts from worries and lifts mood with the main ingredient being an informal approach which permitted laughter, humour and a chance to forget problems.

FG4P: Yes, yes laugh FG4P: Singing, joking, dancing, just chatting. FG4P: Sometimes we raise a question, to discuss about that but not personal, FG4P: About health as well. Yes. FG4P: But then we talk about general group discussion we can give opinion, but not personal. ... we've got

confidentiality, what we discuss ... FG4P: It stays in this room. [A127, p.108:970-984]

The participants appreciated a 'happy group' that remains respectful of religious and cultural considerations.

FG4P: We don't bring culture to this group. Yes. What we do like is celebrate festivals Hindus festival then Muslim festival then Sikh Festival, but if somebody keep going on about culture, we stop there. FG4P: ... this group is for everybody ... [A127, p.107:891-893]

There was a focus on interpersonal well-being and joint activities which the group also appreciated along with the ability to 'let our guard down'. Certainly the vast majority would prefer to be served as a group rather than as an individual. (e.g. FG6, FG4, P5F)

Another evident view was:

P5F: If we separate the people according to their mental health then it will only isolate them more and this will increase their sadness and loneliness. ... We are different from other communities and unique [A116, p.29-30: 1044-1070].

Reducing perceptions of isolation and difference and develop inclusive groups to aid socialisation is helpful.. However alternative participant suggestions (e.g. P10M, P77F and P86F) were to design services around groups for those with similar experiences. In addition, preventative services which are open to all and facilitated by a knowledgeable person would also be of benefit to the community P14M [A120, p.60:57-58].

Although a few indicated that they should *design services for the individual*, this was less emphasised but P14F specified the following be available:

P14: I would prefer to see someone face to face – more helpful. Some may prefer privacy. Some might not want to talk about their problems openly so telephone may be [A120, p.60:92-94].

Table 5 Master and Constitute Themes Table: 8. *Service Delivery Considerations for the Sikh Community*

One example for a superordinate theme is indicated within the table. Super-ordinate numbers from the participant’s Table of Superordinate and Subordinate Themes are indicated in bold, where associated themes and in vivo quotes can be viewed. The Nodes Report comprehensively lists all themes associated with each Master Theme (see Appendix 112)

Master Theme	FG1F	FG4F	FG6M	P3F	P5F	P7M	P10M	P11M	P14M	P27F	P35F	P41M	P77F	P86F
Constitute Themes	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:	Page:
	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
8. SERVICE DELIVERY CONSIDERATIONS FOR THE SIKH COMMUNITY														
Opening hours and refreshments			6-124: 270 6-121: 136-137	5-5: 249			5-53: 328-331	4-56-57: 46,81		6-67: 256		1-80: 49	4-82: 94	1-83: 25-26
Account for religious beliefs	4-87: 57	13-105: 803-806			6-29: 1049	4-45: 497-503	5-52: 279-281	4-65: 72 no pref.	1-60: 84-85	6-70: 396-400		2-80: 75	4-82: 83-85	1-83: 13-14 Don’t
Preference towards Integration with the English culture		7-96: 320-321												
Challenges to the uptake of services	5-87: 67-68 6-87: 91-92	6-92: 108								1-70-71: 415-418 4-70: 408-409			1-82: 77-78	
Fear of gossip, importance of confidentiality		5-94: 226						4-56: 40						
Qualities valued by service users	4-87: 59-60	9-118: 1458							2-59: 51-52	6-68: 298-304		2-80: 53		
Aids to support seeking - support, publicity, familiarity and encouragement						4-44: 461-479		4-56: 46		6-67: 240		1-79: 43	4-81: 46,47-48	

8. Service Delivery Considerations for the Sikh Community

The majority stated that services need to *account for religious beliefs*. Sikhs range in their reliance upon religion but suggestions include adopting a non-extremist approach by being selective as to when religious considerations might be applied within a service. Despite some mixed views, ultimately, “religion has its place, as long as it isn’t forced onto people” *P10M[A118, p.52:276-293]*. There is a need to respect, tolerate and be accepting of all religions or individual beliefs with ‘no racism’ *P27F[A121, p.70:400]*.

One participant stated that staff needed to be:

P77F: aware of the different religions and their individual beliefs and understanding that all Asians do not believe in one belief -- they have various beliefs and customs *[A124, p.82:83-85]*.

Services are requested to account for religious beliefs in personal care, home care and centres. As elderly Sikhs appear to view others as either scientific or religious, expressing an understanding of religious viewpoints may help build rapport. While the advice is to avoid cultural issues, the community would appreciate being able to celebrate important religious and non-religious dates which can be inclusive towards other communities. Religion can be proscriptive and it is important to avoid ‘my religion is better than your religion’ discussions as this divides and generates animosity, even in well established groups. A few participants had no preference about accounting for religion e.g. *P11M [A119, p.57:72]* or stated that there was no need to account for it (e.g. *P86F [A125, p.83:13-14]*) as long as people are treated equally and respectfully with kindness and sensitivity.

A few outlined the potential *challenges to the uptake of services*, some are outlined above e.g. recognising important religious and non- religious occasions e.g. *FG6M [A128, p. 122-123:169:194]* which could have implications for appointment times.

Others include 'hidden costs' for carers in supporting the elderly in attending services and the preference for central, local services within familiar settings. This is due to transport concerns where 'easy to get to' is 1 bus away and local is within 3 to 4 miles and within ½ an hour's travelling distance. Dietary concerns also dissuade the elderly in attending services, where specific vegetarian food is preferred and includes no fish or eggs *P27F[A121, p.71-72: 455-512]*. The language barrier, working with interpreters and limited support for those with sensory difficulties were also cited.

A few participants mentioned *fear of gossip, importance of confidentiality*. The main concern is the risk and fear of exposure when working with those from their own close knit community that extends nationwide.

FG4F: I've got one service user she lives within the same community, same culture but she doesn't want to have a support worker to support her emotional support, from [the] same culture. What she's saying 'if it's the same culture, she will go and talk about me' ... to the rest of the community. So they want someone from outside ... *[A127, p.94:223-239]*.

Sikhs may speak more openly with a neutral person who speaks the language, understands the culture, and is outside the community. This appears counter-intuitive to the practice of client-therapist matching based on cultural similarity and appears tied to *izzat* (Gilbert, Gilbert & Sanghera, 2004). However, non-Asian Punjabi speaking practitioners are limited. Language and culture is used interchangeably within this community:

FG4P: My husband also he says, we are all Gujarati's together then we tend to gossip, and that's what they were meaning, when she said, the same culture. They gossip a lot. And he said, this group is such a varied group and they don't ever gossip there *[A127, p.116:1382-1389]*.

Sikh Service users may have greater confidence in services if confidentiality is emphasised, e.g. *P11M [A119, p.56:40]*, gossip is stopped by having mixed languages

and cultures within groups; and informed that practitioners do not gossip and do not belong to the local community.

Some highlighted the *qualities valued by service users* such as their anonymity being rigorously retained by holding confidential the address and contact details of members. Similar to the qualities that practitioners would traditionally provide for their clients, participants confirmed that they also appreciated respect, understanding, encouragement and care from services. Being valued within the group was important. Service providers can demonstrate these aspects by being patient, initiating conversations with the person, listening and endeavouring to understand the person's views and needs e.g. *P14M [A120, p.60:58], P41M[A123, p.80:70]*. This suggests adopting a collaborative and proactive approach with this community. Knowledge and understanding of the person's condition while providing appropriate empathy is also necessary:

P27F: Main thing is understanding. Because some people they don't understand [how/why] their feeling occurred ... these things, so they [staff] must have the understanding, how [it] feel[s] *[A121, p.68:269-271]*.

They appreciated feeling valued, looked after, being encouraged to attend and persistent demonstrations of interest and concern in their welfare e.g. *[A127, p.115:1314-1330]*.

A holistic approach to working with people was evident within community group initiatives whereby approachable facilitators combined the informal within formal interactions. Women appreciate the ability to speak freely about taboo and sensitive topics and the group was perceived as fun and supportive.

FG4P: we are making friends, because every week we look forward, if somebody doesn't come then 'where's [] gone today?' We ask about each other ... *[A127, p.118:1456-1457]*.

Service users appreciated opportunities to off load with approachable facilitators.

FG4P: ... one lady came this morning, she was very, very upset from her daughter that lady, she said 'I didn't want to come, but she came'. It's something encouraging her to share with me when there is a ten minutes 'oh, this happened, that happened.' I said 'oh everybody get it'. [A127, p.116: 1365-1368].

Openness and time was given to express feelings while humour and anonymity appeared aids to self-expression.

