



SEHHAT

IMPACTS OF SUICIDE IN PUNJABI COMMUNITIES

June 2024



Foreword

MESSAGE FROM FOUNDER AND DIRECTOR OF SEHHAT

The importance of research such as the 'Impacts of Suicide in Punjabi Communities' is not about numbers and statistics; it's about providing the unheard a space to be heard. Suicide is a silent killer, resulting in individuals worldwide feeling alone and isolated, this is something we aim to change, and we are doing this by listening to their experiences and ensuring they feel represented in resources created. Before I began this report, I have had a wealth of years working on the ground with communities; from this experience my team and I know the countless journeys which have gone unsupported from the lack of culturally appropriate services and limited bereavement groups.

We explored the difficulties participants experienced with seeking help; whether the help received was useful after a service user had aimed to complete a suicide, or if people who were bereaved by a completed suicide were able to receive relevant and appropriate support.

In 2022 The Rt Hon Sajid Javid MP stated, "I am determined to focus not just on those who are at risk of suicide, but of course also their loved ones too. The sudden and unexpected circumstances of death from suicide can bring huge trauma. I know the toll of losing a loved one, and we need to be better at supporting those who are left behind. Not only because it is the right thing to do but because those who are bereaved from suicide are themselves at greater risk of suicide. The evidence suggests that for every suicide, 135 people are directly affected and so we need to do everything we can to break this cycle of grief and suffering"⁽¹⁾

Therefore, in the context of the 158 individuals who participated in this study, if they had died by suicide, 21,330 people would have been impacted by their death.

I wish to see a world where suicide is preventable.



Sandy Kaur

Sandy Kaur, Founder & Director of Sehhahat

Acknowledgements

As a collective team of individuals who have worked on making the 'Impacts of Suicide in Punjabi Communities' study possible, we would like to thank all the participants who opened their hearts and shared their experience of suicide with us and have trusted us with their journeys. Sehhat's aim is to make a future where mental health and suicide is preventable for Punjabi and South Asian communities.

I wish to thank the incredible individuals who freely gave their time to be interviewed for the following case studies:

Those who ;

- Were bereaved by suicide
- Shared their lived experience
- Are professionals who have supported individuals with lived experiences

They gave us insight and different perspectives on language, culture and terminology when speaking about suicide.

A thank you also goes to the organisations and institutes who shared the details of our study with their communities and platforms.

To all the individuals who have tirelessly worked the late hours across days and months, a heartfelt thanks with full gratitude. These individuals believe in Sehhat's vision and as the founder I am truly grateful for the hard work put into this study.

Editors

Sandy Kaur and Dr Juhee Pahuja

Contributors

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Thank you all for your time and cooperation in completing this study.

To enable the study to go ahead, this study has been funded by Sandy Kaur.



Executive Summary

Introduction

It has been known that Punjabi and South Asian communities are not prevalent in national studies, especially those focusing on mental health. We understand this is due in part to communities not knowing about the studies or not fully trusting that their participation will make any difference. This means findings demonstrated in studies may be less relevant to Punjabi and South Asian ethnic groups. Hence, it is important to engage and empower Punjabi communities, accurately representing their voices and experiences so that interventions can be tailored to address any unique mental health needs for these communities.

Aim and Objectives

This study is focused on suicide within Punjabi communities, emphasising the need for increased support services. The objectives include understanding why some individuals did not receive the help they needed, their experiences of suicidal ideations and the root of these thoughts and feelings.

We aim to provide hope by conveying that suicide is preventable, however, as a collective there needs to be education behind the basics of visible and invisible health inequalities and the overall struggles individuals are experiencing which could lead to suicide.

The 'Impacts of Suicide in Punjabi Communities' study focuses on incorporating the voices and perspectives of people with lived experiences of suicide into decision-making processes and the development of resources. This research explores various aspects, including experiences of both direct and indirect links to suicide, the support and services available around prevention, as well as the preferences and priorities of individuals with lived experiences of suicide and grief. Additionally, it aims to identify how these experiences may differ among different groups within the Punjabi population.

In summary, the research seeks to shed light on the presence of suicide within Punjabi communities, highlight the need for enhanced culturally appropriate support services, and ensure that the insights and perspectives of those directly affected are considered in decision-making and resource development.

Methodology

This was a mix-method study and composed of two parts:

1. Online and in-person study with participants (aged 18+) with lived experiences of suicide
2. In-depth case studies on individuals who:
 - Were bereaved by suicide.
 - Shared their lived experience.
 - Are professionals who have supported individuals with lived experiences.

Key Findings and Discussion

With 162 individuals taking part in the study, We found that nearly two-thirds (62.3%) of participants have had suicidal thoughts at some point in their lives, and more than half (55.6%) of participants have been impacted by the suicide of their loved ones. Although they sought tailored therapy and support groups, the lack of appropriate resources and cultural barriers reduced the effectiveness of such supports.

This study underscores the urgent need for improved access to culturally sensitive resources and interventions to effectively address mental health challenges and mitigate the barriers against existing support systems.



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Introduction

Introduction

Sehhat's vision is to shape the current mindset of Punjabi and South Asian communities on mental health and suicide,⁽²⁾ by building spaces and resources where mental health and suicide prevention is at the forefront of health conversations. This enables Sehhat to provide tailored supports services.

We aim to give people who are struggling their valued space where they are accepted for who they are, where we promote and protect mental health conditions and where we imprint in communities that suicide is preventable. This space should be where anyone can exercise their human rights and access affordable, bilingual resources full of representation and enhancing the quality of care.

Your health is made of several factors: social, environmental, psychological, physical, and additional factors such as cultural, financial and biological. These health factors and other life experiences, like traumas, can influence an individual's mindset.

From our community outreach work we understand that there is an interlink between poor mental health struggles and suicide, and that anyone can experience poor mental health, and anyone can experience suicidal feelings. Therefore, it is pivotal to breakdown the meanings of mental health and suicide and the lived experiences of the community.

By developing evidence-based interventions and support services across healthcare and non-healthcare settings, we aim to aid vulnerable people and their families, ensuring there are pockets of relative supports available.

Defining Mental Health

The World Health Organisation⁽³⁾ defines mental health as: "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in."

Defining Suicide

Suicide is when someone ends their own life. It is a very tragic response to difficult situations and feelings, perhaps most tragic because it is preventable. Suicide is the result of many factors in a person's life and some people who end their own lives do not want to die, but feel they have no other option. Therefore, having suicidal thoughts doesn't mean that someone has a mental illness, but there is a connection between mental ill health and suicidal thoughts.⁽⁴⁾

Mental Health

is defined as

"a state of **mental well-being** that enables people to **cope** with the stresses of life, **realise** their abilities, **learn well** and **work well**, and **contribute** to their community."

– World Health Organisation (WHO)⁽³⁾

Suicide

Is defined as

"**death** caused by **self-directed injurious behaviour** with **intent to die** as a result of the behaviour."

– National Institute of Mental Health⁽⁵⁾



The National Institute of Mental Health⁽⁵⁾ defines the following:

- **'Suicide as death** caused by self-directed injurious behaviour with intent to die as a result of the behaviour.
- A **suicide attempt** as non-fatal, self-directed, potentially injurious behaviour with intent to die as a result of the behaviour. A suicide attempt might not result in an injury.
- **Suicidal ideation** refers to thinking about, considering, or planning suicide.'

General Statistics

According to the World Health Organisation⁽⁶⁾ 703,000 people globally take their lives every year, with many more attempting to do so.

Suicide is the 4th leading cause of death among 15-to-29-year-olds and 77% of global suicides occur in low-middle income countries.⁽⁶⁾

The table below shows the number of registered suicides in each region of the UK.⁽⁷⁾

Table 1: Registered Suicides in 2021 and 2022 in England, Scotland and Wales

Region	2021	2022
England	5219	5284
Scotland	753	762
Wales	347	339

Source: Adapted from Samaritans, 2023⁽⁷⁾



In England, males aged 50 to 54 were found to have the highest suicide rates with 23.1 per 100,000. In Scotland, males are three times more likely to die by suicide than females, but it is important to note that suicide rates amongst women have been increasing since 2017.⁽⁷⁾

People living in Scotland's most deprived areas are over two and a half times more likely to die by suicide than those living in the least deprived areas. The overall suicide rate is 13.9 per 100,000 people.⁽⁷⁾



Suicide is the

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leading cause of death among young people aged between 15 and 25.⁽⁶⁾



Men are

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more likely to die from suicide.⁽⁷⁾



More **deprived**

areas have almost

two times

more suicide rate.⁽⁷⁾



Who is affected?

