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A Pretest-Posttest Survey Study of Parent Perceptions of the Effectiveness of Occupational Performance Coaching on Caregiver-Child Play Occupations

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**A Pretest-Posttest Survey Study of Parent Perceptions of the Effectiveness of Occupational
Performance Coaching on Caregiver-Child Play Occupations**

Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Occupational Therapy

Eastern Kentucky University
College of Health Sciences
Department of Occupational Science and Occupational Therapy

Hailee Lewis House, MSOT, OTR/L
2023

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Executive Summary

Background: When the COVID-19 pandemic began, and telehealth was utilized it was apparent that most of the client families did not have occupation-based play objects readily available in the home. Through this personal experience, the researcher began to realize that many of the client families had to drive 30 minutes to the closest convenience store, could not afford extra play-based objects due to having other children in the home, or did not know play objects that were age-appropriate for their child.

Purpose: The purpose of this study is to explore home program education strategies, and explore the relationships between store access, socioeconomic status (SES), and parental education levels on having age-appropriate play-based occupational items in the home.

Theoretical Framework. Occupational Performance Coaching (OPC) is a coaching intervention that helps parents to recognize and implement changes for more successful occupational performance for themselves and their child (Graham et al., 2009).

Methods. The study was a quantitative one group pretest/posttest design. The OPC educational program was conducted one time a week for four weeks in 20-minute therapy sessions with their child. The parent was educated on a particular play area/area of occupation. Each session was framed with the three domains of OPC, focusing on reflection with emotional support, goal setting and collaborative performance with the structured process domain, and components of information exchange (Kraversky, 2019).

Results. The increase in confidence in choosing a toy used for addressing therapeutic goals was found to be statistically significant. The remainder of survey questions resulted in a positive score change. The majority of parents reported this study was very valuable to them, they had improved interactions with their child, and had improved carryover of therapeutic goals. The study demonstrated the majority of participant parents were interested in their therapy sessions being led utilizing the domain of OPC with coaching, making goals for the home, and giving feedback on ways to problem solve issues their child may be having.

Conclusions: While all the data was not considered statistically significant, it was important in the fact that the post-tests show this four-week study intervention was valuable to the parents. The three objectives were to find if there was a change in parent perceptions and comfort with play, knowledge of access to age-appropriate toys, and knowledge of developmental milestones. Quantitative data shows the study was valuable to families and had potential to be statistically significant with a larger participant group.

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**EASTERN KENTUCKY UNIVERSITY
COLLEGE OF HEALTH SCIENCES
DEPARTMENT OF OCCUPATIONAL SCIENCE AND OCCUPATIONAL THERAPY**

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Occupations

Certification of Authorship: I hereby certify that I am the author of this document and that any assistance I received in its preparation is fully acknowledged and disclosed in the document. I have also cited all sources from which I obtained data, ideas, or words that are copied directly or paraphrased in the document. Sources are properly credited according to accepted standards for professional publications. I also certify that this paper was prepared by me for this purpose.

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Section 1: Nature of Project and Problem Identification

Introduction of Problem

As a pediatric occupational therapist (OT) in Southeastern Kentucky for five years, the researcher has addressed a variety of occupation-based goals for a wide variety of clientele. In her practice, prior to COVID-19, client families were given a home program to continue addressing the child's occupational therapy session tasks and goals throughout the week at home. The researcher experienced parents stating they were addressing these home programs, but no home program progress from week to week was evident. Then, whenever the COVID-19 pandemic began, and telehealth was utilized for all visits for one to two months, it was apparent that most of the clients did not have occupation-based play objects readily available in the home. The researcher began to provide more education on how to utilize various dollar stores, or other convenience stores, to access age-appropriate toys to add to the home to promote reaching developmental milestones. Through this personal experience, the researcher began to realize many of the client families had to drive 30 minutes to the closest convenience store, or some could not afford extra play-based objects due to having other children in the home. There were also multiple experiences where parents were asked if the child had puzzles to address visual perception and attention to task goals, and a parent would bring something inappropriate to the table. For example, one parent brought a 50-piece jigsaw puzzle to the table for a three-year-old child to complete. Through these observed experiences, two questions were formed: First, would parents improve home program participation with an educational program on developmental milestones and resources to purchase age-appropriate toys? Second, was this lack of play-based objects in the home secondary to living in Southeastern Kentucky with poor access to convenience stores, low socioeconomic status (SES), or low parental education levels leading to lack of knowledge on child development?

This study explores home program education strategies, and the relationships between store access, SES, and parental education levels on having age-appropriate play-based occupational items in the home. This research could improve home carryover of therapy goals with the use of Occupational Performance Coaching (OPC) giving parents confidence in their interactions of play with their children to improve occupational performance, therefore, presenting the need in the community for OTs to coach families on age-appropriate play, resources, and to improve parental independence in goal carryover.

Problem Statement

Play is essential to well-being and contributes to learning and development (Movahedazarhouligh, 2018). Play promotes school readiness, physical and mental health, and is closely tied to development of cognitive, socio-emotional, and physical behaviors (Movahedazarhouligh, 2018). However, for children with disabilities, their play may be different, neglected, or they may rely on others to initiate play (Hui & Dimitropoulou, 2020). Therefore, a lack of age-appropriate toys could negatively impact fine and gross motor development and reduced imaginative play. Reduced social development, and poor attention to task skills can impact school performance and family engagement (Movahedazarhouligh, 2018). As observed through the researcher's OT sessions, many children do not have age-appropriate toys in the home. Rural communities like those in Appalachia may be particularly impacted as there is reduced access to convenience and department stores. There also is the potential for reduced levels of education on developmental milestones. In the primary county of this study, Laurel, 18.9% of the population has at least a high school diploma (Zimmerman & McAlister, 2019). There are barriers to services and play for children in Appalachia at the community-level within the built environment, transportation, time constraints, limited

playmates, and financial limitations (Nolan et al., 2016). OTs are uniquely qualified to educate parents on age-appropriate toys, due to recognizing the opportunities each toy can bring to development through task analysis and their knowledge about developmental milestones.

Coaching and feedback can be a powerful tool for improving participation and performance and OTs can provide this training to families in meaningful contexts (Laverdure & Beisbier, 2021).

Research is needed to determine the impact of an educational program with parents on available, and affordable, age-appropriate toys for their child for improved occupational performance.

Purpose of the Project

The purpose of this quantitative pre-test/post-test intervention study was to determine the impact of an educational program with client families had on access to affordable age-appropriate toys for their child for improved occupational performance. An educational program using OPC was conducted over four weekly sessions. Caregivers were educated on developmental milestones and how/where to access age-appropriate toys that are economically feasible for their SES. Four weeks was determined to be appropriate based on the recommendations of Ahmadizadeh et al. (2022) that four to 12 sessions were an effective dosage of OPC for generalization of skills. Sessions included discussion with review of age-appropriate tasks in fine/gross motor coordination, play, school readiness and attention span related to milestones and age-appropriate toys, assessed with a pre-post survey. Outcomes measured included parents' knowledge of developmental milestones and age-appropriate toys, as assessed with a pre/post-test.

Project Objective and Research Questions

Will parent perceptions and comfort with play with their child at home change as a result of developmental education using an OPC approach?

Will caregiver knowledge of access to age-appropriate toys change as a result of developmental education using an OPC approach?

Will caregiver knowledge of developmental milestones change as a result of developmental education using an OPC approach?