FG4P: We discuss [matters], but in a funny way! [all laughing]. FG4P: We can speak freely, [about] whatever we want. FG4P: ... in our culture, ... there [are a] few things [that] men and woman can't talk about [some of] these subjects openly, like sex, like boyfriends, like all these women's problems [All laughing]. FG4P: ... in a woman's group we can laugh at the menopause ... FG4P: Menopause! [All laughing]. ... Yes, we let our guard down here. FG4P: We do a lot of jokes as well. ... FG4P: Yes. So this group is important to let all these feelings out for them. [A127, p.116: 1391-1429].

Practitioners' humanistic foundation and skills in delivering the core conditions

(Rogers, 1951, 1957, 1958, 1961) would be fundamental in engaging with the Sikh community. It would assist those clients that like to share secrets and their 'inner child'

(e.g. Price, 1996; Capacchione, 1991).

FG4P: ... when we are aged, we are expected at home to be wise and not to be direct [or] talk about funny things, we are expected from our children, ... certain ways, but in this group, because everybody [has] got their child [with]in their self, and that self comes out [members start laughing] which it can't come out in the home. FG4P: A bit naughty. ... that's why they like to come. [A127, p.118: 1465-1469].

Service users appreciate a break from their role expectations, responsibilities and concerns. The group can stimulate relief from emotional distress and troubles at home.

Regular meetings or place to go reportedly provides opportunities to go out, socialise, exercise and relax in the company of same sex service users e.g. FG6M[A128,

p.124:261-303], FG6M[A128, p.131:598-606]. Participants appreciated warm

welcomes/partings FG4 [A127, p.109-110:1017-1053] and were treated as family:

FG4P: ... they encourage us to come, if they didn't look after us the way they do FG4P: You go home, yes. FG4P: ... then perhaps it could be like

going to school or something, where you're afraid and you don't want to go.
[A127, p.116:1362-1363] see also FG4P [A127, p.96:351-354].

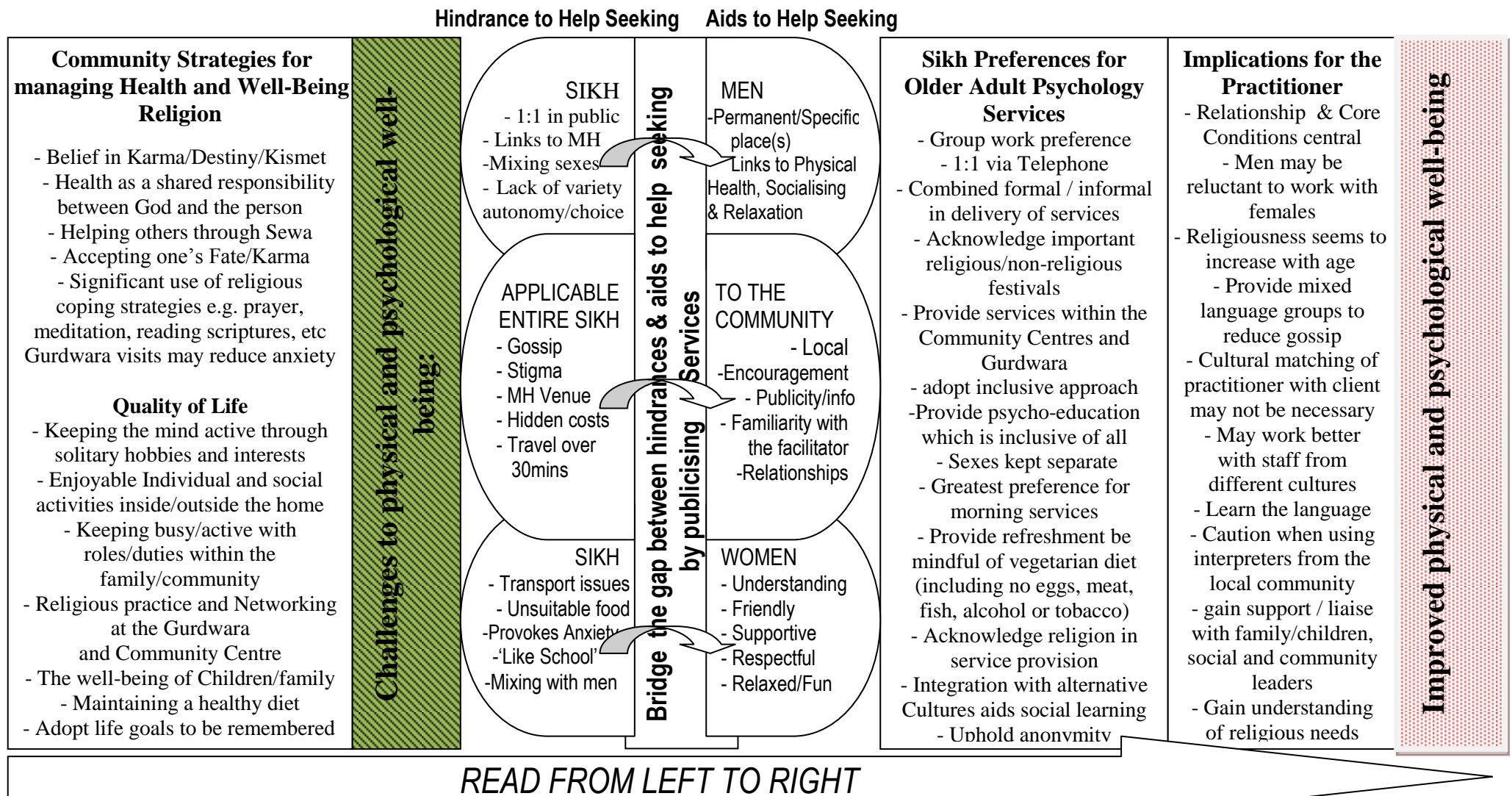
The non-specific, generic elements of therapy (Horvath, 2000; Fiedler, 1950; Martin, Garske & Davis, 2000) are crucial for any initiatives devised for Sikhs. It seems the greatest therapeutic gains can be made during moments when the person seeks out the practitioner to off load their concerns in brief, unassuming interactions. Art, Dance and Poetry Therapies (Hogan, 2009; Lindner, 1982; JPT, 2008) and Expressive Writing (Baikie & Wilhelm, 2005) may be acceptable group activities.

A number of participants identified the *aids to support seeking* as *support, publicity, familiarity and encouragement*, P77F states:

Support from others will help me and encouragement. Discouragement will not help and actually knowing people are there to help and acknowledge me
[A124, p.81:46-48].

A sense of familiarity and a good relationship with professionals increased attendance as did support from close others, such as: children, family, friends, neighbours, community workers, social services, and the GP (e.g. see P27F; P11M; P41M transcripts). Support seeking is reduced if immediate family do not recognise mental health conditions or there are concerns about the family's honour. Socialisation to psychological thinking and mental health conditions would help as will advertising the services available. FG1F: "P2: Services should be mentioned or written in different languages like Punjabi, Urdu and Hindi etc" [A126, p.87:59-60] and applies equally to Service Directories P7M[A117, pp.44-45:458-479].

Figure 2: Diagram illustrating Service Development issues for Practitioners and Service Providers.
Selected examples of Master and Superordinate Themes



Master Theme/columns headings: (1) Current Community Strategies for managing health and well-being – can provide clues as to what might help for some clients from the Sikh Community. (2) Challenges to well-being. 3) Hindrances and Aids to Support Seeking (top, for Sikh men; middle, for both sexes; bottom, for Sikh women). (4) Bridge gap between hindrances and aids by *Publicising and Advertising Services*. (5) Sikh Community's for Older Adult [Psychology] Services. (6) Clinical Practice Implications for the Practitioner.

Quantitative Analysis Results

Descriptive Statistics

Tests and graphs of normality for distribution and dispersion were computed for the entire sample, age and gender groups (Appendix 58-65 for descriptive statistics). The Table in Appendix 68 shows that although skewness and kurtosis is evident within the sample, the Kolmogorov-Smirnov and Shapiro-Wilk tests show that these are not significantly different from the population norms for age and belief in GLHC for the entire sample. For middle and senior age groups, non-significant differences were found for belief in GLHC only. For gender, non-significant differences were found for age, female UK Residency and belief in GLHC only. Homogeneity of variance tests shows the variances between senior and middle-aged groups and male and female groups (except for age) were similar and not significantly different from the normal population. These results allow for parametric tests where assumptions of parametric data have been met and tests of normality are not violated ($p > 0.5$ for K-S/S-W tests).

Scenario and Service Needs Response Patterns

Response counts were completed from the Scenarios and Service Needs Response Sheet (see the contingency table, Appendix 66). Depression was the most frequently diagnosed condition, but was often confused with anxiety. Insufficient numbers commented upon the Dementia scenario to draw valid conclusions. The majority stated that their advice would equally apply to both sexes. Morning and afternoon sessions were frequently cited as the time to run services for the elderly and 80.6% (N=32) indicated they would prefer services to take account of their religious beliefs.