Anyone can be affected by poor mental health regardless of a country's development levels. There are links between suicide and mental conditions including, alcohol use and depression, as well as previous suicide attempts in high income countries.⁽³⁾ Suicide is a serious mental health problem across all population groups. Feelings of being suicidal can happen impulsively in the moments before the crisis, with a breakdown in the ability to deal with life stressors such as relationship struggles, financial troubles or chronic pain/illnesses.⁽⁴⁻⁶⁾ There are high rates amongst vulnerable populations like those experiencing discrimination: ethnic minorities, refugees, migrants, indigenous people, LGBTQIA+ people and prisoners.⁽⁴⁻⁶⁾

Suicide in Punjabi and South Asian Communities

Focusing on ethnic groups in the UK, studies have demonstrated variations in suicide rates and risk factors for suicidal behaviours over the years.⁽⁸⁾ With one of the first studies on attempted suicide in South Asian immigrants in Birmingham in 1976,⁽⁹⁾ differences in ethnic groups were noted.⁽⁹⁾ Although rates were found to be lower in South Asians than the general population in that study, South Asian females had high suicide rates.⁽⁹⁾ Since then, national data in the 1990s have shown increasing suicide rates in young South Asian women in the UK.⁽¹⁰⁾ In a study of patients in West London,⁽¹¹⁾ South Asian women had the highest overall suicide rates: 1.6 times the rate among White women and 2.5 times the rate among South Asian men. The rates were lowest among older women. Among South Asian women younger than 30, the rates were 2.5 times higher than those of White women and 7 times higher than those of South Asian men. Self-poisoning was the most common method of self-harm.⁽¹¹⁾ In a different study, self-harm rates were 2.6 times higher in South Asian females compared to White females, and 7.8 times higher among UK-born Indian females than their UK-born White counterparts.⁽¹²⁾ In another study, South Asian women aged 16–24 exhibited a higher self-harm rate compared to White women, while self-harm rates were lower in South Asian men across all age groups compared to White men.⁽¹³⁾

South Asian women aged 16–24 have a higher self-harm rate than White women.⁽¹³⁾

Ethnic minority children and adolescents accounted for **increased** proportion of **self-harm** compared to **White** ethnic groups.⁽¹⁶⁾

Certain studies have also identified older South Asian individuals as a high-risk group for suicide and depression.^(8,14,15) An observational cohort study⁽¹⁶⁾ revealed that ethnic minority children and adolescents had a lower rate of hospital presentations due to self-harm compared to their White counterparts. However, over a 16-year study period, rates of self-harm increased more within ethnic minority groups than within the White group.⁽¹⁶⁾ Supporting these findings, ethnic minority children and adolescents accounted for an increased proportion of self-harm presentations to hospitals over time compared with White ethnic groups.⁽¹⁶⁾

Additionally, these ethnic minority groups were less likely to receive specialised psychosocial assessments by psychiatry liaison staff.⁽¹⁶⁾



South Asian adults

are more likely to report

higher levels of mental distress

compared to White British

adults during **COVID-19** pandemic.⁽¹⁷⁾

More recently, the UK Health and Life Sciences (HLS) published a study in April 2020⁽¹⁷⁾ which revealed that South Asian adults, on average, were more likely to report higher levels of mental distress compared to White British adults during the COVID-19 pandemic.⁽¹⁷⁾ The study found a general decline in mental health across all ethnic groups, including the White British population, since the onset of the pandemic.⁽¹⁷⁾ Notably, there was limited robust data on ethnicity and mental health, particularly focusing on Punjabi and Sikh communities, before the pandemic.

According to the 2018 British Sikh Report (BSR) survey,⁽¹⁸⁾ 10% of Sikh women and 5% of Sikh men reported having a mental health condition. A significant majority of Sikh individuals (80% of Sikh women and 68% of Sikh men) knew someone who had experienced poor mental health in the past year.⁽¹⁸⁾ The prevalence rates for mental health conditions among Sikhs under 65 years of age were estimated to be at least 6-8%.⁽¹⁸⁾ It is vital to note that these figures excluded individuals who chose not to disclose their mental health status and individuals who are Punjabi/speak Punjabi but are not Sikh, suggesting that actual prevalence rates within the Sikh and wider Punjabi community may be higher than reported.⁽¹⁸⁾ The study underscores the need for more comprehensive data collection on mental health within the Punjabi community to identify and address mental health issues and experiences.

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Factors in Poor Mental Health and Suicide Rates

Self-harm and suicide rates continue to increase in Punjabi and South Asian communities. For that reason, acknowledging the complexity of cultural factors is important. Studies have also found higher impulsivity but also, in contrast, longer time planning suicide attempts without coming forward to seek help in South Asian communities. Certain studies touch upon cultural conflict but fall short in providing a comprehensive exploration.⁽⁸⁾ Digging deeper into the prevalence of mental illness, exploring the impact of cultural and social factors, and analysing variations in Punjabi and South Asian communities can aid in crafting targeted service provisions. Implementing interpersonal problem-solving interventions are crucial for mitigating self-harm and suicide attempts.^(13,19,20)

Various life stressors contribute to mental health in the broader community, such as general stress, loss, traumatic incidents, financial difficulties, unstable employment status, social isolation, interpersonal connections, low self-worth views and physical well-being.⁽²⁰⁻²²⁾ For individuals of diverse ethnic backgrounds, specific factors pertinent to mental health have been recognised and explored to some extent, only recently gaining prominence in mainstream discussions.



Culture

Cultural conflict, interpersonal and marital issues and societal matters have also been suggested to impact mental health, especially in those who identify as females, and are risk factors to self-harm and suicide.⁽²¹⁾ Conflict with close family members, especially revolving around relationships, can be a cause of stress for single females. The loss of a partner or a prolonged illness can lead to feelings of depression and, in some cases, thoughts of suicide, especially seen in older women. Cultural expectations, such as the traditional role of men as providers and pressures to excel academically, religiously, or in marriage, can place significant burdens on men, contributing to thoughts of suicide.^(22,23)

‘Acculturative stress’ arises when individuals try to integrate into the culture of their current environment.

‘Acculturative stress’ arises when individuals try to integrate into the culture of their current environment. When family members adapt at different rates and ways, it can result in friction, tension and lack of mutual understanding within families. This dynamic raises the risk of individuals experiencing feelings of alienation, loneliness, and even contemplating suicide. This is particularly evident between older and younger generations, when the younger generation has grown up in a Western society.⁽²¹⁻²³⁾

This can often result in the struggles of having a dual identity from living in a Western society and not having a place of belonging.

Language

Language barriers have also contributed to suicidal feelings.⁽²²⁾ For some, generally older, Punjabi populations, lack of proficiency in English can act as a barrier in accessing appropriate mental health services as they have reported they do not feel understood by Western healthcare providers. Resources and services being delivered in English mainly can cause hesitancy which can be overcome in information being translated in various languages. Language is also a barrier when explaining mental health feelings and symptoms as they are very limited like for like translations. Previous research indicates various other issues such as difficulty in arranging and keeping appointments, difficulty with instruction in terms of healthcare, increased stress, decreased confidence, and issues around appropriate diagnosis and medication.⁽²⁴⁾

...lack of proficiency in English can act as a barrier in accessing appropriate mental health services...

...stigma and taboo around mental health, particularly in the Punjabi and South Asian communities...prevent people from accessing mental health services...

Stigma and Taboo

There is a huge stigma and taboo around mental health particularly in the Punjabi and South Asian community that prevent people from accessing mental health services.⁽²¹⁻²³⁾ Mental health problems or suicidal thoughts are often viewed as shameful and indicative of ‘weakness.’ These inaccurate beliefs and misconceptions in communities and society can result in people fostering feelings of guilt and isolation and exacerbate their symptoms of mental illness. This can lead individuals to believe suicide is their only option to end suffering. The fear of stigmatisation also negatively impacts on help-seeking behaviours and leads to delays in diagnosis, under-reporting and under-treatment of mental health conditions, self-harm and suicide.⁽²¹⁻²³⁾



Lack of Culturally Appropriate Clinical Care

Mental illnesses such as depression associated with stress and impulsive acts of self-harm are frequent in the South Asian community but are improperly diagnosed due to doctors overlooking symptoms.⁽²²⁾ Patients lack trust in healthcare providers, leading to delays in accessing the help they need, influencing suicide.⁽²²⁾ Psychological therapies are standardised to White population cohorts with minimal regard to cultural differences, further alienating Punjabi and South Asian communities in accessing and receiving maximum benefit from therapy.

