

Autism Spectrum Disorder (ASD) and Cultural Context: An Intersectional Analysis of Diagnostic Barriers Affecting School-Age Children in the BIPOC Communities

By

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Paper submitted in partial fulfillment of the requirements for the degree of

**Master of Counselling
in the
Division of Arts and Sciences**

**City University
of Seattle
2026**

This paper is accepted as conforming to the required standard.

Date

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Acknowledgements

I want to express my deepest gratitude to everyone who made this Capstone possible: my supervisor, Dr. Koreen Martfeld, the Capstone Coordinator, Dr. Christine Mhina, and the faculty at City University, Edmonton Campus. Their insightful feedback, guidance, and encouragement throughout this process have been invaluable to my academic growth.

I am especially grateful to my family and peers for their unwavering support, patience, and belief in me. To my husband, Olamide, and our lovely children, Temi, Gustavo, and Tito, thank you for your endless love, understanding, and encouragement. Your steadfast support and faith in me have been my greatest motivation, and I look forward to making up some of the precious time we missed now that this milestone is complete.

Finally, I acknowledge the strength and resilience of the BIPOC families navigating autism diagnoses. Your voices, stories, and advocacy inspired this Capstone. Your courage continues to motivate the pursuit of equity and understanding in this crucial field.

Abstract

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition that requires timely diagnosis and early intervention to support optimal developmental outcomes. However, school-age children from Black, Indigenous, and People of Colour (BIPOC) communities continue to experience significant disparities in ASD diagnosis. This Capstone explores the intersection of race and disability, with a particular focus on the systemic, cultural, and institutional barriers that contribute to missed, inaccurate or delayed diagnosis of ASD in BIPOC children. Guided by Disability Critical Race Theory (DisCrit), this literature review aims to answer the research question, “How do systemic, cultural, and structural barriers within the Western diagnostic system affect BIPOC families’ access to ASD diagnostic tools and support for their children?” The DisCrit theoretical framework synthesizes current research to examine how ableism and racism operate in tandem to marginalize BIPOC children and families navigating ASD services. Key findings highlight issues such as implicit bias among professionals, lack of culturally responsive screening tools, language barriers and limited access to services in underserved communities. The project also outlines practical recommendations for educators, counsellors, and policymakers, including implementing culturally attuned practices, providing multilingual resources, engaging communities, and reforming policies. This capstone underscores the urgent need for equity-driven changes in diagnostic practices and early intervention services to foster inclusive and just outcomes for children with ASD.

Keywords: Autism Spectrum Disorder (ASD), BIPOC, Intersectionality, Disability Critical Race Theory (DisCrit), Diagnostic Disparities, Cultural Competence, Systemic Racism, Early Intervention, Education Equity, Neurodiversity.

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Autism Spectrum Disorder (ASD) and Cultural Context: An Intersectional Analysis of Diagnostic Barriers Affecting School-Age Children in the BIPOC Communities

This literature review explores the intersection of autism spectrum disorder (ASD) and race, with particular attention to barriers faced by school-age Black, Indigenous, and People of Colour (BIPOC) children in accessing ASD diagnoses within Western systems. It explores the intersection of race and disability with a particular focus on the systemic, cultural and institutional barriers that contribute to diagnostic experiences of ASD in BIPOC children. The review further considers the impact of these disparities on access to assessment services and discusses implications for counselling and service delivery.

Autism spectrum disorder (ASD) is a neurodevelopmental condition characterized by differences in social interaction and restricted or repetitive behaviours or interests (American Psychiatric Association, 2013; Hodges et al., 2020). Earlier diagnosis and timely support in educational settings are associated with improved developmental, educational, and social outcomes, including enhanced communication and quality of life (Grzadzinski et al., 2021; Okoye et al., 2023). However, children from BIPOC communities frequently encounter barriers that delay or prevent accurate ASD diagnosis, limiting access to appropriate interventions and influencing long-term outcomes (Aylward et al., 2021).

Diagnostic Disparities

Although ASD occurs across all racial and ethnic groups, disparities persist in diagnostic timing and accuracy (Aylward et al., 2021). BIPOC school-age children are typically diagnosed 1.5 to 2.5 years later than White peers, resulting in missed opportunities for early support and intervention (Angell et al., 2018; Habayeb et al., 2022). Delayed diagnosis is associated with increased difficulties in socialization, communication, and adaptation, which can adversely affect academic performance, mental health, and quality of life (Habayeb et al., 2022). Misdiagnosis is also a significant concern. BIPOC school-age children are disproportionately diagnosed with conditions such as attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), or other behavioural/disciplinary categories rather than ASD (Constantino et al., 2023). These diagnostic pathways can delay access to appropriate supports and result in interventions that do not align with neurodevelopmental needs (Mandell et al., 2009; Aylward et al., 2021; Constantino et al., 2023; Onovbiona et al., 2024). These patterns are frequently linked to systemic inequities, implicit bias, and limited access to specialized diagnostic services (Aylward et al., 2021).

Research Problem

The research problem arises from a limited understanding of how systemic, cultural, and structural factors within Western diagnostic systems contribute to disparities in ASD diagnosis among BIPOC children. Although awareness of inequities is increasing, research on culturally responsive diagnostic tools and assessment practices that account for cultural, linguistic, and social differences remains limited (Aylward et al., 2021). Diagnostic methods continue to be standardized using norms established largely within White, English-speaking populations, heightening the risk of underdiagnosis, delayed diagnosis, or misdiagnosis in BIPOC communities (Leeuw et al., 2020; Zwaigenbaum et al., 2019).

The absence of culturally sensitive assessment tools and practices stems from multiple factors, including systemic barriers in healthcare and education, cultural misunderstandings, financial constraints that limit access to specialized services, and inequitable healthcare distribution (Aylward et al., 2021). These intersecting challenges disproportionately impact BIPOC communities, impeding early and accurate identification and diagnosis, and exacerbating disparities in developmental outcomes and long-term support (Mandell et al., 2009). Accordingly, this literature review examines structural inequities embedded in diagnostic processes and aims to inform the development of more inclusive and culturally responsive assessment services.

Objectives and Research Questions

The objective of this research is to examine the systemic, cultural, and structural barriers that contribute to disparities in ASD diagnosis among school-age children in BIPOC communities. Specifically, the study assesses the extent to which current diagnostic practices lack cultural responsiveness, identifies gaps in access to intervention services, and underscores the need for more diverse assessment tools that reflect the experiences of children from BIPOC communities. The following research question guides this capstone research:

“How do systemic, cultural, and structural barriers within the Western diagnostic system affect BIPOC families’ access to ASD diagnostic tools and support for their children?”

Rationale and Justification

Early and accurate diagnosis of autism spectrum disorder (ASD) enables timely access to intervention services that support developmental progress and improve long-term outcomes (Okoye et al., 2023). Persistent diagnostic disparities among school-age BIPOC children,

however, contribute to inequitable or delayed access to support, misdiagnosis, and increased behavioural, emotional, and educational challenges (Aylward et al., 2021; Bruno et al., 2025). BIPOC children who remain undiagnosed during their school years are less likely to receive supports that facilitate successful transitions into adolescence and adulthood (Benevides et al., 2024). Barriers related to transition, such as insufficient healthcare coordination, limited provider preparedness, and disparities in mental health services, are exacerbated when autistic youth are not accurately identified in childhood. This results in cumulative gaps in care across the lifespan (Benevides et al., 2024).

Although there is increasing recognition of diagnostic inequities, ASD research has historically focused on White, middle-class populations. This focus limits the generalizability of assessment tools, intervention models, and service frameworks (Ressel, 2023). Recent scholarship has begun to incorporate perspectives from BIPOC communities, yet significant gaps persist in understanding how families experience and navigate systemic, cultural, and institutional barriers to diagnosis (Onovbiona, 2023). Without direct examination of these barriers, inequities may be mischaracterized as isolated clinical errors rather than as manifestations of broader structural dynamics within diagnostic systems.

Research of this nature is essential because diagnostic processes serve as gatekeeping mechanisms that determine access to services, funding, educational supports, and long-term care trajectories. When systemic and cultural factors are not sufficiently examined, disparities may persist unchallenged within institutional practices. Centering the lived experiences of families provides critical insights into the practical operation of diagnostic systems, revealing barriers that may not be apparent from quantitative prevalence data alone (Kaiser et al., 2022). By examining the intersections of race, culture, and institutional norms within ASD assessment pathways, this

capstone aims to advance a more comprehensive understanding of inequity and to inform the development of more culturally responsive and equitable diagnostic practices.

Significance of the Study

This study contributes to counselling psychology by elucidating how race, culture, and ASD intersect to shape the diagnostic and therapeutic experiences of autistic BIPOC children and their families (Hotez et al., 2024). For counsellors and healthcare professionals, cultural context influences the interpretation, reporting, diagnosis, and management of ASD (Leeuw et al., 2020). Cultural beliefs about disability, behavioural expectations, and communication norms affect how behaviours are understood and how families engage with services, highlighting the need for treatment plans that are both clinically effective and culturally responsive (Kang-Yi et al., 2018). This review also supports advocacy for school-age BIPOC children whose families may have experienced discrimination in healthcare, thereby informing policy development, resource allocation, and culturally competent services (Aylward et al., 2021).

Theoretical Framework

This capstone is grounded in Disability Critical Race Theory (DisCrit), a framework that analyzes how racism and ableism operate as interconnected systems of oppression shaping institutional practices and lived experiences at the intersection of race and disability (Annamma et al., 2018; Love & Beneke, 2021). DisCrit builds upon Critical Race Theory by emphasizing disability as both socially constructed and racialized, while critiquing disability frameworks that inadequately address race. The core tenets of DisCrit include recognizing the mutual constitution of racism and ableism, critiquing deficit-oriented ideologies that pathologize difference, examining institutional norms that privilege whiteness and ability as standards, and centering

marginalized experiential knowledge as a valid source of insight and resistance (Annamma et al., 2018).

These elements are directly relevant to the research question guiding this capstone, which investigates how systemic, cultural, and structural barriers within Western diagnostic systems influence BIPOC families' access to ASD diagnoses and support. DisCrit elucidates that diagnostic inequities are not solely attributable to individual clinician bias but are embedded within institutional norms that define “typical” development based on white, Western behavioural standards. In ASD assessment, these norms inform the interpretation of communication, eye contact, emotional expressiveness, and behavioural regulation (Leeuw et al., 2020). Consequently, behaviours that deviate from dominant cultural expectations may be pathologized, overlooked, or reframed through behavioural or disciplinary perspectives. DisCrit thus offers a framework for understanding how misdiagnosis, delayed diagnosis, and under-identification arise at the intersection of racialization and disability labelling. For example, students may encounter biased evaluations or disciplinary actions framed as behavioural management, which can lead to misdiagnosis or delayed diagnosis (Love & Beneke, 2021). This framework also identifies structural inequities in assessment tools, practitioner bias, and cultural misinterpretations of behaviour and communication as contributors to diagnostic disparities (Butterworth et al., 2024).

The framework informed the analysis in several keyways. First, it shaped the coding process by focusing attention on structural inequities, institutional bias, and racialized constructions of behaviour, rather than viewing disparities as isolated or individual-level issues. Second, it guided the interpretation of themes such as cultural stigma, diagnostic substitution, and disciplinary pathways, situating these patterns within broader systems of racialized ableism.

Finally, DisCrit facilitated a critical examination of how assessment tools, referral processes, and professional standards may privilege white, middle-class norms while marginalizing alternative cultural understandings of development. By situating ASD diagnosis within intersecting systems of power, the framework enabled a more comprehensive analysis of how diagnostic practices perpetuate inequity and how they may be reimagined through equity-oriented and culturally responsive approaches.

Definition of Terms

This section defines the principal concepts used in this capstone, including autism spectrum disorder, BIPOC, diagnostic disparities, intersectionality, systemic barriers, cultural factors, underdiagnosis, and misdiagnosis.

Autism Spectrum Disorder (ASD)

A neurodevelopmental condition characterized by differences in social communication and interaction, and patterns of behaviour or activities that may include restricted or repetitive features (American Psychiatric Association, 2013).

