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Perils and Pitfalls of OT Research in a Foreign Country: A Reflection

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Cover Page Footnote
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Occupational therapists from developed countries have increasingly traveled to developing countries to undertake practice and research (Ekelman, Bello-Haas, Bazyk, & Bazyk, 2003; Hansen, 2013). While the importance of assessing the effectiveness of such interventions has been documented (Hayward, Li, Venere, & Pallais, 2015), it is also important to document the pitfalls that can ensue (Reisch, 2011). Little research has been available in the literature regarding challenges encountered when conducting research in a foreign country. The purpose of this paper is to use narrative and thematic analysis of field notes and personal reflections to explore the perils and pitfalls of conducting occupational therapy (OT) intervention research in a foreign country.

Background and Significance

In August 2014, a U.S.-based team of investigators completed a research project in Belize regarding a falls prevention intervention, which was conducted in partnership with local Belizean agencies (Howard, Beitman, Walker, & Moore, 2016). Many methodological pitfalls occurred during the data collection, which prompted me, the primary investigator, to reflect on the experience. During the data collection process, I kept a reflective journal. Analysis of the reflective journal and other field notes yielded recommendations for future investigators in capturing data on the effectiveness of interventions provided in a foreign context, while maintaining an ethical relationship with community partners and study participants (Reisch, 2011).

In the reflexive process, narrative storytelling emerged as a powerful tool to understand experiences and to generate recommendations. Narrative analysis is grounded in the belief that health care professionals use stories in the clinical reasoning process (Mattingly, 1991). Narrative has also been used in the inquiry process to add the texture of a personal voice to analytical writing (Wertz, Nosek, McNiesh, & Marlow, 2011), make sense out of lived experiences (Monrouxe, Rees, Endacott, & Ternan, 2014), revise perspectives (Mattingly, 1991), and find meaning in both familiar (Jenstad & Donnelly, 2015) and unfamiliar contexts (Ekelman et al., 2003; Fisher & Hotchkiss, 2008). Narrative reflections have also been used to explore emotional experiences and develop relationships with global partners (Main, Garrett-Wright, & Kerby, 2013).

Literature on methodological pitfalls in health care intervention research has further provided a context for reflection on the challenges that arose during the data collection. Investigators have identified logistical concerns (Lee, Hayes, McConnell, & Henry, 2013), the challenges of mixed methodology (Kahlke, 2014), unpredictability in qualitative data collection (Marshall & Edgley, 2015), and the need for flexibility and ongoing self-reflection (Ortlipp, 2008) as among the pitfalls that can occur.

As occupational therapists and OT educators have become more active in international practice, it has become increasingly important to address the challenges to investigating the efficacy of international OT programs (Hayward et al., 2015; Reisch, 2011). Limited literature is available on challenges to establishing the efficacy of international OT intervention programs.

Method

The original study (Howard et al., 2016), including the collection of the field notes used in this study, was approved on June 24, 2014, by the University of Indianapolis Institutional Review Board (UIndy Study #0628) and on July 21, 2014, by the Institute of Social and Cultural Research in Belize (Permit No. ISCR/ H/2/27). Data collection for the original study occurred in August 2014 in three locations in the country of Belize.

During the data collection, I completed daily field notes and reflective journal entries in an electronic file format. To describe the experience of completing intervention research in a foreign context, I explored these documents with thematic and structural narrative analysis (Riessman, 2008; Wertz et al., 2011). I used techniques from the grounded theory tradition to complete data analysis, including multiple readings of the data, word frequency results, open coding of emergent themes, and constant comparison of the data (Fisher & Hotchkiss, 2008; Holton & Walsh, 2017; Riessman, 2008). Continued re-readings of the data with line-by-line analysis revealed thematic relationships. Cyclical reading and coding persisted until code saturation was reached. An audit trail was kept to document the sequence of data analysis and methodological decision making. Data were analyzed with QSR NVivo 10. To provide a rich phenomenological description of the data collection experience, I analyzed one reflective journal entry for structural narrative content. I applied the elements of story, including complicating actions and resolution (Riessman, 2008), to understand relationships among the themes.

Findings

I analyzed 15 documents for this study. The documents included all journal entries, field notes, and a final self-reflection. In analyzing the documents, I found that the themes told a story of conflict and resolution occurring throughout the research experience. During the first few days, the journal entries were upbeat with an excited and energetic tone. Words such as "excited," "awesome," "wonderful," and "thrilled" characterized these comments. The entries also included a sub-theme of "going"—a sense of industry, purpose, and directionality.