Theoretical Framework/Scientific Underpinnings

For this study, the Person-Environment-Occupation-Performance (PEOP) model (Cole & Tufano, 2020) and OPC model (Kravetsky, 2019) are the theoretical constructs to explain the daily routine changes that will have to occur in each family to integrate the knowledge learned into daily practice. These constructs also guided the approach to creating the sessions of the study. With this program families are going to learn the resources of their community and integrate these into their homes to improve their child's occupational performance to better improve therapy goals. Therefore, these families will have to integrate play opportunities for their child into their daily schedule/routine. By learning through this program, parents should become motivated to address this in the home. PEOP guides a practitioner to address the person, occupation, performance, and most importantly the environment. Through clinical practice and daily experience, one can come to value how PEOP looks at the environment as an integral part to families participating in certain occupations. OTs can help them to realize all the resources that are available to help them overcome potential barriers. The PEOP model also fits into this study because the natural process of the model aligns with the study's design. PEOP guides therapists to begin with the narrative phase of assessing the client's strengths and problems (Cole

& Tufano, 2020). Then using the information gained from the interview, the therapist chooses a standardized assessment that best applies (Cole & Tufano, 2020). Then, the therapist would complete the interventions with the Occupation-Based Practice (OBP) research and frameworks that apply (Cole & Tufano, 2020). Lastly, as the therapist completes the interventions, they reassess to measure if the intervention is working (Cole & Tufano, 2020).

OPC “is a coaching intervention that assists parents to recognize and implement social and physical environment changes supporting more successful occupational performance for themselves and their child” (Graham et al., 2009). Therefore, OPC is the guiding model for this study due to being the educational plan format for the parents. Therefore, this study will follow the three domains of OPC-structured process with goal setting, emotional support, and information exchange (Kraversky, 2019). A chart created by Kraversky (2019) of the three domains of OPC and their tasks can be seen in Appendix A. First, structured process was utilized in the making of this study by having a set guide for each session, a set time for reflection, coaching on the next area of discussion, and then giving homework where the caregiver would create a goal for the next week. Secondly, emotional support was integrated into the study sessions with having the discussion time between parent and therapist, where the parent could discuss issues they may be having where the researcher could empathize, guide, or encourage the parent on ways to problem solve their situation. Lastly, information exchange was used by the study itself with the parent being educated on developmental milestones, and available toys in community stores. Using a coaching strategy gives OTs a more precise way of talking about occupations and keeping them client-centered (Kessler et al., 2018). Using OPC allows the training of identifying and problem solving through small weekly goals and helps develop self-efficacy to manage challenges a parent may face with their child’s participation in occupations

(Kessler et al., 2017). Coaching allows the parents to have an opportunity for insight and reflection (Kessler et al., 2018). OPC is a top-down approach with domains and specific steps to guide therapist-caregiver collaboration to empower the family (Kraversky, 2019). This standardized structure also promotes in the study a high reliability, validity, and generalizability with confidence for intervention effectiveness (Shin et al., 2022).

The worldview of this research is based on the data found on the population of the community of this study. Southeastern Kentucky, specifically Laurel County, the location of the researcher's clinic, has the following demographic as shown in Table 1:

Table 1: Demographic of Laurel County

Population	60,669
Median household income	\$39,830 (yearly)
Full-time workers falling below poverty level	4.3%
Grandparents responsible for raising their grandchildren	910
People with at least a high school diploma	18.9%
Food insecurity rate	16.3%
Median rent	\$699 (monthly)
Population below poverty level	27.4%

Note. (United States Census Bureau, 2022; Zimmerman & McAlister, 2019).

This poverty level is twice as high as the national average of 12.8%, (Data USA, 2021). In Southeastern Kentucky, Laurel County is considered a larger county, meaning these rates may

be worse for other counties in the Southeastern Kentucky area. Looking at the data and seeing a community with a high poverty and food insecurity rates, the numbers could be portraying families with lower healthcare access, community resources, or educational opportunities. These numbers provide a way to see the community as a range of potential challenges for children and families. Families with lower education levels, living in rural areas with little extra money to provide play opportunities for children, may not know their child's developmental milestones and how to meet them. They may not know that the major occupation of children is play, and that providing play activities in the home provides opportunities for development. Therefore, PEOP and OPC align with this background information to support the family's context, integrating changes needed in daily routines to make this educational program in a clinical setting a success.

Significance of the Study to Practice

This study directly correlates with the overall goal of Healthy People 2030 of improving healthy equity, health literacy, improving the environment to attain full well-being potential, and promoting healthy development across all life stages (American Occupational Therapy Association [AOTA], 2020). First, health equity will be addressed by the parents being educated on resources around them to find affordable and appropriate toys for their children. Secondly, health literacy is used in the study by giving parents information on developmental milestones to know what their child could be working towards. Third, improving the environment is directly addressed in the study by each educational session by coaching parents on how to better interact with their child through play to enhance their environment at home for occupational performance. Lastly, promoting healthy development is given in the study with coaching about

developmental milestones, teaching parents their child's age equivalency in a variety of skill areas, and what skill is to be worked towards next.

Then, when considering the AOTA Vision 2025, this program directly addresses the four pillars with OT being effective, leaders, collaborative, and accessible (AOTA, 2018). This study will provide effective services by bringing evidence-based research on the best coaching methods and developmental milestones to client's everyday routines in the home with affordable toys to improve their therapy carryover and generalization of skills for improved performance (AOTA, 2018). This is a leadership opportunity for occupational therapy by the local environment and making it more accessible to those in the community (AOTA, 2018). This is a collaborative opportunity to allow occupational therapists to attend to what resources in the community their clients are searching for and help make these attainable (AOTA, 2018). Lastly, this is an accessible opportunity from beginning to end, in educating client families with what the town has to offer, and how the ideas are easily integrated into the home daily (AOTA, 2018).

Summary

In summary, the purpose of this study was to explore the impact of education about developmental milestones and age-appropriate toys on parents' knowledge of age-appropriate play-based occupational items in the home and typical development for their child with a developmental delay. This program addresses current community concerns through Healthy People 2030, and AOTA's Vision 2025 (AOTA, 2018, 2020). This research could improve home carryover of therapy goals for increased generalized learning, with improved interactions from caregivers. Therefore, presenting the need in the community for OTs to educate families on resources, using OPC to improve parental independence in goal carryover.

Section 2: Literature Review

OPC Compared to Other Coaching Strategies

Coaching is an evidenced based approach to educating parents of children with disabilities. Systematic reviews of literature show evidence of child improvements in nonverbal communication, joint attention and engagement, initiation, behavior, play, adaptive functioning, Autism symptoms, sensory processing, and self-regulation (Althoff et al., 2019). Miller-Kuhaneck and Watling (2018) assessed parents and teachers in school settings using OPC specifically addressing sensory processing and integration needs, and found that OPC could result in positive outcomes for both parents and children, often in a relatively short time period. Coaching engages parents in the therapist role, where the therapist can guide and collaborate with the parent (Althoff et al., 2019). Coaching is supposed to be thought provoking and creative, focusing goals identified by clients, and promoting problem solving skills to empower them (Gerhardt et al., 2022). These skills can provide skillful questioning, reflective responding, and leveraging of clients' strengths and that it should be used to optimize health, wellness, and participation in daily activities (Gerhardt et al., 2022). There are also multiple forms of coaching styles, and so one must choose the best style for their therapeutic approach. Seruya et al. (2021) advises coaching needs defined as it varies. OPC helps parents to be autonomous by learning the structure and steps of OPC to guide them to confidently apply learning at home with their child (Graham et al., 2009). OPC supports enabled, positive, and strength-based conversations for families, which are contemporary for occupation and client-centered practices of the occupational therapy field (Graham et al., 2009). OPC is context and child-focused giving high level of engagement between parent and child (Graham et al., 2016). Lastly, OPC helps parents

to specifically adjust their interactions with their child, and to match a task to their child (Graham et al., 2016).

