

Improving access to alcohol treatment for Punjabi Sikh men in the UK

1. Introduction

People of Indian origin comprise the UK's largest minority ethnic population, with the number of individuals identifying as British Indian rising from ~1 million in 2001 to over 1.7 million in 2013¹. This broad category houses a number of different peoples and cultures, including a group from the North Western state of Punjab, many of whom follow the Sikh religion. As the world's fifth largest faith, Sikhism has over 20 million followers worldwide and 430,000 adherents in the UK, with British Sikhs considered by many as one of the most successful minority groups in terms of work ethic and cultural integration². However, with prosperity comes problems, one of the biggest being the high incidence of alcohol abuse among British Sikh men. Despite having long been regarded as an "open secret" by many members of the British South Asian community, alcoholism remains under-treated in the British Sikh diaspora. Indeed, black and minority ethnic people have been identified as the most disadvantaged in terms of access to alcohol treatment, under-performing rural communities and homeless people³. This essay will first consider the epidemiology and multi-faceted relationship between alcohol and Sikhism, highlighting the culture-religion disconnect and effects on individuals and their families, before going on to discuss the barriers that British Sikhs face when accessing alcohol treatment and what steps might be taken to break down these hurdles.

2. Sikh Men and alcohol

2.1 Epidemiology

The prevalence of alcohol abuse within British South Asian communities is often underestimated due to a limited evidence base, with some of the early literature identifying alcohol consumption to be

lower in people of Indian origin compared to other ethnicities in the UK. A General Household Survey run in the late 1970s, for example, found drinking ratios of 103 for men born in England, but only 45 for men born in the Indian subcontinent, indicating significantly lower consumption levels than the UK national average⁴. Similar findings were also noted in a survey conducted by the Department of Health in 1999, which reported that British men born in India drink less than the general population⁵. Paradoxical, then, are the statistics for alcohol-related health problems in the same community; not only are the hospital admission rates for alcohol-related disorders higher in Indian men than white, British men, but alcohol-related mortality has been noted to be similarly high in Indian men⁵ – how can this be?

One reason for this could be the unreliability of self-reported data, as some people - particularly heavy drinkers – prefer not to divulge the amount of alcohol that they consume⁶. Regarding South Asian people in particular, religious taboo and fear of community ostracization could exacerbate this reluctance, leading to figures that fail to represent the real picture. Indeed, several studies have noted contrasting findings to the reports described above, often reporting higher levels of alcohol consumption in Sikhs than in any other British Asian ethnic group. A survey conducted by Alcohol Concern, for example, analysed the drinking habits in 1,684 men and women living in the Midlands, finding that although most Pakistani and Bengali men and women, and Sikh and Hindu women, were non-drinkers, alcohol was consumed by most Sikh men⁷. This is supported by another community survey comparing 200 Sikh, Muslim and Hindu men and 200 age-matched white English-born men, which found that Sikh men consume the highest level of alcohol between Sikh, Muslim and Hindu communities⁸. Most recently, a survey conducted by the BBC found that 27% of British Sikhs report having someone in their family with an alcohol problem⁹, with evidence indicating that this high level of alcohol consumption among Sikh men is steadily rising⁴.

2.2 Case study: Mrs Kaur*

Growing up as a person of mixed Punjabi origin in Birmingham, which has a significant Punjabi Sikh population, I have always known Punjabis as the “life of the party,” with Punjabi weddings known for having unlimited drinks and energetic dancing until the late hours. However, the problem of unhealthy drinking in the British Sikh community first came to my attention during a GP placement when I met Mrs Kaur.

Mrs Kaur is a 56-year-old lady of Punjabi Indian origin who moved to the UK almost 30 years ago with her husband and two daughters. Although she used to work as a teaching assistant in India, she stopped working when she came to the UK and instead devoted her time to raising her children and volunteering at the local Gurdwara. She currently lives with her husband and one of her daughters, the other having married and moved into her husband’s family home.

