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Barriers to and Facilitators of South Asian Indian-Americans' Engagement in Advanced Care Planning Behaviors

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Abstract

Purpose—To identify barriers to and facilitators of older South Asian Indian-Americans' (SAIAs') engagement in behaviors associated with advance care planning (ACP).

Methods—Using a descriptive qualitative design guided by the transcultural nursing assessment model, data were collected in focus groups of community-dwelling older SAIA participants, SAIA family caregivers, and SAIA physicians. A directed approach using predetermined coding categories derived from the Transcultural Nursing Assessment model and aided by NVivo 10 software (Melbourne, Australia) facilitated the qualitative data analysis.

Results—Eleven focus groups with 36 older SAIAs (61% female, 83% 70+ years old), 10 SAIA family caregivers, and 4 SAIA physicians indicated prior lack of awareness of ACP, good health status, lack of access to linguistically and health literacy–tailored materials, healthcare provider hesitation to initiate discussions on ACP, trust in healthcare providers' or oldest sons' decision making, busy family caregiver work routines, and cultural assumptions about filial piety and after-death rituals as major barriers to engaging in ACP. Introducing ACP using personal anecdotes in a neutral, group-based community setting and incentivizing ACP discussions by including long-term care planning were suggested as facilitators to engage in ACP.

Clinical Relevance—The study's findings will guide development of culturally sensitive interventions to raise awareness about ACP among SAIAs and encourage SAIA older adults to engage in ACP.

Keywords

Advanced care planning; focus group; South Asian Indians

Advanced care planning (ACP), defined as planning ahead for treatment during severe illness or end of life, involves informal discussions with family members, health-care providers (HCPs), and important others about the kinds of care that will be considered appropriate when a patient cannot make decisions (Institute of Medicine [IOM], 2015). ACP encompasses not only preparation of legal documents such as advanced directives or health-care proxies, but also discussions with family members and physicians about what the future may hold for people with serious illnesses, how patients and families want their beliefs and preferences to guide decisions, and what steps might alleviate concerns related to finances, family matters, spiritual questions, and other issues that trouble seriously ill or dying patients and their families (IOM, 2015). When patients engage in ACP, surrogate decision makers are five times more likely to know patients' preferences for care (Kirchhoff, Hammes, Kehl, Briggs, & Brown, 2010), and conflicts between family members and HCPs during end-of-life discussions are reduced (Song, Kirchhoff, Douglas, Ward, & Hammes, 2005). Moreover, it has been found that patients who had end-of-life discussions with their physicians had 35.7% lower costs of care than did patients who did not have such discussions (Zhang et al., 2009).

Culture is an important factor for ACP (Kwak & Haley, 2005), and effective ACP is therefore particularly important for minority communities. South Asian immigrants, for example, are one of the fastest growing minority communities in the United States, with a growth rate of 69.37% from 2000 to 2010 and a population of 3.5 million, of whom Asian Indians make up 2 million (Hoeffel, Rastogi, Kim, & Hasan, 2012). South Asian Indian-Americans (SAIAs) comprise American-born Indians and immigrants of Indian origin from India, the United Kingdom, Africa, and the Caribbean nations. Yet despite the growing numbers of SAIAs in the United States, only two small studies have explored end-of-life preferences and advance directives in this population (Rao, Desphande, Jamoona, & Reid, 2008; Sharma, Khosla, Tulskey, & Carrese, 2012) and have done so only with SAIAs fluent in English. In a study assessing advanced directive rates among Asian-Americans in central Texas (Jang, Park, Chiriboga, Radhakrishnan, & Kim, 2016), where the present study was also based, only 10% of SAIA participants reported completing advanced directives. Little is known about the barriers and facilitators related to ACP among SAIAs or about culturally sensitive strategies to engage older SAIAs and their families in the ACP process. Encouraging older SAIAs to participate in ACP discussions can empower them to communicate their preferences for care at the end of life or during periods of severe illness before they become too incapacitated to express such preferences. There is an urgent need for research to understand SAIAs' awareness of ACP, to identify the information that they need as well as facilitators for their engagement in ACP, and to tailor the ACP process to SAIAs' unique cultural context. The purpose of this study is to identify barriers to and facilitators of older SAIAs' engagement in behaviors associated with ACP.