Current Research Supporting OPC

Current OT research has focused on coaching strategies for parental supports, with many research trials being completed just within the past five years through AOTA's critically appraised topics and the American Journal of Occupational Therapy publications. Graham et al. (2013) educates on occupational performance coaching with mothers of children with developmental delays or autism spectrum disorder. This study examined and found the effectiveness of OPC in improving children's and mothers' occupational performance and parenting self-competence (Graham et al., 2013). As the field of occupational therapy focuses practice on family and occupation centered goals, this evidence illustrates that OPC may lead to generalized improvements in children's performance in other occupations beyond their specific intervention goals (Graham et al., 2013). Related to parent experiences with OPC, it was found mothers had insights about themselves, and their child's performance levels (Graham et al., 2014). The mother had more understanding of their child, a calmer/happier tone was used amongst the family, and felt OPC was a valuable support to their family (Graham et al., 2014). Next, in 2018, Graham et al. researched therapist perception of OPC, finding therapists reported the following benefits: listening better, sharing power, reprioritizing processes, and found it liberating and challenging at the same time. Therapists felt that trust developed quicker between themselves and their clients and helped build competence and confidence with caregivers (Graham et al., 2018). These study results relate to this research by demonstrating children and parents both benefit in multiple forms of outcome measures by coaching strategies. These interventions include modeling strategies and feedback from therapist to parent, parent coaching,

and individualization of intervention strategies. This study demonstrates that parent education in home programs could increase generalization of learning, learning in a natural environment for the family, and improved skill maintenance over time. Overall, based on literature review, more research is needed on specific implementation of age-appropriate, play-based objects in the home to improve home program participation and increased development towards milestones, while also addressing parental factors.

OPC in International and Various Settings

Internationally there has been more research completed on OPC as reported in the British, Australian, and Canadian Journals of Occupational Therapy. Therapists in multiple countries report positive results in the use of OPC with a wide variety of disorders and different settings. Suja Angelin et al. (2021) utilized OPC specifically in India, with significant results on the mothers' and the children's occupational performance, and self-competence with three major themes of acceptance, self-learning, and challenges. They found these results lasted for over a month with the cultural perception of OPC that it was effective in diverse settings (Suja Angelin et al., 2021). Therefore, it is appropriate to demonstrate OPC is effective across cultures and family lifestyles, such as for this study in Appalachian Kentucky.

OPC has also been found to have significant effects with children and adults with a multitude of disorders. Ahmadi Kahjoogh et al. (2019) found that OPC had significant effects on participants' occupational performance and self-efficacy for mothers of children with cerebral palsy. Ahmadizadeh et al. (2022) is preparing a randomized control trial of OPC with adults with heart failure, on the hypothesis that OPC generalizes skills for self-care and autonomy. There have been multiple studies assessing OPC with strokes, finding improved self-efficacy, participation in occupations, goal performance and satisfaction (Kessler et al., 2014; Kessler et

al., 2017; Kessler et al., 2018). Shin et al. (2022) found OPC to be a reliable and generalizable way to give effective interventions with clients needing assistance with diabetes management. OPC has even been found to be a successful tool with picky eating in feeding therapy, with parents having improved satisfaction in their role, improved child performance, and reduced maladaptive behaviors (Johnson, 2017).

Lastly, it has been found that OPC can be integrated into various therapy settings such as schools and clinics as well as alternate delivery systems such as telehealth. Hui et al. (2016) found that OPC helped teachers manage disruptive behaviors resulting in an improved perception of performance and satisfaction. Wallisch et al. (2018) was able to integrate OPC into sessions via telehealth and found there were significant cost savings than typical therapy delivery models. Little et al. (2018) also used OPC through telehealth, finding that parents were able to feel more effective in working with their children, and the children had better participation with their parents, which would correlate with how this study began with seeing how parents engaged with their children in their homes.

Family's Home Adaptation

A major part to this study is utilizing OPC in a way that families can utilize these skills in the home and better interact with their children. Therefore, the home needs to be taken into consideration of how a therapist integrates strategies into a family's routine. It is thought, such as in the bagless coaching style in early intervention practices, that therapists must introduce therapy in the natural environment (Lydell & Bolton, 2020). If therapists are taking objects into the home, the family is not empowered, the therapists are only empowering themselves (Lydell & Bolton, 2020). A bag of toys should not be the agent of change for the child, but the family should be given tools and skills to promote development (Williams & Ostrosky, 2020).

Therefore, when integrating therapy with a family, one must consider the home environment and analyze the overall lifestyle and what changes the family is ready to make. Kaelin et al. (2021) completed a qualitative study looking into how parents and caregivers were most commonly able to make adaptations to their homes or support their children with therapy goals. They found four overall themes: adaptation of child's environment or context, supporting child's sense of self, utilizing child's preferences to support participation, and improving the child's activity competence. This study analyzes the relationship between caregivers and OTs in supporting home and community participation of children (Kaelin et al., 2021). The authors recommend gathering information through an examination, and then provide opportunities and support for children and caregivers to learn together through participation-focused interventions (Kaelin et al., 2021). The implications to practice also discusses the importance of asking caregivers about their strategies to give the most support (Kaelin et al., 2021). Earlier studies began touching on this information, such as Larson in 2010, who looked to identify the key factors of well-being in caregivers with children with disabilities to assess quality of participation in the home. Researchers found that the psychological well-being key indicators were personal growth, self-acceptance, positive relations with others, purpose in life, and autonomy (Larson, 2010). The biggest well-being indicator was the ability to balance life demands (Larson, 2010). This article gives a foundational knowledge in this research area that has little other research that has been conducted. This study applies to the study being completed, because it addresses that these well-being factors of parents with children with disabilities must be met before a therapist can give a parent more to do in the home. As the results showed, the biggest well-being factor is the family having occupational balance (Larson, 2010). This will need to be addressed during the educational program before the families could begin adding more interventions to the home.

The Importance of Play

Another consideration in this study is the effect of play on the family, and how the family participates in play. Studies have shown that children with autism may play less than others or have a non-functional form of play (Althoff et al., 2019). Children with disabilities have more interactions with play when toys are limited and well chosen (Movahedazarhouligh, 2018). Caregivers of children with disabilities may benefit from additional guidance from therapists on what is best for their child, and toys provided in therapy can serve as a model and aid in decision making (Healey et al., 2019). Therefore, therapists should expand play and promote developmentally appropriate play which is meaningful and client-centered towards goals (Hui & Dimitropoulou, 2020). Therapists must educate families that the occupation of play is essential and not frivolous. Play actively enhances brain structure and function. This knowledge can balance many current media technology uses with children, which, per Yogman et al. (2018) encourages passivity. Current culture includes marketing to families that the best toys for their child are electronic and expensive toys, when some of the best toys for development are quite inexpensive and easily made in the home (Yogman et al., 2018). Therapists need to educate families about the occupation of play and developmentally appropriate resources.

