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Exploration of Occupational Therapy Practice for Children with Autism Spectrum Disorders in the Dominican Republic

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Exploration of Occupational Therapy Practice for Children with Autism Spectrum Disorders in the Dominican Republic

Abstract

Background: To better understand the current practice trends of ASD treatment globally and promote practitioner collaboration, it is important to complete studies in countries where little is known about the diagnosis and treatment of ASD through an occupational lens. The aim of this study was to gain an insight into how occupational therapists in the Dominican Republic evaluate and treat children diagnosed with ASD.

Method: This qualitative descriptive study explored the perception of occupational therapists (n = 6) and caregivers of children with ASD (n = 28) through a questionnaire and focus group. Interview transcripts and questionnaire text were analyzed using thematic analysis. Trustworthiness was established through member checking, an audit trail, triangulation, reflexivity, and a thick description.

Results: Three themes emerged: caregiver ability to access quality services, importance of caregiver involvement in the treatment process, and value of client-centered care.

Conclusion: Promoting cultural humility, which focuses on continuous critical self-reflection and lifelong learning, can lead to improved outcomes for this population from initial diagnosis to the overall treatment process.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords

autism, global health care, autism spectrum disorder, occupational therapy, dominican republic

Cover Page Footnote

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Credentials Display

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The World Health Organization (2019) stated that 1 in 160 children worldwide has been diagnosed with autism spectrum disorder (ASD), demonstrating the global prevalence of this diagnosis. To receive a formal ASD diagnosis, children must meet the criteria identified in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). However, this condition is unique in the complexity of symptoms and the difficulty of identifying these symptoms within different cultural norms (Burkett et al., 2015; La Roche et al., 2018). With the diagnostic process assessing areas of high cultural variability, such as social interaction and expression of emotion, studies have noted significant differences in treatment approaches for this population (Tincani et al., 2009; Zuckerman et al., 2014). According to the Centers for Disease Control and Prevention (2019), the treatment of children with ASD is highly individualized, with treatment methods having high variation among practitioners in various professions.

Both naturalistic developmental behavioral interventions (NDBIs) performed by certified behavior analysts and developmental interventions performed by certified occupational and speech therapists are strongly supported by evidence; however, they are led by different specialties (Sandbank et al., 2020). Since symptoms of ASD are variable, there are also many treatment methods with less sufficient evidence that target specific symptoms, such as behavioral, sensory, and technology-based intervention therapies (Sandbank et al., 2020). While each treatment has demonstrated some effectiveness, the key takeaway is that starting intervention in early childhood will yield the most positive outcomes (Sandbank et al., 2020).

Little is known, however, about the types of treatment provided to children with ASD who live in developing countries, such as the Dominican Republic. To better understand the current practice trends of ASD treatment globally and promote practitioner collaboration, it is important to complete studies in countries where little is known about the diagnosis and treatment of ASD through an occupational lens. In this study, the researchers chose to understand further occupational therapy treatment for ASD in the Dominican Republic, where this profession is developing (Dominican Rehabilitation Association, 2022).

The Santo Domingo Catholic University offers the only occupational therapy bachelor's program in the Dominican Republic (Diaz & Matos, 2022). Therefore, many citizens will travel to other Latin American and Caribbean countries for occupational therapy training and education. However, the profession continues to evolve in the Dominican Republic, and in 2010, the World Federation of Occupational Therapy (WFOT) granted funding for the continued development of occupational therapy. In addition, in 2014, Santo Domingo Catholic University began the process to meet WFOT training requirements for occupational therapists (Castillo & Matos, 2022). Despite the continuing development of occupational therapy in the Dominican Republic, treatment for children with ASD has not been thoroughly examined or understood. A literature search of Medline and Latin American and Caribbean Health Sciences Literature (LILACS) databases revealed no published articles in peer-reviewed journals on ASD treatment in the Dominican Republic specifically. However, articles were identified that assess the diagnosis and treatment of ASD in Jamaica and the barriers to accurate diagnosis and effective treatment for the Latino community living in the US (Samms-Vaughan et al., 2017; Zuckerman et al., 2014).

