Considering the nuances of working with South Asian Punjabi families around substance abuse
Abstract

According to Statistics Canada (2013), in 2012, approximately 21.6% of the Canadian population met the criteria for a substance abuse disorder at some point during their lifetime. This speaks to the importance of having evidence-supported treatments (ESTs) available to inform the work of therapists when working with this clinical population and their families. However, there is a gap in the research literature on ESTs for substance abuse in that cultural factors have been underexamined and the South Asian community is consistently excluded from research. This is alarming as the South Asian population is one of the two largest visible minority populations in Canada (Nakamura, Lalomiteanu, Rehm & Fischer, 2011). The current paper examines the beliefs held by the South Asian community around substance abuse, reviews the literature on substance abuse, its effects on the family system and the treatment options available, explores the cultural factors that must be considered when conceptualizing substance abuse, considers the implications of the lack of ESTs for substance abuse for the South Asian Punjabi population, and discusses how therapists can be culturally competent in their work with South Asian Punjabis.

Keywords: substance abuse, evidence supported treatment, culture, South Asian, Punjabi

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Considering the nuances of working with South Asian Punjabi families around substance abuse

The impacts of substance abuse extend far beyond the individual. Not only does it have fiscal impacts at a societal and economical level, it is also very detrimental to the family of the individual who is struggling (Grant, 2009). According to Baliunas et al. (2007), “almost 18% of total acute care hospital days were the result of substance use and misuse in Canada in 2002” (p. 888), and in 2012, “approximately 21.6% of Canadians met the criteria for a substance abuse disorder during their lifetime...[with alcohol being the most common substance being abused]” (Statistics Canada, 2013). Given the scope of this paper and the given data, the focus of this paper will primarily be on alcohol abuse and the ways in which individuals can make changes to their drinking behaviours so as to reduce its impact. The data described above speaks to the importance of current evidence supported treatments (ESTs) available to inform the work of therapists working with individuals who abuse alcohol and their families. However, the majority of EST research has neglected to consider one important factor. Specifically, cultural factors that may influence alcohol abuse itself and/or the outcome of its treatment are almost non-existent in EST research.

This gap in the research literature can have grave consequences for therapists working with culturally diverse populations around substance use and abuse. For example, the majority of studies examining ESTs for substance abuse typically occur within a North American context with a focus on white, middle class populations. Very little attention is given to developing effective treatment options for people of different ethnicities and cultures, or even to investigating whether current ESTs are effective outside of North America and/or with individuals who are not considered majority. This is a problem, given substantial evidence suggesting that individuals from different ethnicities expect and need different things during treatment, and taking into consideration a client’s race and ethnicity is important in order for therapy to be helpful (Bender, et al., 2007; Diala, et al., 2000). A “one model fits all clients” approach is, therefore, not sufficient and research should examine how treatment models can be molded to fit the client and not the other way around.

One group of individuals who have been consistently excluded from research on substance abuse and its treatment is the South Asian community. The term ‘South Asian’ describes people originating in the subcontinent comprising India, Pakistan, Bangladesh, Sri Lanka and Nepal. The severe underrepresentation of this group of individuals in substance abuse research means that there is no foundational evidence to inform the work of therapists who are working with the South Asian population. Given that the South Asian population is one of the two largest visible minority populations in Canada (Nakamura, Lalomiteanu, Rehm & Fischer, 2011), this calls into question their ability to seek out appropriate treatment options when struggling with substance use and raises a high level of concern for their well-being as a result.

The primary religious groups within the South Asian community are Sikhs, Hindus and Muslims (Thandi, 2011). The community most represented within the South Asian group is the Punjabi community, which is the ethnic group of people originating from the Punjab region of India and who speak Punjabi as their first language. A distinction should be made here in that identifying as ‘Punjabi’ is different than identifying with a particular religious group (Thandi, 2011). For example, all Punjabi’s are not Sikhs and not all Sikhs are Punjabis. Identifying as

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Punjabi refers to the culture that the individual represents, while identifying as a Sikh entails following the Sikh religion (Thandi, 2011). Evidence suggests that the Punjabi community has a high likelihood of concerns related to the abuse of alcohol (Cochrane, & Bal, 1990). For the purposes of this paper, from hereon in the focus will be on the immigrant South Asian Punjabi community living in Canada, as research has shown that this community is more likely to use and abuse alcohol compared to other groups within the South Asian community (Cochrane, & Bal, 1990).

The aim of this paper is to examine how couple and family therapists can work with the immigrant South Asian Punjabi community around alcohol use and abuse. This will be extrapolated from current published research in the following ways: First, an examination of the beliefs held by the South Asian community around substance abuse will be conducted; Second, a general review of the substance abuse literature, the effects that substance abuse has on the family system, as well as the treatment options currently available will be presented; Third, cultural factors that must be considered when conceptualizing substance abuse will be highlighted along with possible treatment options for minority populations; Fourth, implications of the lack of ESTs for substance abuse that are specifically oriented to South Asian Punjabis will be discussed; Finally, current research findings with respect to how therapists can be culturally competent in their work, specifically as related to their work with South Asian Punjabi individuals, will be explored.

The South Asian Community and the Beliefs Around Substance Abuse

Canada is often referred as being a mosaic due to the various ethnic communities that reside in Canada (Statistics Canada, 2013). The rates of immigration over the past few years have increased and there are individuals migrating from various parts of the world in the hopes of calling Canada their home (Statistics Canada, 2013). According to Statistics Canada (2013) the South Asian population in particular was at 1.3 million in 2005 and by the year 2031, it is expected to grow to greater than 3.6 million individuals.