Punjabi communities would benefit from qualitative research and in-depth analysis to explore negative and positive mental health factors and experiences. This would improve mental health outcomes and reduce self-harm and suicide rates.

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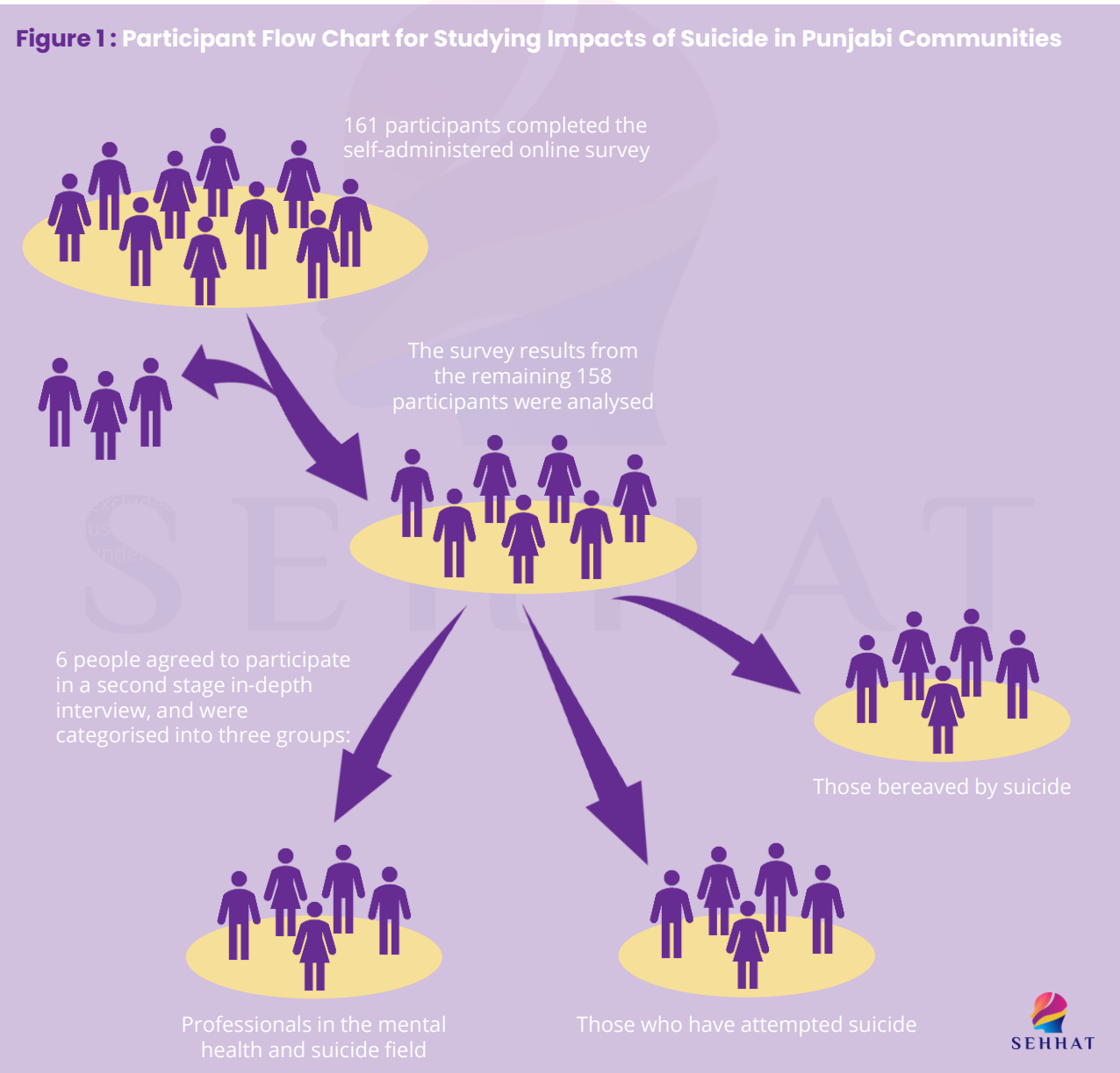
Methodology

Participants

We conducted a survey of adults over 18 from Punjabi communities. This was an anonymous self-administered questionnaire completed online. The questionnaire included information on gender, age (in age groups), location and sexuality. The questionnaire consisted of 15 questions.

There were a total of 161 participants. Of these, three indicated that they were under 18 and were redirected to the end of the survey and to other specific mental health services, as they could not provide legal consent (Figure 1). The survey result from the remaining 158 participants were analysed and presented for the purpose of this report.

The second stage of the study was split into three categories: (1) those bereaved by suicide, (2) those who have attempted, and (3) professionals in the mental health and suicide field. These were conducted as in-depth interviews (each lasting for two hours) and included six participants from the Punjabi community: three participants were aged 18–34, three were aged 35–64.



Demographics

The study includes a diverse sample of participants from various regions across the UK. The participants' ages range from under 18 to over 65, although the responses from the under-18 participants were excluded from the study. Participants aged between 35 to 44 made up most of the sample size, making up more than one third of the entire sample.

A large majority of participants were female (n=99), whereas the number of male participants (n=58) were just slightly more than half the number of females. One participant identified themselves as non-binary. Table 2 presents the key descriptive characteristics of the participants.

Residents from various regions across the UK participated in the study, with the majority residing in urban centres such as London

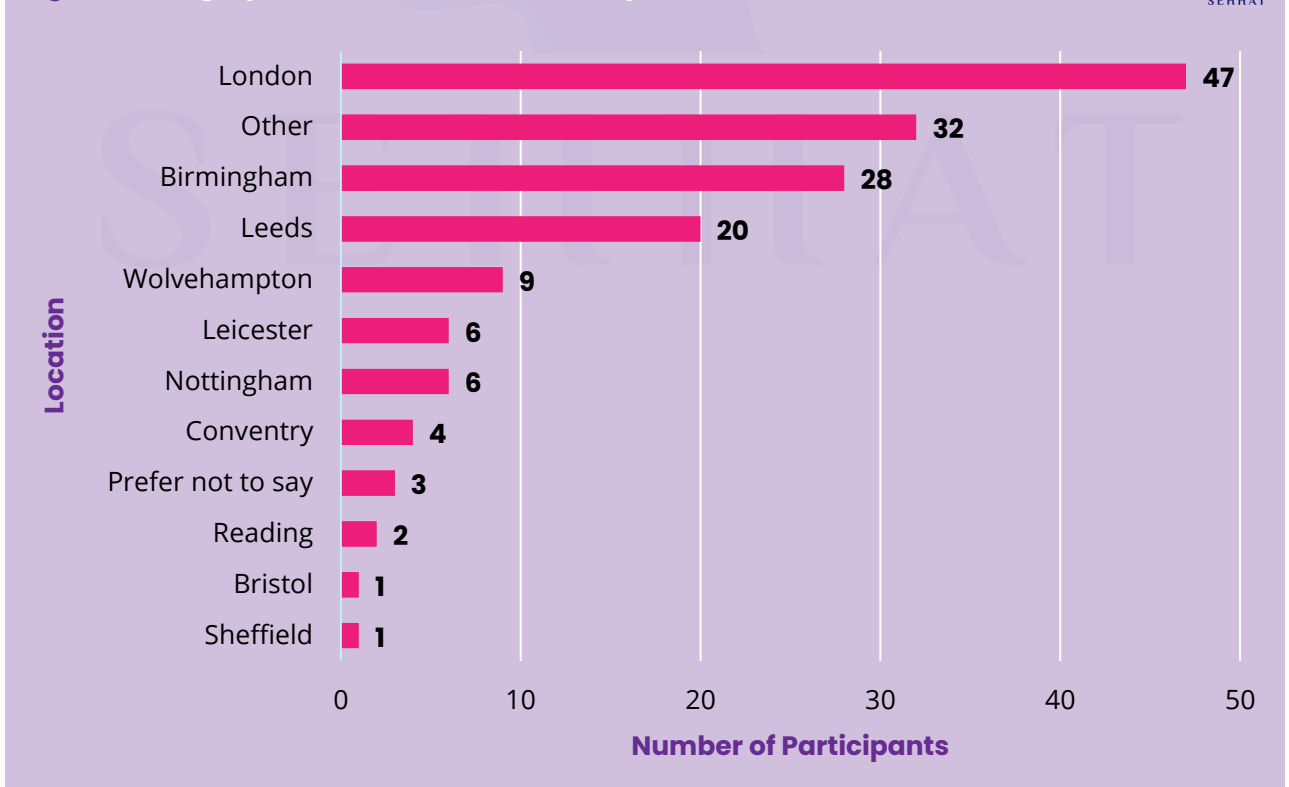
(n=47, 29%) and Birmingham (n=28, 17.2%). Figure 2 shows distribution of participants across the UK.