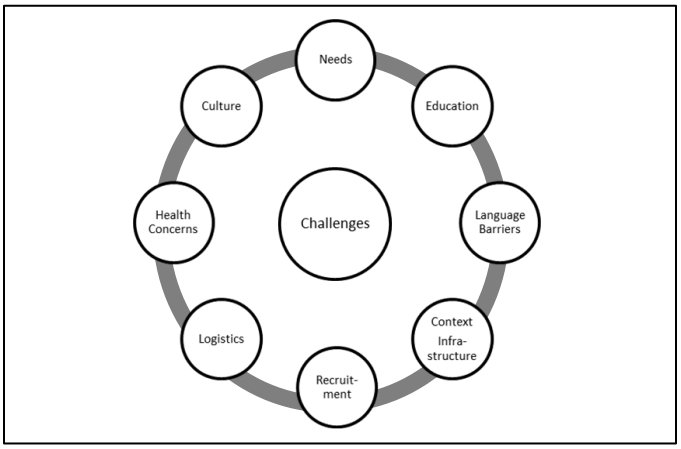

Figure 1. The theme of challenges and interrelated sub-themes.

The tone of the journal entries changed rapidly once the intervention began. The theme of challenges became by far the largest theme, with eight interrelated sub-themes (see Figure 1). Some of these challenges were anticipated, such as educational and cultural differences and a limited infrastructure as compared to that in a developed country. Unanticipated challenges included communication, extremely poor health literacy, logistics, time management, and cultural

expectations. These challenges left me with a feeling of chaos: "It is so difficult to be efficient when everyone is coming in late and in shifts, people don't understand the paperwork, and the room is crowded with multiple conversations going on in various languages" (Day 13). Educational limitations, together with language barriers and overwhelming health needs, further limited the ability to carry out the intervention.

> I had to do so much more explaining than I would with people in the United States. Literacy, and health literacy in particular, (is) very low in Belize; I had under-anticipated just how low the health literacy would be. I had never imagined that people would not understand the concepts of risk, "more likely," and percentages. I had not anticipated that there were quite a few health conditions and medications that they had never heard of and would need explained to them. Some of the difficulties may have been created by generational differences; the younger generations seemed to understand much better than the over-60 group. These challenges made data collection difficult. (Final Self-Reflection, Lines 29-37)

I summed up my experience on Day 5: "So many challenges exist. We can complete intervention, but is it really working?" Questions arose regarding efficiency in conducting the intervention, how to measure the intervention's effectiveness, and how to get past superficial responses to interview questions. These questions indicated there was much to learn: "I have more work to do in both educating the people and finding out more for myself how to relate to people culturally in Belize in order to help them hear and understand what I am trying to teach" (Final Self-Reflection, Lines 65-68).

Investigator assumptions and biases were further unveiled during careful reading of the data. Positive emotions were attributed to efficiency, productivity, and meeting schedules; and negative emotions were associated with comments such as "takes too long," "tedious," and "difficult to be efficient." This finding revealed Western values that link positive self-esteem to efficiency and productivity rather than to connectedness and mindfulness.

Despite the challenges, strengths emerged that would aid in a successful intervention. In this cultural context, people were often the greatest resource available to the participants: grandsons interpreted for grandmothers, nephews provided a leaning arm for going out in the community, and family members rigged up homemade modifications. "The human caring that goes on–we don't have that in the US. We can learn from the people here how to respect and care for our elders" (Day 4). The experience deepened my respect for people of other cultures and highlighted the importance of self-awareness regarding personal biases and assumptions. Remaining flexible and listening to the needs of others helped to overcome those biases. Resolution took the form of letting go of my agenda and expectations, truly listening to

those with whom I was present, trying to meet the needs in front of me, and observing the results. I tried to remain focused on the objectives that had first prompted me to pursue this research.

> I think it is important that we in the Western world do not keep all the health care knowledge and services to ourselves, but carry what we know to other places and educate health care workers to continue the message when we go home. It can leave one frustrated that we can't "fix" the problem, but if everyone does what they are able, we can make small differences in people's lives. Those small differences can add up to something big in the future. (Final Self-Reflection, Lines 71-76)

Structural analysis (Riessman, 2008) of the journal entry from Day 7 provided a rich description of the data collection process as it unfolded. Figure 2 provides an excerpt from the entry.