BIPOC

A term describing racialized minorities who have been historically marginalized, including Black, Indigenous, and People of Colour.

Diagnostic Disparities

Inequities in the timing, accuracy, or quality of diagnosis across different groups are often influenced by systemic, cultural, and socioeconomic factors (Mandell et al., 2009).

Intersectionality

A theoretical framework examining how multiple identities (e.g., race, gender, class, ability) intersect to shape experiences of oppression or privilege (Bauer et al., 2021).

Systemic Barriers

Institutionalized practices, structures, and policies that hinder marginalized individuals from accessing services and resources (Gee & Ford, 2011).

Cultural Factors

Attitudes, beliefs, norms, and practices within a community that shape how developmental differences, including ASD, are perceived, addressed, and reported (de Leeuw et al., 2020).

Underdiagnosis

Failure to identify and diagnose a condition when it is present often leads to delayed intervention and access to relevant supports (Camilo, 2023).

Misdiagnosis

Incorrect identification of a condition, such as when ASD is mistaken for another developmental, behavioural, or psychiatric disorder. Constantino et al. (2023) highlight patterns in which Black boys are more likely to be misdiagnosed with conduct-related or behavioural disorders rather than ASD, contributing to delayed diagnosis (Constantino et al., 2023).

Research Paradigm

Most of the literature reviewed adopts a constructivist–interpretivist approach, conceptualizing knowledge as constructed through context, culture, and lived experience (Creswell & Creswell, 2018). Research paradigms reflect the perspectives and beliefs that guide inquiry and interpretation (Creswell & Poth, 2018). This approach aligns with the capstone’s focus on the influence of systemic and cultural factors on diagnostic access, interpretation, and outcomes.

Literature Search Process

Relevant sources were identified through literature searches conducted using City University of Seattle (City U) Library databases and Google Scholar. Within the City U library system, searches were conducted using PsycINFO, ProQuest, and PubMed, which provide peer-reviewed scholarship in psychology, education, and health care. Google Scholar supplemented these searches by providing access to additional scholarly articles, reports, dissertations, and theses addressing ASD, racial disparities, and systemic barriers in education and healthcare.

Most sources were published between 2018 and 2025 to ensure that the review reflects contemporary scholarship on ASD diagnostic disparities within BIPOC communities. This timeframe encompasses a period of intensified academic and policy focus on racial inequities in healthcare and education, especially following the increased global attention to systemic racism after 2020 (Butterworth et al., 2024). It further captures ongoing developments in culturally responsive assessment practices, structural competency, and equity-oriented diagnostic frameworks.

Earlier foundational studies were included if they established widely cited evidence regarding racial disparities in ASD identification or contributed theoretical frameworks that

continue to inform current research (e.g., Mandell et al., 2009). These works offer historical grounding and contextual continuity. Recent publications were prioritized to ensure that the analysis incorporates emerging empirical findings, updated diagnostic considerations, and current policy developments relevant to equity in ASD assessment.

Search terms included *autism diagnosis and race*, *autism in Black children*, *racial disparities in autism*, *BIPOC children and autism*, *systemic barriers in autism diagnosis and intersectionality and autism*. As the research focus was refined, additional terms such as *cultural stigma surrounding autism*, *educational bias and neurodivergence*, *healthcare disparities*, *BIPOC parents' experiences with autism diagnosis*, and *diagnostic delays in BIPOC children* were incorporated. These searches identified literature across education, psychology, public health, and social work, demonstrating the multi-systemic nature of ASD diagnostic disparities.

Search results were screened for relevance by reviewing titles and abstracts to ensure alignment with the research question and objectives. Studies addressing diagnostic disparities, systemic barriers, institutional inequities, or cultural factors within BIPOC populations were prioritized. A snowball method was used to examine the reference lists of key studies to identify earlier research and relevant work not captured in the initial searches. Peer-reviewed literature from 2019 to 2025 was prioritized, with older works included when necessary for conceptual or historical relevance. This approach supported a broad but focused evidence base covering persistent barriers and proposed solutions for diagnostic inequities in school-age BIPOC children.

Inclusion and Exclusion Criteria

Relevant sources were identified through systematic database searches using keywords pertaining to autism spectrum disorder, diagnostic disparities, race, cultural factors, and BIPOC

communities. Initial search results were screened at the title and abstract level to assess relevance to the research question. Articles explicitly addressing ASD diagnosis within racially and culturally marginalized populations were selected for full-text review. During full-text screening, studies were evaluated for conceptual alignment with the research focus on structural inequities, cultural interpretation, and diagnostic pathways.

Sources were included if they were peer-reviewed, published primarily between 2018 and 2025, and focused on children and adolescents, particularly school-age populations, within BIPOC communities. Priority was assigned to studies examining diagnostic timing, misdiagnosis, underdiagnosis, structural barriers, clinician bias, or culturally responsive assessment practices. Relevance was determined by the degree to which each article contributed substantively to understanding systemic and cultural influences on ASD diagnosis, consistent with a constructivist–interpretivist framework.

In instances where peer-reviewed evidence was limited for specific subtopics, graduate dissertations and theses were included if they demonstrated methodological rigour and provided substantive empirical or theoretical contributions. Review articles, policy briefs, and reports from government or non-profit organizations were also included when they presented relevant themes grounded in empirical evidence and demonstrated methodological and ethical rigour consistent with qualitative inquiry (Creswell & Creswell, 2018). Sources were excluded if they focused exclusively on adults, relied solely on genetic or biological frameworks without consideration of social context, or did not address racial or cultural disparities. International studies were included selectively if they provided transferable insights into structural inequities relevant to North American systems.

Ethical Standards in Source Evaluation

Ethical standards guided the evaluation process, utilizing the Canadian Psychological Association (CPA) Code of Ethics and the Tri-Council Policy Statement (TCPS 2). Studies were prioritized if they demonstrated cultural sensitivity, respect for autonomy, inclusivity, informed consent, and efforts to minimize harm and power imbalances. Studies that neglected ethical considerations or reinforced deficit-based narratives about BIPOC communities were appraised with caution.

Methodology: Thematic Analysis

This capstone employed reflexive thematic analysis, as outlined by Braun and Clarke (2019), to examine patterns across the selected literature. This approach was appropriate for analyzing the complex intersection of ASD diagnosis and race within BIPOC communities (Waerass, 2022). The analysis was primarily theoretically informed (deductive), guided by the research question and conceptual frameworks related to diagnostic disparities, race, and intersectionality. While coding was shaped by these sensitizing concepts, the process remained iterative and flexible, allowing for refinement of themes through sustained engagement with the literature.

Following Braun and Clarke's six-phase process, analysis began with repeated reading of peer-reviewed articles, dissertations, and policy reports to support familiarization and analytic note-taking. Codes were generated reflexively, acknowledging the researcher's active role in interpretation. Themes were subsequently reviewed, refined, and defined to ensure conceptual coherence and alignment with the capstone's aim.

Initial codes were generated to systematically capture meaningful features, focusing on structural barriers, cultural perspectives, systemic inequities, diagnostic delay and misdiagnosis

pathways, and ethical issues. Coding integrated inductive processes derived from the literature with deductive processes guided by the research question and the study's theoretical framework, which emphasized ASD diagnostic disparities, race, and intersectionality. The framework informed how patterns were interpreted, particularly in identifying themes related to structural inequities, institutional bias, and cultural marginalization. Codes were subsequently organized into broader themes, such as cultural stigma, institutional bias, parental advocacy, and systemic barriers across healthcare and education, and were reviewed, refined, and defined. Findings were synthesized into a narrative that highlights convergences, contradictions, and gaps in the evidence base while maintaining attention to ethical principles and cultural responsibility.

Challenges Encountered During the Literature Search Process

A key challenge was the limited number of studies explicitly examining ASD and race together, particularly studies focused on school-age BIPOC children. Many studies used deficit framings or centred White, middle-class samples, limiting transferability to BIPOC families. Additionally, some literature focused primarily on systemic inequities affecting Indigenous Peoples without comparable depth across other racialized groups (e.g., Black, Latino, Asian communities), restricting subgroup-specific understanding of diagnostic disparities.

Variations in terminology also complicated searching and synthesis. Differences between identity-first ("autistic children") and person-first ("children with ASD") language reflect ongoing debates regarding identity, stigma, and clinical framing (Arnhart et al., 2022; Tobaas et al., 2023; Lampp, 2023). Inconsistent terminology required expanded keyword strategies to locate relevant literature. Another gap that occurred during this process was limited research addressing generational differences in ASD recognition and diagnosis within BIPOC communities. While generational perspectives may influence symptom recognition, help-

seeking, and advocacy, targeted studies remain scarce, indicating an underdeveloped evidence base.

Researcher's Perspective and Research Samples

Most studies reviewed employed interpretive–constructivist methods (e.g., interviews, subjective observations, document analysis). While these methods offer rich contextual insight, interpretation is shaped by the researcher's positionality, which can affect objectivity, reliability, and validity. Approximately ten reviewed articles were authored by researchers outside BIPOC communities, raising concerns about how systemic inequities may be reproduced in ASD scholarship, particularly regarding Indigenous populations (Bruno et al., 2023). Limited Indigenous-led research suggests the literature may not fully capture Indigenous experiences, beliefs, and barriers shaping ASD recognition and service access.

Sampling limitations were prevalent. Many studies relied on small convenience samples from clinics, schools, or community organizations, which limited generalizability. Some studies aggregated heterogeneous groups under broad terms such as “BIPOC” or “minority,” obscuring subgroup-specific cultural contexts and diagnostic pathways. Under-representation of Indigenous communities and other historically marginalized groups was also frequent, and some studies lacked sufficient detail about sampling procedures, raising concerns about selection bias and representativeness. These issues suggest that the evidence base may not fully capture the diversity and complexity of BIPOC children’s experiences with ASD diagnosis.

Researcher's Positioning

As a student researcher, my personal and professional experiences may influence my interpretation of this topic. Experience in educational settings, particularly with school-age

children with disabilities, has provided insight into the challenges students face due to systemic barriers, which may be intensified in BIPOC communities. As a person of colour, my lived experience has shaped my commitment to equity and advocacy for marginalized groups. This perspective aligns with the capstone's objective to raise awareness of disparities in ASD diagnosis among school-age BIPOC children and to explore safe, inclusive assessment tools and policies that can reduce inequities in diagnostic access and accuracy.

To mitigate potential bias, I engaged in ongoing reflexivity, examining how my beliefs, background, and experiences may have shaped interpretations of the literature and the analysis. This continuous self-reflection was intended to support ethical, inclusive, and balanced scholarship. I consistently examined the underlying assumptions present in dominant theoretical frameworks and critically assessed how these perspectives privilege certain narratives while marginalizing others.

Capstone Project Overview

The structure of this Capstone follows a systematic sequence. Chapter One introduced the rationale for investigating the intersection of ASD and race and articulated the research problem, objectives, guiding questions, and the methodological framework. Chapter Two offers a comprehensive literature review that addresses diagnostic disparities, systemic and structural barriers, and the impact of cultural factors on ASD diagnosis. It further investigates patterns of underdiagnosis and misdiagnosis among BIPOC school-age children and examines historical and institutional factors contributing to inequities in ASD care. Chapter Three discusses the clinical implications of these findings, emphasizing the effects of diagnostic inequities on assessment practices, service access, and client outcomes. Chapter Four provides actionable

recommendations to enhance culturally responsive diagnostic practices, promote equitable recognition and referral processes, and inform policy reforms aimed at reducing disparities in ASD care for school-age BIPOC populations.

Chapter Two: Critical Analysis and Synthesis of the Literature

This chapter presents the key findings based on the analysis and synthesis of 15 primary research articles (see Table 1) that explore the intersection of ASD and race, with a specific focus on the barriers to ASD diagnosis for school-aged children from BIPOC communities. The significance of this capstone project lies in its critical examination of the research question: “How do systemic cultural and structural barriers within the Western diagnostic system affect BIPOC families' access to ASD diagnoses and support for their children?”

