### Supplemental Table 1. Summary of Child and Youth Practice Area Publications in the *American Journal of Occupational Therapy* in 2008 and 2009

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Objectives</th>
<th>Level/Design/Participants</th>
<th>Intervention and Outcome Measures</th>
<th>Results</th>
<th>Study Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashburner, Ziviani, &amp; Rodger (2008)</td>
<td>Basic research</td>
<td>Quantitative, 2-group, non-randomized, case-control study using convenience sampling</td>
<td>No intervention was provided.</td>
<td>A pattern of auditory filtering difficulties, sensory underresponsiveness, and sensory seeking was associated with academic underachievement in children with ASD.</td>
<td>Participants were recruited from a limited geographic area. Small sample size limits generalizability of results. Issues of inadequate power for data analysis are also present.</td>
</tr>
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- intervention and outcome measures:
  - Kaufman Brief Intelligence Test
  - Gillian Autism Rating Scale
  - Gillian Asperger's Disorder Scale
  - Connor's Teacher Rating Scale–Revised Long Version
  - Achenbach System of Empirically Based Assessment: Teacher Report Form

- statistics used:
  - Independent-sample t tests
  - Pearson correlation coefficients
  - Spearman's correlation coefficient
  - Stepwise backward-elimination
  - Multiple regression analysis

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<tr>
<td>Asher, Parham, &amp; Knox (2008)</td>
<td>Instrument development and testing</td>
<td>Quantitative reliability study of instrument involving 20 therapists rating participants' score profiles</td>
<td>Interrater reliability was moderate to high for interpretation of the presence of sensory integrative dysfunction using SIPT scores. Percentage agreement was 70% for Case A and 100% for Case B. Percentage agreement for identifying specific patterns of sensory integrative dysfunction ranged from 50% to 100%.</td>
<td>Participants were not randomly selected and were from 1 geographic region.</td>
<td></td>
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</tbody>
</table>

- intervention:
  - Using 2 deidentified cases, therapists had to rate the likelihood of the presence of sensory integrative dysfunction on the basis of SIPT scores alone. Therapists also had to rate the SIPT score profile on the relevance of several foundational abilities and dysfunctional patterns.

- instruments used:
  - SIPT
  - Researcher-designed rating scale

- statistics used:
  - Interrater reliability was calculated through the percentage of agreement among the therapist's scoring for the 2 cases.

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<tr>
<td>Bazyk, Michaud, Goodman, Papp,</td>
<td>Effectiveness study</td>
<td>Level III</td>
<td>Children received direct and indirect occupational therapy services</td>
<td>Children made statistically significant changes in the fine motor and emergent literacy measures when Small sample size was from 1 geographic region. No comparison group was included.</td>
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<tr>
<td>Hawkins, &amp; Welch (2009)</td>
<td>Quantitative, 1-group, pretest–posttest design</td>
<td>Convenience sample: 37 kindergarten-age children with and without disabilities enrolled in 2 kindergarten classrooms with fully integrated occupational therapy services participated in the study</td>
<td>in an integrated kindergarten context 2 days/wk. The kindergarten curriculum also included an emergent literacy framework.</td>
<td>the pretest–posttest data were compared.</td>
<td>randomization of participants or power analysis was included as part of study.</td>
</tr>
<tr>
<td>Bharadwaj, Daniel, &amp; Matzke (2009)</td>
<td>Basic research</td>
<td>Quantitative, prospective 1-group, cross-sectional design using convenience sampling</td>
<td>Convenience sample: 30 children with congenital, severe–profound hearing loss and their caregivers recruited from the North Texas cochlear implant pool. Children had either 1 or 2 cochlear implants. Length of cochlear implant experience at the time of the study ranged from 0 to 7 yr. Inclusion criteria were that the children had to have a cochlear implant.</td>
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<tr>
<td>Bose &amp; Hinojosa (2008)</td>
<td>Efficacy study</td>
<td>No intervention was provided. Therapists viewed their interactions with teachers as challenging but Small sample of therapists recruited from 1 specific</td>
<td>Small sample size for comparison of scores. No randomization used in the recruitment of participants. Only 6 participants completed the MAP and the SCPRNT, a small sample size. Using isolated sub-tests from the MAP to assist with the detection of children with sensory processing disorder is also questionable.</td>
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</table>
Brown, Rodger, & Davis (2008) Instrument development and testing

Quantitative, prospective quantitative cross-sectional construct validation study using convenience sampling

Inclusion criteria were (1) parental consent, (2) between ages 5 and 11, (3) proficient English-language skills, and (4) no intellectual or physical impairment.

