Linguistic and Sociocultural Diversity Among South Asians

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The aim of this paper is to provide information about the ethnocultural and linguistic characteristics of South Asians, because South Asians are one of the most rapidly growing groups in North America. This paper overviews demographic and immigration history and describes sociocultural characteristics and major languages used by speakers of South Asian origin, including dialectal differences in English. I emphasize that, although there are overarching sociocultural similarities among South Asians in terms of family structure and values, there is also considerable heterogeneity depending on specific subgroups, time since migration, and extent of acculturation. Finally, I present guidelines for clinicians who may make service delivery decisions about their South Asian clients.

Among the various ethnic minority groups residing in North America, South Asians comprise one of the largest and fastest-growing groups (BC Stats, 2010; U.S. Census Bureau, 2007). The term South Asian refers to persons originally from the Indian subcontinent (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka; United Nations Statistics Division, 2011). Persons of Indian origin are the largest subgroup of South Asians (henceforth, Asian Indians) and also one of the largest growing ethnic groups in the United States, with a growth rate of over 200% in the past 2 decades (Camarota, 2007). South Asians are by no means a homogeneous group: they speak over 30 different languages, which collectively have over 1,600 regional dialects (Dryer & Haspelmath, 2011; Zogra, 1982). Religious affiliations are also considerably diverse, with at least eight distinct religions, each with different belief systems and lifestyle expectations (Gutmanis, 2000). Another variable contributing to the large diversity of South Asians in North America is the time since the original migration. In addition to a steady influx beginning with the Immigration and Naturalization Act of 1965, there were two sizeable waves of immigration: that of health professionals in the 1970s–1980s and information technology professionals in the late 1990s. Hence, although a majority of South Asians are born outside the United States, there is also a rapidly growing number of second-generation immigrants (U.S. Census Bureau, 2010).

Not surprisingly, South Asian cultural and linguistic background significantly differs from that of the mainstream North American population, but is also heterogeneous in itself. As with other minority groups, such as Hispanics, Asian Indians represent different levels of English language proficiency, bilingualism, and acculturation, and these individual differences can affect service delivery. Limited awareness of these differences is likely to negatively affect the process of assessment, interpretation of test performance, and delivery of intervention by health-care professionals. A review of professional literature targeted at speech-language pathologists and audiologists reveals hardly any publications on South Asians despite the large numbers of South Asians residing in the United States. Therefore, the primary objective of this article is to provide readers with a background of the ethnocultural and linguistic characteristics of South Asians that will serve as a guideline for clinicians who may make
service delivery decisions about their South Asian clients. This article focuses on major characteristics that bear some overarching sociocultural similarities across South Asian subgroups, although most published resources primarily focus on Asian Indians.

**Sociocultural Background**

**Family Structure and Values**

Among South Asians, the family unit plays a strong foundational role in an individual’s life, even after the person has reached adulthood and achieved financial independence. In this respect of familial interdependence, South Asians may be comparable to Hispanic and African American families and unlike mainstream North American families, where the role of family diminishes once individuals are ready to be independent. South Asians possess a strong sense of group solidarity and mutual dependence on group members (Ramisetty-Mikler, 1993). Hence, the practice of bonding with one’s family has the connotation of maturity, voluntary cooperation, and respect for authority and conformity. This is in contrast to Western cultures, where this kind of bonding may be negatively viewed as lack of independence, individuality, and self-sufficiency (Ramisetty-Mikler, 1993). For South Asians, social obligations are important (e.g., care of aging parents), and overall needs of the family supersede individual needs and aspirations. Families play an important role in major life decisions, such as career and marriage. The implication of this tightly knit family structure for service delivery is that (even adult) clients may hesitate to make decisions about treatment options before consulting with their family members.

Traditional South Asian parenting styles are more authoritarian and directive than Western styles, but also include more caretaking, playing, and modeling relative to Western parenting styles (Paniagua, 2005). When working with South Asian clients, Sue and Sue (2008) suggest that a therapist advise parents to use positive aspects of traditional parenting strategies, such as modeling desirable behaviors. It should be pointed out that some South Asian families in North America may adopt a more Western egalitarian parenting style based on their level of acculturation. Finally, relative to Western society, South Asians tend to overemphasize their educational and job achievements, which are the principal status symbols in Asian society (Ramisetty-Mikler, 1993). These high career expectations may produce distress in South Asian clients who have educational or communication special needs.