Known as a “frequent attender” at her local GP practice, Mrs Kaur has made an appointment to see her GP almost once every 3 weeks for the last several years, presenting with a variety of complaints. On this occasion, she presented with tiredness and general body ache, which she has complained of before on multiple occasions. At one such appointment, when asked about what she thought might be causing her symptoms, Mrs Kaur complained of being woken up by her husband coming home from drinking with friends at extremely late hours several nights a week. She said that before coming to the UK, her husband was quite a religious Sikh and so did not drink alcohol. However, several months after moving to England, Mrs Kaur recounted that her husband had taken to drinking with his friends after work on Friday nights, then on Friday and Saturday nights, and eventually on most nights of the week. She said that although her husband was usually good-natured - albeit loud - when he drank, he would sometimes come home from the pub in a foul mood. On such nights, Mrs Kaur said that she often woke up to the sound of her husband shouting and throwing household objects around in fits of temper that typically revolved around the house being untidy or the fridge being empty. However, she denied any incidences of domestic abuse against her or her daughters.

Despite strong encouragement from her GP, Mrs Kaur has always been reluctant to voice her concerns about her husband’s drinking habits with him directly or encourage him to seek help. She argues that doing so would be disrespectful to her husband, and that his drinking is not hurting her; she has always denied low mood and anxiety, arguing that the only downside of her husband’s behaviour is the interruption to her sleep. Mrs Kaur also denies any negative effects of alcohol misuse for her husband, stating that he is the “picture of health.” Thus, Mrs Kaur has frequently asked her GP to prescribe her sleeping pills, although the GP has always been reluctant to do so. Instead, the GP has offered to refer her for support and psychotherapeutic treatment on several occasions, which Mrs Kaur has always declined.

My experience interviewing Mrs Kaur and learning about her history from the GP raised a number of points about the relationship between British Sikh men and alcohol:

2.2.1 Religion vs. culture

Mrs Kaur mentioned that the reason for her husband's abstinence in India was him being more "religious." Abstention from alcohol, tobacco and other drugs is highlighted as a necessity for Sikhs according to the Khalsa code of conduct, with this dislike of alcohol reinforced in the Guru Granth Sahib (the Sikh Holy Book): "Do not drink this liquor if you wish to swim across the ocean of life" and "Never should a Sikh take wine." It is unsurprising, therefore, that religious affiliation has been noted as a protective factor against substance addiction, with some studies identifying people who report higher religiosity as being less likely to take drugs or consume alcohol¹⁰.

Although Sikhs make up almost 60% of the population in Indian Punjab, however, alcohol consumption is more frequent and expenditure on alcohol greater in the Punjab than in any other region of India¹¹. Indeed, alcohol consumption has always been very high among Sikhs, with drinking often tied to issues such as status and class. Importantly, researchers have also put forward a strong tie between alcohol consumption and perceptions of masculinity, as drinking, especially heavy drinking, is frequently accepted as part of male Punjabi culture. A study in 2010, for example, reported clear connections between masculine ideals and alcohol use in senior Sikh men, with participants describing alcohol as the "social glue" for male bonding. Intriguingly, the same cohort denied drinking alcohol in public and tended to separate drinking from Sikhi (the practice of the Sikh religion)¹², highlighting the tension between religion and culture; while the Sikh faith disapproves of alcohol consumption, Punjabi male culture holds strong traditions of heavy drinking.

2.2.2 Acculturation

Another interesting theme raised by my conversation with Mrs Kaur was the role of acculturation in promoting excessive alcohol consumption. Research has shown that, over time, living in a new country can cause ethnic minorities to start adopting new attitudes and behaviours in line with the country that they are now living in, including those associated with the drinking culture of the general population³. Thus, given Britain's reputation as a nation of binge-drinking, this process of acculturation could partly explain the change in the drinking habits seen in Mrs Kaur's husband, and, more generally, the changes in drinking rates observed in some ethnic groups.