Table 2 : Age and Gender of Participants



		Number (Percentage)
Age	Under 18	3 (1.9%)
	18 to 24	18 (11.2%)
	25 to 34	30 (18.6%)
	35 to 44	59 (36.6%)
	45 to 54	26 (16.1%)
	55 to 64	18 (11.2%)
	65+	6 (3.7%)
	Prefer not to say	1 (0.6%)
Gender	Male	58 (36%)
	Female	99 (61.4%)
	Non-binary	1 (0.6%)
	Did not specify	3 (1.9%)

Figure 2: Geographical Distribution of Participants





Results & Findings

Astonishingly, of the 158 participants, 62.3% (n=99) indicated that they had experienced suicidal thoughts. Of these, 65 were female and 34 were male, as shown below in Figure 3. Despite this, there is very limited culturally specific support for Punjabi and wider South Asian communities.

Figure 3 also shows that 18.9% (n=30) of participants attempted suicide, and of those, 70% (n=21) were female, and 30% (n=9) were male. Of those who attempted suicide, 23 accessed or received help (female=17 and male=6). This highlights the urgent need for more culturally sensitive support systems within the Punjabi community and acknowledging the intersectional differences.

Figure 3: Total Number of Participants, by gender. Further broken down into; those who have experienced suicidal thoughts, those who have attempted suicide, and those who had received help after their suicide attempt.

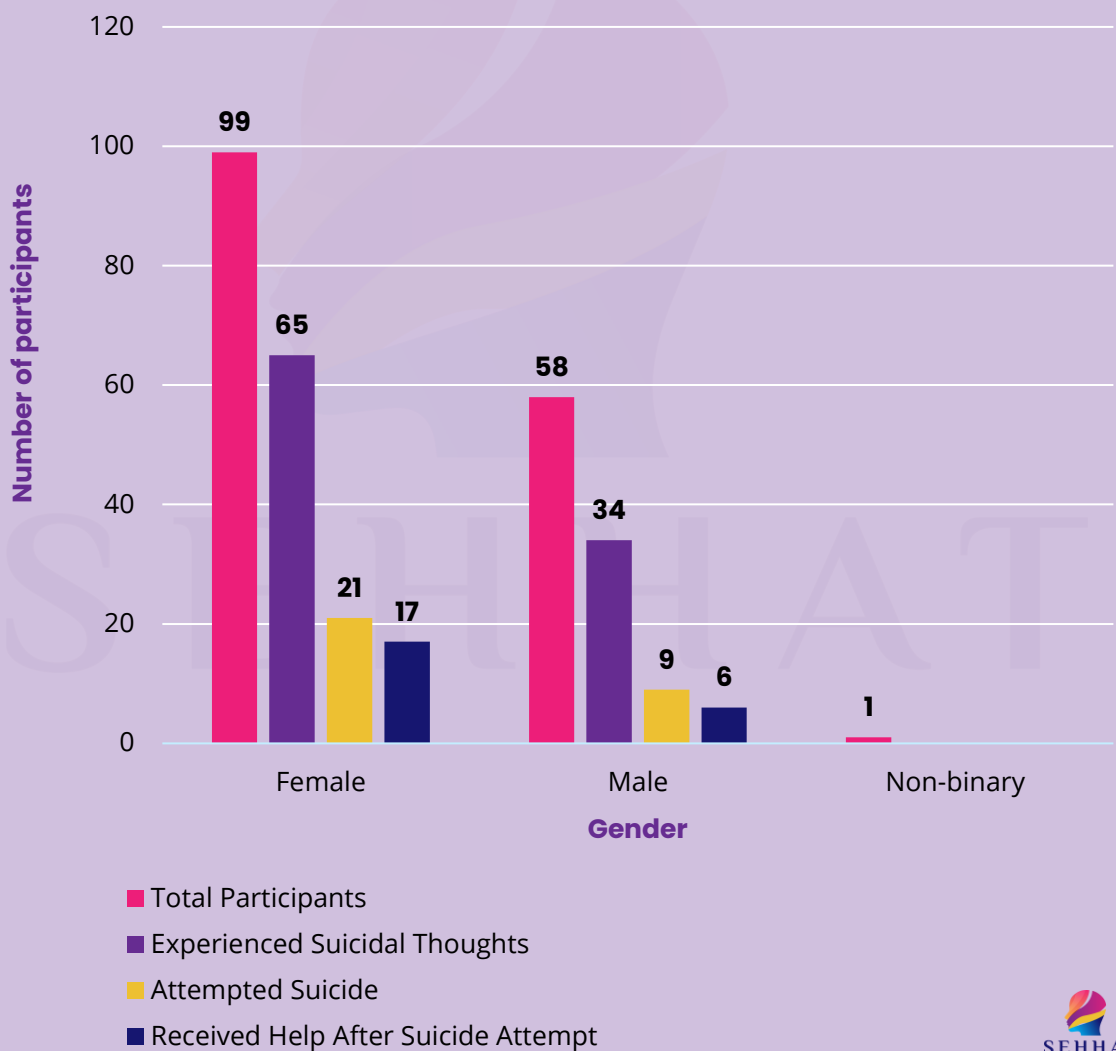
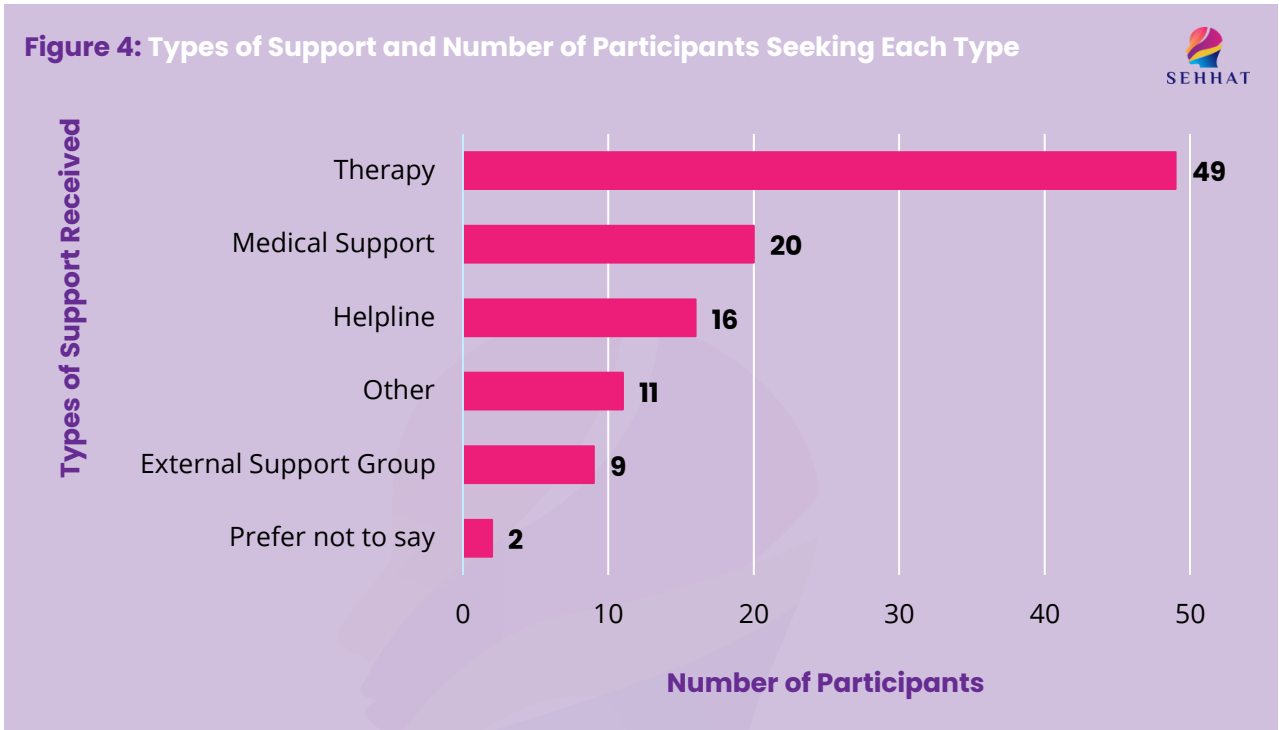


Figure 4 shows the various types of support received by participants, with the majority accessing therapy. The participants were able to select multiple options when answering the question for the types of supports accessed.



While the data shows that individuals are seeking help, there is still a significant number of participants who have not accessed nor received support after experiencing suicidal thoughts. Figure 5 shows that more than one third (35%) of those who have experienced suicidal thoughts did not receive support.