The consumption of alcohol is incorporated into the Punjabi culture and identity. Other communities often view Punjabi men, in particular, as “heavy drinkers” (Agic, Mann, & Kobus-Matthews, 2011; Cochrane, & Bal, 1990). Many individuals living in India drink excessively and this is more common among older men who were born in India (Agic et al., 2011; Thandi, 2011). Western countries such as Canada, the United States, and the United Kingdom have more liberal attitudes around alcohol consumption. These attitudes coupled with acculturation stress often accompanying immigration, may contribute to increased drinking in the newcomer Punjabi community as a coping mechanism and exacerbate the excessive drinking (Sandhu & Malik, 2001). Some of the cultural explanations as to why South Asian Punjabi men engage in excessive drinking behaviours are presented below.

For South Asians more generally, alcohol is seen as a form of celebration; to be happy or celebrate an achievement means that a toast is in order. For example, in a study examining alcohol consumption across different ethnic groups, one Punjabi participant explained, “Every

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2 This study, although 25 years old, was included in this paper as it is one of the few studies which notes that South Asian Punjabi men are at a higher risk of alcohol abuse compared to other South Asian groups, as cited in the article by Thandi (2011).
birthday party, wedding or picnic is associated with alcohol consumption” (Agic et al., 2011, p. 119). Another participant reported, “Men sit by themselves and keep “bonding” with each other. The more they are drinking, the more “bonding” happens” (Agic et al., 2011, p.119).

In addition to alcohol being seen as a way for men to celebrate and bond, South Asian cultural beliefs about masculinity is linked to alcohol consumption itself and to consuming large quantities of alcohol, in a society where masculinity is favoured (Agic et al., 2011; Sandhu, 2009; Thandi, 2011). There are also many references that are made in Punjabi folk tales and songs that reiterate this idea and further encourage men to drink (Sandhu, 2009).

Alcohol has also been linked to status within the South Asian population and in Punjab, India, “Alcohol, especially imported liquor, is viewed as a status symbol among the land-owners and upper classes” (Sandhu, 2009, p.25). This belief has been especially true for the Punjabis living in India but has now transferred into the Western world as well. The availability of alcohol at home is seen as a symbol of a good host and the larger the drink, the more generous that host. Furthermore, if a host were ever to run out of alcohol while entertaining guests in the home, his or her reputation would be negatively affected and potentially lead to stigmatization of the whole family.

In a study by Agic et al., (2011) 179 participants (47.4% female, 52.6% male) were recruited from seven Ontario communities: the Polish, Portuguese, Russian, Tamil, Punjabi, Serbian and Somali communities to participate in focus group discussions about their perceptions of cultural patterns and values around substance abuse. The participants’ religious backgrounds included Muslim, Roman Catholic, Christian Orthodox, Sikh and Hindu. In all communities, there is a lot of stigma around having alcohol related problems and so secrets are kept in families and many women endure their husband’s abuse and avoid breaking their silence to avoid stigma (Agic et al., 2011). Given that alcohol abuse is very common in various ethnic communities and impacts the whole family system, research on substance abuse in general and its influence on the family system will be examined next.

**Substance Abuse**

In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, the definition of substance abuse has been modified from previous versions to combine substance abuse and substance dependence into a single ‘substance use’ disorder (American Psychiatric Association, 2013). Under this newly formed category, each specific substance is defined as a separate use disorder, and 2-3 symptoms from a list of 11 need to be present in order to receive the diagnosis (American Psychiatric Association, 2013). For example, an individual diagnosed with alcohol use disorder might exhibit the following symptomology: (1) taking the substance in larger amounts or for longer than you are meant to; (2) cravings and urges to use the substance ; (3) continuing to use, even when it causes problems in relationships. In this case, the presence of these symptoms would indicate to the diagnosing clinician that the use of alcohol is interfering with a given client’s ability to carry out his or her daily routines and functioning at an optimal level (American Psychiatric Association, 2013). Not only is substance use linked with a greater risk for psychiatric conditions and other mental health problems, it can also have direct and indirect consequences for physical health. Direct consequences include greater risk for physical health concerns such as cirrhosis of the liver, diabetes and hypertension; indirect consequences include increased risk of motor vehicle accidents.

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accidents and falls (Blow & Barry, 2012; Breslow, Faden, & Smothers, 2003; Clapp, Reed, Martel, Gonzalez, & Ruderman, 2014).

**Effects of Substance Abuse on the Family System**

Evidence suggests the effects of substance abuse extend beyond the individual. A great deal of research exists with respect to the psychological, physical and behavioural effects of alcohol abuse on the spouses and children of those who excessively consume it (Christoffersen & Soothill, 2003; Marshal, 2003). A brief review of these effects on spouses and children follows.

The spouses of men who abuse alcohol report more incidents of depression, anxiety and psychosomatic complaints and a decrease in sexual intimacy and sexual satisfaction (Marshal, 2003). There is also considerable research linking chronic alcohol use to the risk of intimate partner violence (IPV). Research findings indicate an increased risk of violence among heavy to moderate drinking men as well as an increased likelihood of violent episodes, as compared to men who were non-drinkers (Murphy, O’Farrell, Fals-Stewart, & Feehan, 2001; O’Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004). Given these findings, it is not surprising that excessive alcohol consumption is associated with decreased marital satisfaction and increased rates of separation or divorce when conflict and substance abuse are left unresolved (Murphy et al., 2001; O’Farrell et al., 2004).