Figure 3: Histogram illustrating the pattern of response to the GLHC Scale

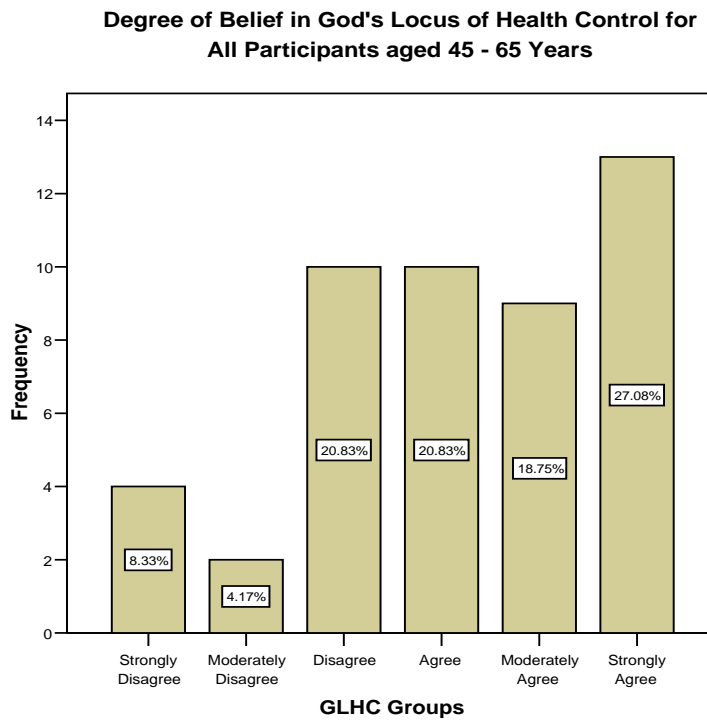


Figure 3 shows that for the entire sample (n=48) 33% disagreed to strongly disagreed about God being the locus of health control while 67% stated they agreed to strongly agreed with the belief that God does influence their health status.

Figure 4: Boxplots comparing GLHC beliefs by age and gender groups

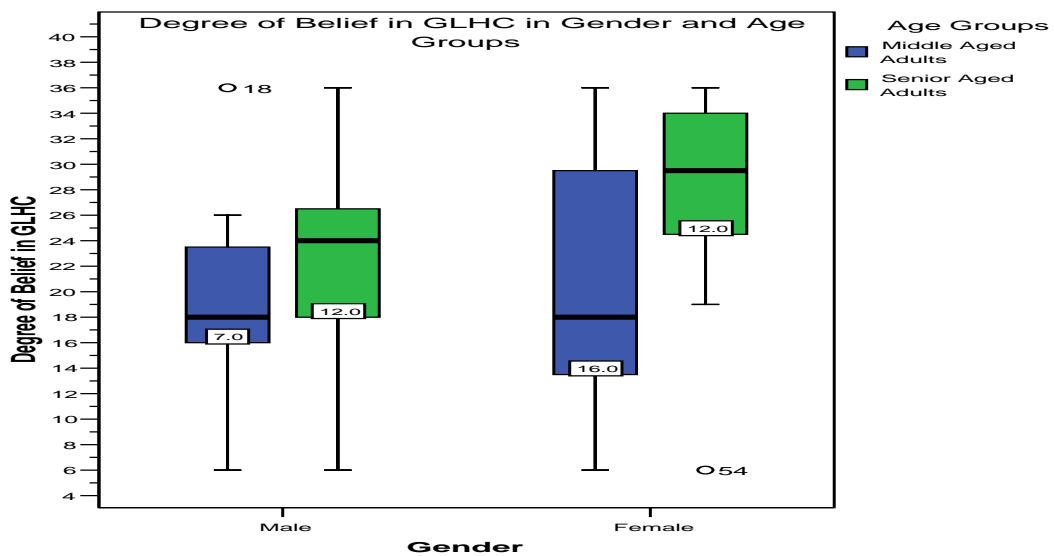


Figure 4 shows group median scores, confidence intervals, dispersion and outliers for men and women in the 45-54 and 55-65 age groups. Middle aged men and women in the sample hold less belief in God's control over their health than Sikhs of both genders in the Senior group. Older women have greater belief in God's locus of health control.

Inferential Statistics

Years in the UK

The T-test showed there was no significant difference between men and women in their length of residency ($t=.355$, $df=51$, $p=.989$, two-tailed, $r=.10$). A (4*1) Kruskal-Wallis was computed to test the hypothesis that the number of years in the UK (MR for up to 15yrs=38, 30yrs=19, 45yrs=24, 65yrs=21) effect belief in GLHC. A non-significant effect indicates that duration of UK Residency does not significantly influence the community's level of belief in GLHC ($H=4.666$, $df=3$, $p=.198$, 2-tailed).

UK Literacy

The hypothesis that there would be a difference between age groups and comprehension of English was tested. The Mann-Whitney also showed non-significance between the age groups; middle aged (MR=26.66) and senior-aged group (MR=28.40) in their self-reported comprehension of English ($U=340.500$, $N_1=28$, $N_2=26$, $p=.673$). The Mann-Whitney was also used to test the hypothesis that males and females differ in their comprehension of English. This showed non-significance for gender; males (MR=23.65), females (MR=30.49) in their self-reported fluency in English ($U=263.000$, $N_1=20$, $N_2=35$ $p=.114$ two-tailed). A (5*1) Kruskal-Wallis was computed to test the hypothesis that English comprehension (Excellent MR=20, Some MR=22, Enough MR=31, Less MR=29 and No understanding=25) influences belief in GLHC. The test revealed a non-significant effect indicating individuals abilities to comprehend English does not significantly influence their level of belief in GLHC ($H=4.796$, $df=4$, $p=.309$).

Years in Education

The hypotheses that there would be a difference between age groups and gender in their level of education was tested. The Mann-Whitney statistic did not show a significant difference between middle aged (MR=14.94) and senior age (MR=13.70) groups in their years in education ($U=.82.000$, $N_1=18$, $N_2=10$, $p=.699$, two-tailed). Neither did the Mann-Whitney show significant differences between men (MR=16.32) and women (MR=14.19) in their years of education ($U=.84.500$, $N_1=11$, $N_2=18$, $p=.512$, two-tailed). The (4*1) Kruskal-Wallis was used to test the hypothesis that belief in GLHC would differ due to years within education (MR for up to 5yrs=18, 10yrs=11, 15yrs=17 and 20yrs=10). Number of years in education showed a non-significant effect ($H=5.670$, $df=3$, $p=.129$). An individual's level of education does not significantly influence their level of belief in GLHC.

GLHC

T-tests for GLHC for age and gender groups were computed. Results did not show a significant difference between middle-aged and senior age groups ($t=-1.659$, $df=45$, $p=.104$, one-tailed, $r=.24$) or between men and women ($t=-.626$, $df=46$, $p=.534$, one-tailed, $r=.09$) in their belief in GLHC. A Two-Way ANOVA design (2*2) was employed where age and gender were between-subjects factors. There was not a significant main effect of age ($F_{(1, 43)}=2.798$, $p=.102$) or gender ($F_{(1,43)}=1.404$, $p=.243$) which indicates no major difference between Sikh men and women aged 45-54 and 55-65 years in their belief in God's control over their health status. There was no significant interaction between the factors of age and gender ($F_{(1,43)}=.588$, $p=.448$) which accounts for 4.1% of the variance for the belief in GLHC.

Linear regression.

Using the *Enter* Method a significant model emerged in identifying predictor variables for the Criterion variable, GLHC ($F_{(3, 41)}=4.036, p=.013$) Adjusted $R^2 = .171$. The model accounts for 17% of the variance. Table 6 shows age and years of residency in the UK are significant predictors of belief in GLHC while Gender failed to reach significance as a predictor.