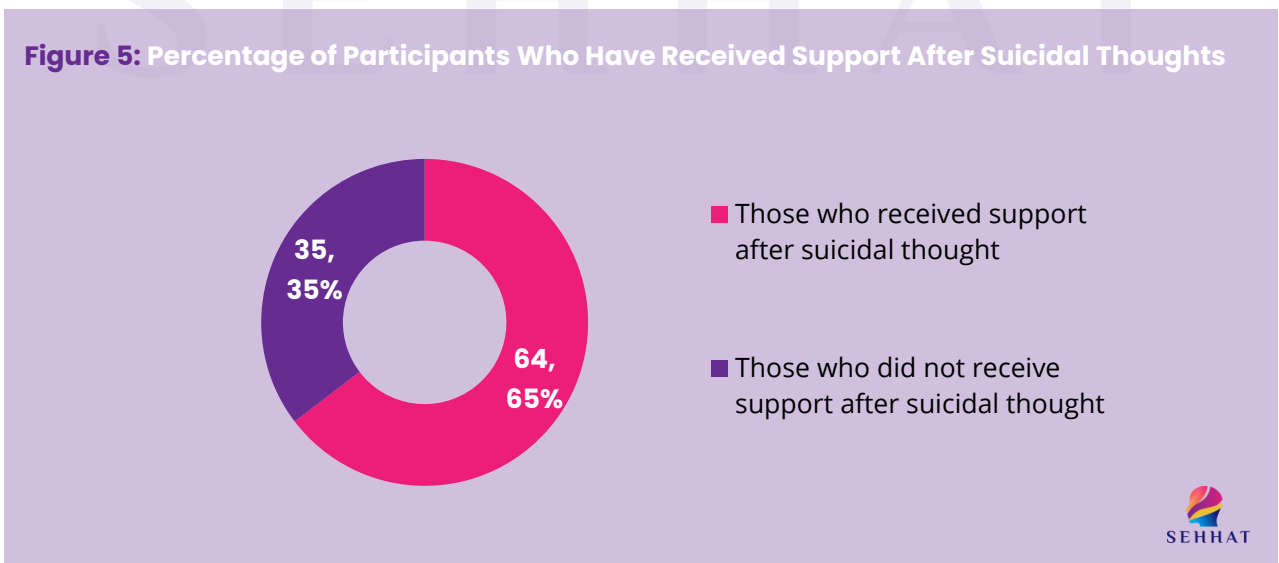
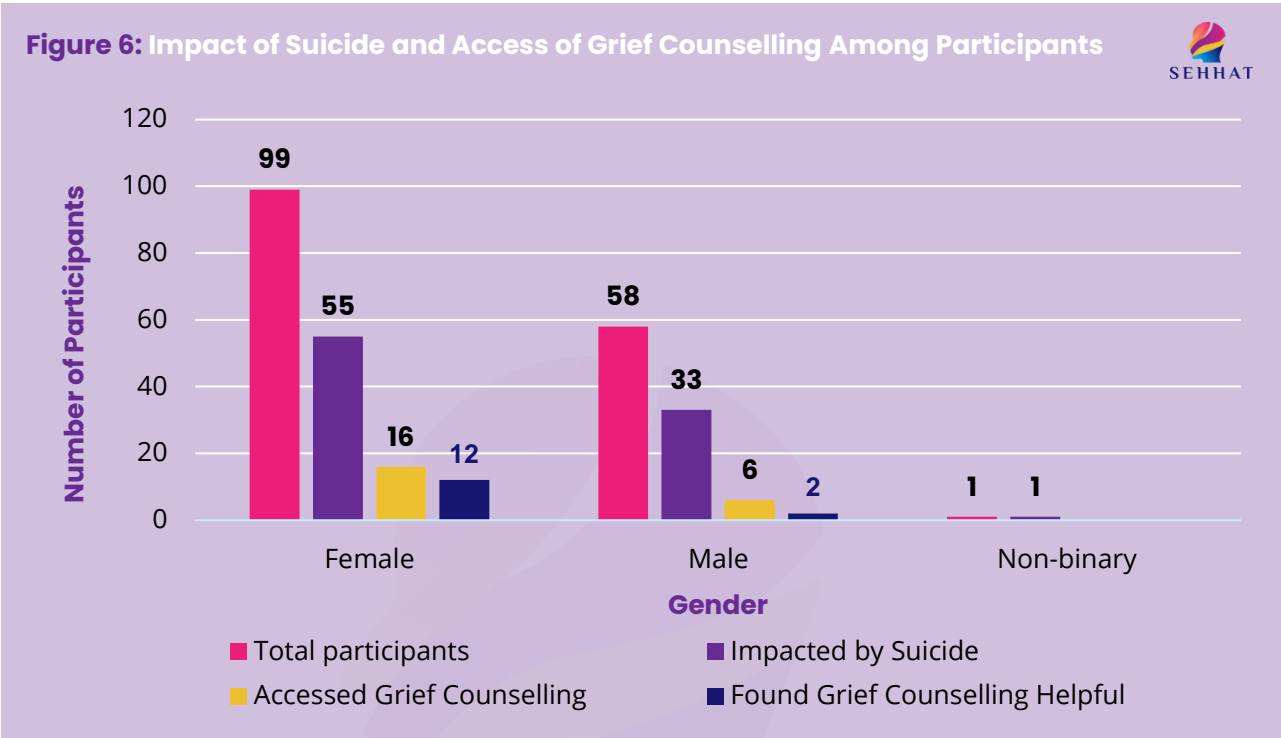
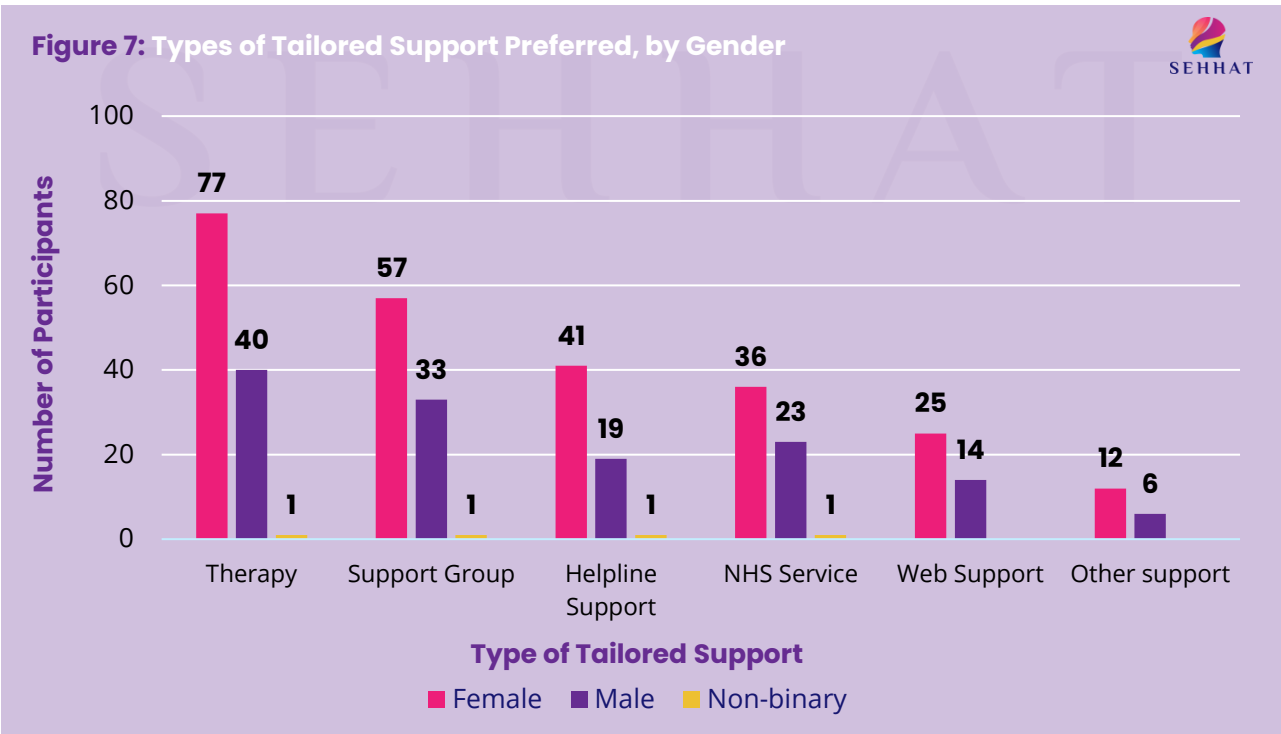