It is worth noting, however, that the progression of acculturation can be very stressful, with acculturation-specific hassles including prejudice and discrimination, language difficulties, problems with family members and conflict with other members of the cultural group¹³. With regards to Punjabi Sikhs, different stresses can manifest in the first and second generations. On the one hand, migrating from the traditional, collective society of village Punjab to the modern, individualistic one seen in the UK can be particularly troublesome for first generation Sikhs, often causing a breakdown of traditional forms of social control¹⁴. For generations who grow up in the UK, the expectation from British youths for Sikh individuals to "share" cultures rather than differentiate between their Sikh identity and British identity can create conflict between two lives: a traditional, cultural Sikh life and a British, modern life¹⁵. Such acculturative stress has been posited as being more important than acculturation itself in relation to worsening drinking habits in the Sikh diaspora¹³, encouraging those affected to turn to alcohol as a coping mechanism.

2.2.3 Impact on the individual

Although Mrs Kaur denies any ill effects of alcohol misuse on her husband, the literature suggests that South Asian men are over-represented as patients for alcoholic liver cirrhosis in comparison to other ethnic groups and the general population, with Sikh men in particular making up 80% of the mortality from alcoholic liver disease¹⁶. Intriguingly, however, while drinking levels have been identified as being significantly high among Sikhs, their drinking rates fail to account for the reported numbers of alcohol-related hospital admissions for the Sikh community in the UK¹⁷. Alongside unreliability of the self-reported data regarding drinking habits, biological factors could also play a role in accounting for this discrepancy, including genetic differences in how alcohol is metabolised and affects the body. A study in 1995, for example, found that South Asians who presented with alcohol dependency had much higher rates of acetaldehyde-mediated haemoglobin modification than white British people, despite having shorter histories of heavy drinking¹⁸. Another proposed reason is that some cases of liver cirrhosis could be attributable to causes other than alcohol, such as viral hepatitis, which is widespread in the Indian subcontinent¹⁹. Nevertheless, the higher rates of liver disease among men suggest a link with alcohol.

2.2.4 Impact on family members

Mrs Kaur's experience as the wife of someone with problematic alcohol use highlights the importance of considering the impact of addiction on family members. Researchers estimate that 7 million people in the UK are affected by the substance misuse of a relative²⁰, with surveys finding that the presence of one relative with a drinking problem is significantly associated with anxiety and depression²¹. In relation to British Sikhs, much of the burden of care falls on female relatives (i.e. wives and daughters), often with the expectation that they provide support in isolation without input or advice from the extended family network²². This can have substantial effects on the women affected. Researchers in 2003, for example, interviewed 24 female family members of Sikh men in the West Midlands identified

as being alcohol dependent, finding that the women's mental health was significantly impacted by their husband/father's drinking habits²³.

Although Mrs Kaur denied any incidence of intimate partner abuse, domestic violence has been recognised as a widespread issue for family members of men with substance abuse issues, with the World Health Organisation²⁴ reporting that "the role of alcohol in aggression extends across many different forms of violence, including youth violence, sexual violence, wife abuse, child maltreatment and elder abuse." Indeed, research suggests that >50% of men going through batterer programs are also substance abusers, and >50% of men in substance abuse programs have used intimate partner violence in the year prior to admission²⁵. With regards to Sikh diaspora communities, a recent survey of front-line social service practitioners in Canada indicated high co-occurrence between intimate partner violence and alcohol misuse in Punjabi Sikhs, with one practitioner estimating that "between 70 and 80% of the files [related to domestic violence reports from Punjabi Sikh households] involved some form of alcohol use or misuse."²⁶ This violence can also extend to daughters; a thesis submitted in 2000 at the University of Birmingham, for example, interviewed a sample of 24 wives and 10 daughters of Punjabi Sikh men with drinking problems, identifying that all but one daughter had endured some physical abuse from their father when under the influence of alcohol⁴. Alongside this, female relatives of British Sikh men with drinking problems have also identified lack of affection, breakdown of communication, financial difficulties and educational interference as problems stemming from their male relative's alcohol misuse, highlighting the importance of considering family members – particularly female relatives - when discussing the problem of alcoholism in the British Sikh diaspora.

3. Barriers to treatment

Despite the worrying statistics surrounding alcohol misuse in British Punjabi Sikhs, minority ethnic groups remain severely under-represented in alcohol treatment programs, with the National Alcohol Treatment Monitoring System reporting that only 1% of people in alcohol treatment in the year 2011-2012 identified as “Indian.”²⁷ A variety of reasons account for this, including shame, a lack of awareness of the effects on the individual’s health and wellbeing, a lack of knowledge surrounding what help is available, and a lack of local, culturally competent services.