Table 6 Linear Regression Model for Criterion variable: Level of belief in GLHC

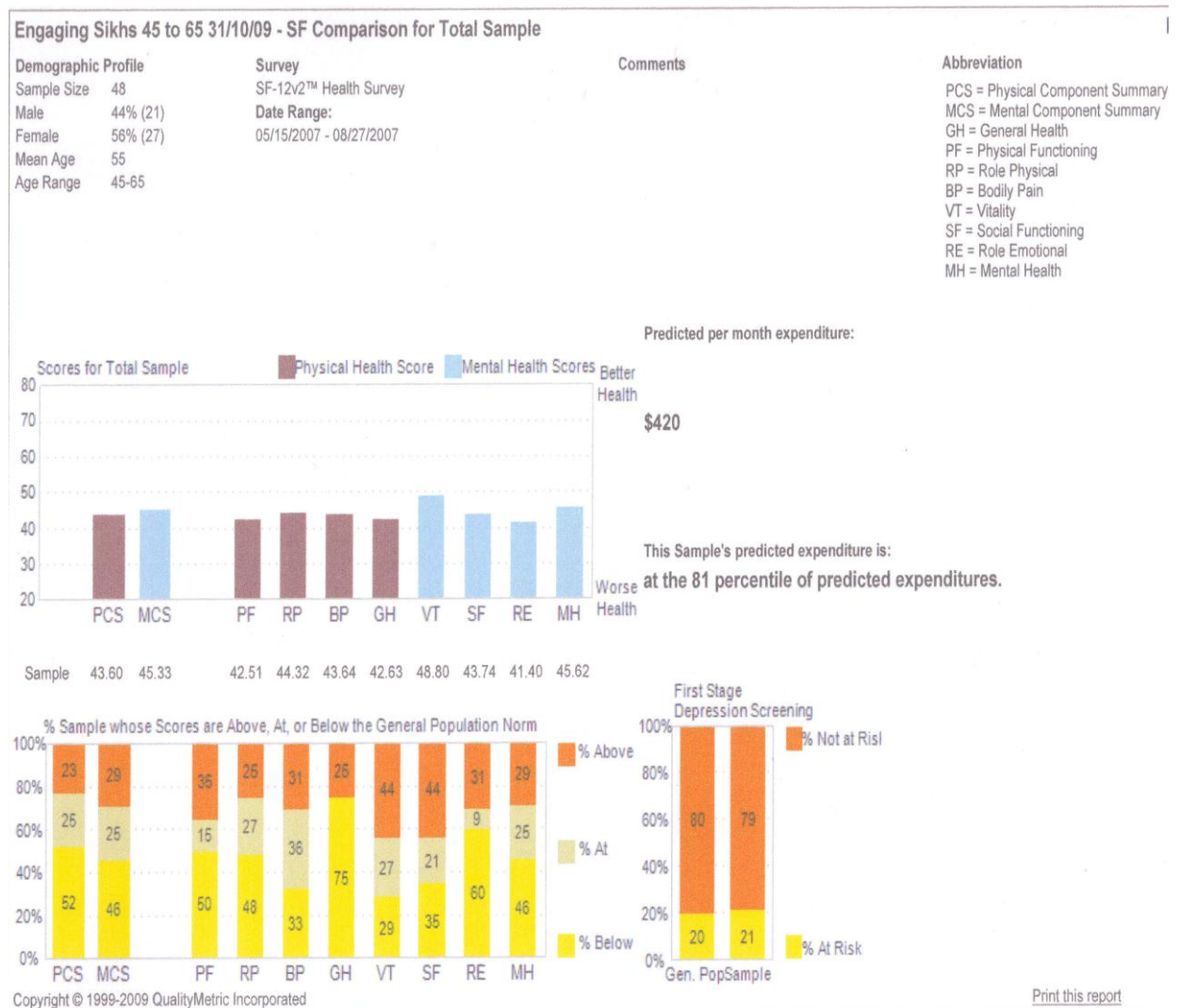
Predictor Variable	B	Beta	SE Beta	P
<i>Constant</i>	-13.993		13.414	.303
<i>Age</i>	.729	.460	.234	.003
<i>Years in UK</i>	-.250	-.322	.113	.033
Non Significant Predictor				
<i>Gender</i>	3.626	.200	2.525	.159

SF12v2 Well-Being and Health Outcomes

48 participants completed the SF12v2 whose results were calculated for mental and physical health components of well being; *figure 5*^{*8}. Comparisons were calculated and reported in *figures 6 and 7* for age and gender groups respectively. Individual reports are producible, see examples in Appendix 75-76. The program formulas and algorithms used to calculate scores are available in Appendix 17. Data quality indicators for data completeness, responses within range, estimable scale scores with and without missing data estimation, convergent and discriminant validity were satisfactory (Appendix 77).

*⁸ US 1998 population norms are appropriate for UK samples, e.g. Gandek et al.(1998).

Figure 5: Stacked Histograms for Total Sample Comparisons with General Population Norms for Physical Health (PCS) and Mental Health (MCS) Components of Well-Being.



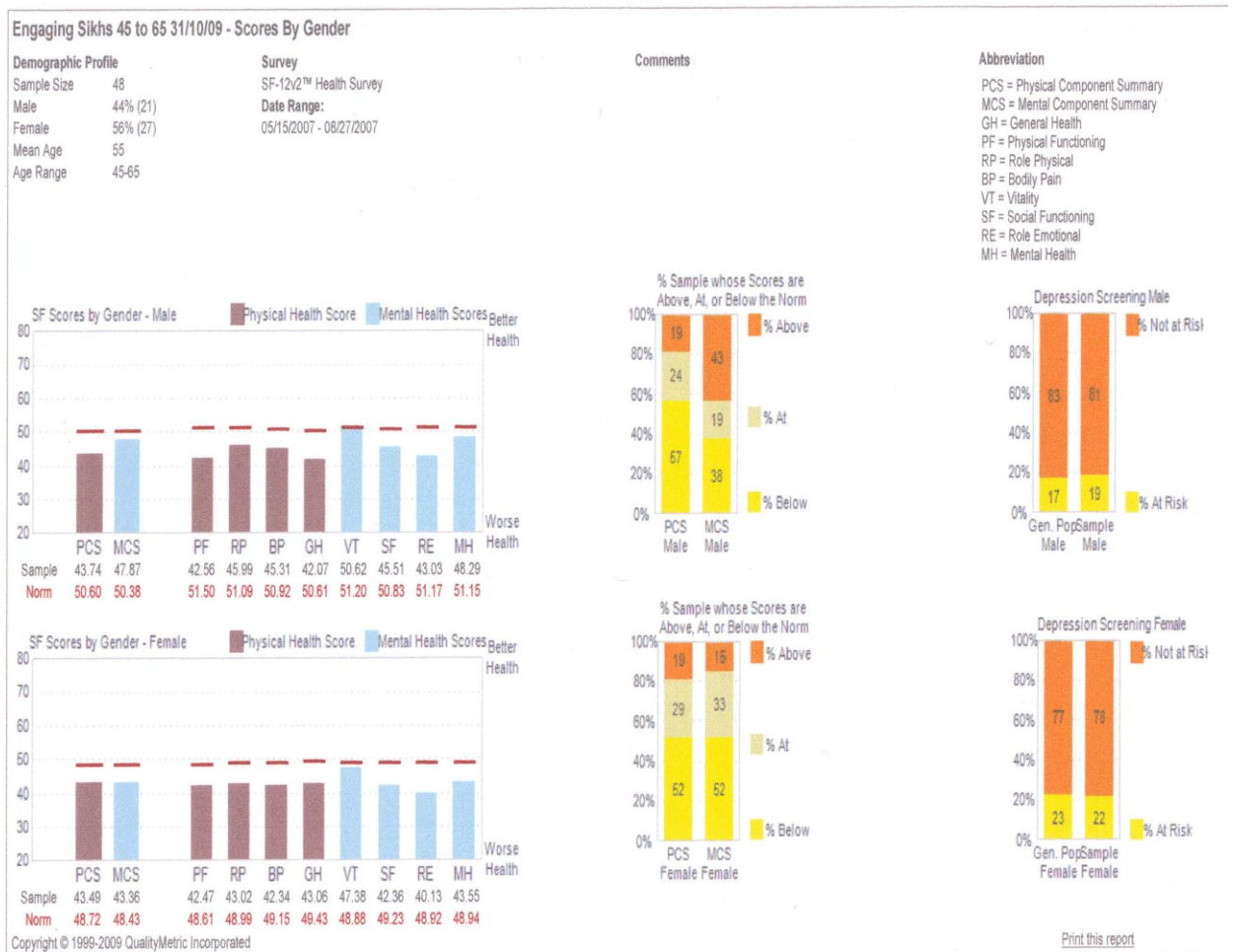
The bar graphs show PCS and MCS summary scores for the sample. Sample means are generally below average compared to the population norms. The subscales for physical and mental health indicate general health and role emotional are particularly affected at 75% and 60% below the population norm, respectively. First stage depression screening indicates the sample is only 1% at higher risk of depression than the general population.

Figure 6 Comparisons by Age Groups



The bar graphs show the population norm mean averages for physical and mental health summary scores compared to young and older adults in the sample. In both physical and mental health, the means for the 45-54 and 55-64 age groups are below the population norms with worse health. The 5 in the 65-74 age group were slightly above average in physical health outcomes.

Figure 7 Comparisons by Gender



The bar and stacked histograms demonstrate that males and females aggregate results were below the population norms for physical and mental health summary and subscale component scores. Only 19% and 43% of male and 19% and 15% of female participants' individual scores were above the norms for physical and mental health summary scores respectively. Sikh men are 2% more at risk of developing depression while women are 1% less likely to do so compared to the general population.

Correlations.

A Spearman's Rho Correlation Matrix was calculated for various variables, see Table 7.

Table 7: Correlation Matrix illustrating the associations between age, gender, English literacy, years of UK residency, years in education, attitudes towards GLHC, mental and physical health scores.