Theoretical and Conceptual Framework

Traditionally, interventions for ACP have focused on providing patients and their surrogates with standardized information and forms (Bravo, Dubois, & Wagener, 2008). However, ACP is increasingly being recognized as comprising interrelated health behaviors that include

clarification of values; communication among patients, surrogates, and clinicians; and completion of written directives (Fried et al., 2010). As SAIA individuals can vary in their motivations, barriers, facilitators, and self-efficacy regarding their participation in ACP, the transcultural nursing assessment model (Giger, Davidhizar, & Fordham, 2006) was used to guide identification of the contextual aspect related to older adult SAIAs' ACP behaviors. The transcultural nursing assessment model provides a framework to collect and organize cultural information on SAIAs' ACP behaviors related to end-of-life concerns, completing advance directives, and communicating preferences for end-of-life care around six phenomena: (a) communication, (b) time, (c) space, (d) social organization, (e) environmental control, and (f) biological variations (Giger et al., 2006). The phenomenon of communication is concerned with decision making in the family, trust of healthcare providers or family members, and preference for communication on ACP behaviors and end-of-life issues. The phenomenon of time is concerned with past, present, or future time orientation for engaging in ACP behaviors. The phenomenon of space is concerned with impact of family closeness or proximity as well as location preference on engaging in ACP behaviors. The phenomenon of social organization is concerned with function of the cultural and religious institutions, role of family caregiving, and cultural preferences for after-death rituals on engaging in ACP behaviors. The phenomenon of environmental control is concerned with perceptions on internal and external locus of control as well as financial control on engaging in ACP behaviors. And finally, the phenomenon of biological variation is concerned with impact of health status and tolerance towards pain and suffering on perception and engaging in ACP behaviors (Giger et al., 2006).

Methods

A descriptive qualitative design was used to explore determinants of SAIAs' engagement in ACP behaviors. Data were collected in focus groups of community-dwelling SAIA older adults; participants were recruited from two SAIA senior citizen community-based organizations in central Texas and were fluent in at least one of the three languages of English, Hindi, or Gujarati; Hindi and Gujarati are the most commonly spoken Asian-Indian languages in the United States (Terrazas & Batog, 2010). The two SAIA community-based organizations invited the first author to introduce and explain the study during one of their weekly meetings, at which recruitment flyers in English, Hindi, and Gujarati were distributed. The Institutional Review Board of the University of Texas at Austin approved this study.

Focus groups were also conducted with physicians of SAIA origin and family caregivers of SAIA older adults living in the United States, who were recruited using word of mouth referrals and suggestions from SAIA community leaders. All focus groups were scheduled for 90 min and conducted at a public City of Austin facility or participants' homes until data saturation was attained. The data collection period lasted from March to September 2015. The focus groups were conducted by the first author, who is well trained in qualitative research and has conducted several qualitative studies with older adults.

Participants were told that quotes from the focus groups might subsequently be used in publications to illustrate themes that were heard across all the groups; however, pseudonyms

would be used and any identifying information would be removed. Eight focus groups were conducted in English, and three were conducted in Gujarati and Hindi, depending on participants' native Indian language preferences. A demographic survey was used to collect participants' age, gender, education level, income level, insurance status, and duration of stay. Due to the small number of physicians of SAIA origin in central Texas, we have not included physician participants' demographic data in this article in order to protect their confidentiality.

The focus group questions were in a semistructured format and were guided by Giger and Davidhar's transcultural nursing assessment instrument (Giger et al., 2006). The focus group questions addressed (a) barriers and facilitators related to participants' understanding and preparation for severe illness events; (b) participants' understanding of ACP and awareness regarding access to ACP-related resources; (c) barriers and facilitators to engage in ACP behaviors; and (d) culturally appropriate strategies to engage SAIA older adults in ACP behaviors. Follow-up questions were used to clarify participants' responses as needed.

All English transcripts were transcribed by a professional transcription service. All non-English (Hindi or Gujarati) transcripts were transcribed by an SAIA community member who was unconnected with the study, well-versed in all three languages, and a professional transcriber for Indian languages in the Texas court system. All transcripts were cross-checked for any errors or omissions by the first author, who is also fluent in English, Hindi, and Gujarati.

Qualitative Data Analysis

The English transcripts were analyzed by the first author and a graduate nursing student trained in qualitative analysis. Aided by NVivo 10 software (Melbourne, Australia), a directed approach in which a theory or relevant research findings guides initial codes (Hsieh & Shannon, 2005), was used for qualitative content analysis of the focus group data in this study. Existing theory can provide predictions about the variables of interest or about the relationships among variables, thus helping to determine the initial coding scheme or relationships between codes (Mayring, 2000).