3.1 Shame and stigma

“Log kya kahenge?”

(“What will people say?”)

In a survey of 89 people - mostly of Sikh origin - in the wider Birmingham area, shame was identified as one of the major reasons that might stop people from seeking help if they were worried about their own drinking²⁸, with a more recent study also identifying “fear of being talked about” as a central factor that prevents family members of people with alcohol abuse in the Sikh community from accessing and engaging with alcohol services²². This stems partly from the clash between Punjabi culture and Sikh religion when it comes to alcohol consumption, with the aforementioned survey in Birmingham finding that declarations such as “real Sikhs do not drink alcohol” were frequently met when trying to initiate conversations around alcohol misuse in the local Sikh community.

Intertwined with shame is the issue of stigma, which is defined as prejudice and discrimination that occurs because of stereotypes and beliefs associated with a specific group that society applies to individuals within that group²⁹. Alongside the general stigma associated with seeking help for an addictive problem which would be true for members of any ethnicity, British Sikhs also must face the

stigma of seeking psychiatric help, which is pervasive within Asian ethnic minorities³⁰. Furthermore, given that those with drinking problems in the Punjabi Sikh community are most likely to be men, there is also stigma associated with ideals of masculine identity – as commented by one survey respondent in Birmingham, “Some people might think that it is not right for a man, especially in the Asian community that I am supposed to be the main food provider and the main man in the house, to seek help.”²⁸

The outcome of most forms of stigma is isolation, alienation, avoidance and ambivalence about seeking help³¹, causing individuals to deny their problem or attempt to handle problems within the family. Indeed, a hierarchy of help-seeking has been noted in the Sikh community, with “sorting it out within the family” being at the top²⁸. However, not only has denial been identified as a significant obstacle to recovery in alcoholics³², with the silence generated only serving to continue the cycle of taboo around alcohol misuse, but family treatment is unlikely to yield the same therapeutic effects as formal treatment, particularly when shame and denial can even extend into families²⁸. Hence, by the time the problem reaches such an extent that formal treatment is inevitable, the patient will be further along in their addiction and will have associated addiction with increased negative emotions such as anger, denial, frustration and desperation³¹. Hence, stigma and shame require serious consideration as a barrier to treatment.

3.2 Lack of knowledge

A lack of knowledge has been identified as one of the foremost barriers to help-seeking in British Punjabi Sikhs. For example, a lack of knowledge about “gradations of drinking” has been noted as an issue within the community, as has ignorance regarding units of alcohol and not realising the effect that drinking is having on an individual’s health or wellbeing²⁸. Alongside this, there is also the

deficiency in awareness regarding what help is available, which has been noted among Pakistani, Chinese and Indian communities³³. There also appears to be a lack of awareness of this ignorance; although 73% of respondents in the aforementioned Birmingham survey answered “yes” when asked ““if your friend or family member said they wanted some help with their alcohol problem, would you know who to suggest,” the internet was cited most frequently as who they would suggest, with only 7% of respondents recommending an alcoholics service²⁸. Compounding this is the lack of awareness surrounding confidentiality of the services available, leading to a fear of being talked about by others within the Sikh community²².

3.3 Lack of culturally competent services

Although workers in the field propose that services at every level of education, health advice and treatment need to be culturally and religiously sensitive, this expertise is not evident in many mainstream service providers³. While most organisations do conduct some form of training around race, culture and diversity, the contents of these programmes are considerably variable, and the meaning and implication of cultural competence is highly dependent on the local context. Indeed, there remains no nationally recognised standard by which to measure or define cultural competence³⁴, despite a Joint Alcohol and Drugs Needs Assessment in 2011 highlighting the need for work to “focus on those areas where numbers in treatment do not reflect the ethnic populations.”²⁸

In the practical sense, this includes factors such as language; although this is less of a problem for the younger generations, it still remains a significant barrier for the older generations, who might have a limited speaking/reading ability in the English language compared to Punjabi or Hindi. This could impact on their ability to access common alcoholics services - 12-step support groups, for instance, may not suit individuals who have difficulty expressing emotions and thoughts in a foreign language.