**Social Interactions**

In most South Asian cultures, interpersonal interactions are more formal than in Western cultures, and there are well-defined conventional and hierarchical expectations regarding the manner of interaction. These social hierarchies are based on age, status in the family (e.g., grandparent or oldest male relative), and gender. For example, it is generally considered impertinent for persons lower in the social hierarchy (such as a grandson or daughter-in-law) to make eye-contact or disagree with persons of a higher familial status. However, South Asians’ level of comfort with making eye contact, hugging, shaking hands with persons of the opposite gender, initiating conversation, and displaying strong emotions varies considerably depending on their level of acculturation. A majority of South Asian immigrants socialize extensively within their subculture in an effort to preserve and cultivate their cultural traditions, languages, and social expectations (Minde & Minde, 1976; Sridhar, 1985). In contrast to the socialization within their subculture, the extent of socialization with non-South Asians and mainstream North Americans varies considerably across families. In some cases, the practice of limited social contact with non-South Asians may intensify feelings of social isolation and sense of minority status (Minde & Minde, 1976). However, more research on the impact of socialization styles on emotional well-being is warranted. In North America, South Asians also have relatively strong support networks in the form of cultural and religious organizations. Overall, South Asian clients—both first-generation immigrants and their American-born children—may feel uncomfortable while interacting in the spontaneous and
informal style of Westerners, as in a typical clinician-client interaction (Ramisetty-Mikler, 1993). Other features that are likely to affect client-clinician interactions are that South Asians value modesty, try to refrain from overtly disagreeing with conversational partners (even if their opinions and values are at odds with what is being said), hesitate to admit having any problems, and may experience shame in receiving treatment and counseling (Bean & Titus, 2009; see Mahendra’s article in this issue for further discussion).

**Language Background**

South Asians collectively speak more than 30 different languages, each with numerous regional dialects (Dryer & Haspelmath, 2011). Eighteen of these languages are spoken in India. South Asian languages evolved from a variety of Indo-European and Dravidian language subfamilies and have their own script (Dryer & Haspelmath, 2011). Immigrants to North America are most likely to speak the following Asian Indian languages at home: Bengali, Hindi, Gujarati, Marathi, Punjabi, Tamil, Telugu, and Urdu, although not all speakers may be proficient readers of those languages (BC Stats, 2010). In general, first-generation Asian Indian immigrants have a conversational knowledge of English and, compared to other immigrant groups, are most likely to have English-speaking family members (Barnes, Adams, & Powell-Griner, 2008). English speakers are most likely to speak Indian English (IE), which is recognized as a dialect of English (Crystal, 2003; Sailaja, 2009). IE is most distinct in its phonological features, which are described by Shah (this issue). Standard Indian English (SIE) is the variety of English used by highly proficient speakers, and its morphosyntax is almost indistinguishable from native varieties of English (British English [BE] and American English [AE]), although phonological and lexical usage of SIE can be distinguished from native English. In addition to SIE, less-proficient speakers use non-standard and informal varieties of English (henceforth vernacular Indian English [VIE]), and some speakers can shift between SIE and VIE depending on the conversational situation. Speech-language pathologists performing evaluations need to be sensitive to the characteristics of IE, and especially VIE, in making decisions about disorder versus difference. Hence, some characteristics of IE are highlighted here (all examples of IE in the following section are from Sailaja, 2009; audio-recordings of these examples can be accessed at [http://lel.ed.ac.uk/dialects/india.html](http://lel.ed.ac.uk/dialects/india.html)).

**Morphosyntactic Characteristics**

Syntactic constructions of IE mostly conform to BE (and some to AE), but are stylistically more formal (Sailaja, 2009). VIE speakers exhibit the following linguistic differences, most likely due to influence from the morphosyntax of their native language.

- **Verbs**: Verbs may be produced with argument structure violations. For example, transitive verbs may be used as intransitives (e.g., *I didn’t expect for* I didn’t expect this) and ditransitives as transitives (*Karuna gave Maya*; *Karuna gave a book*). Sailaja (2009) suggests that argument structure violations may stem from the use of the same syntactic frame for semantically similar verbs (e.g., *agree* and *accept* may be interchanged: *agreed/*accepted to go; *accepted/*agreed an invitation). Second, the verb particle *off* and the word *only* are used to denote emphasis and intensity (*I'll write off as in I'll finish writing and be done with it; The light bulb didn’t work only*). Finally, some speakers may not split the verb and particle when there is a pronoun (e.g., *They called up him*).

- **Tense and Aspect**: Progressive and past perfect aspect may be overused, even with verbs for which these aspectual forms are not permissible in AE and BE (e.g., *I am having three books with me; I have returned the book yesterday*). Modals such as *would* are more likely to be used than auxiliaries (e.g., *Attached to this, you would find my answers*). Additionally, tense agreement may be violated across clauses (e.g., *Girish thought that he will pass*).
• **Functional Morphology:** Determiners may be omitted or used without the count/mass noun distinction (e.g., *We had group discussion*; *Where is watch?*). A related count/mass noun error occurs with plural morphology (e.g., *furnitures; a furniture; a scissor; I want to share a good news with you*). Irregular verbs mostly follow BE rather than AE (e.g., *spilt, dreamt, burnt* instead of *spilled, dreamed, burned*).

• **Adverbials:** Adverbials indicating place and time may be placed at the beginning of the sentence (e.g., *At 4 o’clock, the movie begins*).