Predetermined coding categories derived from the transcultural nursing assessment instrument were used to code key words or phrases that appeared to convey attitudes or perceptions about ACP behavior and their determinants. Coding reports were summarized and cross-checked to ensure consistency of interpretation. Whenever divergent interpretations occurred, transcripts were reviewed again and discussed until consensus was achieved on the subthemes and themes.

For the non-English transcripts, the first author summarized each transcript in English and coded the translated summary using the predetermined coding categories. She then cross-checked her translation and coding with the SAIA community member who had earlier transcribed the transcripts. This method was used due to the scarcity of professionals fluent in the three languages of English, Hindi, and Gujarati.

Results

The 11 focus groups were composed of 36 older SA-IAs (61% female, 83% 70+ years old), 4 physicians of SAIA origin (75% male), and 10 family caregivers of SAIA older adults. Descriptive information and statistics for the SAIA older adults and SAIA family caregivers are provided in Table 1.

Qualitative Themes

The themes and subthemes for SAIAs' engagement in ACP behaviors were based on the six concepts of communication, time, space, social organization, environmental control, and biological variation in the transcultural assessment model. Inter-rater reliability for the eight English transcripts was 0.73. Inter-rater reliability for the non-English transcripts was 0.97. Total inter-rater reliability for all transcripts was 0.91.

Communication—Communication that can support SAIAs' engagement in ACP were impeded by several barriers. Lack of any prior awareness of ACP, as well as having received printed ACP forms from HCPs without any discussion about the purpose and benefits of ACP discouraged communication on ACP. Lack of communication protocols among physicians led to uncertainty as to whether a primary care physician or a specialist should provide ACP information. Physicians also feared alarming their patients about their health status by providing information on sensitive topics such as end-of-life care during routine visits. Uday, a male SAIA cardiologist, for example, said,

As physicians we are there to save lives, right? Make them better. We often are not doing the other side. So we're not talking about them dying. We're talking about them living. So that's always a focus. So generally we don't bring up that discussion because when you put that, it's considered negative for the patient.

Many older adult SAIA participants further confirmed that they had never received any information on ACP during their interactions with the healthcare system, whether during hospital stays or during visits to physicians.

Misconception about the ACP process was revealed as older adult SAIA participants reported fears of being denied basic health care during traumatic events such as accidents if they completed ACP forms. In addition, complete trust in adult children's (oldest sons') or the HCP's medical decision making were also barriers to engagement in ACP. Family caregivers feared engaging in ACP discussions with their older parents as that might foster their parents' suspicions about their care being burdensome to their children. Thus, for example, Shilpi, a 49-year-old woman, remarked that "the challenge became my brother didn't want to raise that topic because he didn't want dad to think that he's after dad's wealth."

Prior awareness of ACP through discussions with family members who were HCPs or with physicians who were aware of the SAIA culture was a facilitator for engagement in ACP discussions. Prior experience with difficult end-of-life decision making as well as lack of trust in HCPs' decision making were facilitators for engagement in ACP. For example, Indira, a 65-year-old female SAIA participant, remarked as follows:

The life support, yes. If it comes to that, if they have to put me on life support, please don't do that because now my sister's daughter and mother is having the same problem. She was sick too. She was in the hospital for 3 months now. Now, she's gone to kidney failure. But the daughter can't take the responsibility. She can't shake and let go. She's still holding onto her. The doctor has given her there's no hope. So I don't want that.

Jignesh, a 72-year-old man who felt that his previous coronary artery bypass graft surgery had been unnecessary, reported that "Doctors in US can do anything and children can't say anything. Therefore, the living wills can be protective." At the same time, there were some older adult SAIA participants who reported that they trusted their physicians implicitly and, on further probing, reported sharing a pleasant rapport with the physicians whom they trusted.

Many older adult participants reported conveying their end-of-life wishes orally and informally, as opposed to using written forms. Participants who were not fluent in English also preferred receiving paper brochures with ACP information in their own language. Some older adult and family member participants suggested that discussions on financial or long-term care planning might serve as contexts to initiate discussions of ACP either personally with lawyers or on a community level.