1	Here's how the day went: We started the day heading to	(Abstract)
2	(city) on the highway bouncing on the bus. After a few	(Orientation)
3	delays … we arrived at (day center), where there was the	
4	same mass chaos we encountered on Tuesday. Matron	
5	greeted me and told me that… there was some	(Complicating action)
6	confusion…. So, once again we had to sit down and	
7	figure everything out. Nurse C got really excited (about	
8	our intervention) and said we had to meet her friend	
9	Nurse R. So, she took (us) over to the hospital. There,	(Complicating action)
10	we walked all around the one-story structure and its	
11	courtyards, and found out Nurse R wasn't there….	
12	Then I asked Nurse C to take us to Miss G's house….	
13	She (Nurse C) then said she had to be going, and couldn't	
14	go on with us…. She is a volunteer.	(Complicating action)
15	(While at the second home) Mr. M called us to tell us our	
16	driver had to take the first group back, and he was going	(Complicating action)
17	to "try" to get (another driver) to come pick us up. The	
18	driver arrived before we finished. We went on to Mr. J's	
19	house, after stopping three times (at a store on the	
20	highway, a man's house, and another small village store)	
21	to ask where he lived. We finally found him. Mr. J lives	
22	in a concrete (block) house with concrete floor and	(Complicating action)
23	"outdoor bathroom."	
24	(While waiting on our driver) the neighbor came over and	(Complicating action)
25	invited us to sit under the tree with his sister while we	
26	waited, and we then had a 10-min political conversation	
27	with the grandpa sitting by the house (about care of older	
28	adults in Belize).	
29	Once again, I think I handled myself professionally in the	
30	face of some really challenging organization.	(Evaluation)
31	Had an epiphany about the study. I am not going to be	

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32	able to (get much useful from) the quantitative data…. (I	(Evaluation)
33	feel) much better now that I have given up the	(Resolution)
34	quantitative piece.	

Figure 2. Excerpts from Day 7's reflection journal entry.

The first sentence implies a tone of frustration regarding the day's unforeseen challenges. The next sentence provides some context: The group was on a bus, sharing transportation to multiple sites, which created some delays in getting started with the day's work. Then a multitude of complicating actions ensue, including confusion about the day's agenda, meeting cultural expectations for professional socializing, difficulty finding homes with no labeled street addresses, and navigating challenging home conditions. The cultural and physical context demanded constant re-evaluation of occupational performance assumptions and required client-centered, creative problem solving. The narrative reaches resolution with two evaluative comments: (a) A self-assessment of positive conduct in the face of obstacles and (b) a need to let go of conducting the study exactly as I had envisioned it. In those moments, I became mindful of the enormity and complexity of the health care problems the participants were facing and the importance of being sensitive to the needs immediately in front of me. The study became secondary to being present and client-centered, and I experienced a sense of purpose and contentment.

Discussion

In using a narrative and thematic approach to explore reflective journals, I sought to understand research challenges and to provide recommendations to future investigators. The theme of challenges echoed in the literature regarding interventions provided in a cross-cultural context. Horton and Dickinson (2011) recommend that any cross-cultural intervention include service providers from that culture who can provide effective communication. The World Federation of Occupational Therapists (WFOT, 2013) recommends learning as much as possible from health professionals in the host country in order to be effective in service provision. Despite collaboration with Belizean partners and self-education regarding the culture prior to undertaking this research, I uncovered many biases and assumptions throughout the research and reflexive process.

Biases and Assumptions

Perhaps the biggest assumption I maintained as a Western health care provider was that I had the correct answers to the health care problem I was confronting (in this case, falls prevention). On Day 5, when asking the question "Is it really working?" I revealed that I did indeed believe that I had the answers to what constituted a successful intervention that would fix a problem. My goals were based on the facts of reviewing literature about the increase in falls and their impact on people in developing countries (Marin, 2007; National Council on Ageing [Belize], 2010). However, I assumed that a Western solution–education–was the

correct answer to this problem. As I worked closely with community partners, I recognized that preventing falls was just one goal, and a falls prevention program was just one means. The community partners had a more comprehensive awareness of perceived health needs, local solutions to those needs, and how the program that I offered fit into those solutions. My assumption that helping people not fall would equal improved quality of life corresponded only partially with the partners' and participants' views that quality of life meant richness of relationships and being able to enjoy the present moment.