Emerging from the literature are two competing diagnostic realities that illustrate the complexity of ASD recognition in BIPOC populations. The first reflects overdiagnosis and

cultural pathologization, in which culturally normative behaviours are misinterpreted as autistic due to Eurocentric diagnostic criteria (Leeuw et al., 2020; Huda et al., 2024; Antony et al., 2024). The second represents underdiagnosis and diagnostic exclusion, where BIPOC children are diagnosed late, misdiagnosed, or not diagnosed at all due to systemic inequity, stigma, mistrust and barriers to access (Bruno et al., 2025; Kang-Yi et al., 2018; Atherton et al., 2023). These dual realities guide the organization of this chapter, with the first explored through discussions of cultural framing, clinical interpretation, and bias embedded in diagnostic tools, and the second examined through themes related to service access, structural inequity, and community systems.

In the course of my thematic analysis, five overarching themes were identified across the literature (see Table 1). These themes were organized according to the two central diagnostic realities: overdiagnosis and underdiagnosis, reflecting the ways in which inequities manifest within ASD assessment processes. The synthesis draws on 15 studies published between 2018 and 2025. The chapter is organized based on two diagnostic realities and thematically as follows: (a) Overdiagnosis and Cultural Pathologization, which includes (1) Cultural differences in the recognition of ASD; (2) ASD assessment process; (b) Underdiagnosis and Diagnostic Exclusion, which includes (3) Access to ASD services; (4) Cultural Interpretations: Strengths and Barriers; and (5) Lack of policy support and advocacy for equitable ASD diagnosis.

Table 1

Thematic Similarities in the Literature

Articles	Theme 1: Cultural differences in the recognition of ASD	Theme 2: ASD assessment process Subtheme A: Cultural bias in	Theme 3: Access to ASD services in BIPOC communities	Theme 4: Role of family and community support: Strengths and Barriers	Theme 5: Lack of policy support and advocacy for equitable ASD diagnosis Subtheme A: Absence of
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		standardized diagnostic tools Subtheme B: Clinician bias and misinterpretation of symptoms	Subtheme A: Location and Financial barriers Subtheme B: Limited availability of community-based and culturally embedded services	Subtheme A: Community norms and family decision making Subtheme B: Religious or spiritual perspectives	advocacy networks Subtheme B: Lack of cultural competence Subtheme C: Language and Diagnostic Inequities.
Antony et al. (2022)	✓	✓	✓	✓	✓
Atherton et al. (2023)	✓				
Aylward et al. (2021)		✓	✓		
Broder-Fingert et al. (2020)		✓	✓		✓
Bruno et al. (2024)	✓	✓	✓	✓	✓
Bruno et al. (2025)	✓		✓	✓	✓
de Leeuw et al. (2020)	✓	✓			
Doda et al. (2024)			✓		✓
Huda et al. (2024)	✓	✓	✓		✓
Kang-Yi et al. (2018)	✓			✓	✓
Li et al., (2024)	✓			✓	
Lee at al., (2025)	✓			✓	
Papoudi et al., (2020)	✓			✓	
Pearson et al., (2021)	✓			✓	
Constantino et al., (2023)	✓				✓

Through the lens of DisCrit theory, the chapter synthesizes these findings and provides a Systematic Literature Review (SLR) of research to date, organized around five themes uncovered during the research process. Analysis of these themes will uncover key insights into structural, cultural, and institutional factors that contribute to persistent inequities in ASD diagnosis among BIPOC children. The chapter will conclude with a summary of the findings and a discussion of the ethical considerations.

Cultural Differences in the Recognition of ASD

A common theme seen in the selected studies concerns how culture mediates the recognition of ASD in children (Atherton et al., 2023; de Leeuw et al., 2020). This theme investigates the influence of cultural norms on the recognition, interpretation, and labelling of autism spectrum disorder (ASD) traits in school-age children within BIPOC communities (Atherton et al., 2023; de Leeuw et al., 2020). Since this capstone addresses systemic and cultural barriers that contribute to delayed or inaccurate diagnoses, it is crucial to understand how culture mediates developmental expectations. Differences in cultural beliefs regarding communication, behaviour, disability, and child development may determine whether ASD-related traits are identified as concerns, normalized, or stigmatized.

(Atherton et al., 2023; Bruno et al., 2024; Bruno et al., 2025; de Leeuw et al., 2020; Huda et al., 2024; Kang-Yi et al., 2018).

Cultural conceptions of child development play a critical role in shaping the interpretation, evaluation, and response to behaviours associated with autism spectrum disorder (ASD). Developmental norms are socially constructed and reflect specific cultural frameworks that define typical and atypical behaviour (Matson et al., 2017). In Western contexts, early social engagement, sustained eye contact, verbal initiation, and participation in peer activities are

regarded as indicators of healthy socio-emotional development (Leeuw et al., 2020; Stengelin et al., 2020). Children who do not meet these expectations may be identified for developmental concerns, including ASD. However, communication norms differ substantially across cultures (Huda et al., 2024). In collectivist societies that emphasize harmony, humility, and group cohesion, behaviours such as quietness, emotional restraint, and deference may represent valued socialization practices rather than social-communication deficits (Li et al., 2024; de Leeuw et al., 2020).

This divergence acquires clinical significance when behaviours consistent with cultural values overlap with diagnostic criteria for ASD. Limited verbal initiation, reduced eye contact, or emotional restraint may be viewed as indicators of social impairment within Western frameworks, even when these behaviours are culturally normative (de Leeuw et al., 2020). The diagnostic risk arises from treating culturally specific developmental expectations as universal standards. When Western behavioural norms serve as the implicit benchmark, children whose socialization reflects alternative cultural values face an increased risk of misclassification or delayed identification.

Language development further demonstrates how culturally narrow benchmarks can result in inequitable diagnostic outcomes. In English-speaking Western contexts, early sentence formation and grammatical fluency are considered central developmental indicators (Trelles & Castro, 2019). However, multilingual children may exhibit uneven expressive and receptive abilities across languages due to simultaneous or sequential exposure (Feldman, 2019; Trelles & Castro, 2019). These patterns are typical within bilingual development but are sometimes misinterpreted as speech delays suggestive of ASD (McLeod & Verdon, 2017; Trelles & Castro, 2019). When clinicians apply monolingual benchmarks, multilingual language variation may be

pathologized, increasing the risk of overdiagnosis. Conversely, genuine social-communication concerns may be dismissed as typical bilingual development, leading to underdiagnosis. In both cases, the inability to distinguish difference from disorder distorts referral pathways, delays appropriate intervention, and perpetuates disparities in ASD identification among BIPOC children.

Cultural interpretations of repetitive or restricted behaviours also highlight epistemological tensions between Western psychiatric criteria and community-based explanatory models. Behaviours identified as core ASD symptoms, such as hand flapping, body rocking, insistence on sameness, or restricted interests (APA, 2022), may be understood differently across cultural contexts. In some African and Caribbean communities, repetitive behaviours may be viewed as spiritual engagement or culturally normative expressions of energy rather than clinical symptoms (Huda et al., 2024). Within Black, Indigenous, and other communities of colour, rigid routines or focused interests may be attributed to temperament, spirituality, or parenting practices. These interpretations affect whether behaviours are perceived as warranting assessment. When families conceptualize diagnostic markers differently, the threshold for seeking formal evaluation changes (de Leeuw et al., 2020), contributing to delayed engagement with diagnostic systems. Conversely, when clinicians interpret culturally mediated behaviours without contextual understanding, the likelihood of misclassification increases. These dynamics support a central argument of this capstone: diagnostic inequities arise not only from access barriers or individual bias but also from epistemological mismatches between Western psychiatric models and culturally embedded understandings of development.

Cultural stigma further exacerbates these inequities by influencing help-seeking behaviours and disclosure during assessment. When developmental differences are perceived as

familial disgrace, moral failure, or spiritual punishment, families may avoid diagnostic systems to protect social reputation and family honour (Kang-Yi et al., 2018). These responses are situated within broader structural narratives that link disability with shame and social hierarchy (Babik & Gardner, 2021). Religious or spiritual interpretations, such as viewing disability as a curse, karmic debt, or divine punishment, may prompt families to pursue faith-based or private coping strategies instead of institutional services (Schuelka, 2013). Consequently, children may miss critical developmental periods for early identification (Pearson et al., 2021).

Stigma functions not only as a set of beliefs but also as a structural mechanism that shapes participation in screening, openness during assessment, and sustained engagement with services (Stahmer et al., 2019). Educational systems that lack inclusive curricula and media with limited disability representation reinforce deficit-based narratives and normalize marginalization (Barroso-Moreno et al., 2024). These stigma-driven perceptions extend into broader social domains, such as marriageability, where individuals may be considered unsuitable partners due to having a relative with a disability (Kang-Yi et al., 2018). When disability is associated with a familial defect or moral failing, the social consequences affect the entire family, further discouraging the pursuit of a formal diagnosis.

While some Indigenous communities adopt strength-based interpretations that challenge deficit models (Bruno et al., 2025), stigma remains widespread in many contexts. In Black communities in the United States and Canada, ASD is frequently framed through medicalized, deficit-oriented narratives that increase fear and avoidance (Burkett et al., 2015). Comparable patterns are observed in East Asian contexts, where norms emphasizing harmony, conformity, and academic achievement contribute to underrecognition and diagnostic hesitation (Atherton et al., 2023; Kang-Yi et al., 2018; Shyu et al., 2010). In certain African and South Asian

communities, ASD may be linked to psychiatric deviance or danger, leading to institutionalization or reliance on traditional interventions (Botha et al., 2020; Kantawala et al., 2023; Pellicano & den Houting, 2021).

Taken together, these dynamics indicate that stigma and culturally grounded interpretations serve as structural mediators of diagnostic inequity rather than peripheral influences (Kang-yi et al., 2018; Atherton et al., 2023). By shaping recognition, help-seeking, disclosure, and engagement with services, cultural frameworks interact with institutional systems to either mitigate or intensify disparities. When Western diagnostic criteria are regarded as culturally neutral, despite their basis in specific normative assumptions, children whose developmental trajectories are interpreted differently within their communities are at greater risk of delayed identification, misclassification, and exclusion from services (Constantino et al., 2023). Thus, cultural perception and stigma can operate as mechanisms that perpetuate inequitable diagnostic trajectories across generations.

ASD Assessment Process

The assessment process lacks cultural neutrality, as substantial evidence demonstrates systemic bias within autism spectrum disorder (ASD) diagnostic pathways. Global research consistently indicates that autistic children from Black, Indigenous, and other culturally diverse backgrounds are diagnosed later, less frequently, or inaccurately compared to their White peers (Aylward et al., 2021). Population-based studies in the United States reveal that Black and Latino children often receive ASD diagnoses two to three years later than White children (Constantino et al., 2023). In Canada, Indigenous families report fragmented or absent diagnostic pathways, with assessments delayed due to structural barriers, limited access to culturally appropriate tools, and mistrust of healthcare institutions (Bruno et al., 2024; Ressel, 2023).

These diagnostic inequities have substantial consequences. Delayed or missed identification limits access to speech and occupational therapy, educational accommodations, family support services, and other essential interventions. Children may miss critical developmental periods when neuroplasticity is greatest and intervention outcomes are most effective (Aylward et al., 2021). In the absence of timely diagnosis, educational and health needs remain unmet, perpetuating systemic exclusion (Broder-Fingert et al., 2020). The literature identifies two primary contributors to these inequitable diagnostic outcomes: cultural bias embedded in standardized assessment tools and clinician bias or misinterpretation of symptoms.

Cultural Bias in Standardized Diagnostic Tools

ASD is diagnosed through a comprehensive clinical assessment by trained professionals such as psychologists, developmental pediatricians, psychiatrists, and speech-language pathologists. The assessment process includes structured behavioural observations, caregiver interviews, developmental histories, speech and language evaluations, and reports from educators and other caregivers. Diagnostic decisions are informed by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013), which is based on Western psychiatric classifications that define and operationalize symptoms.