Time—Lack of time available to discuss ACP with relevant decision makers such as their physicians or with their adult children was a major constraint reported by participants. Their adult children had busy work schedules and daily routines, and physicians were restricted by the current healthcare reimbursement model, which favors episodic care. Physicians did not even consider the current Medicare policy of reimbursing end-of-life discussions to be an incentive, because reimbursement amounts were too small to justify time for such discussions. As Rema, a female Indian primary care physician, pointed out,

If the patients came to see me, I have 15 minutes. First of all, first 5 minutes you have to get them an exam to be able to talk. Well, there's your 5 minutes gone. Then you take a list of drugs they're taking. That's another 5 minutes gone. So, you'll be lucky to spend 20, 25 minutes. And then you get into this discussion and you're going to feel so hurried. They're going to say, "Okay. So doctor, you want me to die now?"

At the same time, the onset of severe illness or a deterioration in health status either in patients or in elderly parents were considered to be suitable moments to begin discussion of ACP with SAIAAs. Aslam, for example, a 57-year-old physician, said:

My father-in-law is 74 now. My wife believes that he's developing some early Alzheimer's. With him we don't know yet, how he will progress. But certainly that will, I think soon we need to have a conversation with him about what he wants to do.

Space—Participants indicated that both geographical and emotional proximity of loved ones would facilitate engagement in ACP. Participants had mixed feelings about receiving initial ACP information from physicians in clinic settings, and they suggested that neutral,

community-based group settings would be non-confrontational contexts in which to initiate discussions about ACP. As Aarushi, a 47-year-old woman, explained,

One might have town hall meetings, at library, that sort of thing. Where we give out this information. Then, it's easier to approach it with the family member who comes with the elderly person. Then it's easier to, when you're going home, and then the mother also maybe there, may feel comfortable, talking about it because it has become an open issue now.

Participants' preference to receive end-of-life care in the hospital due to prior positive experience, concerns about complicated caregiving at home, uncertainty about location of receiving end-of-life care whether in the United States or in India, as well as preference to receive end-of-life care in India, were all major barriers for older adult SAIAAs to engage in ACP. Thus, for example, Seema, a 51-year-old woman, referred to having two people looking after him, because he's completely dependent. "In India it's easy for that kind of care. Somebody, taking him to the bathroom, somebody running the house, cooking this, that. For me to have him here it would be really, really difficult."

Participants' preference to receive end-of-life care at home as well as openness to the hospice model were facilitators to engage in ACP discussions. Anand, for example, an 85-year-old man, said that "I am afraid to be in a hospital and scared for myself. It is much freer to be in my home, but movements are restricted in a hospital. Nobody visits you in a hospital except the doctors."

Social organization—Although participants did not express discomfort about participating in this study, they did admit that a lack of cultural precedence in planning about end-of-life care as well as a cultural hesitance to talk about death or discuss private issues especially in families with older patriarchal parents were social barriers to engagement in ACP. As Joy, a male primary care physician, said,

Our culture is, if I have a problem, I need to figure it out. Let's keep it under the rug. I'll find some solutions, but I don't want to talk about it. We came from society we never talked about anything.

Another SAIA family member, Aslam who is also a physician, said,

Self-esteem and the role of a parent in the household of the Asian culture is different to an Indian than it is in US. And respect for the elder and so on. So, out of full respect for him we have not made the decision to have that conversation.

Expected protocols for after-death rituals such as cremation for Hindus were also barriers to engage in ACP discussions. For example, the 57-year-old male physician Aslam clarified,

Especially in the Indian community there's no need to make preferences known because it's a closed unit—there isn't that special need to have that discussion with the parents about what, how would they like end-of-life to proceed. Because say if it's a Hindu then they would like to be cremated and that's just expected.

On the other hand, a strong preference for organ donation was an incentive to engage in ACP. Arvind, a 72-year-old man, stated that "There should be a 'will' where I can say that

my body has to be used by somebody. One should donate their body and that's one reason for the will."

Cultural assumptions about filial piety—the expectation that children should financially, physically, and emotionally care for older parents—were a barrier to engagement in ACP. However, a realization of changes in filial piety, wherein adult children can no longer be expected to provide complete care for their older parents, was a significant motivator for engagement in ACP. The SAIA primary care physician Joy observed,

The younger generation, the younger children think it's burdensome to look after your parents. They don't want to take that responsibility. So increasingly those parents will have to go somewhere, some facility, nursing home where they'll get information anyway. I think that that's what's going to happen in our culture eventually.

