

Asian Culture Brief: India

A collaborative project between NTAC-AAPI and the Center for International Rehabilitation Research Information and Exchange (CIRRIE) at the State University of New York at Buffalo

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The purpose of this brief, developed as part of a series of Asia and Pacific Island culture briefs, is to present readers with a quick overview of the Indian culture and to introduce references that will provide more in-depth perspectives. It is adapted from: Pinto, P. E., & Sahu, N. (2001). *Working with persons with disabilities: An Indian perspective*. Buffalo, NY: Center for International Rehabilitation Research Information and Exchange (CIRRIE).

Introduction

Despite 1.7 million people in the US identifying themselves as Asian Indians or Indian Americans in the 2000 Census,¹ Indian immigrants are not highly as a group in America because they usually speak English...and values acquired in India prior to immigrating to the US.

Despite their numbers, however, Indian immigrants are not highly visible as a group because they usually speak English and do not tend to concentrate in distinct neighborhoods. Moreover, because many are highly educated there may be a perception that their assimilation into American culture is an automatic by-product of that education. But not all Indians in the US are highly educated or successful professionals. Even among those who do fit that profile many maintain customs, traditions, and values acquired in India prior to immigrating to the US. Also, it is not uncommon for Indians who have settled in the US to bring aging parents to live with them who may not have previously lived abroad and do not always speak fluent English. They may find some aspects of life in the US confusing or unsettling, including rehabilitation service systems.

Since each region of India (and sometimes each state) has its own language, dress, diet, and customs, it would be difficult for rehabilitation service providers to be well informed about all variations of these cultural components. However, an understanding of certain core values underlying Indian culture would enable them to begin to appreciate the needs and wishes of Indian consumers within the context of that culture. The purpose of this brief is to provide an introduction to such a perspective.

Profile of Indian Immigrants

Roughly 83 percent of Indian immigrants are Hindu, reflecting their proportion in India, with another 14 percent Muslim, and about 3 percent from other religious groups. Most who have come to the US since 1965 speak English. By state, California has the largest Indian population, followed by New York and New Jersey. In the last 10 years, the largest

increase in Indian population has been in the west and in Florida, possibly because of climate and job opportunities.¹

Role of the Family

While extended families may be the traditional norm in India, the nuclear family is the basic unit of family organization in the immigrant population. It includes the male head of the house, his wife, and unmarried children. Some households may also have older parents or an unmarried brother or sister of the husband or wife. Joint households (i.e., those with extended family) are viewed as temporary, a result of family obligations and hospitality afforded newly arrived immigrants. Kinship obligations also go beyond the immediate family and secondary kin. Indians feel quite comfortable availing themselves of the hospitality of other Indians, whether related or not.

Customs

Forms of address: The suffix *ji* (pronounced “jee”), is appropriate for both sexes, regardless of age, and for almost any occasion. It can be attached to a given name as in “Michael-ji”, “Diane-ji”, or “Jones-ji”. A more familiar (though more humble) suffix is *sahab* (pronounced “saab”, like the car). It can also be used with titles (e.g., “Doctor- sahab” or “Professor-sahab”).

People older than you are never addressed by first names. Their names are often followed by *aunty* or *uncle* (e.g., “Sheila Aunty”), whether they are related to you or not. Teachers and professors are always *Sir* or *Ma’am*, with these forms of address often persisting well after graduation, out of respect for authority.

Greetings: The traditional Indian greeting *namaste* is uttered while joining palms together (as if in prayer) under the chin, slightly nodding the head, and looking down. In business meetings however, a firm handshake is most appropriate. When expressing sincerity or when saying goodbye, both hands may be used to clasp the other’s hand. There is one caveat however: most Indian women are unlikely to follow suit. The rule of thumb is to wait for the woman to offer her hand in greeting. If she does not do so, respond with a polite half bow and a simple “hello”.

Indians are not in the habit of saying “Good morning”, “Good night”, or “Thank you.” Rather, the greeting *namaste* (pronounced “nu-musth-ay”) is a catch all and could pass for “Thank you”, “See you soon”, or “Good morning.”

Embracing members of the opposite sex is unacceptable. However, members of the same sex may embrace or hold hands if meeting after a long time or on special occasions. In general, public displays of affection are not encouraged. Deliberately touching someone you do not know very well, even as a friendly gesture, will only serve to make an Indian uncomfortable.

Marriage: Marriages are often arranged alliances negotiated between parents. Strategic issues are considered. Is the boy or girl from the right caste; from a good family? Does the potential groom have a good job, good character, and reputation? What assets (e.g., jewelry, cash, furniture) does the bride bring in her dowry? Among educated and less traditional families, it is now more acceptable to choose a spouse on one’s own. However, arranged marriages and the customary dowry are still the norm. When their spouses die, women usually do not remarry. Widowhood is considered the end of “normal” life although no such restrictions apply to men.