Occupational Therapy in Rural Communities

There are very few studies discussing the challenges, or differences, of being an OT in rural areas, specifically in Appalachian Kentucky. In the creation of this study, it was taken into account that 54% of American adults read below a sixth-grade level (Nietzel, 2020), and 30 million adults struggle to complete basic reading, which could negatively impact locating community services, filling out forms, sharing information with their healthcare providers, managing diseases and managing self-care (Centers for Disease Control and Prevention [CDC],

2010). Therefore, the study content was constructed at the reading level appropriate for the parent participants. Lastly, as found in the data describing demographics of Laurel County residents, many children in the Appalachian area are raised by grandparents. Keller et al. (2018) found that in Appalachia, one in five kids are raised by grandparents, as compared to one in 14 for the rest of the United States (Scommegna, 2012). Grandparents as parents may result in higher levels of stress, inadequate resources, and poor health (Keller et al., 2018). Lynch et al. (2016) evaluated socio-cultural influences on infant play occupations in Irish home environments, where they were able to analyze parent and cultural backgrounds effects on access to play, finding play is influenced by different forms of parental reasoning-work, culture, routines, life balance, parent play preferences, and discipline. This study informs the current study by emphasizing educating parents, seeing what play is occurring in the home, and how this play is being affected in rural or urban communities. In the Division for Early Childhood (DEC) Recommended Practices (2014), play is used both as an evaluative tool and an intervention modality addressing: volition, habituation, and performance of the child and family, strengths and weaknesses of the environment; demonstrating play is a primary measure of competence and change. This organization provides a framework for occupational therapy, and others, in early intervention settings. They explored the use of adapting play environments, creating toy libraries, communicating with parents on facilitating skills/knowledge/developmental stages of play (including social, cognitive, physical, and emotional development). These are all key factors that the current study is going to further assess with families in Southeastern Kentucky.

Research shows the success of parenting groups in Appalachia. Hilton et al., (2022) found that when providing a group intervention study in Appalachian counties teaching parenting strategies for those with children with attention-deficit/hyperactivity disorder, therapy services

were utilized to the same degree as other geographical locations when offered. In Hilton et al.'s (2022) study they had multiple participants driving 30 minutes to over an hour to attend the group sessions; therefore, demonstrating that parents in Appalachia will still participate in services even if they are located a great distance away. Another study found that parents were more trusting when the group leader was also from an Appalachian area (Studts et al., 2020). Some parents were afraid of being judged for their mental health or faced barriers to participate in regular therapy sessions to be geographic access, SES, and ethnic differences (Taubenheim & Tiano, 2012). Lastly, parents were afraid of being judged for their lifestyle, distrusted outsiders, and felt they may have a loss of privacy (Owens et al., 2007).

Parenting traits in Appalachia have been studied as well. Li et al. (2020) found higher SES status impacted parenting styles towards increased homework support and positive styles of discipline, types of communication, and time spent with their children, while lower SES status had more strict styles of discipline. Slocum et al. (2019) looked at how parents supported college participation, finding that many parents had difficulty navigating the economic landscape to utilize and understand what different universities had to offer. Bornstein et al. (2012) analyzed the different parenting traits between older and younger mothers in Appalachia, finding older mothers were more sensitive to their child's emotional needs and had more structured environments. Fish et al. (2007) assessed the differences of negative and positive parenting styles, finding that rural Appalachian mothers had a wide range of parenting styles and behaviors, just like other regions. This is to be utilized for this study by the knowledge that there will still be a wide variety of parenting approaches by the participants.

Summary

A variety of literature was used to inform and define the study. First, a specific coaching strategy had to be chosen for the study. Coaching evidence supports educating parents leading to improvements in communication, attention, engagement, behaviors, self-care, adaptability, and play (Althoff et al., 2019). Therefore, OPC helps parents to specifically adjust their interactions with their child, and to match a task to their child (Graham et al., 2016). Secondly, current literature on OPC was assessed. Majority of the current studies are finding consistent improvements in mother satisfaction with child performance and self-competence improved, and child performance increased for goals addressed during interventions and goals addressed at home without the therapist (Graham et al., 2013). Thus, OPC has consistent results which would assist in this study being integrated with the therapist and families. Lastly, OPC has been utilized in studies across the world and with a wide variety of diagnoses. Therefore, demonstrating that OPC is effective across cultures and family lifestyles, such as for this study in Appalachian Kentucky.

Next, literature was found about integrating programs into households, specifically those in Appalachian Kentucky. Many studies discussed the importance of attending to the client family before addressing client deficits. Parents were found to independently adapt their environments in the home or with people to better provide predictable environmental structure or routines (Kaelin et al., 2021). Parents tied mental well-being to personal growth, self-acceptance, positive relations with others, purpose in life, autonomy, and the biggest measure was sense of balance in life demands (Larson, 2010). Meaning for this study, the parent needs to have their needs met before integrating more tasks into the home. Secondly, for this study there is the focus on education of play for the families. Supporting engagement in occupations between caregivers

and children was found to improve performance and participation in ADLs, play and leisure (Laverdure & Beisbier, 2021). Play was found to be possibly used as a framework, as an evaluative tool, and as an intervention modality used as a measure of competence and change, that addresses the volition, habituation, and performance of the child and family (DEC, 2014).

Lastly, literature was used to assess how parenting impacts play, and how Appalachian Kentucky could potentially differ from national views. Parental reasoning can shape home learning by play occupations being shaped and influenced by parental values, attitudes, play preferences and characteristics, what they were allowed to play for safety, and including/segregated play (Lynch et al., 2016). Different SES levels are shown to reflect different home-based parental involvement in and styles for parental homework support, discipline, parent-child communication, and parental time with children (Li et al., 2020). Lastly, it was found that to be successful in rural environments therapists must develop good relationships with clients, find a new normal based on the families present, understand the context that shapes the behavior, and be a jack of all trades to address all client-centered goals (Waite, 2015).

Section 3: Methods

Project Design

The study was a quantitative one group pretest/posttest survey design. Survey design puts quantitative measures on attitudes and opinions, and answers questions about the relationships between variables which this study is seeking to find (Creswell & Creswell, 2018). Survey questions were created for a pretest-posttest to analyze knowledge found before and after the educational program. The content areas were composed of access to local stores with age-appropriate toys, knowledge of affordably priced objects, and knowledge of developmental

milestones. The survey questions were generated to assess the families' value in the knowledge gained, how much knowledge was gained, and how they can apply the information. See Appendix B for survey questions. The OPC educational program was conducted one time per week for four weeks in 20-minute therapy sessions with their child. The family was educated on a particular play area/area of occupation during each session. Each session was composed of the three domains of OPC, focusing on reflection with emotional support, goal setting and collaborative performance with the structured process domain, and components of information exchange (Kraversky, 2019). In session one, the parent participant completed the pre-test and a developmental milestone checklist to establish the age-equivalency of their child. Session two began with the parents reflecting on how their view potentially changed at looking at toys or at stores from the previous week. Then they were asked to select two developmental milestones they had identified that their child could not perform the previous week. They were then educated on multiple ways to address the milestones in the home such as child's needs in gross/fine motor coordination, play/social skills, or self-care/IADLs. Session three began with reflective time to discuss what had resonated with the parent since the last session and how addressing their two milestone goals had gone in the home. Then the parents were given a handout and discussed local toy access to help address their child's developmental milestone goals further in the home. In the fourth, and final session, assessment was completed again through the posttest to understand how the program was carried over to the home, how often, and the parent confidence level in their knowledge of play activities for their child. See Appendix C for session layout.