However, cultural competence also encompasses a lack of knowledge regarding the actual diversity present within British ethnic minorities; the term “South Asians” encompasses a variety of different peoples and ideologies, which will significantly impact on the experience of alcohol misuse and what services might be more appropriate. For instance, the taboo of alcohol consumption is likely to be significantly greater in Pakistani Muslims than Punjabi Sikhs, as neither culture nor religion widely accepts drinking. Within the Sikh diaspora itself, alcohol consumption is regarded much more sternly in women than men and so is associated with greater stigma and shame³⁵, indicating the possibility of different engagement and treatment approaches being needed for the different sexes. Thus, a lack of cultural awareness is likely to generate higher drop-out rates and less chance of engagement with treatment in the first place, highlighting it as an important barrier facing the British Sikh population.

4. How can we overcome these barriers?

4.1 Increasing awareness

“It’s about taking the lid off it really, in an intelligent way.”²⁸

Increasing education and awareness has been identified as a key step looking forward, with the majority of respondents in the aforementioned survey in Birmingham highlighting this as a necessity²⁸. This includes making the British Sikh population aware of not only what constitutes unhealthy drinking habits, but also making sure that they know what help is available. Particular attention has been brought to the need to target this to all generations; although some argue that young people are better educated about alcohol and the harms of dangerous drinking, others believe that younger people drink more than the older generations in the Sikh community, positing that Sikh elders are more responsible drinkers and have contrasting motivations for consuming alcohol (social lubrications vs. drinking to get drunk). With regards to distributing educational material, the finding that most members of the Sikh community regard the internet as their initial source of information for treating

alcohol misuse suggests that online and computer-based materials would be extremely helpful. Other mediums put forward include Sikh television/radio channels and the “Punjabi paper,” as these media seem popular within the community²⁸.

Regarding the content of these messages, careful thought is required to ensure cultural and religious competency. Emphasising the confidential nature of treatment is especially important given the association between alcohol misuse and shame, as is drawing attention to the free cost of seeking help to avoid isolating those of a lower socioeconomic background²⁸. The choice of language used also needs to demonstrate some sensitivity; researchers in 2014, for example, found that asking members of the Punjabi community about alcohol use and problems directly is unlikely to work, whereas relating the issue to health or family is much more likely to engender open discussion³⁶. Similarly, one must ensure that the language used is able to be understood, as posited by one alcohol service staff member when asked about working with members of the Sikh community: When working with Sikh family members of someone with alcohol dependence, four participants identified a community who held a lack of understanding in relation to the confidentiality of alcohol services: “...cuz confidentiality, data protection act is something that we need to explain in layman’s terms...”²² More practically, speaking Punjabi has been noted as being crucial for building trust and rapport with the target population, with the same research team reporting that it made “a lot of difference to the reception the researchers received [from members of the Punjabi Sikh community].”³⁶ Through culturally competent approaches, therefore, the British Sikh population could be made more aware of the issues regarding problem drinking and what help is available.

4.2 Tailoring therapy to the target population

Making treatments more culturally competent is a crucial step for improving uptake of alcohol treatment in the British Sikh diaspora. Issues surrounding this include who should provide the service and where they should occur. Regarding the former, not only have staff selection, education and training been highlighted as important for enhancing cultural sensitivity³, but the title of those involved has also been identified as a point of concern, with some advising that using the term “wellbeing/health worker” might be more palatable to British Sikhs than “alcohol worker” due to issues of shame and stigma²⁸. Furthermore, there is also debate around whether patients would prefer community-led services or non-community led services; on the one hand, the literature highlights the importance of language skills and cultural competency, but on the other hand, speaking to someone in your community could raise questions about confidentiality. As remarked in one member of the Sikh community in Birmingham, “How do you get past someone wanting to see someone of [your] own culture but who won’t judge [you] because of the spiritual aspect of [your] drinking? In the latter respect white doctors are seen as safer in terms of confidentiality.”²⁸