Variable r. Significance	Age	Gender	Literacy in English	Years in the UK	Years in Educ.	GLHC	MCS	PCS
Age	1.000	-.199 .137	.166 .230	.283 .042	-.229 .240	.383** .008	-.172 .248	-.205 .167
Gender	-.199 .137	1.000	.215 .115	-.149 .287	-.124 .522	.099 .501	-.194 .186	-.030 .838
Literacy in English	.166 .230	.215 .115	1.000	-.111 .432	.032 .868	.235 .112	-.266 .071	-.415** .004
Years in the UK	.283* .042	-.149 .287	-.111 .432	1.000	.008 .969	-.081 .594	.189 .207	-.113 .454
Years in Education	-.229 .240	-.124 .522	.032 .868	.008 .969	1.000	-.274 .157	.288 .146	.284 .151
GLHC	.383** .008	.099 .501	.235 .112	-.081 .594	-.274 .157	1.000	-.151 .310	-.042 .780
Mental Component Summary	-.172 .248	-.194 .186	-.266 .071	.189 .207	.288 .146	-.151 .310	1.000	.349* .015
Physical Component Summary	-.205 .167	-.030 .838	-.415 .004	-.113 .454	.284 .151	-.042 .780	.349* .015	1.000 .

*Correlation is significant at the 0.05 level (2-tailed); **Correlation is significant at the 0.01 level (2-tailed).

The majority of relationships between variables were non-significant at the .05 and .01 level. Significant positive correlations exist for age and GLHC attitudes (rho=.383, N=47, $p < .01$, 2-tailed) which may mean GLHC beliefs increase with age; age and length of UK Residency (rho=.283, N=52, $p < .05$, 2-tailed); Mental and Physical Health (rho=.349, N=48, $p < .05$, 2-tailed) and Mental Health and Spoken Languages (rho=.346, N=48, $p < .05$, 2-tailed). There were also significant negative associations between English literacy and Physical Health (rho=-.415, N=47, $p < .01$, 2-tailed).

Figure 8: Scattergram of the positive association between Physical and Mental Health

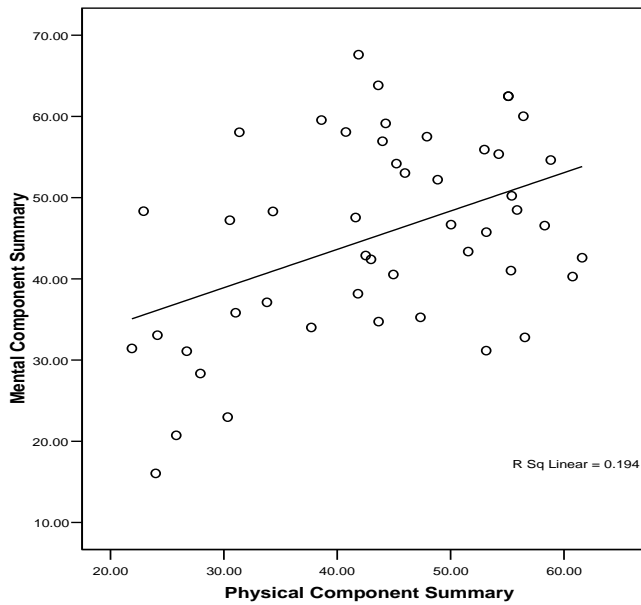


Figure 12 demonstrates well-being improves as physical and/or mental health improves and accounts for 19.4% of the variance on well-being. There is a medium effect size ($r > .3$) although points do not cluster around the regression line and the direction of causality is uncertain.

Figures 9 and 10 show a non-significant correlation between mental and physical health and GLHC beliefs. Well-being does not substantially improve or worsen as a consequence to believing in God's influence over health concerns.

Figure 9 Scattergram of association between Mental Health and GLHC belief

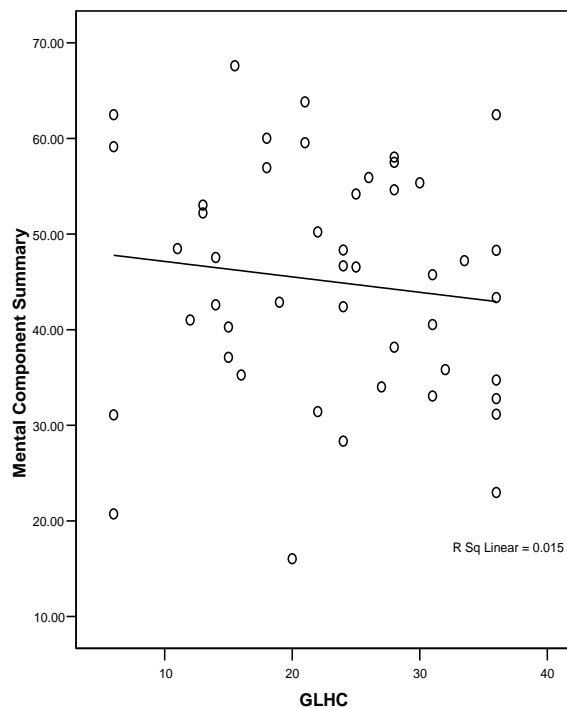
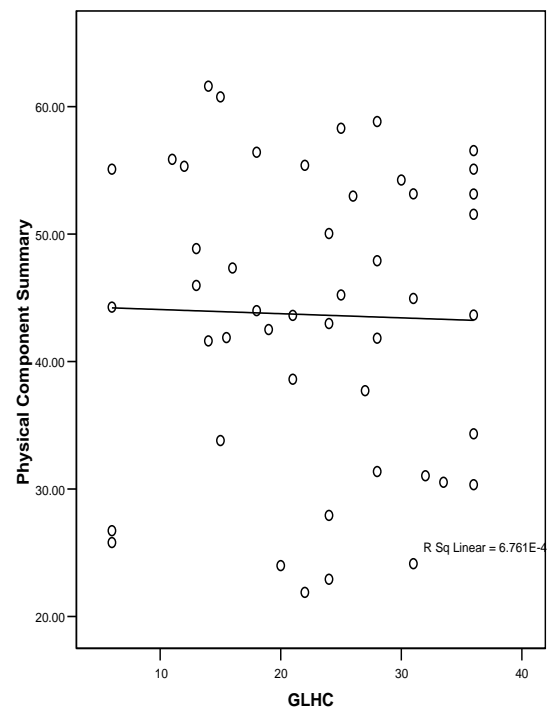


Figure 10 Scattergram of association between Physical Health and GLHC belief



Discussion Section

Integration and Summary of Findings

To address the main research question 1, second generation Sikhs indicate that they require a range of services and psychological support tailored to their community from older adult services to promote their psychological health and well-being. The reason for this is likely to be the integrated nature of their religious beliefs within their identity as the manner in which they define themselves as an individual and as a faith community. The collectivist culture and the effects of migration and acculturation within a secular society where they are a minority is likely to compound the need for the community to draw together within their cultural and religious beliefs and practices (Bruce, 1995). The other reason is because they do not separate the religious for psychosocial and somatic existence. They do not recognise psychiatric mental health illness and tend to somatise their emotional distress where it is usual to seek the advice of religious faith healers, medical staff. Medical professionals from an individualist society that are non religious maybe viewed as not understanding their needs. If this status quo does not change, then their willingness to engage in mental health services will remain limited. Further the issue of stigma remains a huge block to service uptake. Practitioners need to work around this challenge creatively to assist the Sikh Community. Also karma, a central feature of Sikh religious life may have consequences which inadvertently create a sense of reticence to seek help or to remain resigned to their fate. This will inevitably generate significant low mood and anxiety a sense of helplessness that needs to be sensitively adapted in order that people are

reminded to be proactive in the improvement and maintenance of their health and well-being. Preferences are summarised in *Table 3 Structural overview of the master and constitute themes* (p.67); in *Figure 1 Religion in the interpretation of health concerns with potential practitioner/service provider interventions* (p.71) and in *Figure 2 Service development issues for practitioners and service providers* (p.82). Table 3 demonstrates the objects and structures found to be associated and relevant to the Sikh community within the domains of religion, QoL and service development. Figure 1 illustrates the meaning of and that which can be inferred about the objects and structures associated with Sikhs in the religious interpretation of health concerns. It shows what could happen in terms of practitioner intervention. The potential consequences are: greater equality and quality of service, increased accessibility and uptake of older adult services as stigma is reduced. This is through the development of a shared, collaborative understanding of religious and psychological health issues between Sikhs, their familial, social and religious support networks and the service provider, facilitator or practitioner. Further, improved outcomes are likely to be identified in physical and psychological health, well-being and QoL and less reticence in support seeking from Older Adult Services. The essential objects, their structures and powers involved in the manner the Sikh community manage their religious and QoL practices are illustrated in Figure 2. This shows some relationships and possible events, consequences and outcomes.