• **Questions:** VIE speakers may not use subject-auxiliary inversion to form questions (e.g., *When you will begin?*; *What you are reading?*). Tag questions may involve an overuse of *isn’t it* and *no* (e.g., *You will come, isn’t it? You will come, no?*).

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**Lexis and Discourse**

Lexical usage of IE is largely British (e.g., *jam for jelly, jug for pitcher, tap for faucet*), although there are some preferences for AE words (e.g., *stove, pharmacy*). In addition, IE includes some unique terms that are neither in AE nor BE (e.g., *brinjal for eggplant*). Some IE words are used in semantic contexts that are different from the usage in AE and BE, such as *shift* (to move out of one’s office or home), *hotel* (for *restaurant*), and *bearer* (for *waiter*). Compound formation is quite productive in IE (e.g., *black money for unaccounted money; hill station for a place in the hills that has a cool climate; air-dash as in to rush by airplane; cousin-sister for female cousin*). Idioms may be literally translated from Asian Indian languages (e.g., *He will eat my brain/head as in He will harangue me*). There is also a unique use of politeness markers in IE. For instance, *just* and the tag *no* are used instead of *please* (e.g., *Would you just move a little?*; *Come, no for Please come*).

Written IE is considered to be more archaic and formal in style than spoken IE, with a preference for Romance words and some constructions that are inappropriate in native varieties of English (e.g., *Kindly do the needful; We shall be highly obliged to you*; Sailaja, 2009). Clinicians also need to be aware of possible differences in non-verbal communicative gestures, such as head nodding, which may not be consistent with Western gestures (Shah, 2007). For example, some South Asian subgroups may use head nodding to encourage the speaker to continue speaking, and others may use sideways head movements to indicate agreement or helplessness.

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**Guidelines for Assessment**

In order to deliver culturally competent services, it is important to be cognizant of the general sociocultural and linguistic characteristics of South Asians discussed above and to be cautious about casting clients into stereotypes (Bean & Titus, 2009). There are important individual differences across clients, especially in terms of acculturation and bilingualism. *Acculturation*, which refers to the gradual cultural modification of a person due to prolonged contact with another culture, could vary significantly within a community or even members of the same family (Paniagua, 1996). That is, the level of acculturation falls along a continuum, ranging from one end where persons of South Asian origin may in fact feel and act “American” or Westernized, to the other end of the continuum where the person has maintained most typical characteristics of South Asian culture (e.g., food, clothing, and language). Hence, a quick survey of the level of acculturation allows clinicians to explore variables such as the client’s generation relative to the first immigration, languages preferred, and culture-specific social activity. An instrument such as the Minority-Majority Relations Survey (MMRS; Sodowsky, Lai, & Plake, 1991)—a 43-item questionnaire of perceived prejudice, social customs, and language usage—or an adaptation of a questionnaire used with Hispanic clients (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) could be used to explore acculturation. The second significant individual variable is the extent of bilingualism and proficiency in each language (both spoken and written), which largely depends on each person’s sociolinguistic,
educational, and vocational background. Some households maintain fluent usage of their native language at home, while other multilingual immigrants may not use all their known languages on a regular basis after migration (Sridhar, 1985). Language attrition, progressive loss of a less-frequently used language, is further discussed by Datta (this issue). Language-use questionnaires also can be used with clients to obtain valuable language background information, such as ages of acquisition of languages, language preference, and relative time spent using each language for socializing and media use (e.g., Marian, Blumenfeld, & Kaushanskaya, 2007).

The following guidelines are recommended for clinicians during their first session with South Asian clients (compiled from Bean & Titus, 2009; Braun, Fine, Grief, & Devenny, 2010; Paniagua, 1996, 2005; Sue & Sue, 2008):

1. Consult with a cultural informant who is South Asian in advance of the first session.
2. Make a positive first impression by exhibiting your expertise and credentials, because South Asians expect the professional to be an authoritative figure with expert knowledge.
3. Explore levels of acculturation using questionnaires mentioned earlier or during the intake interview.
4. Inquire/explore history of bilingualism/bidialectalism/language-use patterns and validate choice of maintaining bilingualism, when applicable.
5. Use formalism when addressing clients and avoid personalism. For instance, one may address the client with a formal title (Mr. Shetty) instead of their first name and could refrain from jokes.
6. Inquire if clients are familiar with the scope of practice of speech-language pathologists and audiologists; provide information and resources accordingly.
7. Provide concrete and tangible evidence of test outcomes and in support of interventions recommended. Allow time to process information provided on the first session; indicate availability to answer questions subsequent to the evaluation.
8. Engage the family, be sensitive to the role of the family and extended family, and include family members in the decision-making process.
9. Develop comfort in discussing issues of shame and humiliation resulting from the stigma of illness. Explore whether it is difficult to talk about their problems in public rather than just say, Tell me about your problems.
10. Conduct a thorough, culturally modified assessment, with sensitivity to non-native language status and cultural appropriateness of test-items. Test findings may need careful interpretation within the client’s sociolinguistic context.

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References