Confidentiality is also important when deciding where alcohol interventions should take place, necessitating a balance between providing treatment centres that are locally situated and easily accessible, but not so obvious that privacy might be at risk. Particular debate has been drawn to whether Gurdwaras (Sikh place of worship) might be a good location for alcohol treatments. As mentioned previously, religion has been identified as a protective factor against substance abuse¹⁰, and so some argue that Gurdwaras might be extremely useful for tackling alcoholism. Indeed, researchers have found that South Asians often undergo a course of re-affirming their religious world-view rather than being drawn into the twelve-step programmes, with recovering alcoholics of Sikh background frequently citing gurdwara visits as a key component of their recovery: “There was a void in my life which was filled up with drink, going to the temple fills that void.”³⁷ However, attention has

also been drawn to the fact that, given its visible status within the Sikh community, housing alcohol treatment within a Gurdwara could deter some patients for fear of shame and gossip. Alongside this, there is also the issue of religious sensitivity; as Sikhism teaches abstinence from alcohol and other mind-altering substances, many people hold a firm stance that alcohol should have no place in Gurdwaras. Particular concern surrounds the possibility of intoxicated individuals entering Gurdwaras, which goes against many Sikhs' beliefs regarding the sanctity of their place of worship²⁸. Thus, further research into the attitudes of Sikhs regarding religious involvement in alcohol education and treatment is needed in order to ensure that any proposals put forward are sensitive to and welcomed by the communities that they serve.

Eliciting whether family involvement might enhance alcohol treatment in British Punjabis also requires further consideration. Given the negative impacts of substance abuse on family members, particularly female family members in Punjabi Sikh households, it is insufficient to treat the drinker in isolation when managing alcohol abuse, with greater efforts needed to provide support to family members. In fact, research has identified family involvement as a source of support in helping people to change problematic drinking habits, particularly in some minority ethnic groups with cultures of strong family ties³. However, concerns with regards to implementing this in the Punjabi Sikh community have been raised.

Some have found that family members within the Sikh community can add to the problem of substance abuse by failing to change their own behaviour to support the individual, instead continuing to drink in front of them, providing alcohol for them and pressuring the alcohol-dependent relative to drink; "...when they are having parties or getting together even then the person makes excuses like, 'I'm on medication', or, 'I've been on detox, I don't drink', they are forced to just have one, 'one won't hurt'."²² The concept of shame and stigma also comes into play, as some fear that the presence of

family members might encourage drinkers to minimise or deny their habits. Indeed, not one of the Sikh alcohol service users surveyed in the aforementioned study in Birmingham suggested family-centred interventions, with one participant positing that the Sikh/Punjabi culture makes it difficult for men to discuss their drinking in front of their wife or children; “He is going to be in denial. He will not want his wife there for the simple reason that his wife will tell the truth. The wife will say he is drinking so much and he will say shurrup, shurrup [shut up] and that will start bringing tension between the two as well. It is an awkward situation.”²⁸

Nevertheless, this is only one study and so, given the existence of literature that supports the efficacy of familial involvement in treating alcoholism in other ethnic minorities, this approach to treatment should not be discounted yet. Rather, greater research and discussion targeted directly at the British Sikh community is needed to give a more concrete picture of the benefits and harms of familial involvement.

5. Conclusion

In conclusion, alcohol misuse is a significant problem in the British Punjabi Sikh community, with substantial repercussions on the affected individuals and their families. Important to note is the evidence that the problem is only forecast to worsen, demonstrating the relevance to today’s medical students and wider health services. Despite the extent of the issue, black and minority ethnic communities remain underserved by current alcohol treatments, with barriers including shame and stigma, lack of knowledge within the community and an absence of culturally competent services for people to turn to. Although this essay outlined several strategies that might be useful in overcoming these hurdles, ultimately it will be greater research into the issue that yields the greatest outcome with regards to providing evidence-based approaches for prevention and intervention, including

studies looking at the feasibility of providing alcohol services in Gurdwaras and whether family-based therapy might be useful in the setting of Punjabi Sikh culture. Looking forward, therefore, it is my view that raising awareness of the issue, alongside increasing the funds available for suitable research, will be instrumental in tackling the problem effectively.

(4,881 words)

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