For ASD treatment to address the whole person appropriately, health care professionals have an obligation to consider the role of cultural humility in practice. Promoting cultural humility, which focuses on continuous critical self-reflection and lifelong learning, can lead to improved outcomes for this population from initial diagnosis to the overall treatment process (MacKenzie & Hatala, 2019). As it relates to occupational therapy, the core concepts of the profession reflect Western origins, which creates a gap in cross-cultural care (Bourke-Taylor & Hudson, 2005). Therefore, there is a need for research to

understand further the current occupational therapy treatment process at clinics in the Dominican Republic and identify areas for cross-cultural collaboration and improved client-centered care for ASD. The purpose of this study was to explore how occupational therapists in the Dominican Republic evaluate and treat children diagnosed with ASD. Specifically, the research question was: What are the cultural factors and occupational therapy treatment protocols for children diagnosed with ASD in the Dominican Republic?

Method

Design

This descriptive qualitative study used a focus group with occupational therapists and occupational therapy assistants who provided services in the Dominican Republic to preliminarily explore the evaluation and treatment practices for children with ASD. In addition, caregivers of children with ASD were qualitatively explored to gain deeper insight into cultural factors that influence occupational therapy practice in the Dominican Republic. A qualitative approach was deemed most appropriate, as it allowed for a preliminary exploration into the topic and a “more complete and nuance[d] understanding of the complex issues involved in health and health care” (Hammel, 2005, p. 131). Employing a descriptive qualitative approach further allowed for the broad collection of data that can be analyzed and condensed into themes, linking the themes to the research objectives (Thomas, 2006). A proposal was sent to the Director of El Centro de Atención Integral para la Discapacidad (CAID), Santiago, to obtain approval to conduct a study at their facility. Once a letter of agreement was obtained, approval was granted by the Creighton University Institutional Review Board. All participants provided consent.

Context

The research study was conducted at CAID. CAID is one of two facilities created as part of First Lady Candida Montilla de Medina’s initiative to provide collaborative treatment to children ages zero to 12 with Down syndrome, ASD, and cerebral palsy (Mena, 2019). CAID is the first public facility in the Dominican Republic to provide evaluation, diagnosis, and treatment for these conditions (“CAID Santiago serves 42,219”, 2018). Children diagnosed with ASD comprise the highest percentage of individuals being treated at this facility (“CAID Santiago serves 42,219”, 2018).

Collaboration with CAID was deemed appropriate for this study because of the large percentage of children with ASD. In addition, the center possessed the ability to make sustainable changes through continued collaboration between the researcher’s university and CAID. Creighton University has had an established presence in the Dominican Republic for the past 45 years that includes various health services and language programs. These programs are designed to promote immersive experiences and create an additional resource for community health services. Creighton University is hosted throughout the year by a local nonprofit organization, Centro de Educación para la Salud Integral (CESI), well-known by its English name, Misión ILAC. CESI works within a growing community network of 140 rural communities in the Dominican Republic. It is expected that this study’s findings will facilitate continued program growth, improving client-centered treatment approaches for children with ASD.

Participants

The first author recruited two groups of participants for this study. The first group consisted of caregivers who were 19 years of age or older, the primary care provider to a child aged birth to 10 years who received occupational therapy services at CAID, and those able to read and write in Spanish. For the purpose of this study, a caregiver was defined as an individual responsible for the primary care of a child with ASD, and families were defined as all individuals who interact with the child on a day-to-day basis.

The second group consisted of occupational therapists and occupational therapy assistants working at CAID. The occupational therapists received credentials by attending an accredited university, and the occupational therapy assistants had a background in psychology and received additional on-the-job training and mentorship from the occupational therapists. There is no formal credentialing process in the Dominican Republic for occupational therapy assistants.