For sub-question 2 there is a preference for services to account for religious beliefs. Sikhs report utilising religious coping. An intrinsic and extrinsic religious orientation can be inferred which is known to have consequences for well-being. A collaborative coping style with God is evident and frequently reported in relation to health and well-being. This coping style is associated with positive outcomes for psychological health and well-being.

Similar to previous findings (Smith & Simmonds, 2006; Daleman & Nease, 1994), 80.6% of those answering the question indicated that they do want services to account for their religious beliefs. Despite psychologists not tending to be religious themselves (e.g. Delaney, Miller & Bisono, 2007) practitioners could benefit the relationship with Sikh clients if they considered religious beliefs in their work. Sikhs range in their reliance upon religion but suggestions include adopting a non-extremist approach. A divide was mentioned between professionals being viewed as 'scientific' and 'educated' and Sikhs being 'religious'. Education was cited as causing less religiousness in professionals and the younger Sikh generation. Solomon (2003) confirms that the scientific western world views beliefs in 'God's will' as superstitious. No association was identified between Sikhs' years in education and belief in God's control over health.

Religious coping such as prayer, reading of scriptures, seva, meditation and contemplation were frequently reported as helpful for older adults in enhancing well-being, calmness, comfort and support, and is reported elsewhere (Breslin, & Lewis, 2008; Koenig, 1998; Maltby, Lewis & Day, 1999; Maltby, Lewis & Day, 2008; Smith and Simmonds, 2006). However in this study, as in King et al. (2006) significant

effects of religious coping resources on physical and mental health outcomes appear limited, for the community, gender and age group aggregate summary scores. This may be explained by a predominately extrinsic religious orientation, but requires further investigation using Brief RCOPE (Pargament, et al., 1998; Pargament, 1999).

Alternatively, although Sikhs advocate collaborative religious agency and collaborative religious coping with God as desirable (Fabricatore et al., 2004; Pargament, 1997) it could be that individuals' beliefs in karma/kismet and fate may lead them to instead adopt a deferring religious coping style in real life situations (i.e. passively deferring responsibility in solving difficulties to God). A deferring style produces no effect on well-being and worsens stress and mental health outcomes (Fabricatore et al., 2004; Klassen et al., 2006; Pieper, 2004). Equally, the issue of 'burden' can lead to religious meaning making associated with a punishing God reappraisal that has negative outcomes on well-being and mental health status (Phillips & Stein, 2007).

Psychologists could sensitively enquire about this to offer appropriate intervention where necessary to adjust unhelpful cognitions.

For sub-question 3, it was reported that all psychological services could be utilized but greater assistance with depression, anger, addiction, relationships, ageing, loneliness and isolation is required with less preference for assistance with psychosis, life-long addictions and behavioural problems. Below average summary scores for physical and mental health for the community, gender and age groups, particularly for emotional and general health, support the need for psychological intervention and services. There is a request for local services within community based venues, near or in the religious and social centres of the

community. Group rather than individual modes of delivery are preferred.

Anonymity and confidentiality are paramount.

UK Sikhs in this study did not have difficulty identifying depression. This differs from Bhagra (2005) who found women from the Punjab were unable to. Unfortunately, the current study is inconclusive in middle and senior aged Sikhs' abilities to identify dementia, but findings suggest dementia and anxiety are less well recognised. Sikhs in this study tended to utilise religious coping strategies as consistent with other research into South Asian communities (e.g. Hussain & Cochrane, 2003) particularly attending the Gurdwara and community centre. There was no support for reliance upon religious healers which were not mentioned by respondents other than by advocates for the community (see Appendix 137) and is counter to some previous research (e.g. Snowden & Yamada, 2005). There is the argument that people would not wish to be pathologized or that as a white, British, professional; I might not understand (Bhagra, 2005; Hwang et al., 2008; Hussain & Cochrane, 2002). Respondents were less likely to seek help from the GP for depression, anxiety or memory loss, particularly when it is associated with normal ageing, a finding similar to Seabrooke & Milne's (2004) and Turner's (2005) studies. Findings support Howse, Ebrahim, & Goberman-Hill (2005) and Sarkisian, Lee-Henderson & Mangione (2003), which found ethnic minority elderly often fail to inform GPs of psychological and emotional distress because they accept poor physical and mental health as a normal part of ageing which they consider untreatable. They are more likely to rely upon family friends and children. As for other Asian communities (Sashidharan, 2003; Snowden & Yamada, 2005; Butt & O'Neil, 2004 and Kalathil, 2008) it is important to increase Sikhs' psychological knowledge, signpost and provide information regarding available services.

For sub-question 4, The Sikh community have indicated a range of qualities they prefer, particularly the quality of their relationships with each other, facilitators and professionals. This is central to developing and maintaining continued engagement with services. Challenges to the uptake of services are identified, such as stigma and karma, and ideas on how to address these include offering support, actively publicising services, becoming known to the community and providing encouragement to attend services.

The qualities valued by service users are those relational, non-specific elements (e.g. Martin, Garske & Davis, 2000) that are inherent in therapeutic practice. Awareness of services is limited and has led to requests for advertising initiatives in their own language. Greater uptake is likely if initiatives are directed to the service user and their personal support network. Informing and gaining the support from social-leaders/advocates, family, children and the wider Sikh community about these initiatives and generally becoming known and trusted across the community will potentially have the consequence of encouraging initial access and continued engagement with services over the longer term.

This study draws similar conclusions to Kalathil (2008), who identifies for instance, difficulties accessing services, gaps in service provision, lack of religious sensitivity in the assessment and treatment process and assistance with social isolation as important. Butt & O'Neil (2004) identified lack of awareness regarding what is available and issues with the approach of service providers. Some challenges in accessing services remain long standing such as the communication barrier in the linguistic sense, thus requiring interpreters, and in the misunderstanding of and needing assistance with,

mental health terminology. Practitioners would also benefit from gaining training in working with interpreters, within postgraduate diversity modules and CPD training (BPS, 2008; Rea, 2004; Patel, 2000).

For sub-question 5. Sikhs demonstrate differences in the type of services and mode of delivery preferences they would appreciate from older adult psychology services, due to their religious affiliation.

Sikhs did not report cultural or institutional exclusion from mental health services unlike Bowl's (2007) findings for South Asians, but did indicate the need for secure services, improved cultural competence and non-stigmatising, inclusive psycho-education about mental health issues and well-being. Findings suggest consideration of developing targeted and specific services for minority groups (McKenzie & Bhui, 2007; Healthcare Commission, 2006^b, 2009, 2009^b; SSI, 1998). Rather than adapt services based on cultural generalisations, counselling psychologists could develop what Wilkinson (2009) calls culturally competent, personalised support initiatives to address individual needs. Service commissioners/providers could expand older adult psychology services from the healthcare system into other sectors involving social services or greater integration within community settings (see McDaid et al., 2007). There is scope for counselling psychologists to consider expanding their remit into working within religious organisations or in partnership with religious practitioners where appropriate - see Kloos & Moore (2000) and Coe & Boardman (2008) who successfully delivered their health message at the Gurdwara, 'the focal point of the Sikh Community,' with good effect. Asian communities do derive benefits from, and want, community services. Unfortunately, these are usually unstable due to short-term

contracts, limited budgets, stringent commissioning and competitive third sector services (Butt & O'Neil, 2004; Milbourne, 2009).

The community requests inclusive, formal and informal groups rather than traditional one-to-one therapy as consistent with Cattan et al. (2005). Similar to Moodley (2007) and Hussain & Cochrane (2002), respondents aired suspicion of one-to-one work, irrespective of whether these were community based or not. This makes the development of cultural and religious orientated one-to-one therapeutic models, like those cited earlier, potentially redundant. It also has implications for the NHS IAPT programme, in its aim to deliver one-to-one CBT therapy for anxiety and depression which is potentially exclusionary (DoH, 2008; DoH, 2009^a; DoH, 2009^b). Similar to Hussain & Cochrane (2002) this study shows groups facilitate social networking, physical exercise, a break from worries, roles and duties and a reason to leave the home and to exchange social and emotional support within relationships where cultural and religious factors are already accounted for.

These findings are contrasted with Nirmal (2004) which stated that South Asian women would like access to confidential therapy within services facilitated by South Asian staff. However, this study concludes that client-therapist matching should not be an automatic necessity for the Sikh community given their concerns about confidentiality, close-knit communities and gossip. Although client-therapist ethnic matching and culturally specific services are reported to be of benefit (Hwang et al., 2008) this research supports others that find these less conducive to positive outcomes (Hussain & Cochrane, 2002; Nesbitt, 2005).

For sub-questions 6 & 7, Sikhs demonstrate a significant belief in GLHC in their health concerns. Karma has the potential to influence Sikh service user's motivation for change. The influence of religion needs to be evaluated and addressed within service initiatives and practitioner interventions for improved outcomes in service user engagement, their health, well-being and QoL. GLHC beliefs increase with age and suggests religiousness increases with age. This may be explained by increased concerns associated with morbidity and mortality that reportedly becomes prominent as people age. There is no significant difference within the population, between Sikh men and women and their belief in God's control over health. One possible cause for this is the complete integration of religion within the Sikh way of life, which is applicable to all Sikhs irrespective of gender.