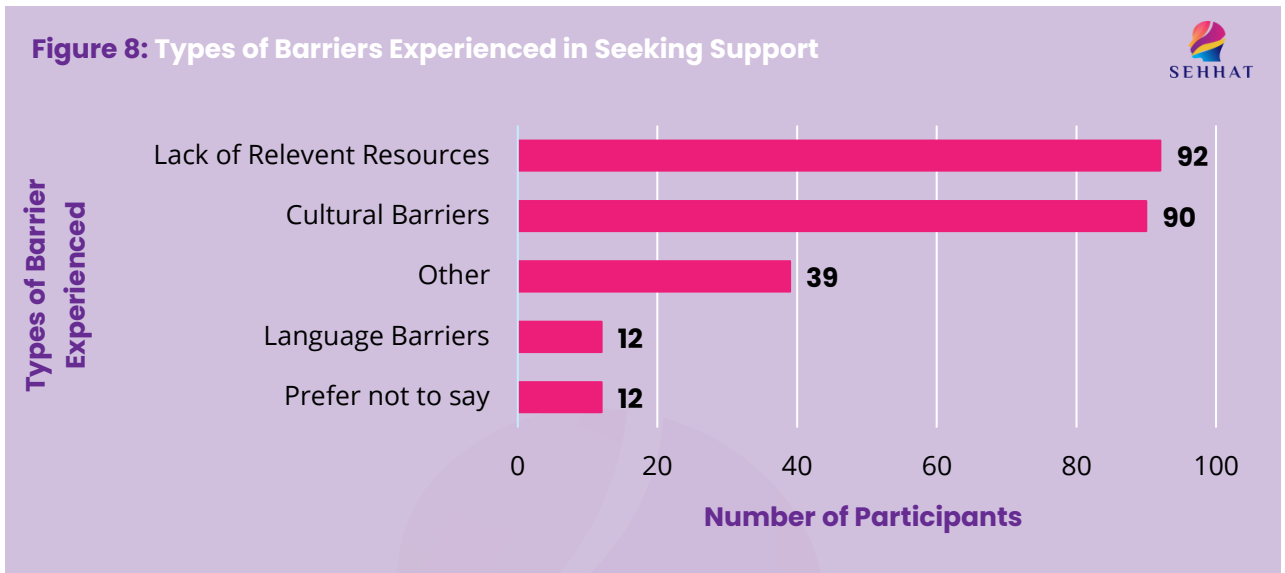
Figure 6 shows that out of 89 (56.3%) participants who had been impacted by suicide: 55 identified as female, 33 as male, and 1 as non-binary. Of these participants, 16 female and 6 male participants (total=22) accessed grief counselling afterwards, and 12 females and 2 males (total=14) found it helpful.



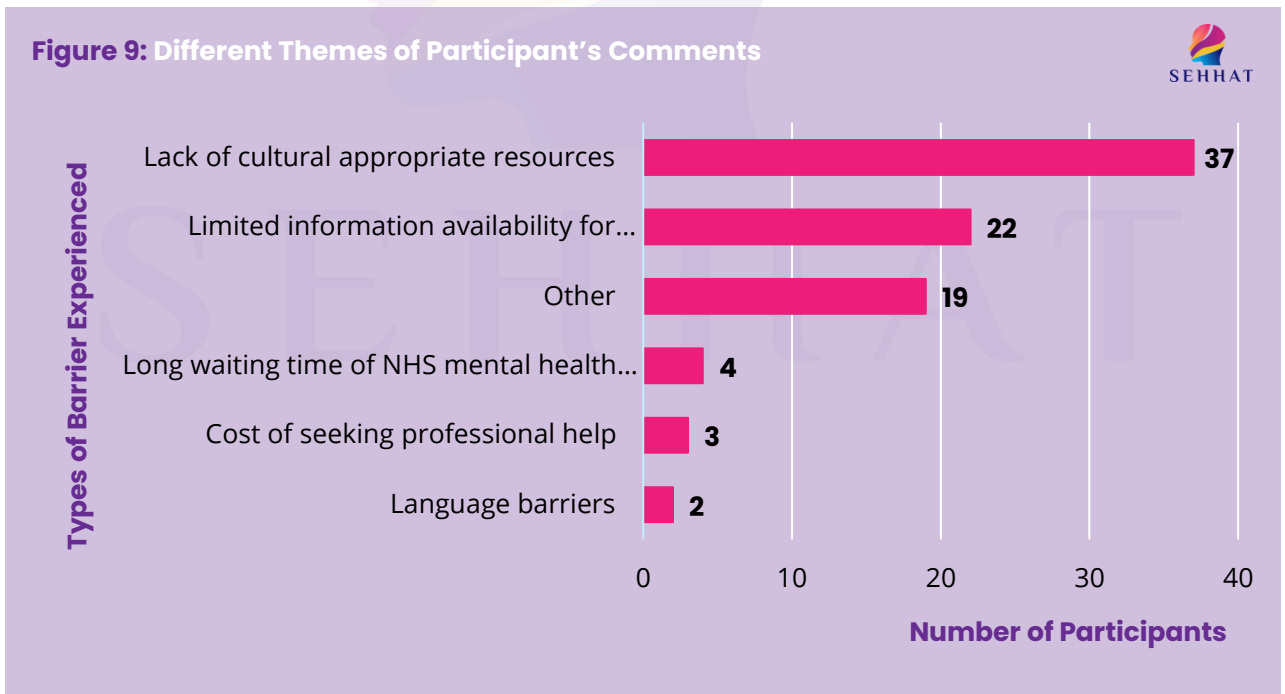
Participants also indicated what type of tailored support service(s) they would prefer to be available (again multiple options could be selected), and this is shown below in Figure 7. Out of the 158 participants 118 indicated they would prefer tailored therapy.



Barriers faced in accessing support are shown in Figure 8 below, with lack of relevant resources and cultural barriers being the most common barriers.



At the end of the survey, we asked the participants if there was anything else they had experienced and would like to share. 86 participants responded to this question, expressing their opinions and perspectives. Figure 9 shows the different topics discussed by participants.



We asked our participants whether there was anything else they would like to share:

It is evident that individuals in the Punjabi community are experiencing the impacts of suicide. Whether that is directly or indirectly, more needs to be done to provide relatable resources and for there to be available therapy services from those who are also from Punjabi heritage or have experience with Punjabi communities to understand cultural needs.



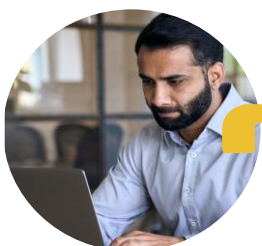
"Our Punjabi society is too fixated on cultural norms and status. Those that are not part of this are not supported and are stigmatised as the 'bachari'. Our society does not know how to help or include those that are battling with mental health issues, and it's those that are the closest that turn a blind eye."

Female, 45-54, London



"Services are mainly run by people who have no idea what it's like to be an English born Punjabi."

Female, 35-44, London



"Building community is the key. The government aren't interested in building communities."

Male, 35-44, London



"[You need to wait] 18 weeks minimum for a mental health referral in NHS. I finished accessing mental health services in 2020 and got a phone call this week for a follow up, 2 years later! Also feel we need more parchariks talking about Mental Health on main stages in UK."

Female, 35-44, Scotland

Please note, the pictures provided are not real pictures of the respondents. Stock photos have been utilised to create a sense of familiarity and empathy among readers.





“The Sikh community can sometimes be very private about family issues for fear of being shamed and talked about by others in the community. I am hearing more and more about members of the Sikh community taking their own lives. We need this stigma to end so that people are allowed to grieve properly and truthfully. Thank you.”

Female, 55-64, Birmingham



“Financial means to be able to access help. Although I now have a South Asian therapist, I didn’t always have the means to pay for private therapy. I didn’t always understand the importance of having a therapist from a similar background to understand those cultural differences.”

Female, 25-34, Northamptonshire



“For there to be a service which was relevant for South Asian and Punjabis to express their needs without judgement but with South Asian and Punjabi professionals who can understand the needs of my issues rather than having to explain my culture before I receive help.”

Female, 25-34, Buckinghamshire



“Mental health is a very taboo subject in Indian culture. It makes it seem like you are failing and not well understood.”

Male, 18-24, Leeds



“[There are] long waiting times within [mental health] services.”

Male, 25-34, Leeds

Comments from participants who have accessed support, clearly demonstrate the disparities and delays in NHS mental health support services and call backs.

Please note, the pictures provided are not real pictures of the respondents. Stock photos have been utilised to create a sense of familiarity and empathy among readers.