Research suggests that children of parents who abuse alcohol experience increased levels of emotional and behavioural problems and are more likely to struggle with substance abuse themselves in the future (Keller, Cummings & Davies, 2005). Researchers seeking to explain these findings link much of them to parent-child interactions. For example, substance abuse has been associated with poor parenting styles such as authoritarianism and harsh approaches to discipline (Mayes & Truman, 2002). Expanding on these findings, Keller et al. (2005) examined the role of alcohol consumption and marital conflict on child internalizing and externalizing problems and explored the possibility that parenting would mediate this relationship. Researchers found “problem drinking may harm children through its association with marital and parenting difficulties” (p. 948). More specifically, the association between problem drinking and marital conflict leads to difficulties in parenting and it is these difficulties in parenting, specifically ineffective disciplining and control, that predict child maladjustment (Keller et al., 2005).

Another study by El-Sheikh and Flanagan (2001), found an association between parental alcohol problems and social problems in their children. In this study, child internalizing and externalizing problems were also explained by marital conflict and parent-child conflict within the family. Furthermore, El-Sheikh and Flanagan (2001) collected child reports of emotional experience and measured their reactivity to simulated inter-adult conflict. Data analysis indicated a positive association between increased levels of conflict in the home and child sensitivity and reactivity to conflict as well as displays of negative affect. It is important to note that the negative arousal and distress often experienced by these children are likely to be generalized to other situations, and in turn can lead to adjustment difficulties (El-Sheikh and Flanagan, 2001).

**Evidence-Supported Treatments for Alcohol Abuse**

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More than 20 years ago, a five-stage model of change was introduced to help professionals understand how clients with substance abuse problems make changes to their behaviour. Two decades later, this model continues to be influential and applied to a broad range of behaviors beyond substance abuse. According to Prochaska, DiClemente and Norcross (1992), “individuals modifying addictive behaviors move through a series of stages from precontemplation to maintenance” (p. 1102). As applied to alcohol abuse, Prochaska et al. (1992), describe the pre-contemplation stage as a time during which a person has no intention to change his or her alcohol use behaviours and is even unaware of the fact that he or she has a problem with alcohol consumption. Stage two, the contemplation stage, differs in that the individual becomes aware he or she has a problem and is thinking about making changes, however, has not taken any steps toward this change (Prochaska et al., 1992). As one moves into the preparation stage, he or she is intending to change his or her relationship with alcohol in the near future and has even started implementing small behavioural changes into his or her life (Prochaska et al., 1992). During the action stage, an individual is actively reducing his or her use of alcohol by changing experiences that feed into its abuse via environmental factors (Prochaska et al., 1992). Finally, in the maintenance stage, the individual is working to prevent relapsing into old alcohol consumption behaviours and strengthen progress made toward sobriety (Prochaska et al., 1992). Helping professionals are advised to be prepared to work with the ambivalence that is present in each of these stages as clients struggle with contradictory thoughts of wanting and not wanting to change (Prochaska et al., 1992). Additionally, helping professionals should be aware of the reality that clients can often revert to previous stages and move from stage to stage in various ways as they struggle with this ambivalence (Prochaska et al., 1992).

In order to make lasting changes, clients may utilize support in the form of treatment programs and interventions to change their alcohol consumption behaviours. Miller, Zweben, & Johnson (2005), examined the conclusions of 10 review studies on evidence-supported treatments for substance abuse. They found that there were a few treatments that were consistently found on most lists of ESTs, despite some variance due to the procedures that the researchers used when conducting their reviews. A select group of ESTs included on the list will be discussed below and are as follows: Alcoholics Anonymous, cognitive behavioural therapy, coping skills therapy and behavioural couples therapy.

**Individual treatments for the alcohol user.**

**Alcoholics Anonymous (AA) Twelve-Step Program.** One of the most common voluntary and educational programs is Alcoholics Anonymous, which is a program comprising of twelve steps designed to help clients maintain abstinence from alcohol. Kelly, Stout, Zywiak, and Schneider (2006) interviewed 227 alcohol-dependent outpatients (84% Caucasian, 11% African American, 5% Hispanic or Native American; 29% female) and found that greater participation in the AA groups was associated with a higher degree of abstinence from alcohol and a decrease in the quantity and frequency of alcohol consumption for participants who continued to drink. Clients were encouraged to follow each step of the program and incorporate aspects of spirituality into treatment or into their lives to help conquer them, getting a little closer to achieving abstinence with each step achieved. It is important to note that the majority of the participants in this study were of Caucasian background. The authors explained this lack of diversity in suggesting that Caucasian individuals were more likely to participate in the AA groups than individuals from the other minority backgrounds. The authors purported individuals
from minority backgrounds were less likely to attend because the majority of the participants in the AA groups were Caucasian and that this, perhaps, made them feel uncomfortable to share and participate (Kelly et al., 2006). Another point to take into consideration is that possession of a telephone number and literacy in English were two of eight inclusionary criteria set for this study, given that follow-up interviews were conducted in English over the telephone. It is possible that these criteria restricted participation of many individuals from immigrant and ethnic minority populations, thus limiting the study’s generalizability to non-Caucasian and poverty stricken groups. In addition, the telephone method utilized by the authors to conduct the study raises questions around selection bias. Specifically, participants who have access to a telephone may share one or more characteristics in common that those without telephones do not have. Therefore, we cannot be sure that the results of this study would apply to those individuals without telephones. Additional evidence suggesting that results of this study may not be generalizable is that 72% of those who took part had a level of education far greater than the general population (i.e. 12 years or more) (Kelly et al., 2006).