This study found that 67% of the sample believed that God influences health status. Years in education, English comprehension and belief in GLHC were similar for middle and senior aged men and women. For Sikhs, individual's level of education, UK literacy and number of years in the UK does not significantly influence their GLHC beliefs. However the less sensitive non-parametric tests may account for this. Further analyses showed age and years of UK residency are positively associated and significant predictors, accounting for 17% of the belief in GLHC.

The link between mental and physical health may lend support to this community's tendency to somatise psychological difficulties. There were also significant negative associations between English literacy and physical health, which may indicate a

tendency to somatise if unable to express psychological and emotional difficulties.

Notably, well-being does not substantially improve or worsen as a consequence to believing in God's influence over health.

Historically it was accepted that religiousness increased with age and women show greater religious attitude and observance than men (e.g. Argyle & Beit-Hallahmi, 1975).

This study finds little difference in Sikh men and women's belief in God's influence over their health. This tentatively supports the view that there is a non-significant difference due to age and gender in religious commitment and religious coping within the Sikh community (Cohen & Koenig, 2003; Coleman, Ivani-Chalian & Robinson, 2004; Francis, 1997; Vaillant et al., 2008) However, conclusions are derived from measures not standardised or validated for the Sikh Community. Further, the frequency of use and coping strategies adopted may differ between men and women and the middle and senior aged.

Recommendations for Clinical Practice & Future Research

This study finds 1) service information needs to be targeted towards informal carers, family members and social peers as these hierarchal relationships influence decision making in accessing services or not; 2) 1:1 clinical support would need to be covert and couched in terms which do not cause shame to the family; 3) psychologists are needed to work outside the usual mental health service structures to offer services in the community in liaison with statutory, non-statutory and religious groups; 4) psychological intervention may need to focus more at the community level in the form of psycho-education and non-stigmatising group work which could include children and carers. The younger generation may benefit from assistance with the issues of stigma

and concerns around older adult care; 5) Increase motivation by addressing the issues of karma and emphasise health as a shared responsibility in which the client does have some control over their QoL; 6) Plans to withdraw cultural specific languages in service literature may be premature and patient/client matching may need reconsideration; 7) Training programmes and CPD initiatives could include religion to improve practitioners' knowledge base. Practitioners and service providers need to incorporate religious considerations into their understanding of the client as well as how this may be evidenced within service delivery initiatives. Future Research could investigate these needs for other faith groups found to be highly populated within specific areas. Comparisons between groups would yield useful findings to support the necessity for inclusive or community specific services.

Research Caveats

A mixed methods design has successfully produced considerable data about an under researched ethnic minority faith community. In outlining the broad picture for the Sikh community it has meant a prioritising of selected master and super-ordinate themes which emphasis the Sikh community experiences rather than individual case experiences. This remit has in categories led to an omission of or surface level analysis on several themes, with less linguistic and conceptual comment analysis (see Smith, Flowers & Larkin, 2009) culminating in limited interpretations at these levels. Additional steps could have increased vignette validity and reliability. For instance, the scenarios have been artificially constructed on known cognitive and behavioural variables for depression, anxiety and dementia, but these variables have not been assessed for their ranges, means, and standard deviations; ecological validity of and inter-correlations between variables (Cooksey, 1996). This may explain difficulties in

participants' ability to accurately diagnosis scenarios (Skaner, Bring & Strender, 2004).

Reported beliefs and real life actions may differ greatly and the use of scenarios is linked to the risk of satisficing*⁹ (Stolte, 1994). Gilhooly, Gilhooly & Bowling (2005) find subjective accounts of well-being are influenced by context, ordering, recency, social desirability, positive self-presentation and the research question(s). Validation from future research is needed, as the findings herein are tentative given the reliance on non-parametric tests and the uncertainty in predicting future needs and preferences.

Summary

Religion has an important role in health and well-being during phases of interpretation, management and help-seeking behaviour of potential Sikh clients. UK communities are likely to be more religious than psychologists may appreciate (e.g. Post & Wade, 2009). The Sikh community have unique service provision preferences which if adopted could improve their future mental health, QoL and engagement with older adult psychology services. 80.6% want service providers to account for their religious beliefs and counselling psychologists are recommended to respect this request in their work with the Sikh community.

*⁹ *where factors in vignettes are not considered as much as they might be in genuine situations*

Conclusions

A critical realist approach described the nature of the Sikh faith community, its reliance upon individual/communal religious practices and explained how religion influences health, well-being and QoL. It identified their preferences for older adult psychology services and revealed the essential structures, processes, causes and consequences for these. It considered entities that are and could be amenable to change for improved QoL and service delivery outcomes. The future Sikh elderly favour psychological services tailored to their community to promote their psychological health and well-being.

Differences exist in the type of services and mode of delivery preferences of Sikhs' who prefer services to account for religious beliefs and report a collaborative religious coping style in the management of health. Sikhs could benefit from available psychological services but greater assistance is requested for depression, anger, addiction, relationships, ageing, loneliness and isolation, but not for psychosis, life-long addictions and behavioural problems. They request that service providers design permanent, public local services for groups within community based venues, preferably close to or in the religious and social centres of the community. One-to-one work other than telephone support is unlikely to be utilised as Sikhs prefer inclusive, non-stigmatising groups that emphasise anonymity and confidentiality. Sikhs value the quality of their relationships and are crucial in developing and maintaining continued engagement with services. Stigma and karma challenge the uptake of services but can be mediated by psycho-education, information and encouraging support seeking. Karma has implications for motivation that need to be addressed.

Psycho-education about mental health conditions, ageing, challenges to well-being and the support of social-leaders, family and children is important. Men and women share similar GLHC beliefs and consider religion in their understanding and management of health and well-being. GLHC beliefs increased with age and did not improve or worsen well-being.

SECTION 3

CRITICAL APPRAISAL

Critical Appraisal and Reflection upon the Research Experience

Designing the study

The original research proposal aimed to investigate the service preferences for three Asian faiths Hinduism, Islam and Sikhism for middle aged and older adults. However, the Research Board decided this would be too much for a doctorate of 25,000 words - justifiably so, given the volume of data this would involve. Nonetheless, news that the size of the project had to reduce to one age group and religious community was received with significant disappointment as I had intended to determine what was important to each group and compare between them. The comment 'this is not your life's work' was perceptive, as it had acquired that status. The lesson learned in this experience is to remember to manage my enthusiasm and idealistic tendencies carefully. My personal and professional objectives need to be realistic and manageable to avoid being overwhelmed emotionally and practically with work.

Selected measures and possible alternatives

The Service Needs Response Sheet was introduced following the decision to replace the *Camberwell Assessment of Need for the Elderly, CANE* (see Reynolds, 2000)

Instrument with the SF12v2 to ensure the broad areas of the former measure were still obtained about this group's preferences. This created considerable concern about developing an appropriate alternative from a standardised clinical measure which was not too time consuming, was socially acceptable and able to draw out the relevant information. The SF12v2 and this form became the suitable alternative with its limited number of questions and population norm figures. **The GLHC measure was selected for its association with the validated Multidimensional Health Locus of Control measure and for its limited items that enquire about the perceived role of God**

within health concerns. However there are drawbacks in using the SF12v2 and the GLHC measure with non-English speaking participants in that the reliability of the results is questionable. Several interpreters indicated that some questions were indistinguishable when translated into Punjabi for both the GLHC and SF12v2. Some participants reported a similarity in their understanding of the meaning of the questions. Several stated the GLHC failed to show the collaborative nature between God and the person in managing their health and well-being. It is difficult to determine how this has impacted on the research findings, but until such measures are validated for older adult Sikhs, there will be a difficulty in obtaining accurate results.

In finding alternative measures I wonder if I have created additional work for myself. For example, The WHO have developed a procedure called the Client Centred Community Needs Assessment (CCCNA) that collates service users' views on prospective services they feel they require (DiVillaer, 1990). Equally, questions arise regarding the religious measure chosen. Pargament's (1988, 2000) Religious problem solving scales could have been selected to determine deferring or collaborative coping styles. Another suitable measure that is used extensively in health related, older adult and QoL research (e.g. Cotton et al., 2006; Tarakeshwar et al., 2006) is The Brief RCOPE (Pargament, et al., 1998; Pargament, 1999). This is a 2 factor, 14-item measure adapted from the RCOPE (Pargament, Koenig & Perez, 2000) assesses the 6^{*10} positive and 5^{*11} negative religious coping strategies and takes to 2 minutes to complete.

*10 religious forgiveness, seeking spiritual support, collaborative religious coping, spiritual connection, religious purification, and benevolent religious reappraisals.

