Clinical Perspectives

Sikh Youth in Child and Adolescent Psychiatry: A Clinical Perspective

Poojajeet Khaira, BS, MD[1], Avneet Soin, MD[2], Narpinder Malhi, MD, MBA[3]

[1] Psychiatry, The MetroHealth System/Case Western Reserve University, [2] Psychiatry, Brigham and Women's Hospital/Harvard Medical School, [3] Department of Psychiatry and Behavioral Health, ChristianaCare

Keywords: religion, cultural psychiatry, sikh, adolescent

https://doi.org/10.62414/001c.169178

JAACAP Connect

Vol. 13, Issue 4, 2026

Sikh children and adolescents represent a growing but understudied population in child and adolescent psychiatry. Many Sikh youth navigate complex intersections of religious identity, family expectations, migration experiences, and minority stress, particularly in diaspora contexts where visible articles of faith may increase vulnerability to discrimination and bullying. At the same time, strong family cohesion, community support, and religious values often function as important sources of resilience. This Clinical Perspectives article reviews key cultural and developmental considerations relevant to Sikh youth, including core religious beliefs, family structure and intergenerational dynamics, acculturation processes, and experiences of stigma and help-seeking. Clinical assessment and treatment recommendations are discussed, with emphasis on cultural humility, family engagement, and recognition of both risk and protective factors. A clinical vignette illustrates how cultural, familial, and minority stress factors may influence presentation and treatment engagement. Greater awareness of Sikh cultural context can help clinicians build trust, reduce misinterpretation of culturally normative behaviors, and provide more effective, culturally responsive care. These principles may also inform work with other youth from visible religious and ethnic minority backgrounds.

INTRODUCTION

Sikhism is a monotheistic religion founded in the Punjab region of India with Sikh diaspora present across the world; there are estimated to be about 25 million followers of the Sikh faith worldwide, with an estimated 500,000 followers in the US. Many Sikhs identify culturally as Punjabi, though the religious and cultural identifiers are separate and important distinctions.[1] These communities maintain strong religious and cultural institutions while navigating the realities of marginalized group status, language adaptation, and sociopolitical marginalization.

Recent child and adolescent psychiatry literature has increasingly examined the mental health experiences of religious and spiritual minority youth populations, including Muslim, Hindu, Jewish, and Buddhist communities.[2-4] These studies highlight the importance of culturally and religiously informed assessment, particularly among youth navigating minority stress, identity development, discrimination, and barriers to help-seeking. Despite being one of the world's largest religions and a visible religious minoritized group in many Western countries, Sikh youth remain comparatively underrepresented in the psychiatric literature, underscoring the need for religion-specific cultural formulations in clinical practice.

Sikhism emphasizes devotion to God, ethical conduct, and service. Sikhs are visibly identifiable through articles of faith such as turbans and uncut hair, which strengthen their identity but also increase the risk of stereotyping, bullying, and discrimination.[5,6]

CORE BELIEFS AND PRACTICES

Sikhism is grounded in belief in one God (*Ik Onkar*), who is formless and infinite. Central to the religion is a commitment to equality and social justice, with rejection of hierarchies based on caste, gender, or religious affiliation. Daily practice is guided by remembrance of God (*Naam Japna*), earning an honest living (*Kirat Karni*), and sharing with others (*Vand Chakna*), all supported by a strong ethic of selfless service (*seva*).

A further defining aspect of Sikh identity is the articles of faith known as the Five K's, which serve as reminders of discipline, integrity, and belonging. These include uncut

This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License (CCBY-NC-ND-4.0). View this license's legal deed at https://creativecommons.org/licenses/by-nc-nd/4.0 and legal code at https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode for more information.

hair (*kesh*), which is typically covered with a turban; a wooden comb (*kanga*); a steel bracelet (*kara*); a modest undergarment (*kachera*); and a ceremonial sword (*kirpan*).

RELIGIOUS PRACTICES IN DAILY LIFE

The *Gurudwara* is the central place of worship, also serving as a cultural and social center for community participation. Daily practices may include prayer, recitation of passages from the *Guru Granth Sahib*, and singing sacred hymns (*kirtan*). Youth often participate, allowing them to learn the principles of equality, hospitality, and collective responsibility, while gaining leadership and service experience.

FAMILY STRUCTURE, INTERGENERATIONAL HIERARCHY, AND PARENTING VALUES

Many Sikhs are native to Punjab, and there can often be overlap between Sikhism and Punjabi culture in traditional values, such as operating within a collectivist and family-oriented decision-making framework. In this structure, young people may be encouraged to prioritize family reputation and obligations over individual preference.

Multigenerational households are common, particularly within immigrant families, and can provide support and continuity of language, culture, and values. Respect for elders is emphasized, and elders are often viewed as authorities whose guidance carries significant weight. At the same time, differing expectations around autonomy, acculturation, and gender roles may create intergenerational tension. These dynamics may be misinterpreted as control rather than expressions of cultural responsibility.[7]

Parenting practices commonly emphasize discipline and academic achievement, with education viewed as both opportunity and obligation arising from parental sacrifice.[7] This emphasis may be motivating for some, while for others it may cause pressure, worry about disappointing family, and reluctance to disclose struggles.