Despite being presented as standardized and rigorous, this assessment process lacks cultural neutrality (Huda et al., 2024). Widely used instruments, such as the Autism Diagnostic Observation Schedule (ADOS) and the Autism Diagnostic Interview–Revised (ADI-R), were primarily developed and validated within Western, English-speaking, middle-class populations (Harrison et al., 2017). As a result, expectations regarding eye contact, social reciprocity, communication style, and pretend play are based on Western developmental norms. In other cultural contexts, eye contact may indicate disrespect, social engagement may follow

hierarchical or community-based patterns, and pretend play may not be emphasized in the same way. These differences increase the risk that clinicians misinterpret culturally normative behaviours as deficits or fail to recognize ASD traits that manifest differently outside Westernized expectations (Harris et al., 2013; Huda et al., 2024).

Therefore, diagnostic systems based on Western behavioural standards may inadvertently disadvantage children whose cultural backgrounds shape communication and development in distinct yet equally valid ways (Huda et al., 2024). The expectations embedded in diagnostic tools, such as norms regarding imaginative play and social expressiveness, may not align with culturally specific developmental practices, leading to inaccurate assessments of ability or impairment (Harrison et al., 2017). These limitations demonstrate how systemic and structural aspects of assessment practices contribute to delayed identification, misinterpretation of behaviours, and under-recognition of ASD among children in BIPOC communities (Harris et al., 2013).

Importantly, assessment bias does not operate in isolation but is compounded by structural racism and historical inequities within healthcare systems. Research indicates that Black and Latino children are more likely than White children to be misdiagnosed with attention-deficit/hyperactivity disorder (ADHD) or behavioural disorders, delaying accurate recognition of ASD (Aylward et al., 2021). Discriminatory assumptions related to parenting practices, poverty, or behavioural presentation can influence clinical decision-making, reinforcing stereotypes rather than centering developmental assessment. Indigenous families in Canada face additional systemic barriers, including limited local access to assessment services and fragmented referral pathways, requiring families to travel long distances or navigate complex bureaucratic systems (Bruno et al., 2024; Ressel, 2023).

These structural conditions are further intensified by medical mistrust rooted in histories of colonization, forced institutionalization, and exploitation (Broder-Fingert et al., 2020). For many families, engagement with diagnostic systems is shaped by intergenerational experiences of discrimination, making caution or reluctance toward institutional assessment a rational response rather than an act of individual resistance (Bruno et al., 2024). Together, culturally bounded assessment tools, clinician bias, systemic discrimination, and medical mistrust interact to shape inequitable diagnostic trajectories. In this way, diagnostic inaccuracy and delay are not simply the result of individual oversight but reflect broader structural dynamics embedded within the assessment process itself.

Clinician Bias and Misinterpretation of Symptoms

Beyond test design, clinician bias plays a significant role in perpetuating disparities. Clinicians may unconsciously interpret behaviours through a Western cultural lens, pathologizing what may be normative in the child's cultural context. For example, storytelling styles that emphasize shifting topics, relational details or collective voice as seen in African, Indigenous or Latino traditions, alongside repetitive speech, or insistence on routine, might be viewed as cultural communication styles or valued personality traits in specific communities but flagged as 'restrictive behaviours' in Western diagnostic frameworks (Kang-Yi et al., 2018). Conversely, ASD traits may be overlooked when they align with cultural expectations: East Asian children who are quiet, compliant, or reserved may be praised for these behaviours rather than assessed for possible underlying developmental differences (Atherton et al., 2023). This misalignment may result in either pathologizing or overlooking autistic traits, depending on cultural factors.

Access to ASD Services

This theme examines the influence of structural inequities on access to ASD diagnostic and intervention services for BIPOC children and families. While previous themes addressed cultural recognition and disparities within assessment systems, the current focus is on post-identification processes, specifically whether families can secure timely, appropriate, and culturally responsive services. Within the context of barriers to equitable diagnosis among school-age children in BIPOC communities, access to services constitutes a critical dimension of inequity. Even when ASD is suspected, systemic obstacles may delay assessment, limit intervention, and perpetuate developmental disparities.

The literature identifies two primary subthemes: location-based and financial barriers to diagnostic services, and limited availability of community-based and culturally embedded supports. Collectively, these factors indicate that diagnostic inequities extend beyond assessment tools and clinician bias. This theme demonstrates how inequitable access reinforces delayed diagnosis, prolonged unmet needs, and persistent disparities in developmental, educational, and psychosocial outcomes. Diagnostic inequities are thus sustained not only at the point of evaluation but also across the broader systems that regulate access to care.

Location and Financial Barriers.

Research indicates that rural or low-income areas often have limited or no access to ASD diagnostic centres and specialist services, creating significant barriers to early identification and intervention (de Vries et al., 2020). In Canada, many Indigenous families face geographic isolation and must travel long distances to access specialists and community supports (Bruno et al., 2024). In the US, inequities are most pronounced in regions where Black or Hispanic children comprise most of the population (Liu et al., 2023). Multiple overlapping factors drive these disparities, such as underfunded healthcare facilities, the availability of fewer professionals

trained in ASD assessments in the region, and systemic neglect of marginalized communities (de Vries et al., 2020). Families may be required to travel longer distances, face longer wait times, or forego services, delaying ASD diagnosis (de Vries et al., 2020).

Financial constraints, including inadequate insurance coverage, present significant obstacles for many BIPOC families seeking an ASD diagnosis for their school-age children (Aylward et al., 2021; Hill, 2024). Socioeconomic status further exacerbates disparities in ASD services, as low-income families may struggle to afford private evaluations, therapy sessions, or specialized education programs (Hill, 2024). Additionally, many public schools, particularly those located in BIPOC communities, lack adequate special education resources, including special needs educators, school psychologists, and speech language pathologists (Ahlers et al., 2023). These public schools may also lack resources to implement inclusive curricula for autistic students or early screening tools due to a lack of funding (Ahlers et al., 2023).

Limited Availability of Community-Based and Culturally Embedded Services

Beyond geographical and financial accessibility, service models often fail to align with community needs. Despite evidence showing the effectiveness of community-based and culturally grounded approaches, a significant gap remains in the development and implementation of ASD interventions that are both accessible and aligned with the cultural values, practices, and strengths of BIPOC communities (Lee et al., 2025). Mainstream ASD services in North America remain grounded in Western diagnostic frameworks such as the DSM, which are built on culturally narrow norms and define ASD through Eurocentric expectations of communication, social interaction, and learning (Leeuw et al., 2020). Additionally, since ASD interventions are validated in predominantly White, middle-class populations, they do not consider the communication norms, parenting practices, or family structures of BIPOC cultures

(Steinbrenner et al., 2022). Despite this, BIPOC families who do not conform to Westernized treatment pathways may be deemed ‘non-compliant’ by service providers (Bruno et al., 2025). This framing reflects a narrow view that assumes that Western medical approaches are the only correct way to support children with ASD. Families who use traditional healing practices, rely on extended family decision making or seek spiritual support may be dismissed as resistant or neglectful. In effect, the ‘non-compliance’ label ignores systemic barriers such as language differences, a lack of culturally adapted services, or mistrust in the system, and places blame on families rather than recognizing how services fail to meet their cultural needs (Leeuw et al., 2020). In this sense, the system does not simply overlook cultural knowledge but actively delegitimizes it, framing Indigenous and racialized understandings of ASD as inferior or irrelevant.

This funnelling of families into Western systems reflects what DisCrit identifies as the intersection of racist and ableist practices. ASD is conceptualized in ways that privilege White, middle-class norms, while rendering other cultural expressions as pathological (Annamma et al., 2018). For instance, the fact that Black children in the US are not only diagnosed later than their White peers but are also often disproportionately misclassified with behavioural disorders reflects deeply rooted racist assumptions (Constantino et al., 2023). These include stereotypes that construct Black children as more prone to aggression, deviance, hyperactivity and even criminality (Constantino et al., 2023). Such narratives pathologize normative cultural expressions, obscure underlying developmental differences and reinforce systemic barriers to accurate diagnosis and equitable care (Constantino et al., 2023).

Similarly, Indigenous families in Canada describe service pathways that exclude cultural traditions, leaving communities with few options to integrate ceremonies, spiritual practices, or

relational frameworks into care (Ressel, 2023). The absence of formal recognition for culturally meaningful practices is therefore not a neutral gap but a form of systemic harm that erases alternative epistemologies and invalidates BIPOC ways of knowing (Bruno et al., 2025). This erasure of alternative epistemologies not only undermines the legitimacy of BIPOC knowledge systems but also contributes to mistrust of healthcare providers, underutilization of available services, and disparities in long-term outcomes (Bruno et al., 2024).

Role of Family and Community Support: Strengths and Barriers

This theme explores the ways in which cultural interpretations of children's behaviours serve as both protective strengths and potential barriers within the ASD diagnostic process in BIPOC communities. Whereas previous themes addressed institutional and structural inequities, the current focus is on family and community meaning-making. Recognizing that cultural frameworks not only present obstacles to diagnosis but also offer relational, spiritual, and communal strengths is essential for understanding how developmental differences are perceived.

In numerous BIPOC communities, behaviours identified by Western diagnostic systems as ASD traits are often interpreted through cultural, spiritual, or relational perspectives that emphasize difference rather than deficit (Bruno et al., 2025; Ressel, 2023). Notably, some communities may neither use the term autism spectrum disorder nor conceptualize it according to Western psychiatric frameworks. These culturally grounded interpretations shape whether concerns are recognized as necessitating clinical assessment, addressed within family systems, or reframed as valued characteristics.

The literature delineates two primary subthemes within this broader topic: community norms and family decision-making, religious and spiritual perspectives on ASD.

Community Norms and Family Decision-Making

Cultural interpretations of ASD differ significantly across communities and fundamentally influence perceptions, discourse, and responses to developmental differences. In certain contexts, ASD is linked to mental illness, shame, or moral failing, whereas other cultural frameworks prioritize acceptance, relational belonging, or individual strengths (Papadopoulos et al., 2013; Bruno et al., 2025). For instance, some Plains Cree First Nations communities regard characteristics such as heightened sensitivity, strong memory, and attention to detail as valuable contributions to community life rather than as deficits (Bruno et al., 2025). Many Indigenous languages, including Cree, do not have a direct translation for ASD, and developmental differences are not conceptualized within Western diagnostic categories (Ressel, 2023). Instead, behaviours are interpreted through holistic frameworks that emphasize relationality, spirit, and balance, as exemplified by the medicine wheel's integration of physical, emotional, mental, and spiritual domains (Greer & Lemacks, 2024). Within these perspectives, differences in communication or social interaction are viewed as variations in relational engagement rather than as indicators of pathology (Bruno et al., 2025; Ressel, 2023).

Communal perceptions are also influenced by cultural traditions, prevailing social narratives, and the availability of information (de Vries et al., 2020; Montilla & Sanderson, 2025). In collectivist societies, developmental differences are often regarded as family matters rather than individual diagnoses, and community perspectives can significantly shape parental decision-making. For example, the concept of "familismo" in many Latino communities emphasizes loyalty and interdependence, which may prompt families to minimize or conceal developmental concerns to maintain cohesion and collective reputation (Montilla & Sanderson, 2025). In certain Asian cultural narratives, disability may be attributed to parental wrongdoing,

courses, or inherited flaws, thereby reinforcing stigma and reluctance to pursue formal assessment (Kang-Yi et al., 2018; Papadopoulos et al., 2013).

Extended kinship networks also influence diagnostic pathways. In family-oriented cultures, intergenerational caregiving structures offer emotional, financial, and practical support that can mitigate family isolation and reduce dependence on formal systems (Li et al., 2024; Pearson et al., 2021). These networks may promote patience or normalize developmental differences, such as the belief that “the child will grow out of it,” and may direct families toward spiritual practices or informal coping strategies instead of clinical intervention (Li et al., 2024). In Japanese and Chinese contexts, elders may encourage parents to minimize or conceal signs of ASD to safeguard family reputation and uphold social harmony (Atherton et al., 2023; Ng & Ng, 2022). Consequently, parents may experience tension between honouring elder authority and seeking assessment or treatment (Kang-Yi et al., 2018; Webber et al., 2024).