*11 spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisal and reappraisals of God's powers.

The Preparation Phase

I prepared over 100 participant packs and liaised with external religious and community based services. I had not anticipated the length of time this would require, nor the extent to which individuals would need reassurances that this endeavour was helpful to the Sikh Community and in their best interests. For instance on some occasions it was necessary to spend additional time to build relationships with organisations, interpreters, group leaders and community group members. This involved partaking of meals, making several return visits, discussing the research with numerous interested parties and attending social and educational events. Many were apprehensive in participating in the research with a psychologist and did not wish their GP, relatives or friends to find out.

Working with Ethnic Minority Groups – McLean & Campbell's (2003) and Sin's (2004^a; 2004^b) comment about and experience of the challenges of conducting research with ethnic groups and older adult populations applied equally in this research. I agree with the need for greater funding opportunities and strategies for collaboration with community organisations. The self-funded costs for this study exceed £15,000 (Appendix 29). It was important to become known within the community where researcher genuineness and trustworthiness are absolute necessities (Edwards, Temple, & Alexander, 2004). The slow pace of participant recruitment was not a shortfall in my abilities as a researcher but that of a cautious and despondent community, who felt let down by previous promises of research turning into action (See FG6M transcript, Appendix 128).

The recruitment of participants was extremely difficult, for every one organisation that agreed, several organisations and participants were unable to assist. This was a very anxious period and one which had me questioning my efforts as the diary entry below illustrates:

Thursday 12th July 2007 at 1.56 am

The last month I have spent contacting organisations with little success. I have attended several meetings with people and a couple have taken a number of my packs, but as of yet I do not actually possess one single completed participant pack for the [] area. This is after five months of contacting organisations! ... I've spent nearly £6,000 pounds on this and yet not one completed pack? ...

This necessitated a significant number of research packs and introductory literature to be prepared and sent out to more organisations than first anticipated. This was time consuming and costly in a manner not accounted for. Follow-up phone calls, several meetings and follow-up visits were required before access to participants were possible. Research endeavours can be met with resistance and mistrust by ethnic minority groups (e.g. Temple, Glenister & Raynes, 2002; Moreno-John et al., 2004). Fortunately I was given the 'all clear' by one community leader who informed others that 'we are supporting this research.'

Working with Interpreters – I remained mindful of the good practice guidelines suggested by Lago (2006) and Tribe (2007) such as establishing a good working relationship with the interpreter; outlining the aims of the study; recognising anxieties they had and attempted to retain the senior role (though this was difficult in some instances). I spent time with the interpreter following the interviews to discuss the process and outcome while gaining additional insights into those nuances of interpretation that I did not understand. There were occasions when the interpreters

expressed their sadness about their elderly population reported predicaments. I was careful to debrief interpreters after sessions and highlighted that this research aimed to improve their circumstance.

Edwards, Temple & Alexander (2004) find that it is the level of trust the participant has in the interpreter which is crucial for truthful reporting by participants, irrespective of whether the interpreter is a professional interpreter or not. This was apparent within this study, in that the male interpreter with the male Focus group 6 was absolutely fundamental in whether the participants were willing to engage in a focus group in the first instance. The male interpreter of the same faith and locality was able to reassure participants that my intentions were ultimately for their well-being. Similarly, the female interviewers were vital in providing this reassurance and allaying their fears and concerns. Of note, all of the interpreters were personable, younger, and from the local Sikh generation. Their respect for their 'aunty' or 'uncle' (colloquial term used to address elders) was evident throughout and perhaps the difference in their willingness to contribute their time and thoughts.

The Literature Review – I resisted any in-depth consideration of the literature until after the analysis of the qualitative data. This inevitably delayed starting the literature review as I attempted to avoid analysis from becoming contaminated by prior knowledge. For several years I'd collected seemingly relevant articles and books while only briefly giving them attention until after the analysis phase. It was a daunting task to read copiously all that had been collected to determine each piece's individual merit to the overall thesis. The challenge has been to maintain my motivation in the face of overwhelming work as there were various disciplines and subsections which the review

could have included. I believe I have been too ambitious in covering so many areas within one short study. It has been difficult to determine what is relevant for inclusion and that which suffices for background reading.

Analysis Phase

A considerable weakness of analysing large data sets and endeavouring to explicate the experience and preferences for a faith community in large fields of study i.e. religion, QoL and service development, is the loss of idiographic, detailed analysis of individual case experience (although this has been in part completed to super-ordinate level for each contribution, see Appendix 93-106). The drawbacks include reports which are largely descriptive of participant's experience, with limited exploration of alternative interpretations informed by a counselling psychology perspective or psychological theory, for instance. There is a sense that I have not drawn out as much new and insightful information from the data as could potentially be done with traditional IPA and its interpretative strategies. Nonetheless, this limitation does allow for future in-depth analysis in the form of independent case studies and across cases for the community, gender and age groups, particularly in the domains mentioned above. This thematic analysis does have the advantage of adopting tested methods from IPA and a respect for personal subjective experience whilst remaining close to participant's understanding, lived experience and preferences. The findings are unlikely to unintentionally offend or be disputed by the Sikh faith community although participants should have been provided an opportunity to review my findings to confirm that it fits with their experience. Adopting a thematic approach has presented many challenges in the design, implementation and presentation of findings. From the development of questions that are not particularly open ended, to ascertain answers that required the

participant to predict what their future personal or community's needs shall be.

Additional concerns were to provide an audit trail without it becoming excessive and to be able to express adequately the links between the data, themes and memos. It has been challenging to present that which individual cases and integration of cases demonstrate and a fine line between relaying their experience and identifying their future predictions about services which they are generally unaware or reticent to engage with.

Concerns arose about the appropriate quantitative aspects to the study following its alteration by the Research Board and Ethics Committee. As the study was reduced from 3 religious groups to just one within one age group – my plans for analysis had also to be amended. As it was, non-parametric tests were required in the majority of cases which is disappointing given my endeavours to show some validity and plausibility in expanding my findings tentatively to the wider Sikh community. The quantitative statistics have been difficult to grasp since I had not completed this type of analysis since graduation in 2002. Considerable amounts of time were necessary to update my skills, which has led to, in part, trial-and-error learning. In my view, moderate success has been achieved in eliciting useful information for service providers while reporting that which has relevance for the community.

Use of Technology – throughout the research I utilised various packages e.g. *Nud*st 6*, *Speaking Naturally*, *Endnote*, and *SPSS 12* as well as electronic publication alerts.

Hindsight suggests Journal alerts were not the best approach in terms of time management, given that another literature search closer to the submission date would have sufficed. Installation, subscription and becoming familiar with the packages and their commands have been time consuming. Some were not as helpful as anticipated

and so contributed to wasted time e.g. I was reluctant to use *Endnote* due to a previous disastrous experience. *Speaking Naturally* required correcting frequently. Nud*ist 6 was an excellent tool for the manipulation of text and reorganisation of themes or 'nodes' of data. However, for the purpose of an audit trail I found that I was unable to easily transfer into report form, that which I could clearly see on the screen. There appeared no facility to list the themes chronologically as they presented themselves in the source list, neither were memos automatically printed with their associated text units and themes. The process of audit trailing became time-consuming, frustrating and laborious as I transferred data to Word and re-organised it into meaningful presentations to show the development of themes and the analytic process. The updated programme NVivo 8 is likely to dispense with many of these problems. I would advocate the use of qualitative programmes in the aid of storage and analysis of qualitative data, as the capabilities of such programmes will have advanced since Nud*ist 6.

Reliance upon the Research Diary – while this reduced my generalised anxiety throughout the research process, it also became a tool for procrastination in that the researcher found it easier to write about the process and personal experience than it is to analyse, synthesise, critique and develop new insights from the current literature for instance. The diary of over 80 pages provides the opportunity to review progression, the challenges and enjoyable moments of the study and reflection on and learning from my researching errors and experiences for future academic work.

Final Phase

The drawing together of all the strands of the research has been a significant task. Every step of this study has been a learning process in personal fortitude and technical

research skills. The most impactful of findings was not that Sikhs rely upon religious coping resources, or the interesting areas of study which has required I investigate various disciplines. It was the reports of the SF12v2 which quite powerfully illustrated that this population were indeed in need of psychological and social support from service providers despite their not approaching them for assistance. It is a shock to realise that I (and therefore others) have mistakenly been convinced by participant's cheerful presentation that all was reasonably well with them. This perhaps illustrates their acceptance of God's will, fate and karma, or their belief that no one 'outside' the community can help them. Finally, sufficient time for the write-up phase and the importance of backing-up work on external drives cannot be overemphasised. Another lesson learned given my hardware failure that took my doctoral work at the '11th hour!'

Final Thoughts

My idealised hope of achieving far more than presented here has become apparent through the research process. Nonetheless, I trust the study's findings will be of value to service providers, the forthcoming elderly and leaves options open for future research.

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