I discovered that I maintained an additional cultural bias of how health care should be and how people should have basic health literacy for health conditions and medications. Though I had educated myself regarding the Belizean health care system and had talked with community partners prior to traveling, having this knowledge was not the same as experiencing it for myself. I learned much from the study participants about how they managed their own health care in the system available to them. Thus, I came to understand that what I perceived as the right way to get health care was not always what worked for persons living in Belize. I had to let go of my assumptions and embrace local solutions for getting things done.

I also discovered that my partnership with community health care providers did not go far enough. Though we had discussed and collaborated on the falls prevention program at length in the planning stages, in the interest of time (because of the brevity of our 2-week stay), I took the lead on the project and the U.S. team conducted the intervention. Though I educated a few health care providers in conducting the intervention, they did not participate in the sessions we conducted. On reflection, this was a serious flaw. Conducting any intervention that is so time-driven that it defers participatory relationships could constitute a serious affront to local partners. It is fortunate that relationships between the community partners and the U.S. team were well-established. If I were to redo any aspect of this study, it would be to fully incorporate the community partners in the development, implementation, and assessment of the intervention, which would make it more useful and culturally sensitive.

Benefits and Pitfalls of Foreign-Led Interventions

My experiences and the literature indicate that both benefits and pitfalls exist when participating in cross-cultural intervention and research. These benefits and pitfalls include, but are not limited to, the following.

Benefits. When a health care team travels to a developing country, they bring with them financial, intellectual, and physical capital. Often, the team will plan to bring useful items for the clinical sessions or will plan to purchase items locally for service projects (Reisch, 2011). In addition, the team will contribute to the local economy through purchasing services, such as lodging, transportation, food, and tourism packages. The team provides manpower for pro bono services to individuals in the community and education for community health care workers. Often, the services provided are not readily available to clients. The

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team provides education and supplies in the hope of creating a sustainable impact.

Although community stakeholders benefit from the presence of a foreign health care team, the team's primary goal is to develop cultural competence and clinical reasoning in students and clinicians. The literature has been clear on the benefits of cross-cultural research to the traveling team (Anderson, Taylor, & Gahimer, 2014; Ekelman et al., 2003). International practice trips have assisted participants to gain global awareness of health care problems and develop lifelong dedication to the ethical pursuit of social justice (Hansen, 2013; Reisch, 2011). In addition, clinicians have enhanced cultural competence by learning to create therapeutic relationships with clients without a shared cultural context (Ekelman et al., 2003) and with resources that are different from those to which they are accustomed (Anderson et al., 2014). The clinicians traveling with teams from developing countries are deeply passionate about using their skills and knowledge to make a difference for those in need. Such deep desire must be tempered by a clear awareness of the potential pitfalls of foreign intervention.

Pitfalls. Along with resources, a foreign travel team brings with it a power differential. A host community may be uncomfortable with speaking up to negotiate a partnership that is mutually beneficial (Reisch, 2011). The cultural norms of the host community often prompt deference to guests, and the foreign travel team may find themselves controlling all of the decisions without true host community input. A foreign travel team must make every effort to develop a mutually beneficial relationship with the unique community in which they serve. At the same time, the foreign travel team must use extreme caution to not over-burden local resources and to leave a minimal environmental footprint, including trash disposal and water usage (Reisch, 2011).

Time constraints constitute an additional pitfall for the travel team. A team is often available for only a few weeks. The planning and follow-up stages are conducted while at home. It is difficult, therefore, to communicate clearly regarding goals for all stakeholders and the needs of the community partners. Face-to-face communication, an expectation in many cultures, is not always possible. Therefore, cross-cultural miscommunication and missed opportunities for cultural sensitivity abound. A team coming from a time-oriented culture will feel the need to be as productive as possible in the limited time available, while the community partners may be more interested in using that time to establish relationships, regardless of how much gets done. Thus, the travel team may miss opportunities for full collaboration with the community partners to create a sustainable program. Travel teams must fully embrace that the host community has as much or more to offer them than the team offers to the host community. Redefining the experience in this way will give the team awareness of how best to use their limited time in the community.