It is important not to oversimplify these dynamics as mere barriers (Li et al., 2024). Formal diagnostic systems are frequently culturally narrow, deficit-oriented, and challenging to access (Huda et al., 2024). As a result, families must navigate between cultural frameworks that emphasize relational well-being and Western systems that assign clinical labels based on individual pathology. Within this context, community norms and extended family involvement serve both as protective factors and as mediators that may delay engagement with formal diagnostic processes (Donohue et al., 2017; Li et al., 2024). These influences can foster belonging and resilience, yet also contribute to the postponement of formal recognition within Western systems.

This tension reflects a broader epistemological conflict between culturally embedded knowledge systems and institutional diagnostic authority (Li et al., 2024). Recognizing this

interplay is crucial for contextualizing help-seeking behaviours and addressing inequities in ASD assessment among BIPOC communities. Parents may balance these competing frameworks by engaging in bicultural or dual-system navigation, which involves honouring relational and spiritual values within their communities while also accessing diagnostic information and services when concerns arise. Instead of viewing cultural knowledge and clinical assessment as mutually exclusive, families may regard formal evaluation as a means of securing educational accommodations, speech therapy, or other supports while maintaining culturally grounded interpretations of their child's identity.

Religious and Spiritual Perspectives on ASD

Religious and spiritual frameworks often shape how BIPOC families interpret developmental differences that Western psychiatry labels as ASD. In some contexts, these perspectives provide families with meaning, resilience, and belonging, as well as spiritual resources for coping and care (Davis et al., 2024). These frameworks diverge sharply from Western medical models, emphasizing spiritual concepts such as divine purpose, ancestral influence, and ritual healing (Kantawal et al., 2023). This divergence is sometimes framed in the literature as a 'barrier' to timely diagnosis or intervention, but this assumes that the formal diagnostic process represents the gold standard, despite extensive evidence that Western systems themselves are culturally narrow, deficit-oriented, and often exclusionary for BIPOC families (Leeuw et al., 2020).

Younger members of some BIPOC communities, such as in the South Korean immigrant families, are more likely to adopt inclusive beliefs, such as the notion that every individual is inherently valuable and deserving of dignity and equal treatment, often informed by both exposure to neurodiversity discourses and reinterpretations of spiritual teachings (Kang-yi et al.,

2018). This perspective reflects a broader movement towards compassion-driven interpretations of faith that challenge stigma and support acceptance of neurodiversity within religious spaces (Kang-yi et al., 2018). In this way, younger caregivers may serve as cultural bridges, drawing from both traditional spiritual frameworks and contemporary neurodiversity values to reframe ASD not as a deficit but as part of human diversity (Kang-yi et al., 2018). Over time, this generational shift can help reduce stigma and reshape family and community attitudes towards ASD (Kang-yi et al., 2018).

Lack of Policy Support and Advocacy for Equitable ASD Diagnosis

Inadequate policy support and weak advocacy infrastructures within BIPOC communities have directly contributed to longstanding disparities in ASD diagnosis and support. Without policies that mandate universal early screening, fund culturally adapted diagnostic tools or require data disaggregation, BIPOC children are more likely to be misdiagnosed, diagnosed late or overlooked altogether (Bruno et al., 2024; Doda et al., 2024). A major contributor to these disparities is the persistent lack of legislative and policy prioritization for equitable, culturally responsive ASD services (Hus, 2023). For example, the absence of universal screening policies in underserved areas increases the likelihood that children from marginalized communities will go undiagnosed during critical developmental windows (Hus, 2023). Even when policies exist, they often fail to mandate cultural and linguistic inclusivity, limiting the effectiveness of programs intended to bridge diagnostic gaps. Without services delivered in families' language or with sensitivity to cultural norms, children are at risk of being misunderstood, misdiagnosed, or excluded from services altogether (Huda et al, 2024). The literature identifies three interrelated subthemes within this broader policy gap: (1) absence of advocacy networks, (2) lack of cultural competence in healthcare and education systems, and (3) language and diagnostic inequities.

Absence of Advocacy Networks

The absence of advocacy networks amplifies these gaps, as families have fewer avenues to challenge systemic inequities or push for reforms that reflect their lived realities (Aylward et al., 2021). Research shows that BIPOC parents often feel that professionals dismiss or underestimate their concerns about their children's development (Leeuw et al., 2020). As a result, BIPOC children are not diagnosed with ASD until later despite parents expressing developmental concerns early on (Aylward et al., 2021). Such disregard not only postpones diagnosis but also deepens mistrust between families and service providers (Leeuw et al., 2020).

In many BIPOC communities, parents are often forced to take up advocacy roles due to a lack of accessible and culturally responsive ASD services (Papoudi et al., 2020). While many caregivers engage in self-education, joining peer support networks, and initiating culturally responsive dialogue to reduce stigma, their advocacy often emerges out of necessity rather than support (Papoudi et al., 2020). This reliance on individual efforts reflects a broader systemic failure to provide adequate institutional resources and culturally sensitive, competent care (Papoudi et al., 2020). Without structural backing, these advocacy efforts can be unsustainable and place undue burden on families already navigating complex diagnostic and care systems (Papoudi et al., 2020).

Lack of Cultural Competence in Healthcare and Education

One significant barrier to timely and accurate ASD diagnosis among BIPOC populations is the lack of cultural competence within healthcare and educational systems (Lee et al., 2025). These systems are not neutral; they have been historically shaped by racism and ableism, producing structures that pathologize difference and exclude BIPOC and disabled communities by design. The absence of culturally responsive training in medical and educational curricula,

along with a professional workforce that does not reflect the racial, ethnic, or linguistic backgrounds of the communities it serves, is not merely a gap but a reflection of these larger oppressive systems at work (Lee et al., 2025).

Another significant barrier is the deep-rooted skepticism toward healthcare systems, stemming from a history of injustices, discrimination, and lack of inclusion in decisions that affect their communities (Doda et al., 2024). Government and institutional providers may lack a trusted community organization or leaders, making families less likely to seek help (Doda et al., 2024). Mistrust in schools, healthcare, and social services can delay or prevent families from seeking evaluations, as they fear judgment, mislabeling, or stereotypical assumptions about their parenting, culture, or socioeconomic status (Benkert et al., 2019). A lack of community-based outreach and collaboration hinders early intervention and discourages families from navigating complex diagnostic systems without support. From a critical theory perspective, these barriers are not merely administrative but are embedded within systems that prioritize white normativity and capitalist efficiency over human-centred, culturally grounded care (Annamma et al., 2018; Butterworth et al., 2024). The result is environments that are psychologically unsafe, linguistically inaccessible, and socially exclusionary, contributing to misdiagnosis, delayed diagnosis, and ongoing marginalization of BIPOC children (Hus, 2023; Lee et al., 2025).

Language and Diagnostic Inequities

Language barriers and the lack of visual or culturally congruent screening tools further reflect these systemic inequities. Families may struggle to articulate their concerns when diagnostic terminology lacks direct translation or carries different cultural connotations (Huda et al., 2024; Perera et al., 2017). What is often described as “miscommunication” is better understood as the consequence of institutions that privilege Eurocentric, deficit-based framings

of development while disregarding community knowledge. In this way, healthcare and education systems function as gatekeepers that reproduce exclusion, doing precisely what they were historically structured to do: maintain racialized and ableist hierarchies that limit access to recognition, diagnosis, and care (Annamma et al., 2018).

Ethical Considerations and Guidelines

Ethical issues in ASD research, particularly in relation to BIPOC communities, must be addressed with attention to established research principles while also being responsive to the cultural contexts and lived realities of the communities involved. This dual focus ensures that research not only advances scientific knowledge but also contributes to equitable and culturally informed support for individuals with ASD. This project draws on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2018) and is further grounded in the Canadian Code of Ethics for Psychologists (CPA, 2017), which together provide the guiding ethical frameworks for its design and analysis.

Informed Consent

Under the TCPS 2 and the Canadian Psychological Association [CPA] Code of Ethics, the first Principle, Respect for the Dignity of Persons and Peoples, requires researchers to ensure that participants provide free, informed, and ongoing consent (CPA, 2017). Aylward et al. (2021) and Constantino et al. (2023) provided unclear details about whether families received accessible or culturally tailored consent materials, which should include essential elements such as the purpose of the research, what the research entails, risks, and potential benefits (CPA, 2017; I23). Huda et al., (2024) did not discuss how informed consent was managed when working with linguistically diverse families, which is a major gap given their population of focus. In the studies by Kang-Yi et al. (2018), Leeuw et al. (2020) and Davies et al. (2024), responses were

research based on outreach materials that were not specifically created for research purposes, but rather for community education (Kang-yi et al., 2018; Leeuw et al., 2020; Davies et al., 2024).

Confidentiality

Even though some participants were anonymous, Kang-yi et al. (2018), Davies et al. (2024), Antony et al. (2022), and Atherton et al. (2023) identified specific BIPOC communities and their general stance on ASD. Such disclosure presents the risk of group-level harm, where research findings could inadvertently reinforce stereotypes or contribute to stigma. Participation of individuals in the studies could contribute to narratives that can further stereotype a community. This practice contravenes the CPA Code of Ethics, particularly Principles I (Respect for the Principle of Persons and Peoples) and III (Integrity in Relationships), which emphasize the obligation to protect the privacy of individual and collective participants (CPA, 2017).

Inclusion Criteria

The TCPS 2 stresses the ethical imperative of inclusive research practices, particularly when working with marginalized or vulnerable populations. At the same time, the CPA Code of Ethics (Principles I and IV) emphasizes the importance of promoting equitable representation in research studies. However, eight of the ten studies excluded significant vulnerable populations, such as the indigenous communities, while the remaining two (Antony et al., 2022; Bruno et al., 2025) specifically focused on just these groups. As a result, the findings do not fully capture the diversity of BIPOC children's experiences and may fail to reflect the unique needs of these school-age children (Papoudi et al., 2021). Most of the articles focused on immigrants, as well as Black, Hispanic, and other non-English-speaking populations, with none representing the

experiences of indigenous children (Kang-Yi et al., 2018; Montilla & Sanderson, 2025; Huda et al., 2024; Constantino et al., 2023; Leeuw et al., 2020).

Cultural Sensitivity

The CPA (2017) Code of Ethics (Principles I and II) requires that research methods and instruments be culturally appropriate and relevant to participants. Aylward et al. (2020) and Constantino et al. (2020), analyzed disparities from a medicalized framework without critically engaging cultural explanatory models, which risks overlooking cultural interpretation of differences as perceived in BIPOC communities. Some diagnostic instruments used in the reviewed studies have been standardized on only a small subset of BIPOC school-age children, and none were standardized explicitly for children from the indigenous communities. Huda et al. (2024) identified linguistic and cultural mismatch but stopped short of proposing culturally grounded adaptations. This highlights the concern regarding the accuracy, reliability, and cultural appropriateness of diagnostic tools used in this population due to their lack of cultural sensitivity (Perera et al., 2017).

Researcher's Perspective

Some of the research found for this literature review was from an outsider's perspective, which might have unintentionally reinforced systemic inequities in ASD diagnosis and interventions in BIPOC communities, particularly in indigenous populations (Bruno et al., 2023). The lack of indigenous-led research might imply that the study may not fully capture the lived experiences, cultural beliefs, and structural barriers that influence ASD recognition and access to ASD services in these communities.

Relevance of Findings

Diagnostic inequities in autism spectrum disorder (ASD) extend beyond isolated assessment challenges and are deeply rooted in broader societal inequities, including structural racism, widening health disparities, educational stratification, and unequal access to public resources (Aylward et al., 2021; Doda et al., 2024; Hus, 2023). The concurrent phenomena of overdiagnosis in certain contexts and underdiagnosis in others illustrate how institutions differentially interpret and respond to racialized children, reinforcing patterns of surveillance, invisibility, and unequal service allocation within child-serving systems (Aylward et al., 2021).

In multicultural societies, systems that claim neutrality often function through culturally restrictive standards. When assessment practices are not culturally responsive, they perpetuate institutional misrecognition experienced by racialized communities in education, mental health, and social welfare systems (Atherton et al., 2023; Leeuw et al., 2020). As a result, diagnostic inequity reflects broader societal tensions, since universal frameworks frequently fail to accommodate cultural diversity while maintaining an appearance of objectivity.