Case Studies: Bereaved by Suicide

The contents of the case studies are extracted from the second stage of the study where in-depth interviews were performed with the participants. The case studies are categorised into three groups those who :

- Were bereaved by suicide
- Shared their lived experience
- Are professionals who have supported individuals with lived experiences

Bereaved by Suicide

Participant Profile: Two participants, both members of the Punjabi community, who have been directly impacted by the loss of their loved ones, shared their experiences and perspectives.



Seeking Professional Support

In depth of the grief after their loved ones' unexpected suicides, the participants shared their journey of searching professional support to help them overcome grief.

One participant shared their journey of seeking an experienced and culturally competent therapist:

"My experience was not too bad as I was able to locate a good therapist who understood child loss, but she was not experienced in the complexity of suicide loss. I then reached out to a Cognitive behavioural therapist (CBT) who happened to be South Asian but found that she too was not experienced enough to deal with this kind of trauma and found her not too helpful after a couple of sessions."

However, it was not difficult for other participant to seek professional help as they themselves worked within the mental health and counselling industry:

"As a professional I have knowledge of existing therapist support services, so I sought those."



Community Support Services

Through their journey, the participants came to realise the need for open conversation about suicide loss. They encourage others to break the silence and raise awareness.

One participant commented:

"People just need to talk more about suicide and mental health and continue to raise awareness."



The other participant shared their thoughts on the importance of raising awareness to support all members of the community who are bereaved by suicide:

"A lot more needs to happen within community settings, though we have come very far from where the community used to be, there is still so much more to do to support all members of the community. More awareness and possibly less judgement on those bereaved as though they are the cause. They carry enough guilt of their own."

"People just need to talk more about suicide and mental health and continue to raise awareness."

Language Matters



Although it has been over 60 years since suicide has not been regarded as a criminal act under the Suicide Act (1961) ⁽²⁵⁾ the term "to commit suicide" is still widely used by the public in the UK and globally. The participants confronted this hurtful language surrounding suicide.

One participant shared that they feel offended hearing the term "committed suicide":

"committed suicide.' Absolutely hate this term and very often correct others and explain why it is offensive to use this term. Very often I hear this term still being used in the media."

One participant also commented:

"That [to commit suicide] is not a nice term. It is too rough."

Conclusion

From this case study, those who were bereaved by suicide agreed with the across-the-board discussion that there is not enough awareness of suicide and sadly it takes trauma or a suicide of a loved one for suicide to be acknowledged. They also expressed that more needs to be done with regards to language used, community support, especially for men, in workplaces, places of faith, faith schools/national schools and universities.





Case Studies: Lived Experiences

Lived Experience

Participant Profile: Two participants, both members of the Punjabi community, with lived experiences, offer their perspectives—both as individuals who sought professional support, experienced suicidal thoughts, struggled with poor mental health, and attempted to take their own lives.

Lived experience: Each participant previously experienced forms of poor mental health before attempting suicide. One participant experienced severe personal trauma which led to long term depression and self-harm, and the other participant struggled with an eating disorder.



Seeking Professional Support

Both being 2nd generation immigrants, they reflected their journey of trying to seek a professional who understood Punjabi culture and gave them empathetic mental health support.

One participant told us:

“Back in 2013, I don’t think it was much of a barrier for me personally, I sought the psychological support of 40 sessions through the NHS. There was a six, seven month wait for me, and that’s when I started private therapy in the interim. But in terms of challenges and barriers, looking back on it, I would have loved to have had a therapist, a Punjabi or South Asian specific therapist who understood my culture and my identity and ethos.”

One participant recounted their journey of having to resort to private therapy to cope with clinical depression and self-harm as the issue they were experiencing, which was perceived by NHS, as a cultural problem:

“When I was admitted into hospital from my attempt [of suicide], I was spoken to by a psychologist on call. Unfortunately, their notes made me ineligible to receive counselling through the NHS, as the trauma I experienced was a cultural problem and I was not referred to the mental health team, or to the NHS support services. The disheartening experience was that none of the NHS healthcare professionals or paramedics displayed any empathy towards me or my family members, which has meant no one received any mental health support during my experiences and attempts to take my own life. I later had to seek my own private counselling.”



Future Outlook

Both participants shared their thoughts and ideas on how Punjabi people in similar situations could be better supported in the future.

One participant reflected how bilingual mental health resources could help them and their family:

“The importance of bilingual resources, and safe spaces to talk, really could have helped me and my family understand that it wasn’t anyone’s fault for the trauma I experienced. These resources could have played a huge part in healing my loved ones if they were available.”



One participant shared their thoughts on the importance of easily accessible community mental health services:

"I think the bottom line is getting the services to come to them at a local level. Whether it's in a Gurdwara library, wherever it is, where our community get together and collaborate, and where those communities are, we need to get the help to them, communicate that understanding and education around mental health and suicide to them and making sure we keep on doing that."



Talking about Suicide

The participants also shared their thoughts on the importance of open discussion around suicide in the Punjabi community.

One participant told us how lack of open discussions about suicide in the Punjabi community leads people to suffer in silence, which they refer to as a "cycle" of silence and trauma:

"As a Punjabi community, we are very quiet people when it comes to mental health and suicide. We are people pleasers. We need to use our voices and experiences for change to be made for present and for generations to come. Otherwise, the cycle of silence will continue and so will the trauma."

One participant also echoed this point:

"As a community we are still afraid of talking about suicide. We need our voices represented. Because if not us, then who? If not now, then when?"

**"We need our voices represented. Because if not us, then who?
If not now, then when?"**

Conclusion

This case study is a compilation of comments from individuals who have personally experienced suicide and see the impacts it has had on them and their families. It is an insight into their experiences and the changes they wish to see in the Punjabi community. It highlights the taboo community members still feel, the struggles into finding suitable professional services and the representation needed in policies, support services, awareness campaigns, and language considerations to foster a more open and understanding dialogue surrounding suicide at local places of faith.





Case Studies: Professionals

Professionals

Participant Profile: Two professional participants, both members of the Punjabi community. One participant with a dual perspective - as someone who sought professional support. Participant two a professional with knowledge the of existing therapist support services and the barriers they have faced in providing support.



Seeking Professional Support

In the face of the pervasive stigma surrounding suicide in the South Asian community, one participant decided to seek professional support and as a professional they were aware of the existing therapist support services.

One participant shared their journey of seeking an experienced and culturally competent therapist:

"The stigma surrounding suicide in our community is palpable. It took courage to seek professional help, but I knew it was necessary."



Cultural Sensitivity in Support

The participants discussed the importance of cultural sensitivity in understanding and supporting those who are impacted by suicide.

Communities are diverse and highlighted by one participant:

"...the spiritual, the religious, the cultural, the social, all of these domains have an interpretation of what mental health is..."

Addressing suicide requires navigating these varied domains. Tailored services and cultural nuances often determine the impact that support services can make:

"...up to third generation [immigrants] people still fear mental health because particularly in the Punjabi culture around, it doesn't make sense [to them]."

They highlighted:

"... [if one] can see someone who is like me in a position of care, that means it must be something that my group are interested in or not uncommon in my culture."

This can help mitigate the challenge of low engagement and, consequently, the fear of being judged or stigmatised when seeking support services.

"...the spiritual, the religious, the cultural, the social, all of these domains have an interpretation of what mental health is..."





Language Matters

The participants discussed their perspectives on importance of language in destigmatising suicide and communicating with people to support them better.

One participant explained:

“Language is a massive thing. If we cannot understand the other person saying the other thing, then we are never really going to create any new awareness or insight.”

A therapist’s ability to communicate with people through precise selection of words and phrases, and in a language that allows them to convey their experiences and emotions as accurately as possible, creates a safe and supportive environment where they feel understood and empowered to explore their thoughts and feelings:

“As clinicians, it’s sort of our role, our job to really help them find the words... [we need to] help them bridge that gap.”

One participant highlighted that language used within the community can be “*disruptive*,” particularly when labelling individuals with mental health conditions. Moving away from defining individuals solely by their mental health struggles ensures that people are not pigeonholed by their experiences.

“Language can (also) box.” (make one feel confined to, in a box)



Talking about Suicide

The participants also discussed the importance of open conversation around suicide, not only to raise awareness, but also to create a safe space to share their experience with mental health.

A participant stated:

“If we want suicide to be a conversation, then we have to make it a conversation.”

Conversation is necessary for the interventions of suicide, healing and prevention. One participant accentuated the need of creating safe spaces through conversation.

“[People] carry their own biases about mental health. So, by having a conversation, we’re opening up a safe space.”