Setting

This study took place at an outpatient pediatric clinic in Southeastern Kentucky. This site was chosen due to the researcher having access to therapy clients and their families.

Identification of Participants

The target population is a convenience sample of client families attending the outpatient pediatric therapy clinic in Southeastern Kentucky. Those who were invited to participate met the following inclusion criteria:

- Parents of a child receiving outpatient occupational therapy services at the clinic where the study was conducted.
- Parents with a child aged one to eight years with a diagnosis of developmental delay or autism spectrum disorder. This would be the primary age range of children who would still participate in play with toys.
- Parents stating willingness to participate in weekly OPC sessions for four weeks.
- Parents who indicate plan to attend a minimum of three out of four sessions.

Exclusion criteria:

- Parents of a child older than eight years of age.
- Parents with a child aged one to eight years with a behavioral diagnosis, because their therapy goal is focused on maladaptive behaviors and attention to task, rather than the skills needed of fine and gross motor development to complete tasks.
- Parents who have an established therapy attendance rate of less than 75% of past scheduled visits at the clinic where the study was conducted. This would impact the family completing the educational program and would impact carryover potential from therapy sessions.

The researcher examined her current caseload to identify families who met the inclusion criteria. Of the caseload, 21 parents met the inclusion criteria and were invited to participate in

the study; 16 signed an informed consent form; and 13 completed the study. All parent participants were mothers. The family name was coded as a number to maintain confidentiality.

Data Collection

Survey questions were created for the pretest-posttest to measure changes in participant perception knowledge before and after the educational program. The content areas were access to local stores with age-appropriate toys, knowledge of affordably priced objects, and knowledge of developmental milestones. These survey questions were also generated to assess the families' value in the knowledge gained, how much knowledge was gained, and how they can apply the information. The data was collected by printing out the survey questions. Then, the researcher gave the surveys to the parents while their child completed their therapy session, so that families had time to think through their questions without the researcher standing present and without child distractions. Three of the mothers were given their pre-test over the phone because they cancelled their therapy appointments due to inclement weather. They were informed the phone call did not apply as a therapy session and the call was for the study's initial session only. The mothers were read the question and the Likert-style answers choices, to ensure they understood all possible answers. This phone pretest option was given to ensure they stayed within the timeline of this study, supporting their continued participation in the study. For in person session one, upon conclusion of the child's therapy session, the survey was collected from the parent participant. They were asked if they had any questions on how to complete the survey, or any questions on the phrasing of the question. This ensured the parents understood the questions asked of them, enabling them to give the most correct responses.

Data Analysis

Once data was returned, data was entered into an Excel spreadsheet. The importance of managing data is to reduce collection errors, and maximize data quality (Finalyson & Denend, 2017). Data analysis can be conducted in the Excel program. Quantitative analysis was performed using Excel's XLMiner Analysis ToolPak to complete a descriptive analysis of demographic variables and tests of association. A test of association, paired-t-test, was used to determine if there were significant differences between pre- and post-test survey questions. Level of significance was set to $p < .05$. These comparisons were to answer the question about the effectiveness of the treatment program from pretest to the posttest data.

Validity

To ensure the results are valid and reliable, the content validity was analyzed through a pilot group of therapists in the clinic to make sure the survey measured/asked what it was intended to measure, meaning the study was most at risk of internal validity threats (Creswell & Creswell, 2018). The study was also at risk of external validity threats, with the interaction of history and treatment, and the setting due to having a limited population, the experiment is time bound in one population area (Creswell & Creswell, 2018). To correct these external threats, a sample of convenience was conducted of the clientele. All clients, falling in the inclusion criteria, were asked to participate. This was in order to ensure the best approach at gathering the most diversity possible on caseload.

Ethical Considerations

With the current research dealing with community access, and socioeconomic status of families, many ethical concerns became apparent. Before the study began, an application to the

Eastern Kentucky University's Institutional Review Board was submitted. See Appendix D for the application and Appendix E for the approved informed consent form. This ensured the ethical nature of the study and consisted of plans for informed consent, research protocol, risks and benefits, identification of the population and the training involved (Workman et al., 2017). In the beginning of the study when it was time to disclose the purpose with the participants, many may have felt that they are being judged, as the study dealt with vulnerable populations with children and families (Creswell & Creswell, 2018). Therefore, close attention to language and educational approaches were used, so that mutual respect was shown for all the families. Informed consent with the participants was completed. Then when collecting data, it was possible that with scheduling difficulties amongst families and in the clinic, that some children would not have the same allotted amount of time as other children, therefore the educational program was structured and timed so that each participant received the same treatment (Creswell & Creswell, 2018). To do this, each lesson was 20 minutes so that each child/family received the entire educational lesson for that session, whether they were scheduled for 30- or 45-minute OT sessions. Lastly, when considering AOTA's (2015) Code of Ethics' principles and standards of conduct, one of the principles is autonomy. During this study, it must be remembered that even after the families are educated on the educational program of bringing toys into the home for their child, the families still have the right to be autonomous, where they can make their own choices of what to do with the information and have their own values and beliefs of how to raise their child (AOTA, 2015).

Section 4: Results and Discussion

Description

As stated previously, 13 participants completed the study. All parent participants were mothers. The family name was coded as a number to maintain confidentiality. The participants completed their pre-tests during the first session, and then completed their post-tests during the final, fourth, session. Data was entered into Excel and analyzed with the data analysis tools.

The pre-test and post-test were composed of six identical questions with a five-point Likert scale answer. The post-test had an additional six questions with five-point Likert scale answers to assess the participants' sense of value in the study and knowledge gained. See Appendix B for the layout of the pre-test and post-test.

The t-test results and the average increase from pre-test to post-test can be seen in Table 2. From the data it was found that only question two was statistically significant with the data being less than $p < 0.05$. However, as seen from the average score for each question (1 to 6), all post-test questions resulted in an increased score. For question five the average score was not a substantial variable due to the question concerning time needed to get to a store that sells toys. However, eight participants found no change, two participants reported an increase in time needed to reach stores carrying toys, and three participants reported a decrease in time needed. Then when looking at the additional six post-test questions, it was found that majority of the participants completed their home plans two to three times each week. Ten participants completed the home plans three times a week, and three participants marked completed one to two times a week. The mothers also reported that on average this study made them feel very confident with working with their child, the information was very valuable, and these sessions improved knowledge of developmental milestones and improved interactions with their child a lot. Results can be seen in Table 3.