It takes years to build partnerships that allow full collaboration between foreign teams and host communities. As trust and understanding develop on both sides, teams and hosts can work together to plan, implement, and assess the impact of the travel

team (Hayward et al., 2015). Only through consistently contributing time and listening intently with cultural sensitivity can a team from a developed country hope to make a sustainable impact in a developing country (Reisch, 2011).

Recommendations

A reflective critical analysis can be most helpful in examining an experience for the purposes of making improvements in the future and for avoiding ethical dilemmas (Reisch, 2011). Based on the reflective analysis and the literature, I offer the following recommendations for future investigators seeking to conduct an intervention research study in a cross-cultural context. While these recommendations arose from a cross-cultural experience in a developing country, clinicians can step into cross-cultural experiences in their own communities (Horton & Dickinson, 2011). Therefore, these recommendations are worth consideration when conducting cross-cultural research and intervention in a variety of settings.

Let go of assumptions. Investigators are not initially aware of what biases and assumptions they possess; that is why they are called assumptions. The narrative reflection in this study revealed assumptions and facilitated their release. Investigators must recognize emergent assumptions and put them aside for the sake of the participants in the study.

Flexibility. However carefully one has designed a study, the investigator will have to make changes once the process of data collection begins. Remaining flexible and open to change throughout the research and intervention process, especially regarding time, is key for achieving goals. Construct the study with ideas for retaining flexibility.

Simplify. Ongoing reflection during the intervention revealed a need to reconsider the use of quantitative measures. Therefore, it is recommended to simplify research methods. Select a small question and address it with carefully selected measures. Establish clear objectives for the research project and create separate but equally clear objectives for the intervention.

Partner with local agencies. Both the literature and my experience have indicated that local partnerships are vital to the success of cross-cultural research. Local partners know how to make things happen in the cultural context and can navigate the finer points of socially accepted behavior for conducting business and providing health care. Listen to what people say about what they need, about what will work, and about what will not work.

Include families and local resources. The most important resources for individuals in developing countries are families, friends, communities, and the human caring they provide. Clinicians can build rapport with clients as well as find sustainable solutions to the problems of daily living when including family members in education, intervention, and health maintenance.

Make client-centered care the cornerstone of intervention. Client-centered care is a hallmark of OT theory and practice (McColl et al., 2005). In an unfamiliar context where the client is truly the expert in his or her own needs, it is vital to focus on what the client values, as opposed to what the clinician values. When the clinician takes a client-

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centered approach, he or she can work with the client to achieve creative problem solving.

Include narrative and storytelling in data collection. Clients often tell stories that provide meaningful information. Stories contribute to clinical reasoning and problem solving (Mattingly, 1991). Investigators should record stories from participants as part of the data set.

Beware of ethical challenges. Most importantly, it is imperative to adhere to ethical principles. It is quite common to assume, as the educated clinicians from the developed country, that a team has the answers to the health care issues of a developing country. Although borne of good intentions to help the underserved, clinicians must consider the ethical issues for all stakeholders, including the burden on the host community and partner agencies, program sustainability, and the tourist footprint left by the visiting team (Reisch, 2011). Careful consideration should be given to these ethical issues. Only if all stakeholders can benefit, and sustained engagement is planned, should a visiting team engage in cross-cultural research and intervention in a developing country.

Limitations

Though the methodology of this study allowed for a measure of bracketing of assumptions, the analysis contained investigator bias. The investigator did not plan for the sampling of reflections in advance of the original study; therefore, a complete data capture did not occur. Only one investigator's reflections were collected; therefore, the study does not include a basis for comparing reflections. Furthermore, the absence of a second reader limited the trustworthiness of the data analysis. The applicability of this study may, therefore, be limited to investigators with similar biases and/or who are conducting research under similar circumstances.

Conclusions

The purpose of this study was to explore the perils and pitfalls of conducting OT intervention research in a developing country through narrative and thematic analysis of field notes and personal reflections. Through thematic and narrative analysis, I achieved a measure of objectification that allowed me to step outside of my own experience and give language to the aspects of the research experience that I had tacitly found wanting. I have offered recommendations to future investigators based on this analysis and evidence from the literature. These recommendations may be most useful to clinicians and investigators seeking to establish international practice partnerships in a developing country for the first time. As clinicians and investigators learn to become mindful of biases and assumptions and to partner collaboratively with the local community, beneficial international practice partnerships can be achieved.

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