Cognitive behavioural therapy (CBT). CBT is an EST that incorporates techniques from motivational interviewing, cognitive therapy and relapse prevention into its treatment (Rangé & Robbe-Mathias, 2012). Motivational interviewing is used to assess a client’s readiness and commitment to treatment and is often used with clients who are resistant to behaviour change (Carroll et al., 2006). It emphasizes the responsibility of the client to change and relies on five techniques including expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy (Rangé & Robbe-Mathias, 2012). Techniques from cognitive therapy aim to help clients restructure their thoughts, develop more adaptive beliefs and find effective ways to control situations that were intolerable in the past (Rangé & Robbe-Mathias, 2012). Relapse prevention techniques are used toward identifying stressful situations under which the client may feel an urge to use alcohol and how to prevent him or her from giving in to that urge (Rangé & Robbe-Mathias, 2012). According to this treatment model, many substance abuse behaviours are seen as learned maladaptive habits that have been found to provide temporary relief from stressful situations. The goal is to encourage the client to abstain from engaging in the habit and instead create change. Despite considerable evidence supporting the effectiveness of CBT (Barrowclough et al., 2009; Glasner-Edwards et al., 2007; Magill & Ray, 2009), there is concern that this treatment approach may not be generalizable to minority populations for various reasons (Windsor, Jemal & Alessi, 2014). First, the majority of the participants in the CBT studies identify as Caucasian (Anton et al., 2005; Brown et al., 2006; Budney, Moore, Rocha, & Higgins, 2006; Griner & Smith, 2006; Sue, Zane, Hall, & Berger, 2009; Windsor et al., 2014). Second, the studies are often conducted in the community and thus the procedure is less thorough compared to that of controlled efficacy trials (Singal, Higgins, & Waljee, 2014; Windsor et al., 2014). Third, higher dropout rates among minority populations are often reported in these studies (Magill & Ray, 2009; Mak, Law, Alvidrez, & Pérez-Stable, 2007; Miranda et al., 2005; Voss Horrell, 2008; Windsor et al., 2014). Finally, the reliability of studies claiming that CBT is a culturally inclusive treatment may be questionable, given that the original studies the investigators use are based on White populations (Windsor et al., 2014).

Helping the family when the alcohol user resists treatment.

Coping skills therapy. Partners and family members of the alcohol user are equally impacted by the negative consequences of the drinking as the user (O’Farrell & Clements, 2012). One way for a partner or family member to cope is to focus on their own behaviours and what

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they can change, especially when the alcohol user is unwilling to seek treatment. In a review of studies examining the effectiveness of marital and family therapies for alcohol use, all of which were conducted between the years of 2002 and 2010, O’Farrell and Clements (2012) found that coping skills therapy is an effective approach when working with families around substance abuse. Two alternative approaches that are also yielding promising results are the Al-Anon facilitation and the five-step coping skills intervention. For example, Rychtarik & McGillicuddy (2002) assigned 171 women with male partners who were abusing alcohol to either a coping skills training group, an Al-Anon facilitation group or a waitlist control group. Results indicated that the coping skills training group was more effective than the Al-Anon facilitation group, but that both treatments reduced the partner’s emotional distress compared to waitlist controls (Rychtarik & McGillicuddy, 2002). Furthermore, the women who had received the coping skills training reported less IPV a year post-treatment (Rychtarik & McGillicuddy, 2002). In developing skills that could be used to better deal with problems accompanying their male partners alcohol abuse, women’s functioning improved, which indirectly lead to improvements in the functioning of their partners. This emphasizes the importance for women with abusive alcoholic partners to partake in coping skills training.

Inviting partners and family members into therapy with the alcohol user.

**Behavioural couples therapy (BCT).** Treatments described thus far are designed for treating the individual alcohol user or family member. Relational interventions, on the other hand, target the substance user along with their partner or members of their family and emphasize a collective effort in order to bring about change. Research on substance abuse and marital quality purports that substance abuse behaviours negatively impact a couple’s relationship and that this relationship distress then further influences the substance abuse behaviours (McCrady & Epstein, 2008). For this reason, it is important to consider the ways in which the distress in a couple’s relationship is exacerbating the alcohol consumption and how relationship improvement can reduce substance use. Inviting a partner or spouse into therapy as additional therapeutic resource can be helpful in several ways. The partner can assume the role of a coach, reinforcing abstinence and supporting the alcohol user to change his or her drinking. It can also give the couple an opportunity to address relationship issues that may have arisen as a result of the drinking and/or may have contributed to the drinking, as well as dealing with any other relationship concerns that the couple may have (McCrady & Epstein, 2008; Powers, Vedel & Emmelkamp, 2008).

The goal of BCT is two-fold. It aims to help clients abstain from alcohol consumption while improving the quality of the couple relationship (O’Farrell & Clements, 2012). In attempts to help clients abstain from alcohol consumption, a “recovery contract” is made where both individuals work towards rewarding abstinence behaviour on a daily basis. The relationship is also strengthened by incorporating positive activities into each partner’s life and improving communication between both members of the couple (O’Farrell & Fals-Stewart, 2003; Powers et al., 2008). A meta-analysis of 12 randomized controlled BCT trials demonstrated that BCT was effective in improving relationship functioning but not in reducing frequency of alcohol use (Powers et al., 2008). However, there is the possibility that relationship satisfaction may be helpful in reducing the frequency of alcohol use overtime (Powers et al., 2008).

Walitzer & Dermen (2004) found that the involvement of spouses or partners in the treatment of male alcohol consumption yielded more favourable outcomes compared to when
the spouse or partner did not partake in the treatment process. The results indicated that by having partners participate in BCT, the male partner struggling with alcohol abuse was more likely to reduce his alcohol intake and remain abstinent. In this study, the role of the female partner was to provide support to her partner throughout therapy, reinforce abstinent behaviour outside of therapy and act as informant to therapist inside of therapy, providing an accurate account of progress. Out of the 64 eligible couples that participated in therapy, “nearly all clients and their partners were non-Hispanic Caucasian (98% and 95%, respectively)” (p. 946). Once again, the lack of diversity in the makeup of the sample suggests that the results may not be generalizable to individuals from minority backgrounds.