Table 2: Results to Questions 1 to 6

Pre/Post Question	1	2	3	4	5	6
T Test Result	0.165	0.012	0.218	0.082	N/A	0.165
Average rating of all responses pre-test	Pre-4.85	Pre-4.46	Pre-3.53	Pre-4.23	Pre-b	Pre-3.85
Average rating of all responses post-test	Post-5	Post-5	Post-3.85	Post-4.69	Post-b	Post-4.31

Figure 2**Appendix B Pre-test and Post-test Questions 7 to 12**

Questions 7 to 12					
1. Were you able to complete the home plans after each session?					
a. Unable	b. 1 or 2 times between sessions	c. 3 times each session			
2. How confident do you feel that you can take this information learned, and continue working on this with your child?					
1	2	3	4	5	
Not at all confident	Not confident	Neutral	Confident	Very confident	
3. Was this information valuable to your family?					
1	2	3	4	5	
Not at all valuable	Not valuable	Neutral	Valuable	Very valuable	
4. Do you feel like you learned more about developmental milestones?					
1	2	3	4	5	
None	Not really	Neutral	Some	A lot	
5. Do you feel that these sessions have made it easier for you to interact/play with your child?					
1	2	3	4	5	
None	Not really	Neutral	Some	A lot	
6. Do you feel that these sessions have made it easier for you to work on your child's therapy goals at home?					
1	2	3	4	5	
None	Not really	Neutral	Some	A lot	

Table 3: Results to Questions 7 to 12

Post-test Question	7	8	9	10	11	12
Average rating of all responses	2.77	4.92	4.85	4.92	4.85	5

Discussion

During these study sessions, specifically sessions two and three, the beginning of the session was started by asking the mother how the previous week had gone. Therefore, allowing the parent to discuss what went well and what further needed addressed. This gave the researcher additional time to educate the parent on additional developmental strategies for use with their child at home, supporting parent problem solving for home program focus for the next week. Integrating this feedback time opened the conversation to other difficulties the parents were having in the home. Multiple parents discussed new topics which never arose during the standard therapy sessions, with mother's educating the therapist on their child having difficulties with potty training or showering, or discussed problems they were having with integrating speech goals into the home. The conversation also led to the mothers showing the researcher what had gone well through pictures/videos of the child, or one child making a craft for the researcher utilizing the craft as a way to address their goals for the week. Mothers stated that they had improved interactions with their child at home, and that they had begun to see toys in a new light with problem solving all their uses.

As found in the research, four weeks was determined to be appropriate on the recommendations of Ahmadizadeh et al. (2022), that four to 12 sessions were an effective dosage of OPC for generalization of skills. For this study four weeks was sufficient to demonstrate a change in knowledge and value of OPC per parent experience. However, multiple mothers expressed that they wished the study was longer, therefore if used in regular practice or in further

research more sessions may be utilized. OPC is utilized to help parents to be autonomous, which was found during this study with mothers discussing new problems they had observed and would initiate the conversation with the researcher on ways to problem solve in the home independently (Graham et al., 2009). Graham et al. (2016) discussed how OPC gives high levels of engagement between parent and child, which was demonstrated in this study with multiple parents making goals with their child. Like Graham et al.'s (2016) discovery, multiple mothers in this study discussed how they perceived their child would work better for the researcher than with them, these mothers made goals to improve their interactions with their child, and all reported an improvement with getting their child to complete a task with them. Majority of the mothers had improved perceptions of interactions with their child. One mother discussed with the researcher that she had previously been unaware of her child's current performance levels on tasks until she participated in the session and engaged in her child's therapy sessions. She stated that from her participation and observations she had been able to perform more age-appropriate tasks with her child that were the just-right challenge for them. Also similar to the findings of Graham et al. (2016), OPC helps parents to specifically adjust their interactions with their child, and to match a task to their child. This study also had similar results to Graham et al. (2013, 2014) with mothers experiencing improved senses of their child's occupational performance and their self-competence, mothers had insights about themselves, mothers had more understanding of their child, and felt that OPC was a valuable support to their family.

OPC was easily integrated into Appalachian Kentucky, therefore following the recommendations of Suja Angelin et al. (2021) that with the cultural perception of OPC it is effective in diverse settings. OPC has also been found to have significant effects with children and adults with a multitude of disorders, which was found during this study that included

children with four different diagnoses-autism spectrum disorder, developmental delays, genetic disorder, and sensory processing disorder.

The researcher experienced similar experiences to what Graham et al. (2018) described, where therapists found themselves: listening better, sharing power, reprioritizing processes, and found it liberating and challenging at the same time. The researcher was able to have in-depth conversations with the participants about their child's progresses at home. The mothers began initiating new conversations of other problems they had experienced in the home. For a few participants, they had made goals to get their child to complete tasks at the same level as they did for the researcher, allowing the researcher to share the power with the mother. The mothers were then able perform tasks with the researcher observing and giving feedback to improve interactions and performance. While the researcher had worked to address education with parents and to build therapeutic rapport, this OPC style of session did change the quality of conversations the researcher had with the mothers, and therefore was liberating and challenging at the same time.

Lastly, it has been found that OPC can be integrated into various types of therapy settings such as schools and alternate delivery systems such as in telehealth. Hui et al. (2016) found that OPC helped teachers manage disruptive behaviors, with an improved perception of performance and satisfaction. Wallisch et al. (2018) was able to integrate OPC into sessions via telehealth and found there were significant cost savings than typical therapy delivery models. Little et al. (2018) also used OPC through telehealth, finding that parents were able to feel more effective in working with their children, and the children had better participation with their parents, which would correlate with how this study began with seeing how parents engaged with their children in their homes.

Interpretation

Therefore, through this analysis, we see from the data that five of six questions were found to be statistically insignificant, which may be due to the mothers thinking they knew the information. However, after the educational sessions of the study they truly learned information. Also, this study had a small sample size. A larger participant group could reveal significant patterns in the use of OPC for parent improvements. However, majority of the parents reported this study was very valuable to them, They had improved interactions with their child and had improved carryover of therapeutic goals. This demonstrated parents were interested in their therapy sessions being led in this manner, utilizing the domain of OPC with coaching, making goals for the home, and engaging in feedback on ways to problem solve issues their child may be having.

For the future of OT practice, AOTA (2018, 2020) works to achieve the goals of Healthy People 2030, and created their Vision 2025, to improve health equity for Americans. OPC is a tool therapists can use to assist in coaching their clients to recognize and implement social and physical environment changes supporting more successful occupational performance (Graham et al., 2009). Therefore, aligning with improving healthy equity, health literacy, improving the environment to attain full well-being potential, and promoting healthy development across all life stages (AOTA, 2020). OPC also allows OTs to be effective, leaders, collaborative, and accessible (AOTA, 2018).

The researcher also plans to continue utilizing OPC with all clientele families following the results of this study. The quantitative data shows the study was valuable to families and had the potential to be statistically significant with a larger participant group. Then with the informal qualitative information that was gathered during the four sessions, and receiving participant

feedback, the researcher experienced an improvement in relationships and conversations with client families. Many recommendations were gathered to expand this study in another outlet such as doing informative videos on social media or having mandatory monthly meetings between therapist and parent during their child's progress and recertification notes to continue OPC techniques.

Limitations

During this study there were limitations. Due to clinic policies already in place, parents were unable to participate if they had other children with them. Per the clinic policy, siblings are not allowed to attend the therapy session. Therefore, for this study parents who bring their other children with them for every session, could not participate in the study. This excluded three parents from participating. Secondly, at the end of a calendar month within the study, there were some session cancellations. This may have been due to a typical client attendance pattern for this clinic believed to be related to reduced financial allowance to drive to therapy clinic. Absences could also be related to seasonal (winter/early spring) viruses/illnesses that were spreading in the community. The three participants who did not finish the study cancelled due to illness and were unable to reschedule a make-up visit within the study timeline. Third, due to the study only having 13 participants there was a small effect size. With the data results, more participants are needed to assess if any of the post-test results would change to establish a larger effect size. Lastly, all participants were mothers, therefore the results do not represent a variety of caregivers such as fathers, grandparents, or foster parents. Therefore, this study had low diversity, and further research should be conducted to assess generalizability to different caregiver relationships.