Structural inequality situates ASD diagnosis within broader debates about healthcare access and public trust. Socioeconomic disadvantage, geographic marginalization, and institutional racism collectively intensify the challenges of navigating screening, referral, and service systems (Antony et al., 2022; Liu et al., 2023). In contexts marked by strained public infrastructure and rising income inequality, these barriers contribute to institutional distrust and disengagement, perpetuating cycles of delayed or missed identification (Antony et al., 2022).

Family and community responses to diagnosis mirror broader societal negotiations regarding identity, assimilation, and authority within immigrant and racialized communities (Kang-Yi et al., 2018; Li et al., 2024). In the absence of culturally grounded institutional partnerships,

families may disengage from formal systems, underscoring the importance of trust, representation, and cultural translation for equitable access.

Policy gaps further demonstrate how ostensibly neutral approaches can perpetuate structural inequity. Without cultural targeting, data disaggregation, and accountability mechanisms, universal policies risk perpetuating disparities while creating the illusion of equal access (Bruno et al., 2024; Doda et al., 2024; Huda et al., 2024). Consequently, ASD diagnostic disparities exemplify the persistence of inequity when structural reforms do not substantively address cultural and systemic exclusion.

Taken together, the challenges in ASD diagnosis reflect broader societal failures to equitably recognize and respond to diversity. Addressing missed, delayed, or inaccurate diagnoses requires both clinical refinement and structural awareness. In today's clinical practice, this necessitates situating assessment within its social context, acknowledging how bias, institutional design, and systemic barriers shape diagnostic pathways, and adopting culturally responsive, equity-oriented approaches that actively counter the reproduction of inequality.

Research Gaps

Although there is a growing body of research on ASD in diverse populations, several critical gaps in research remain. Few studies incorporate the direct voices of BIPOC families, meaning that research often reflects professional or institutional perspectives rather than the lived experiences of those most affected.

This silencing of community perspectives constrains opportunities to understand ASD in ways that reflect families' cultural values, aspirations, and definitions of well-being. The majority of the existing literature also emphasizes individual-level explanations for disparities, such as

parental knowledge gaps, provider bias, or family socioeconomic status, while under-examining the broader systemic and structural forces that perpetuate inequities (Aylward et al., 2021; Angell et al., 2018; Constantino et al., 2020; Leeuw et al., 2020; Wagner et al., 2022). The research does not fully discuss racism in healthcare and education, inequitable funding structures, and discriminatory policy frameworks. These disparities underscore the need for a more nuanced understanding of how structural racism contributes to inequities in ASD diagnosis and care.

Chapter Conclusion

In this chapter, I explored the barriers contributing to ASD misdiagnosis and delayed diagnosis in BIPOC communities through the lens of cultural frameworks and systemic inequities. I drew upon theoretical perspectives, including the DisCrit and cultural competency models, to frame how dominant diagnostic practices privilege White, middle-class norms while marginalizing diverse cultural interpretations of child development. The literature identifies two central diagnostic patterns relevant to understanding inequity: (1) overdiagnosis resulting from cultural pathologization, in which culturally normative behaviours among BIPOC children are misinterpreted as autistic traits, and (2) underdiagnosis and diagnostic exclusion, where structural barriers, stigma, limited access to services, and clinician bias contribute to delayed or missed identification. These opposing yet interconnected phenomena demonstrate that inequity manifests through both the excessive attribution of deficits and the neglect of genuine needs.

I highlighted gaps in the current literature, particularly the limited engagement with cultural explanatory models and the lack of culturally responsive diagnostic tools. I also discussed five overarching themes, cultural perceptions of ASD, diagnostic disparities, structural barriers, family support systems and policy gaps that collectively illustrate the dynamic interplay

of cultural, systemic and intergenerational factors shaping diagnostic outcomes. Each theme was critically analyzed in relation to how inequities are produced and sustained across both clinical and structural contexts.

In addressing the ethical considerations across the reviewed articles, including informed consent, confidentiality, inclusion criteria and cultural sensitivity, I referred to the Tri-Council Policy statements and the Canadian Code of Ethics for Psychologists (CIHR, 2023; CPA, 2017). While most studies adhered to universal principles of research ethics, few fell short in culturally specific applications, raising questions about inclusivity, equity and justice in ASD research.

In the next chapter, I will discuss the application of these findings in clinical practice, with a focus on integrating culturally responsive approaches that bridge research, policy and therapeutic engagement with BIPOC families.

Chapter Three: Application to Clinical Practice

This chapter integrates findings from the literature to examine the clinical implications of autism assessment and service delivery for BIPOC communities. Diagnostic inequities, shaped by cultural interpretations, systemic barriers, unequal access to services, and limitations in standardized assessment tools, directly influence clinical practice and family experiences (Zhang & Chen, 2024). In multicultural contexts such as Canada, where

diversity is a defining social characteristic, assessment processes that lack cultural responsiveness may compromise diagnostic accuracy and client outcomes. These inequities shape clinicians' decision-making across multiple stages, including referral, behaviour interpretation, differential diagnosis, and service planning (Huda et al., 2024). When assessment tools are not culturally grounded, practitioners may misinterpret culturally normative communication styles, multilingual language development, or context-specific behaviours as pathological, contributing to overdiagnosis (Gopal et al., 2024; Huda et al., 2024).

Conversely, implicit bias and systemic barriers may lead to under-recognition, delayed identification, or diagnostic substitution, particularly when behaviours are reframed as behavioural or disciplinary concerns rather than as neurodevelopmental differences (Aylward et al., 2021; Bruno et al., 2024). These patterns alter diagnostic trajectories and determine which children gain access to specialized supports. The consequences for clients and families are substantial. Delayed or inaccurate diagnoses limit timely access to interventions, educational accommodations, and community resources, thereby affecting developmental, academic, and psychosocial outcomes (Stahmer et al., 2019). Misdiagnosis may result in children receiving interventions that do not address their needs, while underdiagnosis can lead to prolonged unmet support requirements.

Both misdiagnosis and underdiagnosis can erode trust in healthcare and educational systems, particularly among families who already experience marginalization (Bruno et al., 2024). Cumulatively, these clinical realities demonstrate that diagnostic inequities are not abstract disparities but concrete factors influencing assessment accuracy, treatment

pathways, and long-term outcomes for BIPOC children (Huda et al., 2024; Perera et al., 2017). These findings underscore the need for practice approaches that critically examine how cultural context, systemic bias, and structural inequities shape clinical work and client experiences.

The following sections analyze these implications within two interconnected domains: autism diagnosis in BIPOC communities and culturally responsive assessment practices. The chapter subsequently addresses scientific contributions, clinical recommendations, and essential cultural considerations. Together, these sections provide guidance for clinicians to integrate cultural humility, structural competency, and trauma-informed care into autism assessment and intervention.

Implications for Clinical and Therapeutic Practice

Autism diagnosis occurs within culturally and structurally influenced systems (Aylward et al., 2021). For BIPOC children and families, diagnostic processes are shaped by cultural beliefs, family narratives, and systemic inequities. Addressing these influences is essential to diagnostic accuracy, trust, and equity. Research shows BIPOC children experience disparities in autism identification, including delayed diagnosis, misdiagnosis, and reduced access to early intervention due to systemic, cultural, and institutional factors (Aylward et al., 2021; Constantino et al., 2023).

Autism Diagnosis in BIPOC Communities

The literature consistently demonstrates that BIPOC children experience significant inequities in autism identification (Aylward et al., 2021; Constantino et al., 2023; de Leeuw et al., 2020). For clinical practitioners, these findings underscore that diagnostic assessment is not a

culturally neutral process. Delayed diagnosis prolongs uncertainty for families, increases caregiver stress, and restricts timely access to accommodations and specialized services, all of which are associated with poorer developmental and psychosocial outcomes (Fenning et al., 2023). In practice, this means that the timing of identification directly shapes access to intervention and long-term developmental trajectories, making early and accurate assessment a critical clinical responsibility.

Misdiagnosis exacerbates these inequities. Black children are disproportionately diagnosed with behavioural disorders, such as attention-deficit/hyperactivity disorder (ADHD), rather than autism (Constantino et al., 2023). When autistic traits are misclassified as behavioural pathology, intervention pathways often emphasize behaviour management over neurodevelopmental support (Constantino et al., 2023). Consequently, children may be perceived as defiant or noncompliant instead of receiving autism-specific interventions, including targeted social-communication supports or structured environmental accommodations (Schreibman et al., 2017). The diagnostic framework directly informs treatment planning, interpreting behaviours through a behavioural rather than developmental perspective can result in inappropriate interventions, reinforce stigma, and adversely affect clinical trajectories. These processes may delay access to developmentally appropriate services and significantly impact long-term outcomes.

Access to specialized autism services, caregiver education, and community-based supports often depends on a formal ASD diagnosis (Aylward et al., 2021). Diagnostic accuracy determines both service eligibility and resource allocation (Bruno et al., 2024). Families may spend extended periods navigating ineffective treatment plans before receiving an accurate diagnosis, resulting in unmet developmental needs. This highlights the clinical necessity of

comprehensive differential diagnosis, precise behavioural interpretation, and ongoing reassessment when treatment responses do not align with initial diagnostic expectations.

Structural inequities within healthcare and community systems further complicate diagnostic processes. Limited access to bilingual clinicians, extended waitlists, socioeconomic barriers, and inconsistent referral pathways disproportionately restrict BIPOC families' access to timely autism assessment (Aylward et al., 2021; Antony et al., 2022; Constantino et al., 2023; Huda et al., 2024; Kang-Yi et al., 2018). For practitioners, this means that children may present later with more complex needs due to systemic delays rather than clinical severity alone. Awareness of these structural influences is essential for accurate case conceptualization.

Diagnostic inequities can result in significant long-term consequences across developmental and psychosocial domains. Without early identification, children are often viewed through behavioural or disciplinary frameworks rather than supported with disability-informed strategies (Constantino et al., 2023). This misinterpretation increases the risk of exclusionary practices, internalized stigma, anxiety, depression, and chronic masking, especially in sociocultural contexts that emphasize behavioural conformity (Atherton et al., 2023). For families, persistent uncertainty and systemic barriers may intensify financial strain and foster institutional mistrust. Structurally, these inequities perpetuate broader racial disparities in disability identification and access to services.

Collectively, these findings indicate that clinicians should approach autism diagnosis with heightened awareness of cultural context, systemic barriers, and the potential for diagnostic bias. Diagnostic decisions influence access to care, shape intervention pathways, and affect long-term outcomes. Practitioners can address these challenges by critically evaluating interpretive

frameworks, conducting thorough differential assessments, and recognizing how structural inequities may impact referral timing, caregiver engagement, and clinical presentation. This approach fosters diagnostic practices that are more accurate, equitable, and responsive to the experiences of BIPOC children and families.

Culturally Responsive Assessment Practices

Recognizing that widely used diagnostic tools such as the ADOS-2 and ADI-R were developed and normed primarily on White, English-speaking populations has significant implications for my future practice and the clients I will serve. When assessment instruments lack cultural and linguistic validity, there is an increased risk of misinterpretation, over-pathologizing culturally normative behaviours, or overlooking autism characteristics that manifest differently across cultural contexts. In my future practice, I must adopt a critical and reflective approach to assessment that does not rely solely on standardized scores but also incorporates culturally informed clinical judgment, caregiver narratives, and contextualized developmental histories. Additionally, it is essential to address language access by collaborating with trained interpreters, utilizing translated tools when available, and advocating for culturally adapted assessment practices to minimize diagnostic bias.

For my clients, particularly those from BIPOC and multilingual communities, these findings underscore the necessity of culturally responsive and trauma-informed engagement. I must remain attentive to how systemic inequities, prior negative institutional experiences, and cultural explanatory models shape families' understanding of developmental differences. In practice, this means prioritizing relationship-building, validating caregiver perspectives, and ensuring that assessment processes are transparent and collaborative. It also necessitates ongoing professional development in culturally responsive assessment, critical self-examination of my

own positionality and potential biases, and advocacy within educational and healthcare systems to promote equitable diagnostic pathways. By integrating these considerations into my practice, I aim to reduce the risk of misdiagnosis and delayed diagnosis while fostering more ethical, inclusive, and accurate support for diverse children and families.