Considering the possibility that some individuals struggling with alcohol abuse may choose to reside with a family member instead of their partner, O’Farrell, Murphy, Alter, & Fals-Stewart (2010), developed a behavioural family counseling (BFC) intervention to expand the population with whom BCT could be used. In this small pilot study, 29 substance dependent individuals living with an adult family member were randomly assigned to either BFC plus integrative behavioural therapy or integrative behavioural therapy only. Results indicated that as compared to individuals receiving integrative behavioural therapy, individuals in the BFC only treatment group remained in treatment longer, demonstrated increased levels of abstinence from substances and a decreased levels of substance use (O’Farrell et al., 2010). Results of this study must be interpreted with caution, however, as larger scale controlled trials are required before solid conclusions can be drawn (O’Farrell & Clements, 2012).

In a study at an inpatient facility in India, 90 males struggling with alcohol abuse were randomly assigned to one of three treatment groups: (1) dyadic relapse prevention – alcohol user and a spouse or family member work together to prevent relapse (based on the BCT treatment manuals from the United States); (2) individual relapse prevention – only the alcohol user received treatment; (3) a treatment as usual group – consists of detoxification and long-term medication as well as psychoeducation for the alcohol user (Nattala, Leung, Nagarajaiah, & Murthy, 2010). After a 6-month follow-up, results indicated that the participants in the dyadic relapse prevention group experienced reductions in their quantity and frequency of alcohol use as well as a decrease in family and relationship distress (Nattala, Leung, Nagarajaiah, & Murthy, 2010). Although these findings demonstrate that BCT may be applicable to alcohol users in India, it is uncertain whether these results would produce similar results with alcohol users who have emigrated from India to Canada. The reason for this may be because individuals residing in Canada may have differing environmental, societal and life stressors compared to individuals living in India (Sandhu & Malik, 2001).

Kelley and Fals-Stewart (2002), recruited men who were entering outpatient substance abuse treatment and randomly assigned them to one of three conditions to examine the effects on children’s psychosocial functioning: (1) BCT; (2) individual-based treatment; (3) couples-based psychoeducational attention control treatment. The results of the study demonstrated that children had increased levels of psychosocial functioning when their fathers participated in the BCT group compared to when the father participated in the individual based or psychoeducational attention control groups. Furthermore, these changes were maintained at 6 and 12-month post-treatment follow-ups (Kelley & Fals-Stewart, 2002). An explanation as to why this may be the case points to the possibility that relationship improvement may have led to greater relationship satisfaction and less fighting, which may have then led to greater functioning for the child and benefiting the overall family environment. This explanation is
based on the idea that change in one family sub-system can influence change in another sub-system, thereby changing the overall functioning of the family system as a whole. Out of the 25, 22, and 24 men that were assigned to the BCT, individual based treatment, and psychoeducational attention control conditions, respectively, 17, 14, and 16 of the men were Caucasian while the remaining belonged to African American and Hispanic ethnic backgrounds. Given that participation in BCT improved children’s psychosocial functioning, Lam, Fals-Stewart, and Kelley (2009) conducted a pilot study incorporating parent skills training into BCT for fathers struggling with alcohol abuse. In this study 30 fathers struggling with alcohol abuse were assigned to one of three treatment groups: (1) parent training with BCT; (2) BCT only; (3) individual treatment. Results indicated that parent training demonstrated an increase in positive parenting practices as well as an improvement in child outcome behaviours. These preliminary results encourage larger, randomized controlled trials to be conducted in order to assess if parenting is a mediator in the treatment outcomes of alcohol abuse. These results have clinical implications in that they suggest that it is viable for preadolescents and children to benefit from parents seeking treatment options to reduce alcohol consumption and improve overall couple functioning, without having to treat preadolescents or children directly (Kelley & Fals-Stewart, 2007).

In the examples of the ESTs for substance abuse that are mentioned above, the quality of the research is questionable in many ways. First, many of the studies include participants who belong to the Caucasian, middle class populations so participants are not representative of, nor can results be extended to the general population. Second, inclusionary and exclusionary criteria, such as fluency in English, further call into question the generalizability of the evidence-supported treatments to minority populations. Third, the sample sizes included in many of the studies are quite small and thus results must be interpreted with great caution. Fourth, data is collected through self-report measures and so there is concern around the truthfulness of the responses as participants are less likely to be honest about substance abuse as they want to avoid potential stigmatization (Agic et al., 2011). Finally, no studies focusing on BCT or other marital and family therapies for minority clients have appeared in the literature (O’Farrell & Clements, 2012), posing a problem for therapists who wish to approach their work with minority populations from an evidence-informed stance.

Cultural Considerations in Substance Abuse Research

Alcohol consumption in minority populations can be attributed to aspects of the acculturation process such as feelings related to not fitting in and stressors such as finding a new job, adjusting to new values, and relationship stress (Sandhu & Malik, 2001). Differences in access to healthcare, economic distress and/or even cultural practices may also shed some light on how drinking behaviours vary in minority populations (Jacobson, Robinson & Bluthenthal, 2007).