Although Sikh theology upholds gender equality, cultural expression of gender roles varies. Expectations surrounding modesty, independence, and responsibility may differ, shaped by migration context and family values. Marriage is often considered a family decision, and dating may be discouraged, particularly for daughters. Adolescents may navigate secrecy, guilt, or conflict when balancing family expectations with peer expectations and personal autonomy.

ACCULTURATION, IMMIGRATION, AND MINORITY STRESS

Sikh immigrant families often navigate complex processes of adaptation as they resettle in new sociocultural environments. Immigration may represent opportunity, upward mobility, and safety, while also causing losses in community, language familiarity, and proximity to family. For some, migration involves downward social mobility or occupational mismatch, challenging previously held identities. These strains can shape family functioning and impact stress, particularly when generational expectations about behavior, independence, and success diverge.[7]

Historical trauma and collective memory also shape Sikh identity with narratives of resilience, martyrdom, injustice, and survival often being transmitted through storytelling, religious practice, and communal gatherings. For some, these collective memories foster strength, solidarity, and moral purpose; for others, they may heighten vigilance, mistrust of institutions, or fear of losing religious and cultural identities, leading to acculturation stress, particularly in diaspora youth.[6,7] Youth may experience internal conflict and role confusion navigating their bicultural identity. Similarly, parents may fear cultural loss, assimilation, or identity erosion, intensifying expectations for conformity.

Sikhs frequently experience discrimination, particularly because of visible religious identifiers such as turbans and uncut hair. Reports describe bullying in schools, workplace bias, racial profiling, and hate-motivated incidents.[1] Associated psychological sequelae may include anxiety, depressive symptoms, diminished sense of belonging, and internalized stigma.[6,7]

ASSESSMENT AND INTERVENTIONS

Clinicians working with Sikhs can effectively foster the well-being of this intersectional community by practicing cultural humility to promote therapeutic engagement and shared decision-making. As collective responsibility is valued, involving parents or extended kin often feels natural, while still providing time for the adolescent to speak privately.

Evaluation should include exploration of religious identity, experiences of discrimination or bullying, and expectations surrounding education, gender roles, and relationships.[6,7] Clinicians should avoid pathologizing culturally normative practices; prioritizing family cohesion, engaging in religious traditions, or deferring to elders may reflect cultural values rather than dependency or avoidance.

Disclosure of abuse or conflict may be limited by concerns about stigma and reputation. Although Sikh teachings discourage intoxicants, substance use may still occur. Migration-related stress, shame, and fear of judgment may contribute to indirect or somatic presentations of mood symptoms, complicating recognition.[7-9]

CLINICAL VIGNETTE

A 15-year-old Sikh female was brought in by parents for ongoing depression and anxiety symptoms. Family reluctantly shared about her recent suicide attempt and inpatient hospitalization. The patient also shared her experiences of bullying since middle school and recent declining grades. She was also bullied by her cousins due to her inability to speak the native Punjabi language in family gatherings. The family was engaged with the Sikh community 1–2 times yearly for major celebrations.

DISCUSSION

Although unsure, family agreed to continue medications and therapy. Genograms revealed the history of the mother's contentious relationship with her own mother, shaped by the family's long-standing preference for male children. These interactions were evident in family gatherings when the maternal grandmother would prefer her grandsons, contributing to emotional and esteem-related vulnerabilities. With ongoing therapy, the patient's mother shared her spiritual disillusionment and internalized guilt, alluding to culturally rooted beliefs that she is being punished for not having sons.

Unresolved trauma in Sikh families may influence parenting styles and emotional availability, affecting their children's sense of competence and identity formation. A trauma and culturally informed approach can facilitate symptom and family narrative exploration. Mother's internalized shame, self-blame, and emotional withdrawal from faith represented culturally transmitted misrepresentations of tradition, in contrast to Sikh teachings of gender equality. Drawing on the 3 core principles of Sikhism: *Chardi Kala* (eternal optimism and resilience) reframed the family's survival of gender-based trauma as evidence of strength, *Sarbat da Bhala* (well-being for all) provided culturally meaningful language to identify injustice and advocate for self, and *seva* (selfless service) provided the foundation for the daughter's role as community advocate. This therapeutic approach differentiated the family's lived cultural experiences and Sikh theology, requiring the clinician to practice cultural humility and respect.

Over time, the family reconnected with the Sikh community in their *Gurudwara* and started participating in the *Sangat* (community gatherings). The patient became actively involved in community mental health initiatives promoting education and awareness of adolescent mental health.