Instruments

Two separate questionnaires were developed to assess the occupational therapy referral process, goal development, treatment approaches, and collaboration between the caregivers and occupational therapists. The researchers developed the questionnaires from their collective clinical and research expertise, this study's literature review, and the study's research objectives. An expert panel of three researchers, each in the profession of occupational therapy and skilled in qualitative research and international practice, reviewed both questionnaires to improve clarity and validity. Following the review process, the structured caregiver questionnaire was reduced from eight to five questions, and the semi-structured practitioner questionnaire was reduced from 13 to nine questions. Questions from both questionnaires used an open-ended format to facilitate in-depth responses. The caregivers provided written responses to questionnaires in a private setting, while the occupational therapists participated in a focus group. See the Appendix for a list of questions asked to both groups.

Procedures

Following IRB approval, the first author spent 6 weeks at CAID collecting data from the occupational therapy department and caregivers of children with ASD who received care at the facility.

For the caregiver group, an initial information letter, translated into Spanish, was given to all caregivers of children with ASD receiving occupational therapy treatment at CAID. All potential participants were given 1 week to review the information letter and caregiver questionnaire and encouraged to ask clarification questions to the first author before agreeing to participate in the study. Potential participants were also informed that the study was voluntary and that they could withdraw at any time. Each participant was assigned a number to ensure confidentiality of responses and given 30 min to fill out the questionnaire. To increase privacy and encourage honesty in the participants' responses, no individuals employed by CAID were present during data collection, and they did not participate in data analysis. A translator from an independent agency worked with the researchers to translate all of the participants' written responses.

The first author emailed the practitioner questionnaire and an information letter to the potential participants of the occupational therapist focus group. The participants preferred to conduct the focus group during a 45-min time slot over lunch. The first author conducted the focus group with a translator present to ensure a clear and accurate understanding of responses and allow for the semi-structured nature of the focus group. The focus group was digitally recorded, and the first author transcribed the interpreted responses verbatim.

Data Analysis

Braun and Clarke's (2006) thematic analysis process guided the questionnaire and focus group data coding. The six phases of thematic analysis were completed: (a) familiarization of data, (b) generation of initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the manuscript (Braun & Clarke, 2006). In Phase 1, the first author read and re-read all of the translated data and individually transcribed the focus group word for word. In Phase 2, the initial codes were identified separately from the questionnaire and transcribed focus-group responses. The first and

second authors then analyzed the collective codes from each group to form seven initial themes, finalizing Phase 3 of the analysis process. In Phases 4 and 5, the first and second authors merged themes across the groups and integrated data to determine common themes from the participants. After peer debriefing with an experienced qualitative researcher (third author), three final themes and eight subthemes were identified as a result of thorough reflection and tallying of supporting evidence.

Trustworthiness was established through member checking with the occupational therapist focus group participants by emailing the themes and subthemes and allowing for feedback (Curtin & Fossey, 2007). All of the practitioners agreed with and provided approval of the final themes and subthemes. Data and methodological triangulation occurred by collecting data from two separate groups of participants (practitioners and caregivers) through two methods (focus group and questionnaire; Curtin & Fossey, 2007). A translator who was not part of the study completed all translations from the caregiver and focus group responses. The first author coded data with mentor guidance to the coding process to remove potential researcher bias. The second author participated in theme generation, and the third author participated in finalizing results. Finally, the researchers kept a detailed audit trail and employed reflexivity through open discussion and journaling throughout the research process, allowing for a thick description of the data and process (Curtin & Fossey, 2007).

Results

Of the 32 caregivers invited to participate in the study, 28 completed the questionnaire. All of the practitioners ($n = 6$) in the occupational therapy department agreed to participate in the study. Therefore, the focus group consisted of four occupational therapists and two occupational therapy assistants. The practitioners in the focus group had a minimum 2 years of experience working with children diagnosed with ASD. Because of the small number of participants in this study, additional demographic information was not collected to ensure confidentiality and protect participant identity.