In the study by Agic et al. (2011), results indicated that alcohol use in various ethnic communities ranged from “total prohibition in the Somali community to wide acceptance in the Russian, Polish and Serbian communities” (p. 118). Interestingly enough, even though alcohol consumption was not acceptable from a religious perspective in many of these communities, many individuals reported engaging in this practice anyways and suggested that alcohol consumption was a part of all aspects of their lives. Results also indicated that different ethnic communities attributed different meanings to alcohol consumption as well as revealed

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variations with regards to what alcoholic beverages each community preferred and to what quantity alcohol was acceptable to consume (Agic et al., 2011).

Even though alcohol consumption is widely accepted in some ethnic communities (Agic et al., 2011), many individuals may not be aware of the negative consequences associated with consuming it in excess, which can make one less likely to seek treatment because they are unaware that they might need the help (Agic et al., 2011; Cochrane & Bal, 1990). Other factors that can prevent members of minority communities from seeking treatment for struggles with alcohol abuse also exist. One such factor is the stigma that can be attached to talking about alcohol-related problems. This stigma can lead to a fear of being “othered” by the community in such a way that it can deter individuals from divulging information related to struggles with alcohol and/or attending therapy (Agic et al., 2011). For example, after analyzing data from a nationally representative sample of 34,653 individuals, Keyes et al. (2010) reported a negative association between perceptions of community level stigmatization surrounding alcohol use and likelihood to have utilized treatment services. Data also suggested that those individuals most likely to perceive stigmatization from the community were male, belonging to a lower socio-economic status, in possession of a lower level of education, and/or were of Hispanic or African American ethnic origin (Keyes et al., 2010).

Researchers who have examined therapy-seeking behaviours by minority populations, have found that minority clients who participate in therapy are more likely to leave before treatment completion. To this end, some argue that even if treatment models are developed to directly fit with the needs of minority clients, these clients may still end therapy prematurely (Bender et al., 2007; Jacobson, Robinson & Bluthenthal, 2007). Support for this argument can be found in a study by Jacobson et al. (2007), who examined data on 10,561 individuals discharged from 170 outpatient and residential treatment centers in the Los Angeles County. The researchers found that African American individuals were less likely to remain in treatment for the intended amount of time (17.5%) as compared to their Caucasian counterparts (26.7%). Further evidence for this trend can be found in research findings suggesting that although African Americans are more likely to struggle with mental health concerns, even beyond addictions, compared to their Caucasian counterparts (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005), they also seem to be less likely to seek support for these struggles (Buser, 2009; Kearney, Draper, & Baron, 2005). With this said, it is important to heed caution when making inferences from research conducted in America to populations within Canada. This is particularly true given that Canada’s minority population is quite different from that of America, both in terms of ethnic composition and recent immigration status (Bloemraad, 2006). It is, therefore, quite unclear if therapy-seeking behaviours among Canadian minorities is similar or different compared to minority populations across America.

In a similar study, Bender et al. (2007), collected data on the likelihood of members of minority group populations to seek mental health treatment for struggles with personality disorders. In this study, 606 participated in a baseline interview (Caucasian: 71.6%, African American: 14.7%, Hispanic: 13.7%) and 547 in a 2-year follow-up (Caucasian: 73%, African American: 14.4%, Hispanic: 12.6%). Results indicated that individuals of Hispanic origin were less likely to seek individual therapy, participate in self-help groups and be admitted to psychiatric inpatient units compared to their Caucasian counterparts. Furthermore, compared to Caucasians, African Americans were less likely to seek out individual and family therapy (Bender et al., 2007). The authors found that the experience of positive support from the therapist by
African Americans and Hispanics was an important factor determining the amount of individual psychotherapy they would receive (Bender et al., 2007). This finding points to the importance of therapists taking into consideration race and culture to maintain a strong therapeutic alliance.

Given findings suggesting that individuals belonging to minority populations are less likely to seek out therapy or continue with therapy until treatment completion, therapists can encounter difficulties finding ESTs for minority populations. As a result, even though there is little data on how ESTs tested with majority populations may or may not be applied to minority populations (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009), therapists continue to take chances and use these treatments with minority populations for lack of other options (Bernal & Scharró-del-Rio, 2001). This raises questions regarding the external validity of ESTs for substance use when applied to minority populations. In particular, it speaks to the importance of examining how ESTs can take race and culture into consideration and how the therapists who use them can do so in a culturally sensitive way, working to incorporate a client’s specific needs and values related to their cultural background.

It is important for therapists to be aware of the ideas and values that minority clients hold around the importance of having a sense of community based on their collectivistic cultures. Furthermore, it would be valuable to be attentive to the role that spirituality may play in their lives and how discrimination and factors of social location may be a barrier to treatment as these are topics that are rarely discussed in therapy (Bernal et al., 2009). Additionally, many treatments that have been designated as evidence-supported using nonminority populations are modified so they can be culturally sensitive (Nagayama, 2001). However, the error in doing this is that the values and beliefs that are the foundations of the ESTs are in line with the nonminority populations and may not fit with those individuals who belong to an ethnic minority. Therefore, it is imperative that ESTs “consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meaning, and values” (Bernal et al., 2009, p. 362). Only after this is complete, can the newly developed treatments be assessed to determine continued EST status so clinicians can use them with minority populations (Nagayama, 2001).

Another way to adapt interventions as discussed by Burlew, Copeland, Ahuama-jonas, & Calsyn (2013), is to incorporate a dialogue, as a part of the treatment, around issues that are related to substance abuse that would be common to the various ethnic groups present in a group setting. For example, if there were individuals belonging to different ethnic groups present in an AA meeting, then it would be important to make everyone feel comfortable and so talking about an issue, like immigration for example, that everyone can relate to would be important to do. This suggestion is based primarily from the work of Greenfield et al., (2007), who had suggested ways to work with women in substance abuse treatment.