By fostering conversations about suicide, we create and gain awareness. We also validate individuals’ experiences, reducing the stigma and isolations communities’ members feel.

“We never truly will know what it means to be suicidal for another person because it’s such a unique and individualised experience...Conversation is crucial because you get an insight into that being’s experience of that phenomenon.”

It’s a delicate balance, as discussing a feared topic may induce anxiety, yet it is essential for dismantling the stigma associated with mental health. Fear, deeply rooted in the collective psyche, serves as a significant barrier to open conversations about mental health. The fear of the unknown and the fear of challenging cultural norms contribute to the hesitation in addressing mental health concerns openly.



One of the participants stated:

"...if we talk constantly, my defences will have to lower because of the topic area, because It can be exhausting to keep my defences up for an hour talking to someone and without burning out. So, the conversation becomes a mechanism as well [as a tool] for suicide prevention."

One participant also advocated the "AAA - always available adult" approach:

"It's helping lay people, non-therapists, non-psychologists, non-mental health professionals, be able to at least hold a conversation with someone who is saying, 'I can't see a point in living anymore...'; 'I am in pain, and I don't know what to do with that', or 'I am in chaos, and I don't know what to do with that'. If we have enough people suicide aware, they will know what to do in that situation; that they won't just then panic and dysregulate the other person who's taken such a massive step into exposing and getting someone into their life."

This brings opportunity for the *sangat* to hold conversations about mental health and suicide in everyday life, situations and places.

"[People] carry their own biases about mental health. So, by having a conversation, we're opening up a safe space."



Future Outlook

Finally, the participants discussed the importance of proactive measure and campaigns to raise suicide awareness in Punjabi communities and the need for further research to address suicide in diverse populations.

One participant expressed dissatisfaction with the current government initiatives addressing suicide in South Asian communities, indicating a perceived gap in efforts:

"Policies only change if there are substantial measures in order to establish that community needs help. The government or the policymakers don't feel that we're an at-risk community because there isn't enough data to share that we are. Yet we know, as individuals in that community, that's not the case, which is the hardest thing because you're a small minority of people who are fighting for acknowledgement of our needs."

There is desperate need for further specific research and representation. Existing research on suicide predominantly reflects a narrow demographic:

"It doesn't represent people with disabilities, neurodivergent individuals, and those from various cultural or faith backgrounds."

This lack of inclusivity continues the challenges of understanding and addressing suicide within diverse communities.



Looking ahead, one participant desires increased awareness of available support. The participant's vision for the future includes *"proactive measures and campaigns"* to suicide prevention within the Punjabi and South Asian community.

"Breaking the silence is the first step toward preventing further tragedies."

Conclusion

From this case study, we observe that it took courage for even clinical psychologists from the Punjabi community to seek mental health support when bereaved by suicide. The pressures of being in a profession and from an ethnic community have an added impact on one's mental health experiences, As judgement also occurs in the professional industries, as mainstream media has demonstrated. They discussed the importance of culturally sensitive mental health support and open discussion around the topic of suicide to destigmatise suicide and foster a safe space for people to talk about their mental health. They also called for further studies like this one to be conducted and available. Where national funders are investing in grassroots to better understand and address suicide in diverse communities. Bettering services and resources for services users.

"Breaking the silence is the first step toward preventing further tragedies."

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Discussion

Discussion

The survey findings and case studies shed light on the challenges and experiences of navigating the conversation of suicides in the Punjabi community, supporting the qualitative evidence of a recent systematic review and meta-synthesis.⁽²³⁾ This underscores the need for culturally sensitive support, awareness campaigns, and language considerations to foster a more open and understanding dialogue surrounding suicide. The participants' journeys serve as a testament to the importance of breaking the silence and advocating for comprehensive support systems within diverse cultural contexts and this is something the Sehhat team has only begun to tackle for the Punjabi community.

Strategies

Suicide prevention requires extensive collaboration and coordination among multiple sectors of society: health, education, labour, agriculture, business, law, justice, defence, politics and media.⁽²⁾ Data quality needs to be improved in order to understand the true scale of issues around mental health; only 80 member states of WHO have good-quality mortality data that can be used to directly measure suicide rates.⁽³⁾

Healthcare services and policies need to evolve with the changing lived experiences of Punjabi patients. Acknowledging the needs of the Punjabi community necessitates addressing the prevalent fear, judgment, and stigma associated with mental health conditions, self-harm, and suicide.⁽²³⁾

Negative perceptions, intertwined with cultural and societal expectations, contribute to issues like low self-esteem and self-worth.⁽²³⁾ As emphasised by a participant, it's crucial we step forward and express ourselves as individuals with our collective identity, acknowledging and addressing the mental health needs within the Punjabi community.

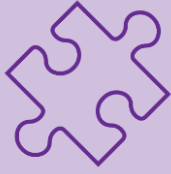
Part of Sehhat's mission is to reshape the mindset on mental health and suicide within the Punjabi and South Asian community and to educate generations to come. Sehhat's vision is to empower people to live a life where suicide is preventable and mental health is managed with tailored and accessible resources for the Punjabi and South Asian community.⁽²⁾ Workshops are run by Sehhat to educate and train individuals to improve self-awareness by creating wellbeing toolboxes and skill sets for people to refer to and expand on over time.⁽²⁾ Sehhat is also collaborating with organisations nationally to enable research and development, which is having a positive far-reaching impact by making representation a requirement in new and updated materials.

The founding project of Sehhat has been Sikh Forgiveness, a mental health project which has dedicated over six years to the Sikh and Punjabi community to develop mental health spaces with gurdwara sahibs, bridging the gap on issues around language barriers, where bilingual suicide infographics have already been installed.

Sehhat will continue to make the conversation of mental health and suicide a talking topic not to be feared but to be addressed with safety, representation, and relatability through bespoke resources and education.



Figure 9 : A Visual Summary of the Discussion and Strategies



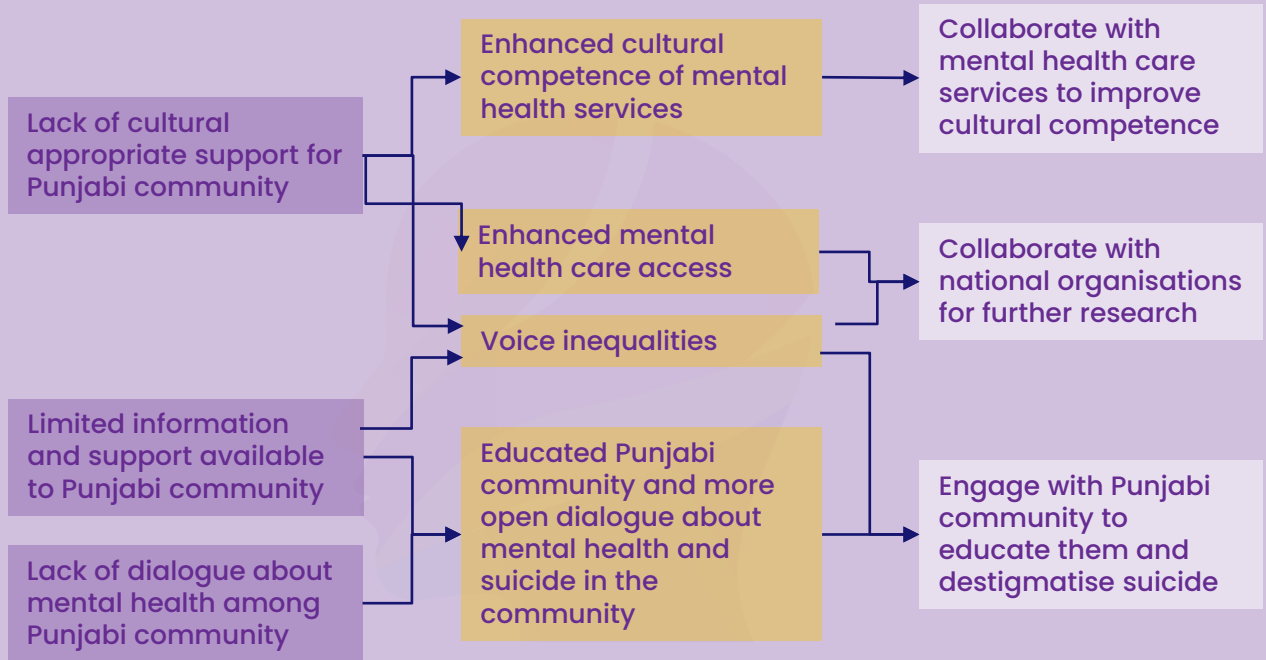
Observations



Outlook



Action



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