Three main themes and eight subthemes emerged from the data analysis: (a) caregiver ability to access quality services, a lack of knowledge of health care professionals, limited services available, time and financial burden; (b) importance of caregiver involvement in the treatment process, providing education to caregivers, barriers to caregiver involvement; and (c) value of client-centered care, use of a collaborative model, prioritizing goals of independence, recognition of the value of occupational therapy (see Table 1).

Table 1
Themes and Subthemes

Theme 1: Caregiver ability to access quality services		
Lack of knowledge of available health care professionals to diagnose and treat children ¹ and lack of exposure to ASD as a condition ^{1a}	Limited services available, long waiting lists ¹ , inconsistent services provided at varying facilities ^a	Time and financial burden in accessing services, including cost for diagnostic testing and treatment, frequency of appointments, ability to schedule treatment after diagnosis is made ¹
Theme 2: Importance of caregiver involvement in the treatment process		
Providing education to caregivers regarding ASD diagnosis, treatment techniques, and carryover of home interventions ^{1a}	Barriers to caregiver involvement, such as discouragement with slow progress, other caregiver demands, like other children, taking time away from work to access services ^{1a}	
Theme 3: Value of client-centered care		
Use of a collaborative model to understand the family system ^{1a}	Prioritizing goals of independence as the child and family define it ^{1a}	Recognition of the value of occupational therapy ^{1a}

Note. ¹ indicates the subtheme is supported by caregiver questionnaire responses; ^a indicates the subtheme is supported by practitioner questionnaire and focus group responses; ^{1a} indicates the subtheme is supported by both caregiver and practitioner responses.

Theme 1: Caregiver Ability to Access Quality Services

Once a caregiver became aware that their child was having difficulties in activities of daily living, the caregivers reported significant difficulty accessing services that could help them better understand their child's health care options. Initially, the general lack of knowledge of health care professionals prevented the caregivers from receiving education regarding their child's functional limitations. Most of the caregivers stated that in the Dominican Republic, few providers diagnose ASD; therefore, there is little information from pediatricians or other medical professionals available to the public. This knowledge discrepancy made it difficult for the entire family to accept their child's diagnosis and functional limitations. For example, Caregiver 32 stated, "Everything with the diagnosis was a challenge. I had no knowledge about this condition. So, we both as parents were not willing to accept." In addition, individuals in the family's environment had difficulty accepting the child's differences because they did not understand an ASD diagnosis. For example, Caregiver 20 stated, "It has been really hard for me to know how people treat my child differently. He only has a small problem, and I see how they treat him differently than other children." Caregiver 21 further explained by stating, "the lack of patience that the population has is another challenge; they do not even know about the term and condition and how to react during evaluation." The practitioners corroborated the caregivers' statements about the family's support system having difficulty with understanding how to interact with a child with ASD. One occupational therapist stated, "The challenge we face most of the time is for the parent to accept that their child has autism symptoms, and sometimes the parent just allows the children to depend one hundred percent on them."

For the caregivers that did receive an official ASD diagnosis for their child, they reported difficulty accessing health care services because of the dearth of provider availability. Caregiver 32 explained how limited services impacted their family by stating, "We could not have access to therapists because there were a lot of children on the waiting list. After many years, after finally getting him in the institution, we have seen better results." The occupational therapists at CAID confirmed that because of inconsistencies in knowledge around the country, they must reassess children once they begin treatment at the facility. One occupational therapist expanded by stating,

It does not matter if the children come or not with a diagnosis from another place, we still perform the testing because we want to make sure that what we are going to treat is what is actually happening and if the children bring a diagnosis we go ahead and confirm if it is real or misdiagnosed.

The occupational therapists wanted to ensure the child's treatment plan was of the highest quality possible.