In addition, participants suggested confusion about the role that cultural institutions might play in engaging SA-IAs in ACP. For example, even though places of worship such as temples are frequent gathering places, the role of priests as counselors to initiate discussions about ACP in the community was unclear. At the same time, however, regional cultural organizations or influential cultural leaders were considered appropriate to introduce ACP to the SAIA community and encourage their engagement in ACP.

Environmental control—Some participants who had received high-quality care through Medicare perceived no need to plan for end-of-life care; they felt that all their expenses would be covered by their medical insurance. However, participants who knew that they lacked resources for caregiving and were aware of the financial expenses involved in end-of-life care stated a dire need to engage in ACP. Thus, Visalam, a 78-year-old woman, said,

Who is going to take care of us in that old age, because our children are all working? They have their own career. There can be a lot of monies involved in the treatment. Very expensive, very, very expensive. They cannot spend out of their pocket. So that gets our apprehension. That's our fear in the back of our mind. What if we all fall sick? How are they going to cope with it?

External loci of control such as feelings of fatalism could preempt participants' need to engage in ACP. Narendra a 68-year-old male community leader, pointed out,

Coming from the Indian perspective and the way the culture, the religion and everything governs you is it will happen. There's always a way. There's a planned way, it's going to take place. I think that's the idea and that's why they don't attach so much importance to it.

Biological variation—Perceptions of pain, suffering, and quality of life significantly influenced participants' beliefs about ACP engagement. A strong preference for quality of life as opposed to longevity, as well as a belief that prolonging life-sustaining treatment in the face of suffering would be tough on one's children, indicated high levels of readiness to engage in ACP. Anil, a 74-year-old man, remarked that "Everybody has a confirmed expiry date. It's better to respect that." Pramila, a 66-year-old female participant, remarked that

“We are dead to the world, but they’re suffering because they’re looking at us. So we don’t want that for them.”

Discussion

This study is one of the first in which we have identified barriers and facilitators related to engagement in ACP among SAIAs, an understudied ethnic minority. Overall, participants acknowledged the importance of engaging in ACP but reported several barriers such as prior lack of awareness regarding ACP, good health status, lack of access to linguistically and health literacy–tailored materials, HCP hesitation to initiate discussions about ACP, trust in HCPs’ or oldest sons’ decision making, busy family caregiver work routines, and cultural assumptions about filial piety and after-death rituals.

Knowledge about ACP through this study appeared to increase older adult SAIA participants’ motivation to engage in ACP, irrespective of their duration of stay in United States in this study. However, despite frequent interactions with the healthcare system, they had been unaware of ACP until they participated in the study, because no HCPs had discussed ACP with them. This was in part due to physicians’ limits on time. Additionally, physicians’ hesitation to address ACP could also have been caused by linguistic and cultural barriers, resulting in a disparity in the completion of advanced directives for SAIAs. Older SAIAs who did not speak English referred to a lack of educational materials in Hindi or Gujarati in the state of Texas, which meant that they had to depend on someone else to explain such concepts to them orally. In addition, despite recently established Medicare policies to reimburse physicians for ACP discussions, physicians in this study were hesitant to talk about ACP during routine visits because they feared scaring patients and lacked time to assure them. Specialists such as oncologists who manage terminal diseases routinely addressed ACP during patients’ visits, as was also seen in the study by Periyakoil, Neri, and Kraemer (2015). Yet waiting for the onset of a severe health crisis or a terminal disease may be too late to initiate ACP for many SAIAs. Dedicated personnel such as nurses or social workers in healthcare offices could initiate discussions of ACP with older SAIAs in order to raise awareness of ACP; such counseling could allow longer meetings to address concerns and reduce possibilities of fearful or confrontational discussions with physicians. Making the effort to develop a rapport with older SAIA patients and addressing their concerns can also provide opportunities to HCPs to introduce ACP-related concepts. There is also an urgent need to develop and disseminate linguistically and health literacy–tailored materials on ACP for the SAIA population, especially in Hindi and Gujarati.