Future Research and Projects

Through this study process the researcher had many reflections on how this could continue in the future for OT practice overall, and in the participating clinic. First, further research on OPC with fathers or grandparents would give another perspective of how coaching could change caregiver interaction with their child. This research could also assess the differences in relationships between father and mother, or parent to grandparent on how they interact and play with their child. As Keller et al. (2018) found, one in five kids are raised by grandparents; therefore, these caregivers could also benefit from OPC for age-appropriate play.

Another future research potential would be utilizing other therapists such as speech, behavioral, or physical therapists and the application of OPC in their therapy process. Multiple times during the study, mothers reported that their child began communicating more when they were interacting with them. Therefore, other therapists could benefit from utilizing OPC with establishing therapeutic rapport with their client families and with goal carryover.

When considering the potential results of the study with generalized learning/carryover and parental education, there is a possibility of reduced time frames of meeting goals. This could translate into reduced medical spending shortened plan of care duration. As with Wallisch et al.'s findings (2018), OPC via telehealth had significant cost savings when compared to typical therapy delivery models. Further research is needed to establish if therapy time frames are reduced with different coaching or therapeutic approaches.

Conclusion

In conclusion, the three objectives were to find if there was a change in parent perceptions and comfort with play, knowledge of access to age-appropriate toys, and knowledge of developmental milestones. The quantitative data shows the study was valuable to families and

had the potential to be statistically significant with a larger participant group. Then with the informal participant feedback, the researcher experienced an improvement in relationships with client mothers and many recommendations were gathered to expand this study in another outlet such as doing informative videos on social media or having mandatory monthly meetings between therapist and parent during their child's progress and recertification notes to continue OPC techniques. While all the data was not considered statistically significant, it was significant in the fact that the post-tests show this four-week study was valuable to the parents, taught the researcher how to better work with clients' parents, and improved rapport.

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Appendices

Appendix A

Table 1. Three Enabling Domains and OPC Steps Within Each Domain

Domain 1: Structured Process Domain	Domain 2: Emotional Support	Domain 3: Information Exchange
Goal Setting	Reflective Listening	Information on Typical Development
Collaborative Performance Analysis: (A) Option Exploration	Empathy	Information on Condition and Impairments
(B) Action Planning	Reframing	Information on Task Analysis
(C) Implementation	Guiding	Teaching and Learning Strategies
(D) Checking Performance	Encouraging	Information on Community and Other Resources
(E) Generalization		

(Kravetsky, 2019, p. CE-3)

Appendix B

Pre-Test

Please circle one answer to each question.

Please give any comments you have about what you are interested to learn from this study:

1. How confident do you feel with using a toy to work on therapy goals with your child?				
1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident
2. How confident do you feel in picking out toys from local stores that could help your child work on skills learned in therapy?				
1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident
3. How difficult is it for you to purchase therapeutic toys for less than \$5?				
1	2	3	4	5
Very difficult	Difficult	Neutral	Easy	Very Easy
4. Rate your confidence in knowing what toys are age-appropriate for your child.				
1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident
5. How far do you have to drive to find a store that offers toys?				
a. 5-10 minutes b. 10-20 minutes c. 20-30 minutes d. 30+ minutes				
6. Please rate how difficult it is to find toys for your child in local stores near you.				
1	2	3	4	5
Very difficult	Difficult	Neutral	Easy	Very Easy

Post-Test

Please circle one answer to each question.

1. How confident do you feel with using a toy to work on therapy goals with your child?

1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident

2. How confident do you feel in picking out toys from local stores that could help your child work on skills learned in therapy?

1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident

3. How difficult is it for you to purchase therapeutic toys for less than \$5?

1	2	3	4	5
Very difficult	Difficult	Neutral	Easy	Very Easy

4. Rate your confidence in knowing what toys are age-appropriate for your child.

1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident

5. How far do you have to drive to find a store that offers toys?

a. 5-10 minutes b. 10-20 minutes c. 20-30 minutes d. 30+ minutes

6. Please rate how difficult it is to find toys for your child in local stores near you?

1	2	3	4	5
Very difficult	Difficult	Neutral	Easy	Very Easy

7. Were you able to complete the home plans after each session?				
a. Unable		b. 1 or 2 times between sessions		c. 3 times each session
8. How confident do you feel that you can take this information learned, and continue working on this with your child?				
1	2	3	4	5
Not at all confident	Not confident	Neutral	Confident	Very Confident
9. Was this information valuable to your family?				
1	2	3	4	5
Not at all valuable	Not valuable	Neutral	Valuable	Very Valuable
10. Do you feel like you learned more about developmental milestones?				
1	2	3	4	5
None	Not really	Neutral	Some	A lot
11. Do you feel that these sessions have made it easier for you to interact/play with your child?				
1	2	3	4	5
None	Not really	Neutral	Some	A lot
12. Do you feel that these sessions have made it easier for you to work on your child's therapy goals at home?				
1	2	3	4	5
None	Not really	Neutral	Some	A lot

Please comment on one area that you think helped you the most, where you learned the most, or was the most valuable to you.

Appendix C

Session 1: Pre-Test and Finding Your Child's Current Age Equivalency Level

(Each session will last 20 minutes)

- Using the Milestone Handout, find the age level that best matches what the child can do.
- Explain to the caregiver: This Handout is a screening tool that asks questions of what the child can do in numerous areas such as: Gross Motor Coordination, Fine Motor Coordination, Self-Care, Social and Play Skills.
- Prepare the caregiver: The remainder of these session will address the milestones of each of these 4 areas from your child's age equivalency, and appropriate toys to work on these skills.

Homework: Start planning in your mind some things you would like to work with your child on specifically at home over the next few weeks.

Also, start noticing your local stores of what toys they have available. Some stores offer more than you think at first glance!

Session 2: Developmental milestones

- Reflect on previous week, what did they notice or learn?
- Use Milestones Handout to go over common developmental milestones.
- Practice these skills with the child in front of the caregiver to show them what to look for in each motor skill- gross and fine motor coordination, play and social skills, and self-care/IADLs (community skills and age-appropriate chores) for older children.
- Ask the parent if they have any questions, or any concerns in this area.

Homework: Create two goals for areas of concern, and practice one of these learned skills at home 3x this week before the next session.

Session 3: Toys to Target Developmental Skills

- Reflect on previous week, what did they notice or learn?
- Use Toys Handout to go over local stores, the cost, and the purpose of each item for the child's current age equivalency. Then show future toys the family may utilize as their child grows.
- Demonstrate and discuss how each object could be altered for their child's specific need.
- Ask the parent if they have any questions, or any concerns in this area.

Homework: Take your goals you chose from Session 2. Practice them at home again 3x before the next session and think on how you could use toys in your house to help encourage your child's participation.

Session 4: Reflection and Post-Test

- Reflect on what they noticed or learned this past week.
- Complete Post-Test
- Do they have any concerns?