Contributions to Scientific Knowledge

This capstone advances scientific understanding of autism diagnosis in BIPOC communities by integrating cultural, structural, and clinical perspectives. It challenges the assumption of cultural neutrality in diagnosis and shows how inequities arise from the interplay of caregiver beliefs, clinical practices, and institutional and sociopolitical structures. By foregrounding these dynamics, the chapter extends existing scholarship and advocates for reconceptualizing diagnostic frameworks to better serve diverse populations.

A central contribution of this capstone is its clear demonstration that autism diagnostic frameworks, frequently regarded as universally valid, are in fact influenced by the cultural norms embedded within assessment tools, referral processes, and interpretive practices (Leeuw et al., 2020). Rather than reiterating observations about cultural difference, this work advances the field by illustrating that neglecting cultural context in diagnostic reasoning can result in delayed diagnoses, misdiagnoses, and diagnostic substitution for BIPOC children (Antony et al., 2022; Atherton et al., 2023). Thus, cultural context is positioned as a foundational element of diagnostic validity.

This capstone further integrates cultural analysis with structural perspectives on diagnostic practice. Previous studies have often examined caregiver beliefs, clinician bias, or access barriers in isolation (Bruno et al., 2024; Alward et al., 2021). In contrast, this work

synthesizes these factors to demonstrate how institutional practices, such as reliance on Western-based assessment tools, inconsistent referral pathways, and unequal access to language-appropriate services, interact with clinical judgment to determine diagnostic outcomes (Huda et al., 2024). Through this integrative approach, the capstone redirects attention from individual factors to the broader systems that sustain inequity throughout the diagnostic process (Bruno et al., 2024).

Finally, this capstone contributes to the scientific discourse by identifying gaps in current research and outlining directions for methodological advancement. It advocates for rigorous cross-cultural validation of diagnostic tools, research that prioritizes diverse developmental trajectories, and empirical studies that examine diagnostic processes and outcomes (Harris et al., 2013; Huda et al., 2024). By highlighting these research needs, this work establishes a foundation for future studies to enhance the validity, inclusivity, and depth of autism diagnostic science.

Recommendations for Clinical Practice

Although diagnostic inequities in autism assessment are increasingly recognized, significant gaps persist in empirical research and applied diagnostic frameworks. Addressing these deficiencies is crucial for enhancing diagnostic validity, reducing inequitable outcomes, and ensuring that assessment practices accurately represent the experiences of BIPOC children and families. In the absence of targeted methodological and structural improvements, current diagnostic systems are likely to perpetuate, rather than alleviate, existing inequities (Aylward et al., 2021; Antony et al., 2022)

Development of Culturally Validated Diagnostic Frameworks

While the limitations of Western-normed autism assessment tools are well established, a significant gap persists in the development and empirical validation of culturally responsive diagnostic frameworks (Donohue et al., 2017; Huda et al., 2024). Future research should extend beyond identifying bias in current instruments and instead prioritize systematic evaluation of alternative assessment approaches. To address these limitations, standardized measures should be considered supportive tools rather than definitive indicators and should be integrated into a broader, culturally responsive assessment framework (Harris et al., 2013; Huda et al., 2024). This approach requires flexible administration and interpretation of tasks, with explicit attention to how cultural norms regarding communication, play, emotional expressiveness, and social interaction may influence children's responses (Leeuw et al., 2020). Standardized instruments should be routinely supplemented with culturally informed clinical interviews, extended naturalistic observations, and collateral input from caregivers, educators, and community members who can contextualize observed behaviours (Lee et al., 2025).

In a culturally valid framework, diagnostic formulation should explicitly consider language exposure, bilingual development, pragmatic language use, and code-switching patterns, rather than interpreting language differences as deficits (Leeuw et al., 2020; Donohue et al., 2017). The involvement of professionally trained interpreters or cultural brokers, especially those with ASD-specific expertise, should be prioritized to facilitate accurate history-taking, minimize miscommunication, and prevent distorted clinical impressions (Huda et al., 2024; Antony et al., 2022). Clinicians should document how cultural and linguistic factors inform score interpretation and diagnostic decision-making, thereby ensuring transparency and accountability in assessment conclusions (Huda et al., 2024). Ongoing training in culturally responsive assessment and consultation with culturally knowledgeable colleagues further supports accurate classification

and reduces the risks of both underdiagnosis and overdiagnosis (Antony et al., 2022; Greer et al., 2024). Collectively, these practices can address the limitations of standardized diagnostic tools and promote more equitable, contextually grounded autism assessments.

Building Inclusive and Trusting Therapeutic Relationships

The reviewed literature demonstrates that diagnostic inequities intensify when assessment processes overlook families' histories of marginalization, institutional mistrust, and power imbalances, which influence how information is disclosed, interpreted, and utilized during diagnostic encounters (Antony et al., 2022; Constantino et al., 2023). Therefore, the clinician–family relationship is a central determinant of diagnostic accuracy, caregiver engagement, and alignment between clinical conclusions and family understanding (Bernier et al., 2010; Antony et al., 2022). In autism assessment, cultural humility functions as a methodological stance rather than merely an interpersonal value (Hook et al., 2013). Emphasizing reflexivity, attention to power dynamics, and recognition of caregivers as experts on their child's cultural and developmental context, cultural humility improves the accuracy and completeness of developmental histories and behavioural reports (Hook et al., 2013). When clinicians treat assessment as a collaborative process by validating caregiver knowledge, clarifying assumptions, and engaging families in shared meaning-making, they reduce the risk that cultural mismatch or clinician bias will distort diagnostic interpretation (Leeuw et al., 2020; Antony et al., 2022). This approach is especially important when assessing children whose communication styles, emotional expression, or social behaviours diverge from Western developmental norms, as it ensures that diagnostic conclusions are based on contextualized understanding rather than normative comparison alone (Bernier et al., 2010).

A culturally informed framework should incorporate trauma-informed practice, as this approach enhances diagnostic processes by shaping the environment in which caregivers share concerns, recount developmental histories, and participate in evaluative procedures (Bruno et al., 2024; Antony et al., 2022). When trauma-informed assessment practices are delivered by culturally responsive service providers who are attentive to power dynamics, historical marginalization, and cultural worldviews, engagement and disclosure can be significantly improved (Antony et al., 2022). Implementing principles such as transparency about assessment goals, predictable procedures, collaborative pacing, and explicit attention to consent reduces uncertainty and facilitates more accurate, nuanced information sharing (Bruno et al., 2024; Aylward et al., 2021). When caregivers perceive the assessment process as emotionally safe, culturally respectful, and responsive to their lived experiences, clinicians are more likely to obtain valid developmental narratives and reliable behavioural observations, thereby improving diagnostic reliability (Bernier et al., 2010).

Within this relational framework, psychoeducation can be a critical tool which serves as an assessment-linked practice rather than solely a post-diagnostic intervention (Donohue et al., 2017). Providing culturally grounded psychoeducation during the assessment and feedback phases fosters shared understanding by helping caregivers contextualize observed behaviours, interpret assessment findings, and understand the rationale for diagnostic decisions (Donohue et al., 2017). Utilizing culturally relevant metaphors, examples, and explanatory models improves comprehension and reduces the likelihood that diagnostic conclusions are misunderstood or rejected due to cultural incongruence (Hinton et al., 2012). Framing autism as a neurodevelopmental difference, while remaining attentive to families' cultural beliefs, supports informed consent, builds trust in the assessment process, and encourages appropriate follow-

through with recommended supports (Bruno et al., 2024). Integrating these approaches into autism assessment can help clinicians mitigate bias and cultural mismatch, increase caregiver engagement, and ensure that diagnostic conclusions are both clinically valid and culturally responsive.

Advocacy in Autism Assessment

Diagnostic inequities experienced by BIPOC children originate from structural factors within autism assessment systems. Consequently, advocacy is framed as an ethical imperative associated with equitable identification and access, rather than being confined to intervention alone (Aylward et al., 2021; Antony et al., 2022). Within this framework, advocacy involves promoting system-level reforms, including increased funding for bilingual clinicians and interpreters, the creation of culturally adapted diagnostic instruments, shorter wait times, culturally informed intake processes, standardized referral pathways, and mandatory training in cultural humility to mitigate bias in diagnostic decision-making (Donohue et al., 2017; Huda et al., 2024; Hook et al., 2013; Leeuw et al., 2020).

Advocacy also requires adopting culturally responsive assessment practices, such as culturally informed clinical formulation, flexible use of standardized assessment tools, and multi-informant approaches that emphasize cultural context in diagnostic evaluation (Antony et al., 2022; Constantino et al., 2023). Continued empirical research is necessary to evaluate whether these strategies improve diagnostic reliability and decrease misdiagnosis and delays among diverse populations without introducing new forms of bias.

Summary

This chapter examines the clinical implications of diagnostic inequities in ASD assessment for BIPOC children and families. It highlights the impact of cultural bias in assessment tools, systemic barriers to healthcare access, and institutional inequities on diagnostic formulation, differential diagnosis, referral patterns, and eligibility for clinical services (Aylward et al., 2021; Bruno et al., 2024; Huda et al., 2024; Leeuw et al., 2020). These factors determine whether children are overdiagnosed, underdiagnosed, or misdiagnosed, which in turn affects treatment planning, access to specialized interventions, and long-term clinical outcomes (Constantino et al., 2023; Antony et al., 2022).

Delayed identification limits timely access to early intervention, developmental therapies, caregiver education, and coordinated care, contributing to cumulative developmental and psychosocial challenges (Fenning et al., 2023; Aylward et al., 2021). Misdiagnosis can direct children toward behaviour-focused or symptom-management interventions that fail to address core neurodevelopmental differences (Constantino et al., 2023). Underdiagnosis frequently leads to prolonged unmet clinical needs and persistent misinterpretation of a child's developmental profile (Aylward et al., 2021; Hus, 2023). Structural barriers, such as limited language access, long wait times, fragmented referral systems, and inconsistent continuity of care, increase caregiver stress and may diminish trust in healthcare institutions (Antony et al., 2022; Kang-Yi et al., 2018; Huda et al., 2024).

Collectively, these findings indicate that diagnostic inequities function as concrete determinants of clinical accuracy, treatment access, therapeutic engagement, and long-term health outcomes for BIPOC children (Doda et al., 2024; Aylward et al., 2021). This chapter positions autism diagnosis within broader cultural and structural systems that influence clinical interpretation, caregiver disclosure, and decision-making processes (Leeuw et al., 2020; Bruno et

al., 2024). Current assessment practices often fail to adequately consider cultural context, family dynamics, institutional bias, and structural inequities that affect the expression, interpretation, and evaluation of developmental concerns (Antony et al., 2022; Huda et al., 2024). The literature underscores a persistent need for increased cultural humility, trauma-informed engagement, and systemic awareness in clinical assessment to enhance diagnostic precision, foster therapeutic trust, and promote equity in care outcomes for BIPOC children (Hook et al., 2013; Bruno et al., 2024; Huda et al., 2024). The chapter situates the capstone within broader scientific discourse, showing how culturally grounded autism research advances rigour and social justice. The next chapter presents overarching conclusions and recommendations.

Chapter Four: Recommendation and Conclusion

The overall purpose of this Capstone was to answer the research question: “How do systemic, cultural and structural barriers within the Western diagnostic system affect BIPOC families' access to ASD diagnoses and support for their children?” Finally, I reflect on what I have learned from this research, both clinically and academically and consider its implications for my future practice.

Conclusions from Literature Analysis

Five overarching themes and their respective subthemes were presented to address the research question, “How do systemic cultural and structural barriers within the Western diagnostic system affect BIPOC families' access to ASD diagnoses and support for their children?” Collectively, these themes illuminate the dual diagnostic realities of overdiagnosis and underdiagnosis that shape inequitable assessment outcomes. The five themes were described as follows: (1) “*Cultural Perception of ASD* (2) “*Diagnostic Disparities*,” (3) “*Structural Barriers and Exclusion*,” (4) “*Cultural Interpretations: Strength and Barrier*,” 5) “*Policy Gaps*”.