Traditional role expectations and filial duties were a barrier for family members to initiate ACP discussions with their older parents. However, awareness of the realities of the U.S. healthcare system and the low availability of caregiving resources increased older adults’ intention to engage in ACP because they wanted to relieve their children of the burden of difficult decision making; this has been found in other Asian-American studies as well (Ko & Berkman, 2012; Sharma et al., 2012). Even though the focus group questions addressed ACP, almost all of the participants commented on the low availability of culturally appropriate resources for taking care of loved ones with severe illnesses at home in the US. Such concerns motivated them to consider reasonably priced final care in India, which was a

barrier to their engagement in ACP in the United States. For this reason, as well as a lack of estate planning in this population (Sharma et al., 2012), some participants suggested that long-term care planning sessions might be used to induce discussions about ACP in order to increase awareness and rates of completed ACP forms.

This is the first study to have included older adult SAIA participants who emigrated to the US as a result of family reunification policies for immigration. Such older adults lack employment experience in the US and typically tend to be dependent on their children financially as well as for transportation and for navigation of the healthcare system. Therefore, initiatives to raise awareness about ACP among SAIAs must include their adult children because they play an important role in decision making and planning (Ko & Berkman, 2012). Suggestions to increase the rate of ACP in the SAIA community included raising awareness of ACP within a neutral, community-based group setting using personal anecdotes. Once the topic is in the open, patients could consult with their physicians or initiate discussions with their family members, including their adult children or older parents, for decision making. A model centered on *whanau* (Maori-language word for extended family) in which ACP is addressed much earlier in the healthcare process and within the community setting (Frey, Raphael, Bellamy, & Gott, 2014) or innovative community engagement exercises using conversation games can also help introduce the importance of ACP in the SAIA community (Van Scoy, Reading, Scott, Green, & Levi, 2016). Multiple doses of interventions involving a variety of media such as seminars, websites, smart phone apps, and printed ACP materials could further help increase SAIAs' engagement in ACP.

Limitations

Although we are confident that our methods of data collection and analysis allowed us to achieve data saturation for our themes and ensured trustworthy results, the analysis was based on data from participants who volunteered for the study. The results and subsequent conclusions represent the sample from which they emerged, so they cannot be generalized to other situations or SAIA populations without caution. However, to the best of our ability, we recruited SAIA participants diverse in their linguistic abilities, socioeconomic status, duration since immigration, and level of acculturation, all of which should enhance the generalizability of our results to other South Asian populations. Strengths of the study include the triangulation of the findings, enabling cross-checking of information in the collected data, facilitated by involving older adult SAIAs, their family members, and SAIA physicians.

Conclusions

This study revealed SAIAs' unique information needs and preferences related to engagement in ACP behaviors. This study's findings can help guide nurses and other HCPs to develop culturally sensitive interventions to raise awareness about ACP among SAIAs and encourage SAIA older adults to engage in ACP behaviors. This will empower SAIA older adults to communicate their end-of-life preferences to family members and HCPs, preventing

unnecessary and unwanted treatment, and improving overall satisfaction with care at the end of life.

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Clinical Resources

- ACP Decisions: <https://www.acpdecisions.org>
- National Hospice and Palliative Care Organization: CaringInfo: <http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3277>
- National POLST Paradigm. Advance care planning resources: <http://polst.org/other-resources/>

Table 1

Demographic Characteristics of Participants

Characteristics	Older adults (n = 36), n (%)	Family members (n = 10), n (%)
Age (years)		
40–49	0	1 (10)
50–59	0	7 (70)
60–69	7 (19)	2 (20)
70–79	20 (56)	0
80–89	8 (22)	0
>90	1 (3)	0
Female gender	22 (61)	7 (70)
Education		
Missing	2 (6)	0
High school or lower	11 (31)	0
Some college	6 (17)	0
Bachelor's	10 (28)	1 (10)
Graduate	7 (19)	9 (90)
Marital status		
Single	1 (3)	1 (10)
Married	30 (83)	7 (70)
Widowed	5 (14)	1 (10)
Divorced	0 (0)	1 (10)
Religion		
Hindu	33 (92)	8 (80)
Sikh	3 (8)	0
Muslim	0	1 (10)
Christian	0	0
Jain	0	1 (10)
Time in United States (years)		
<5	5 (14)	5 (50)
5–10	3 (8)	1 (10)
11–20	13 (36)	1 (10)
>20	15 (42)	3 (30)
Income		
Refused to disclose	3 (8)	1 (10)
<\$5,000	12 (33)	1 (10)
\$5,000–\$34,999	18 (50)	0
\$35,000–\$49,999	1 (3)	0
\$50,000–\$74,999	2 (6)	8 (80)
>75,000	0	
English language fluency	17 (47.2)	10 (100)