After the child began occupational therapy treatment, the caregivers reported a time and financial burden from ensuring their child had consistent access to health care services. Caregiver 9 further extrapolated financial barriers coupled with compounding factors experienced at other health care facilities, stating that "the cost is highly elevated and the lack of empathy and preparation from some of the professionals. There is a lack of centers and lack of private atmosphere in the centers." Caregiver 26 agreed and stated that their "first challenge was to get the right information about my child's condition and then started the financial problem of me being able to pay for the treatment." The families experienced a financial burden to access treatment for their children, and in the Dominican Republic, there is little guarantee that this sacrifice will lead to positive child health outcomes. Although some of the caregivers reported minimal child health outcomes at various health care facilities, most of them did report seeing functional progress with their children who received care at CAID, where this study was completed.

However, most of the caregivers reported that progress takes time because of the limited facilities and number of practitioners available to provide treatment. Most of the caregivers noted that timely intervention is necessary and positive outcomes are possible with increased awareness. For example, Caregiver 29 stated,

We need to support all of these children, and once they help them and let the country know about their condition, they can keep moving forward. In a center like this one, we can see the advance of each child once they receive all of the therapy on time and not having to wait, as we know, the time they have waited is not coming back, and time is gold.

Theme 2: Importance of Caregiver Involvement in the Treatment Process

The unparalleled importance of caregiver involvement was a frequent response on the caregiver questionnaire and during the occupational therapists' focus group. At this facility, promoting caregiver involvement is the cornerstone of treatment, and the occupational therapists believe that goals cannot be reached without this component. One therapist explained the need for caregiver involvement in their child's ASD treatment by stating, "In order for us to find the best solution to what we are working with, we try to involve everyone that is around to continue what they are doing because the time they are in here is really limited." Most of the practitioners and caregivers reported that providing education to caregivers through various resources improves outcomes for children with ASD and creates better rapport between the occupational therapists and families. Caregiver 16 noted, "I feel very grateful that they have given me the necessary techniques and support to be able to improve my child's behaviors, and the therapies are not just to do at the center, but also you have to continue to do them at home." Most of the caregivers reported that they are passionate about supporting their children, and this support allows their children to progress quickly. Caregiver 4 reflected on the treatment process by stating, "It actually has been a great experience that has marked my entire life because I love my daughter." In addition, most of the caregivers explained that they enjoy bringing suggested therapeutic activities into their homes. Caregiver 17 further explained by stating, "Thanks to therapy, we have learned how to spend more time with our child and be with him." Families are required to complete homework, such as fine motor activities or stretching techniques demonstrated by the practitioners, that allow the occupational therapy team to see how the child performs at home and what continues to be difficult in the home environment. An occupational therapist discussed how they provide caregiver training and encourage homework by stating:

When we allow the parents to see the activities, we give them to the parents as homework, and then they have to come back here and prove that they did it; sometimes, they can use a videotape or photo.

The practitioners agreed that providing education and homework to the caregivers allows the occupational therapist to determine if the families have received sufficient education, enabling them to perform suggested activities appropriately.

Although the occupational therapists agreed that the completion of homework by families and the open line of communication between occupational therapists and caregivers is the ideal situation at this facility, the caregivers and practitioners reported barriers to caregiver involvement in the child's ASD treatment. The occupational therapy team expressed difficulty approaching conversations regarding realistic goals for each child. One therapist stated that, "Some of the time we find parents would like to

have children be a small version of themselves, and sometimes that does not happen; that is not the child not progressing, it is the parent not accepting their child's diagnosis." In addition, the caregivers reported difficulty with being able to give their child the time they need to excel. For example, Caregiver 31 stated, "For me, it was really difficult as a single mother having to work, and after the diagnosis of my child, I had to quit my job and dedicate more time to my son to help him." The time commitment of therapy can be an even more significant barrier for larger families, as Caregiver 27 stated:

The biggest challenge has been having to leave my job for a period of time to attend therapy with my child, having to stop taking care of my other little child, who is younger than the one I take to this facility twice a week.