Appendix D

Application Summary

Competition Details

Competition Title: IRB Application for Expedited Review

Category:

Cycle:

Submission Deadline: 06/30/2023 11:59 PM

Application Information

Submitted By: Hailee Lewis

Application ID: 5094

Application Title: A Pretest-Posttest Survey Study of Parent Perceptions of the Effectiveness of Occupational Performance Coaching on Caregiver-Child Play Occupations

Date Submitted: 03/8/2023 2:49 PM

Personal Details

Applicant First Name: Hailee

Applicant Last Name: Lewis House

Email Address: hailee_lewis11@mymail.eku.edu

Phone Number: (606) 344-9646

Mailing Address: 70 Bryants Way, London KY 40741

Applicant Type: ECU Student

Application Details

Proposal Title

A Pretest-Posttest Survey Study of Parent Perceptions of the Effectiveness of Occupational Performance Coaching on Caregiver-Child Play Occupations

Name of Faculty Research Advisor (required for student submissions)

Leslie Hardman, OTD, OTR/L

Name of Department Chair/Unit Director

Dana Howell

Notes/Comments

Status (IRB Use Only)

Approved

Approval Date (IRB Use Only)

Lewis House, Hailee - #5094

1 of 34

01/20/2023

Expiration Date (IRB Use Only)

12/31/2023

Acknowledgment

Investigator Certification

[Acknowledged] I certify that this application fully discloses the involvement of human subjects in this research study and that participants will not be involved in any other way.

I agree to:

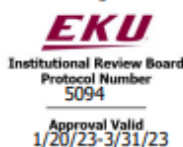
1. Follow the approved protocol in the conduct of this study and to abide by ECU Policy 4.4.12: Protecting Human Subjects in Research.
2. Accept responsibility for the scientific and ethical conduct of this research study.
3. Obtain prior approval from the Institutional Review Board before implementing any changes to the research protocol or the study's documents, including those approved for recruitment, consent, and data collection.
4. Immediately report to the IRB any serious adverse reactions and/or unanticipated effects on subjects which may occur as a result of this study.
5. Follow IRB reporting requirements, including filing the final report.

I understand that I am responsible for maintaining records related to this study for a period of three years from the study's completion, or if I am a student, I am responsible for providing my research records to my faculty advisor or making arrangements with the IRB Office for records maintenance.

Appendix E

Consent to Participate in a Research Study

A Pretest-Posttest Survey Study of Parent Perceptions of the Effectiveness of Occupational Performance Coaching on Caregiver-Child Play Occupations



Key Information

You are being invited to participate in a research study. This document includes important information you should know about the study. Before providing your consent to participate, please read this entire document and ask any questions you have.

Do I have to participate?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide to participate, you will be one of about 20 people in the study.

What is the purpose of the study?

The purpose of the study is to explore educational strategies, and explore the relationships between store access, cost of toys, and parental knowledge of developmental milestones, having age-appropriate toys in the home. This research could improve home carryover of therapy goals for increased learning, and improve parent confidence or perception in using play to meet therapy goals in the home, therefore providing coaching strategies to improve parental independence in goal carryover. You are invited to participate because you have an 8 years old child or younger with a diagnosis which may include delays in meeting developmental milestones.

Where is the study going to take place and how long will it last?

The research procedures will be conducted at Alexander & Associates-London office. You will need to come to your regularly scheduled therapy sessions during the study. Each visit will take about 20 minutes of your regularly scheduled therapy time. The total amount of time you will be asked to volunteer for this study is 4 sessions, over the next 4 weeks.

What will I be asked to do?

The study will consist of 4 sessions each lasting 20 minutes. Each session will target the 3 domains of OPC: Structured Process, Emotional Support, and Information Exchange (Kravetsky, 2019). This will be completed through each session have a set educational area (Structured Process), having you modeling the milestones and activities discussed and you asking questions (Emotional Support), and then there will be homework assigned at the end of each session that you will complete each week, you will then return to the next session and discuss how their homework was completed (Information Exchange).

*Session 1-You will complete the pre-test, and then will use developmental milestone checklist to establish your child's age-equivalency with toys appropriate for them. You will be given homework for the week to become more aware of the stores around you and the toy selection.

*Session 2-You will reflect on homework completed. You will be shown common gross motor coordination, play/social skills, fine motor coordination, and self care developmental milestones, milestones will be demonstrated to you with you also modeling, such as common hand grasps as one example. Homework will be given to address two goals of your choice with your child.

*Session 3-You will reflect on homework completed. You will be shown a handout of common toys at your child's current skill level to help them meet gross motor, fine motor, self care, and play/social milestones. You will be provided a demonstration of how to utilize the toy in various way to support your child, and then you will model back. Homework will be to take your goal set for yourself in Session 2, and integrate toy usage to reflect on differences.

*Session 4- You will reflect on homework completed. Lastly, you will complete the post-test.

Reference

Kraversky, D. G. (2019, November). Occupational performance coaching as an ultimate facilitator. American Occupational Therapy Association-Continuing Education Articles. CE_Article_November_2019.pdf (aota.org)

Are there reasons why I should not take part in this study?

There are no known risks participating in this study. If you do not want to participate in your child's therapy session, including educational exchange from your therapist, then you should not participate.

What are the possible risks and discomforts?

To the best of my knowledge, the things you will be doing have no more risk of harm or discomfort than you would experience in everyday life.

You may, however, experience a previously unknown risk or side effect.

What are the benefits of taking part in this study?

There is no guarantee that you will get any benefit from taking part in this study. However, some people have experienced improved relationships with their children when working towards therapeutic goals. We cannot and do not guarantee that you will receive any benefits from this study. Your participation is expected to provide benefits to others by further education on therapeutic coaching between therapist and parent, and improving work towards goals in the home.

If I don't take part in this study, are there other choices?

If you do not want to take part in the study, there are other choices, including returning your child to their previously planned therapy sessions.

Now that you have some key information about the study, please continue reading if you are interested in participating. Other important details about the study are provided below.

Other Important Details

Who is doing the study?

The person in charge of this study is Hailee House, OTR/L at Eastern Kentucky University. She is being guided in this research by Julie Duckart, PhD, OTR/L, and Leslie J. Hardman, OTD, OTR/L. There may be other people on the research team assisting at different times during the study.

What will it cost me to participate?

There are no costs associated with taking part in this study.

Will I receive any payment or rewards for taking part in the study?

You will not receive any payment or reward for taking part in this study.

Who will see the information I give?

Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

I will make every effort to prevent anyone who is not on the research team from knowing that you gave me information, or what that information is. Your pre-test/post-test will be kept in a locked cabinet in my office. Your name will be taken

off of the data that is used to analyze the results in an Excel spreadsheet that will also be on a password protected computer. Then after 3 years the papers will be shredded to protect your information.

However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court (if applicable: or to tell authorities if we believe you have abused a child or are a danger to yourself or someone else). Also, we may be required to show information that identifies you for audit purposes.

Can my taking part in the study end early?

If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to end your participation in the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the University or agency funding the study decides to stop the study early for a variety of reasons.

What happens if I get hurt or sick during the study?

If you believe you are hurt or get sick because of something that is done during the study, you should call Hailee House, OTR/L at 606-330-0223 immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study. These costs will be your responsibility.

Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your care and treatment because of something that is done during the study will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances.

What else do I need to know?

You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

We will give you a copy of this consent form to take with you.

Consent

Before you decide whether to accept this invitation to take part in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Hailee House, OTR/L at 606-330-0223. If you have any questions about your rights as a research volunteer, you can contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636.

If you would like to participate, please read the statement below, sign, and print your name.

I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study.

Signature of person agreeing to take part in the study

Date

Printed name of person taking part in the study

Name of person providing information to subject