Other Customs: The *bindi* (or dot) on women’s foreheads, is an adornment comparable to wearing makeup. Today, not all women wear a *bindi* on a day-to-day basis; doing so is often a matter of personal choice. Some Indian women decorate their hands and feet with patterns using henna (a red dye) to mark special occasions like weddings or festivals. This is a form of adornment.

Time

Indians are among the least time conscious people in the world. Call it philosophy or cosmology, but the average Indian believes things will happen when they have to happen.

The Concept of Disability within the Culture

Families are reluctant to report disability. Negative attitudes toward disabilities prevail in most communities. The major shifts in thinking about people with disabilities that have occurred in the West have only recently started taking place in India. Although exposure to disabled people in India is common, the contact is very different from that in Western society. Walking the streets in India exposes one to people with severe impairments (e.g., leprosy, amputations, and blindness). These people often use their impairments to solicit money. Consequently, people with disabilities are often pitied, shunned, supported by charity, and are often considered inferior. Furthermore, most adult Indians have not attended school with people with disabilities since integration is only beginning to be implemented in Indian schools.²

Acquired Versus Lifelong Disabilities

Although families go through the natural process of shock and grief when a child is born with a disability, in Indian culture it is accepted as one's fate or destiny. The belief in karma, or payment for past deeds, underlies the accepting spirit. Because rehabilitation services are not easily available to the majority of the population in India, little help is sought for children with lifelong disabilities. Economic hardship, poor transport facilities, and a lack of education make it harder for the parents to access services for their child.³ Indians also see their children as investments for the future. When a child is born with a disability, they do not see that child as a source of support or income in the future. Hence, they would rather spend their income on the healthy children, especially if they are male.

When a person acquires a disability, however, people are more sympathetic since they think of the person's level of function prior to the illness or injury. If there is hope that the person will be fully functional again, efforts are made to provide services.

The Concept of Independence within the Culture

Disabilities are not only problems for the person with the disability, but are family disabilities. The family copes with the demands and special needs of the person by providing daily care, arranging schedules, and ensuring compliance with treatment. The stress is shared by the whole family, especially the women in the household. Significant disruption of family routine, leisure, and interaction can be expected.³

Empowerment of the individual – a Western construct – is considered a selfish and undesirable goal. Altruism – for the sake of the family and the larger society – is highly valued. Women carry this burden much more than men. Disabled women are further burdened because of their gender. The most severe expressions of gender discrimination are found in the field of disability; often cutting across social, economic, political, and cultural dimensions.

Consumers and Service Providers: Implications for Service Provision in the US

Indians tend to respect the authority of health care providers and feel their own role is passive. Depending on the level of acculturation, the relationship with the provider in the US can be expected to remain at a formal level. The consumer or the family may not ask questions or dispute the recommendations

made by the provider; to do so is seen as impolite and inappropriate. If the treatment is at odds with the family's belief system, they are likely to ignore the suggestions rather than voice their opinions or question the provider. This decision might be observed in actions such as missed appointments or excuses for not following treatment plans.

Clients and families expect the provider to be confident in proposing the treatment plan and to be concrete about the treatment process. Indians are generally unaccustomed to being informed of every aspect of treatment. The Western model of informing patients can lead to confusion and fear. By offering a variety of choices of treatment, the provider may be seen as incompetent for not knowing the right one.

With respect to the concept of *karma*, disabilities and chronic illnesses may be attributed to destiny or actions in a past life – essentially beyond one's personal control. This can have a direct effect on referrals and treatment. For example, in early intervention programs compliance may be difficult to establish. The family may see the situation as a test of their responsibility and duty to care for their child rather than an opportunity for the child to work towards maximizing his potential and abilities.

During medical procedures, it is important for Indians to have same sex health care providers. This is especially true for procedures or exams involving genitals, rectal, or pelvic exams. In the rehabilitation process, clients are more likely to accept same-sex service providers.

Because of the shame associated with mental health problems, families often refuse to seek professional help until a state of crisis is reached. The healthcare provider should be prepared to make an immediate assessment and understand the shame felt by families.

Recommendations to Rehabilitation Service Providers

(The provider is cautioned not to generalize. As with all groups, there is great diversity across individuals.)

- Addressing the client: Begin with a formal introduction. Then ask how they would like to be addressed. Indians generally do not use first names, except among peers.
- Verbal exchanges: Be direct and simple. Offer opportunities to ask questions but do not push.
- Explaining the treatment plan: Risks should be discussed with positive reassurances.
- Clients who need hospitalization: Consult family members – they may play a larger role in determining the progression of treatment than the client.
- Mental illness: Service providers should be prepared for a crisis at the first meeting.
- Service providers should avoid ambiguous suggestions or too many options. Indians often prefer concrete solutions. Offer opinions rather than asking clients what they want to do.
- Avoid unnecessary physical contact.

References

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