An open-ended, collaborative approach can support engagement and address communication among family members. Psychoeducation culturally concordant within Sikh values, such as compassion, responsibility, and *seva*, can reduce defensiveness.[8] Introducing treatment options thoughtfully and clarifying confidentiality expectations can build trust.[9,10] Beliefs about mental illness and help-seeking reflect this complexity.[10]

Gurudwaras provide connection, service opportunities, and culturally congruent support, which may buffer isolation and stigma. When concerns about bullying or religious accommodation arise, collaboration with schools may be essential, and, with consent, careful involvement of community leaders can reduce stigma while maintaining boundaries.[5]

CONCLUSION

Working with Sikh youth requires a culturally grounded approach with humility, curiosity, and a willingness to learn the meanings that families assign to faith, identity, and community. Rather than assuming uniformity, clinicians benefit from recognizing the variability in the practice of Sikhism, migration histories, and generational perspectives.

PLAIN LANGUAGE SUMMARY

Sikh children and adolescents often grow up balancing cultural traditions, family expectations, and experiences as a visible minoritized religious group. We reviewed cultural factors that may influence their mental health and described ways clinicians can provide respectful, culturally informed care. Sikh youth may face bullying, stigma, and pressure related to identity and family expectations, but they also benefit from strong family support and community connections. Understanding these cultural strengths and challenges can help clinicians build trust and improve treatment engagement. This approach may lead to better mental health care for Sikh youth and other minoritized populations.

ABOUT THE AUTHORS

Poojajeet Khaira, MD, is an Academic Chief Resident at Case Western Reserve University–MetroHealth Hospital, Cleveland, Ohio, USA.

Avneet Soin, MD, is a Consult and Liaison Psychiatry Fellow at Brigham and Women's Hospital/Harvard Medical School, Boston, Massachusetts, USA.

Narpinder K. Malhi, MD, MBA, is Program Director at the Department of Psychiatry and Behavioral Health, ChristianaCare, Wilmington, Delaware, USA.

CORRESPONDENCE TO:

Poojajeet Khaira, MD; email: **ppoojajeet@gmail.com**.

FUNDING

The authors have reported no funding for this work.

This article is part of a special series related to religion and spirituality in child and adolescent psychiatry. Articles in this series address the intersection of religion, spirituality, and youth from theoretical, philosophical, clinical, or other perspectives. The Religion & Spirituality series was edited by *JAACAP Connect* Editor David C. Saunders, MD, PhD.

DISCLOSURE

Poojajeet Khaira, Avneet Soin, and Narpinder K. Malhi have reported no biomedical financial interests or potential conflicts of interest.

AUTHOR CONTRIBUTIONS

Writing – original draft: Poojajeet Khaira (Lead), Narpinder Malhi (Supporting). Writing – review & editing: Poojajeet Khaira (Lead), Avneet Soin (Supporting), Narpinder Malhi (Supporting). Conceptualization: Poojajeet Khaira (Lead), Narpinder Malhi (Equal).

Submitted: February 16, 2026 EDT. Accepted: July 30, 2026 EDT. Published: September 24, 2026 EDT.

REFERENCES

1. About Sikhs. Sikh Coalition. 2016. https://www.sikhcoalition.org/about-sikhs

2. Black N. Hindu and Buddhist children, adolescents, and families. *Child Adolesc Psychiatr Clin N Am*. 2004;13(1):201-220. doi:10.1016/s1056-4993(03)00095-6

3. Al-Mateen CS, Afzal A. The Muslim child, adolescent, and family. *Child Adolesc Psychiatr Clin N Am*. 2004;13(1):183-200. doi:10.1016/s1056-4993(03)00071-3

4. Hakak RR. *The Relationships Among Religiosity, Ethnic Identity, Social Support, and Mental Health in Jewish Young Adults*. Dissertation. Alliant International University; 2014.

5. Atwal K, Wang C. Religious head covering, being perceived as foreigners, victimization, and adjustment among Sikh American adolescents. *Sch Psychol*. 2019;34(2):233-243. doi:10.1037/spq0000301

6. Nadimpalli SB, Cleland CM, Hutchinson MK, Islam N, Barnes LL, Van Devanter N. The association between discrimination and the health of Sikh Asian Indians. *Health Psychol*. 2016;35(4):351-355. doi:10.1037/hea0000268

7. Roberts LR, Mann SK, Montgomery SB. Mental health and Sociocultural determinants in an Asian Indian community. *Fam Community Health*. 2016;39(1):31-39. doi:10.1097/FCH.0000000000000087

8. Kalra G, Bhui K, Bhugra D. Does Guru Granth Sahib describe depression? *Indian J Psychiatry*. 2013;55:195-200. doi:10.4103/0019-5545.105531

9. Uppal S, Takhar O, Khutan R, Galbraith N. Perceptions of mental health, shame and help-seeking among Sikhs in the UK: A national survey. *J Community Psychol*. 2025;53(7):e70043. doi:10.1002/jcop.70043

10. Kular A, Tuomainen H, Majid M, Singh SP. Exploring lay understandings and help-seeking pathways for psychosis in the Sikh community: A qualitative study in the UK. *BMJ Open*. 2025;15(7):e088168. doi:10.1136/bmjopen-2024-088168