Theme 3: Value of Client-Centered Care

To create treatment that is truly individualized, the occupational therapists reported incorporating a collaborative model. The care team considers the caregiver an invaluable member of the collaborative team. One occupational therapist explained: "One point we evaluate very well is the family opinion about the development of their child and how things have been working and how they accept the challenge that has been put on them." In addition, the occupational therapy team reported working with a treatment team that varies based on the child's needs. One occupational therapist explained that "each treatment team is created based on the child's diagnosis; for example, when we have a child with sensory processing problems, we may work with a dentist and nutritionist and other resources we have available here at the facility." All of the practitioners agreed that looking at a child's progress toward goals is also a highly collaborative process. One practitioner stated: "We re-evaluate the child after four months, as a team, to see what development they have achieved from the challenges they are facing," as an example of an interprofessional, collaborative care approach. This collaboration has been continuously noticed by the caregivers, with most of the caregivers explaining the benefit of being a part of a comprehensive treatment team. For example, Caregiver 16 stated, "The team of the institution help each other do a better job and educate me as a parent to be able to understand a little bit more the message that the treatment team is trying to tell us."

A common child health outcome identified by the practitioners and caregivers was prioritizing goals of independence. In the focus group, an occupational therapist stated, "The main goal for us is to get the children able to do the basic activities of daily living and social ability." Most of the caregivers expressed that the goal of treatment is for their child to be independent and use their strengths. Caregiver 9 further explained, "I want my child to be independent within their possibilities. We hope that all of the therapies are the most precise and effective to reach my child's independence within their diagnosis." Many occupational therapists reported prioritizing client-centered care and writing goals targeting the child's individual strengths.

Another common connection to client-centered care was the recognition of the value of occupational therapy. The focus on independence and the ability of the child to understand their occupations better as a child was a common desire for the caregivers. For example, Caregiver 29 reported they "would like to see my child be willing to come into society as any other person and have professional development as an individual." An occupational therapist stated in the focus group that "another challenge we face is that some of the parents want their child to be still, and they allow the children to use any type

of device, like a tablet or phone. It is like the parents forget what the real occupation of the child is.” While Caregiver 32 stated:

Our child made it to the facility not knowing how to go to the bathroom, not knowing how to eat by himself, not knowing how to think on his own, and now he is showing logical thinking, he is showing us creative/imaginative drawing. When he first came to the center, he did not know how to play with other kids, and now my child is doing this.

This caregiver statement really highlighted the caregiver and therapists' commitment to the children with ASD and the promotion of their functional independence.

Discussion

An initial look at the experiences and perceptions of individuals directly connected to children with ASD in the Dominican Republic can be gained from the results of this study. The participants expressed that within this population, the diagnosis of ASD is still in the early stages and, therefore, identifying symptoms has been more difficult. Other studies have shown this to be a barrier in many countries, given that the criteria for a diagnosis look at social and emotional components that vary widely across cultures (Bernier et al., 2010; Burkett et al., 2015). CAID has created the opportunity for collaboration with other countries by providing the first comprehensive facility addressing the treatment of ASD in the Dominican Republic. This collaboration could assist with the education of health care professionals on what behaviors in this specific culture would fit the criteria leading to earlier diagnosis.

In comparison to the treatment of ASD in the United States, the caregivers in the Dominican Republic expressed concerns about the many barriers, that are felt by caregivers globally. In this study, the caregivers reflected on the time they had lost having to wait for treatment. The caregivers explained that “time is gold,” and they were grateful once they received services, as they finally had the tools to connect with their child at their level. The concerns of long waiting lists are common in all areas of health care and pose a higher concern when timely treatment is necessary for positive outcomes. Through increased education and awareness of ASD, early diagnosis can be possible, and the process of accessing services can begin much sooner. With the proper diagnostic tools and awareness of symptoms, therapists can formally diagnose ASD in children as early as 18 to 24 months of age (Brentani et al., 2013).