The first theme, “Cultural Perception of ASD,” highlights how community beliefs and cultural assumptions shape whether autistic behaviours are recognized as concerns or viewed as normative. In some cultural contexts, traits such as quietness, restraint, or deference are interpreted as signs of maturity or respect, leading teachers and caregivers to overlook early

indicators of ASD and resulting in under-identification (Atherton et al., 2022; Leeuw et al., 2020). In contrast, when medicalized interpretations of ASD are introduced without culturally sensitive communication, families may experience shame, fear, or the belief that a diagnosis reflects moral failure, which can lead to resistance or avoidance of assessment (Tefla et al., 2024). These dynamics demonstrate that culture is not merely a background factor but an active force influencing whether children receive timely and equitable access to diagnostic services and interventions (Atherton et al., 2023; Kangi-yi et al., 2018; Leeuw et al., 2020).

The second theme, “Diagnostic Disparities,” emphasizes how inequities in assessment arise from measurement bias, clinician bias and broader systemic barriers (Huda et al., 2024). Western diagnostic tools are often built on normative developmental assumptions that do not align with diverse cultural practices, increasing the risk that clinicians unfamiliar with these variations may interpret culturally normative behaviours as atypical (Aylward et al., 2021; Constantino et al., 2023). When assessment instruments lack cultural validation, systematic misclassification can occur, while clinicians’ implicit biases may further distort clinical judgment and referral patterns. Administrative datasets compile these disparities by tracking only diagnosed cases rather than true prevalence, creating the false impression of lower ASD rates in underserved communities (Maenner et al., 2023; Steinbrenner et al., 2022). These misinterpretations collectively contribute to the continued underrepresentation of BIPOC children in ASD diagnosis (Doda et al., 2024; Hus, 2023).

The third theme, “Structural Barriers and Exclusion,” underscores how socioeconomic inequities, geographical constraints, and institutional racism intersect to hinder BIPOC families’ access to screening, referrals, diagnostic evaluation, and ongoing supports. These barriers accumulate over time, increasing the financial, logistical, and emotional costs associated with

seeking care and reinforcing distrust of medical and educational systems (Antony et al., 2022; Doda et al., 2024; Liu et al., 2023). The structural barriers interact in multiplicative ways, producing chronic under-service and persistent inequities in ASD identification and support within BIPOC communities (Aylward et al., 2021).

The fourth theme, “Cultural Interpretations: Strength and Barrier,” highlights how family networks simultaneously function as protective factors and potential barriers in the diagnostic process. Extended family systems often shape help-seeking behaviours through elders’ authority, intergenerational beliefs and concerns about collective reputation (Kang-yi et al., 2018). While some families provide essential emotional and logistical support, their responses are deeply influenced by cultural norms that can either facilitate or hinder the pursuit of formal assessments. Younger caregivers are often more open to seeking evaluation, whereas elders may resist. The difference in attitude might be due to varying familiarity with neurodiversity narratives and child development. These intra-family negotiations can delay diagnostic action. At the same time, when cultural understanding and trust are established, family networks can be powerful sources of advocacy, system navigation and practical support such as childcare (Li et al., 2024).

The theme “*Policy Gaps*” outlines how universally framed policies unintentionally sustain inequities in ASD diagnosis in BIPOC communities. Although policies may establish structural supports, the absence of genuine community partnership, culturally competent workforce development, and accountability mechanisms results in persistent disparities (Bruno et al., 2024). Key shortcomings include chronic underfunding of culturally adapted services, lack of mandated data disaggregation, and jurisdictional gaps that disadvantage BIPOC populations. Consequently, families are left to navigate fragmented and complex diagnostic pathways with insufficient support (Stahmer et al., 2019).

Recommendations

Given the influence of cultural perception on ASD diagnosis, clinicians should incorporate cultural formulation interviews to determine whether behaviours interpreted as “shyness”, “obedience” or “respect” may reflect unmet needs (Leeuw et al., 2020). Providing families with culturally attuned explanations of ASD can reduce avoidance, increase trust and promote earlier referrals (Antony et al., 2022). This approach helps counteract underidentification that occurs when ASD is normalized or misinterpreted within specific cultural frameworks (Atherton et al., 2023; Leeuw et al., 2020). Interventions should prioritize culturally responsive psychoeducation delivered through trusted community channels to reduce stigma, clarify misconceptions, and support early identification (Atherton et al., 2023; Leeuw et al., 2020). Community-embedded outreach, such as workshops in faith-based centres, cultural associations, and agencies that serve immigrants, can help create spaces where families feel safe discussing developmental concerns without fear of judgment or moral blame (Tefla et al., 2024).

The research shows the need to prioritize reducing misdiagnosis, delayed diagnosis and culturally incongruent assessment practices that disproportionately affect BIPOC children. Interventions should begin with strengthening cultural competence across all stages of assessment (Aylward et al., 2021; Constantino et al., 2023). Clinicians should engage in ongoing training that enhances awareness of how cultural norms shape developmental expectations, communication styles and behavioural expressions, reducing the likelihood that culturally normative behaviours are misinterpreted as ASD (Leeuw et al., 2020). Improving diagnostic equity also requires integrating culturally responsive assessment practices. This includes the use of validated tools for diverse populations, the involvement of cultural brokers or interpreters

when needed and the practice of asking caregivers culturally grounded developmental questions rather than relying solely on Western benchmarks (Huda et al., 2024).

Given the role of family in ASD diagnosis, better practice should emphasize strengthening family dynamics to facilitate timely assessment and reduce intergenerational conflict surrounding help-seeking. Counsellors should engage primary and secondary caregivers in psychoeducation sessions to enhance their understanding of child development and reduce resistance stemming from cultural, moral, or spiritual interpretations of disability (Kang-yi et al., 2018). Such interventions allow providers to validate caregivers' beliefs while also offering developmentally informed explanations that frame ASD in a non-blaming, non-pathologizing manner. When clinically indicated, family systems-oriented interventions may enhance alignment among caregivers regarding the need for diagnostic evaluation and subsequent treatment planning (Goepfert et al., 2015). These interventions can strengthen the family's capacity for collaborative decision-making, helping reduce delays associated with intra-family disagreement and ensuring that cultural belief systems are incorporated rather than overlooked throughout the diagnostic process.

Beyond the family unit, broader community awareness initiatives are also essential in addressing stigma and misconceptions surrounding ASD (Stahmer et al., 2019). Community-based educational programs, workshops, and partnerships with faith leaders, cultural associations and immigrant-serving agencies can create culturally safe spaces for dialogue about developmental differences (Pearson et al., 2021; Kang-Yi et al., 2018). These initiatives facilitate the normalization of conversations about autism, reduce moralized or shame-based interpretations of disability, and promote earlier help-seeking. The integration of psychoeducation into trusted community networks allows providers to address stigma at both

familial and collective levels, thereby supporting more timely engagement with diagnostic services and reducing systemic barriers to care (Lee et al., 2025).

The systemic and structural challenges to ASD diagnosis in BIPOC populations highlight the need to address the systemic inequities embedded in the diagnostic pathways. Integrating cultural humility training within early childhood and healthcare settings can prepare professionals to recognize how structural racism and cultural stigma influence help-seeking behaviours. Recommendations should focus on reducing socioeconomic, geographic and institutional obstacles that limit BIPOC families' access to screening, assessment and ongoing support. This may include implementing culture-grounded community-based screening programs, embedding diagnostic services within culturally relevant community organizations, and expanding telehealth assessments to increase accessibility for remote, rural or underserved groups (Doda et al., 2024; Maenner et al., 2023). Given the persistent gaps in policy implementation, recommendations should also emphasize targeted policy reforms that mandate timely access to diagnostic evaluations, sustainable funding for culturally adapted services, and the disaggregation of data by race to improve accountability. These policies should be shaped through authentic partnerships with BIPOC communities to ensure that reforms address lived realities rather than reinforcing universal frameworks that ignore cultural differences (Leeuw et al., 2021).

Future Research

In the studies reviewed, most focused on BIPOC children, clinicians, educators, or standardized diagnostic processes, but few directly included BIPOC families as participants. I recommend that future researchers engage more directly with families from diverse cultural backgrounds to gather their perspectives on diagnostic experiences. Additionally, the literature

lacked longitudinal research tracking diagnostic pathways over time, which could provide deeper insight into how systemic, cultural and structural barriers influence the timing and accuracy of ASD diagnoses. There was also limited focus on the broader psychosocial impacts of delayed or inaccurate diagnoses on families, including stress, mistrust and emotional well-being. Future research could explore the effectiveness of culturally responsive diagnostic practices and interventions.

Future researchers can address questions such as:

1. How do BIPOC families perceive and experience the ASD diagnostic process within healthcare and educational systems?
2. In what ways do systemic and provider biases affect the accuracy and timing of ASD diagnoses in BIPOC children?
3. How effective are culturally adapted screening tools in improving outcomes for BIPOC children and their families?
4. What are the long-term psychosocial impacts of delayed or inaccurate ASD diagnoses on BIPOC families, including stress, trust in providers and engagement with services?
5. How can training programs for clinicians and educators be standardized to improve cultural competency and reduce disparities in diagnosis?

Reflection on Learning

Completing this Capstone Project has been a profoundly personal journey of growth and self-awareness. Engaging with the research has challenged me to reflect on my own assumptions, biases and ways of seeing the world. I have come to recognize how my perspective, both as a student and as a future clinician, is shaped by my own cultural lens and how important it is to

remain open, humble and curious when working with families from backgrounds different from my own.

As a person of colour, I carry my own lived experiences of navigating systems that were not always built with people like me in mind. Engaging with the literature on ASD diagnosis in BIPOC communities made me think about how often cultural knowledge, language and identity are misunderstood or dismissed in professional spaces. This project reminded me that these system gaps are not abstract, they have real consequences to families who look like mine and share similar struggles with being unseen or misrepresented.

On a personal level, I have come to appreciate more deeply the responsibility I hold in my future role as a psychologist. My identity shapes how I enter the room, how I listen, and how I advocate. This work has strengthened my commitment to honouring not only the clinical needs of children but also the cultural and historical realities that shape their families' lives. It has also pushed me to reflect on how I can use both my professional training and my lived experiences to stand with families who may not feel heard in traditional diagnostic settings.

Ultimately, this Capstone has left me with a stronger sense of purpose to be a voice for equity and cultural responsiveness in spaces that often overlook them. For me, it is not just about changing diagnostic practices, it is about contributing to a larger movement toward justice, dignity, and compassion for every child and family, especially those whose stories mirror parts of my own. This work has reaffirmed my commitment to ensuring that no child or families feel unheard, unseen, or misunderstood simply because the systems around them were not built with their realities in mind.

Conclusion

In this systematic literature review study, I utilized the DisCrit theory as a framework to examine the systemic, cultural and structural barriers that shape disparities in ASD diagnoses for BIPOC children. The literature underscored that factors such as systemic racism, provider bias, socioeconomic inequities and reliance on Western-centric diagnostic tools significantly influence the diagnostic process. These barriers result in delayed diagnoses, misdiagnoses and underdiagnoses, which in turn impact BIPOC families' trust, access to services and overall well-being. As a result, these findings highlight the importance of addressing cultural bias and systemic inequities that directly affect the diagnostic journey and outcomes for BIPOC children.

This study's findings suggest that clinicians, educators, and policymakers must engage in culturally responsive practices and integrate culturally adapted tools to reduce disparities and improve the accuracy of ASD diagnoses. Central to this process is the recognition of family perspectives, cultural values, and lived experiences, which shape help-seeking behaviours and diagnostic engagement. Training and support for professionals working with BIPOC children are essential to strengthen cultural competency, challenge biases and ensure equitable access to developmental and mental health services.

Ultimately, this Capstone provides a foundation for understanding how race, culture and disability intersect in ways that affect ASD diagnosis in marginalized communities. It also offers recommendations to improve clinical practice and guide future research toward the development of more equitable, culturally sensitive systems of care. By centring equity in diagnostic practices, this work reflects the urgent need to reimagine systems of care so that every child, regardless of cultural background, can be recognized, supported and empowered to reach their full potential.

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APPENDIX