Authors Qureshi and Collazos (2011) point out that even though the therapeutic alliance is considered to be vital in the effectiveness of intercultural psychotherapy, it is rarely examined in the literature. For this reason, in their theoretical paper, the authors explored the possible challenges present in the intercultural therapeutic relationship and possible strategies to overcome these hurdles. One such challenge is a lack of awareness of the impact of ethnic differences between a therapist and a client, which can lead to two significant obstacles in intercultural therapy. First, the therapist will have a difficult time in understanding the content about which the client is speaking of. Second, the therapist may develop a flawed idea of who

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the client is which would not match what the client’s perception is of who they are. They state that being culturally competent when working with minority clients involves 3 things: a) knowledge about general cultural systems and knowing when generalizations are being put on a certain population and perhaps the culture that the client comes from; b) being able to communicate differently in order to match a client’s particular needs or characteristics and adapting the treatment techniques and process that fit for the client; and, c) being able to engage in self-reflection about one’s own attitudes and beliefs around ethnic differences.

Thus far, we have been talking about minority populations in general and the limited research on treatment options that are culturally adapted for these populations. In the balance of this paper, I will return to the focus on treatment needs for the South Asian Punjabi community in Canada as related to alcohol consumption as this group is seen to abuse alcohol the greatest compared to other minority populations (Agic et al., 2011, Thandi, 2011).

Implications for the South Asian Punjabi Community in Canada

Even though research on evidence-supported treatments for substance abuse is growing, there is very little known about the benefits or harm associated with using these treatment modalities with minority populations. Within the non-Caucasian populations that are studied, the South Asian population, and particularly the Punjabi community, is rarely examined (Cochrane & Bal, 1990; Danzer, 2013; Morjaria-keval, 2006; Nakamura et al., 2011; Sandhu, 2009; Sandhu & Malik, 2001; Thandi, 2011). This may be because a lot of research studies that have been done in the United States with non-Caucasian populations are predominantly comprised of Hispanics and African Americans (Windsor et al., 2014) but the non-Caucasian population in Canada is very different than that of the United States (Bloemraad, 2006).

Given the gaps in the literature, the next steps in research should be to examine how alcohol abuse affects South Asian Punjabi families, and how effective are various treatments when working with these families. To begin with, it would be interesting to examine if South Asian Punjabi clients have an understanding of when their drinking behaviours become dangerous and harmful, and how it impacts their own well-being as well as their relationships with members of their family. It would also be worthy to examine if the effects associated with excessive alcohol consumption are represented similarly in South Asian Punjabi families as it is in current research. The repercussions of the limited amount of research in this area is that therapists are unaware of how substance abuse can impact a Punjabi family system, especially since Punjabis rarely talk about their problems with strangers and would rather keep “things in the family” (Agic et al., 2011). Furthermore, there is little to no research on the available evidence-supported individual treatments available for South Asian Punjabi clients. This has great consequences because there is no way for clinicians to know if the work they are doing with a South Asian Punjabi client is effective. Many evidence-supported treatments are considered to be reliable and valid as they suggest that a certain model and technique may be effective in addressing particular concerns. However, given that not a lot of minority populations are studied with these evidence-supported treatment research studies, it calls into question the efficacy of the studies when working with minority populations.

The South Asian Punjabi community has strong rooted values around family closeness and places great value on relationships and togetherness (Agic et al., 2011). So it would be important for researchers to examine how substance abuse can be addressed relationally within
this population, given that the most promising treatments for alcohol abuse are the ones that take a relational approach (Kelley and Fals-Stewart, 2002; O’Farrell & Fals-Stewart, 2003; Powers et al., 2008; Walitzer & Dermen, 2004). This would mean that clinicians are not only working with the substance user but also with members who belong to their family system.

**Being Culturally Informed When Working with South Asian Punjabi Families in Therapy**

Given that South Asian families make up a large majority of the ethnic minority community in Canada, it is important for researchers and clinicians to consider how we can be culturally informed when working with this population.

In a study by Thandi (2011), 17 South Asian Punjabi-Sikh men living in British Columbia, Canada were interviewed on preventative strategies aimed at reducing the occurrence of intimate partner violence in the South Asian community. These participants indicated that in order for therapy to be helpful: First, there is a need for Punjabi-speaking therapists so they can feel more comfortable speaking in their mother tongue and thus continuing with therapy rather than ending prematurely; Second, the participants also expressed the importance of therapists being culturally competent and having some understanding of their culture so they can “buy-in” to what the therapist is selling. Thandi (2011) also talks about how therapists should incorporate spirituality into their conversations with South Asian clients and if they are, then to inquire about how clients incorporate spirituality into their lives. This gives the therapist the opportunity to potentially incorporate religion into the change process and work towards how the client’s behaviour could fit more in line with what their religion says.

A sample of 15 Sikh-Punjabi men who had successfully changed their drinking behaviour were recruited from the English Midlands, within Birmingham, Coventry and Leicester, and provided support for incorporating a religious and spiritual pathway to recovery (Morjaria-keval, 2006). It was clear the first step to incorporating religion and spirituality involved a participant seeking support from the priest of his Gurdwara, which then lead to an increase in his involvement within the community. Therefore, the men were going through a religious transformation, which had three central elements: religious adherence, undergoing purification and seeking redemption. As the author suggests, “an assessment of a client’s spirituality will allow for an exploration of the potential use of incorporating clients’ own positive spiritual elements into the therapeutic process” (p. 114). In this way, the client is able to determine what aspects of their religion or spirituality they would like to incorporate into the recovery process and how they believe this will be helpful in reducing the substance abuse.