A prompt initial diagnosis can enable children to receive occupational therapy services earlier in life, leading to better outcomes. Understanding the many components of an ASD diagnosis and how they relate to diverse cultural backgrounds may lead to more accurate early diagnosis. It has been suggested that cultural competence cannot be achieved, as one can never completely immerse oneself in multiple cultures, and this may be seen as an obstacle to global collaboration (MacKenzie & Hatala, 2019). Still, occupational therapists and occupational therapy assistants in this study expressed a strong desire to collaborate, and by promoting cultural humility for health care providers, obstacles to global collaboration can be overcome. The continuous critical self-reflection required for cultural humility assists with collaboration among disciplines, locally and globally, as well as collaboration with caregivers to provide true client-centered care.

Following diagnosis, the participants expressed that once their child started receiving occupational therapy services, caregiver involvement was imperative to producing positive outcomes. As children are not able to be in lifelong therapy, the true goal of occupational therapy should always be to incorporate treatment goals in the individual's natural environment. For children, this incorporation begins with the caregivers because they set the standard as their child progresses. The caregivers stated they primarily

want to understand how to know their child's needs and determine ways where they can have meaningful interactions with their loved ones. When the occupational therapy team is able to facilitate this relationship, they help to create a support system that leads to long-term success for the child.

In addition to caregiver involvement, the importance of client-centered care was continuously highlighted in the participants' responses. This diagnostic category is identified as a spectrum disorder because no one child is exactly the same as another (American Psychiatric Association, 2013). The range in the presentation of symptoms makes understanding the individual that much more important and challenging. At this facility, there is a strong focus on developing the individual and unique personality of every child in each treatment session. Occupational therapy as a profession is still developing in the Dominican Republic; however, at this facility, it is seen as an essential component of ASD treatment. Promoting the purpose of occupational therapy has the potential to provide hope to caregivers and families who struggle to understand the symptoms their child is displaying.

Limitations

This study was limited because data were collected from only one facility; therefore, the results cannot be generalized to this entire population. Single researcher bias was present as the first author completed data collection and analysis. To reduce this bias, the authors used member checking to ensure an accurate depiction of the participants' perspectives. Future research should include multiple facilities in addition to quantitative data collection methods to provide health care professionals with more information about how to approach treatment for this culturally diverse diagnostic category.

Implications

Because occupational therapy is a newly recognized profession in the Dominican Republic, there are no current requirements for occupational therapists to complete continuing education courses; therefore, each therapist is responsible for finding information they feel will improve their practice. This presents an area for collaboration for therapists globally, as there are many places that have access to evidence-based resources and the ability to support these therapists in their continuous pursuit to expand their knowledge. In addition, university partnerships in countries with emerging occupational therapy programs can lead to the necessary research and professional development. These collaborations can provide insight into effective interventions for diagnoses with diverse symptoms, such as ASD.

Conclusion

This study's results provide insights into the perspectives of caregivers and occupational therapy providers regarding the treatment of ASD in the Dominican Republic. By identifying the themes surrounding treatment and the challenges for caregivers, this study allows health care professionals globally to understand this culture better. The opportunity for collaboration is also established in this study, and focuses on the continuous application of cultural humility in the diagnosis and treatment of ASD. Given the diverse criteria associated with ASD, increased collaboration may create dialogue that leads to additional resources for this population. This study, and others like it, serve as a tool for providing client-centered care that is culturally appropriate and effective.

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Appendix
**Questions asked during Health Care Professional Focus Group
and on Caregiver Questionnaire**

<u>Health Care Professional Focus Group</u>	<u>Caregiver Open-Ended Questionnaire</u>
All of the following questions refer to children being treated for autism spectrum disorder.	
How do you receive referrals for treatment?	What have been challenges to accessing treatment for your child?
Who is included in the child’s treatment team?	What information have you received about things your child has difficulty with?
Explain the occupational therapy initial evaluation?	Explain the goals you have for your child as a result of receiving treatment?
How do you determine what areas to focus on during treatment sessions?	Explain how comfortable you are providing suggested treatments to your child at home?
What treatment approaches are used at this facility?	Is there anything else you would like to share about your experience?
How are treatment suggestions communicated to caregivers?	
What is a challenge to providing treatment for individuals with this diagnosis?	
Is there anything else you would like to share about the services provided at this facility?	