According to Sandhu (2009), it is also imperative that clinicians are able to help clients distinguish between the Sikh world-view and the Punjabi culture, as the Sikh-Punjabi community tends to think that a lot of what they do is based on their religion when this is not the case at all. Therefore, trying to help the client work towards understanding how their religious world-view can aid in healing is of great importance. It gives the client the opportunity to reevaluate their beliefs on culturally accepted norms, and how they intend on moving away from them. This would be especially helpful when the culturally accepted behaviours are detrimental to their well being, as in the case of using and abusing alcohol.

As Danzer (2013) demonstrated from his case study, practicing from a multidimensional family therapy (MDFT) approach may be helpful when working with East Indians, particularly

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with East Indian adolescents. MDFT works to target the four domains of adolescent development: the adolescent, parent, family interaction and extra familial. This model purports that when the adolescent and family members work together, as a whole all members become more receptive to learning new ways of communicating. This goes hand in hand with previous research, which suggests that the participation of a spouse or family members in therapy is helpful in reducing excessive drinking (O’Farrell & Clements, 2012; Powers et al., 2008). Therefore, it seems as though the support of having a family member present is helpful for the individual in holding themselves accountable. Additionally, the distress in relationships decreases once a family enters therapy and thus a change in one part of the family system leads to changes in the whole system (Kelley & Fals-Stewart, 2002), which can also lead to abstinence for the individual abusing substances. Just as the integration of family members into therapy is important, it would also be important for clinicians to encourage South Asian Punjabis to participate in AA meetings and for facilitators of AA to create a safe environment so everyone feels welcome and individuals feel like they have something they can relate to (Kelly, Stout, Zywiak & Schneider, 2006). One aspect that perhaps AA facilitators can emphasize is spirituality as this is something that many South Asian Punjabis believe in and is an area that they would be able to contribute to. Although there is no research confirming that the version of spirituality emphasized in AA is congruent with South Asian spirituality, the outcomes in the study by Morjaria-keval (2006) did indicate that spirituality is an important part of the South Asian Punjabi culture and so more research in this area would be helpful.

Finally, my interview with Sandeep Sekhon, the Addictions Case Manager at the Punjabi Community Health Services in the Peel Region of Ontario, Canada, made it possible for me to see how treatment for substance abuse is conducted within a South Asian community in Canada and what aspects of research informs these treatment programs. Ms. Sekhon stated that she has found that two things are very helpful when working with South Asian men and substance abuse and this entails involving the family of the user into therapy as well as incorporating spirituality (personal communication, November 14, 2014). Furthermore, based on the work that is being done with the community, S. Sekhon recommends that future research should focus on the presence of other comorbid disorders along with substance abuse within the South Asian community as a lot of her clients present with more than one diagnosis making treatment more complex (personal communication, November 14, 2014).

**Future Directions in Research**

Overall, there is a need for more research on evidence-supported treatments for substance abuse in minority populations. As research presented thus far illustrates, many of the current ESTs do not take into consideration the cultural aspects of substances abuse, which leads to clients not seeking help at all or premature dropout rates (Bender et al., 2007; Buser, 2009; Kearney, Draper, & Baron, 2005; Jacobson, Robinson & Bluthenthal, 2007). Given that the minority population makes up the majority in Canada, research on how these treatments can assist minority population groups is more important now than ever before. More specifically, researchers should aim to examine the efficacy of various treatments for the South Asian community as this community makes up a large portion of the minority populations within Canada.

The inclusion of spirituality into treatment would be helpful to examine and the role that this plays in helping South Asian Punjabis maintain abstinence from alcohol. Knowing that
spirituality plays a major role in the lives of most South Asians and is also a foundation of AA, it would be interesting to examine how AA facilitators can emphasize the role of spirituality in maintaining abstinence (Kelly, Stout, Zywiak & Schneider, 2006). Furthermore, it would be important to see if calling attention to spirituality in AA meetings would create a safer environment for minority populations in general and possibly reduce pre-mature dropout.

The need for more culturally competent clinicians is also critical in understanding the culture and beliefs that minority populations have about substance abuse and how to ethically work with this population in therapy. Researchers should examine treatment outcomes and note any differences between South Asian Punjabis working with clinicians whom are also Punjabi versus working with clinicians whom may be of a different background but are culturally competent.

Furthermore, participants in the study by Agic, Mann, & Kobus-Matthews (2011) also expressed the need for educating families on the negative effects of alcohol as participants reported inadequate knowledge about alcohol abuse and dependence. They articulated the need for this education to be in their language and for messages need to be conveyed by people respected by the community, such as religious and community leaders, counselors and physicians. The reason for this is because the message would perhaps be considered more urgent and the fact that it would be coming from individuals, who are respected by the community, would mean that there is a certain degree of truth to it.

Finally, there is a growing trend in the South Asian Punjabi community where alcohol abuse is not limited to just men as a greater number of women are also using alcohol and perhaps even abusing it (Agic et al., 2011). This is an area that is rarely examined and thus the issues that surround women’s drinking are left ignored and untreated. Future research should examine the occurrence of substance abuse in women within the South Asian Punjabi community and the potential treatment options available for them.

In conclusion, from the research that has been reviewed in this paper, there is evidence that suggests that therapists need to be culturally informed and work towards adapting treatments to fit the needs of their clients. Given that the South Asian Punjabi community is growing in Canada, it is recommended that researchers examine evidence-supported treatments that would fit with the cultural values brought forth by South Asian clients when dealing with substance abuse, and more specifically with the excessive use of alcohol.
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