Intervention

No intervention was provided.

Instrument Used

DTVP–2

Statistics Used

Descriptive statistics were computed for all variables. Principal-components factor analysis with orthogonal Varimax rotation was completed on the 4 DTVP–2 subscales.

Position-in-space had items load on 6 factors. Figure Ground subscale had items load on 5 factors. Visual Closure Scale and Form Constancy subscales both had 4 factors. DTVP–2 and its 4 motor-free subscales exhibited multidimensionality instead of the expected unidimensionality.

Bundy et al. (2008) Basic research

Mixed methods

Prospective cross-sectional study using convenience sampling and key informant interviews

20 children (6 boys and 14 girls) ages 5–7 who attended a mainstream primary school in western Sydney, New South Wales, Australia, took part in the study. 9 female teachers were also recruited. Teachers varied in age from late 20s with 5 yr of experience to 1 teacher in her 50s who had taught for 20 yr.

Intervention

Loose-part materials (e.g., car and bicycle tires, crates, wooden planks, trash can lids, strips of foam, cardboard boxes, plastic barrels) were placed in the playground to see whether there was any difference in the children's level of playfulness from when no loose materials were placed on the school playground.

Instruments Used

ToP was used to compare video-taped play segments pre- and postintervention. Teachers who did not implement intervention played a control role.

ToP scores were significantly higher after intervention. Teachers reported that children were more social, creative and resilient when the loose-part materials were on the playground. Children who were creative, rather than physically capable, became leaders in activity. Occupation therapists have a potential role in promoting active school playground environments.

Participants were recruited from a limited geographic area. No randomization was used in the selection or recruitment of participants. There was potential for respondent bias from the teacher participant group.

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<td>Case-Smith &amp; Arbesman (2008)</td>
<td>Quantitative</td>
<td>Systematic review</td>
<td>Intervention N/A</td>
<td>Of the 49 selected studies, 18 were Level I, 17 were Level II, and 14 were Level III. 6 categories of research were identified: (1) sensory integration and sensory-based interventions; (2) relationship-based, interactive interventions; (3) developmental skill-based programs; (4) social cognitive skill training; (5) parent-directed or parent-mediated approaches; and (6) intensive behavioral intervention.</td>
<td></td>
</tr>
<tr>
<td>Cope, Forst, Bibis, &amp; Liu (2008)</td>
<td>Effectiveness study</td>
<td>Quantitative single-case study</td>
<td>Intervention mCMIT that included a nonremovable cast worn on the unaffected arm and 8 hr of occupational and physical therapy for a 2-wk period</td>
<td>Benefits of improved upper-limb function measured right after mCMIT were sustained 6 mo after intervention. mCMIT appears to be a beneficial intervention for a young child with hemiplegia.</td>
<td></td>
</tr>
<tr>
<td>Dickie, Baranek, Schultz, Watson,</td>
<td>Basic research</td>
<td>Qualitative approach using open-ended interviews with key informants</td>
<td>Intervention N/A</td>
<td>Only 1 participant was included in study. Intervention period was brief, only 2 wk. Hard to differentiate whether the change in upper-extremity function measured at 6 mo after intervention was truly attributable to mCMIT or partially because of developmental gains made by the child.</td>
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</table>
Parents of 66 preschoolers were recruited. Parents of 37 children with autism (mean age = 47.9 mo [SD = 20.9]) were recruited using a university-based statewide research registry. Parents of 29 typically developing children (mean age = 42.3 mo [SD = 19.7]) were recruited through local day care centers, university e-mail distribution lists, and word of mouth.

Instruments Used
Interview using a Critical Incident Technique: Parents were asked to describe a situation in which their child had a “good” sensory experience and a “bad” sensory experience and their own perception of how these situations felt to the child.

Statistics Used
Data were collected via telephone or face-to-face interviews. Interviews were audiotaped and transcribed. Atlas.ti software for qualitative analysis was used to facilitate coding and sorting the data. Codes were then aggregated to identify the topic dimensions.

Instruments Used
Parents and the parents’ understanding of the concept of sensory experiences and the manner in which their children responded to such experiences. The most common unpleasant sensory experience for both groups involved sound. The most common pleasant sensory experiences involved touch and movement. Many parents had difficulty understanding the concept of sensory experiences.

Intervention package was effective in increasing the variety and texture of food eaten by both participants. At the end of the intervention, both participants were eating table foods and drinking from an open cup.

Small convenience sample, lack of randomization, no control group for comparison, potential for bias or subjectivity in data collection procedures.

Eckman, Williams, Riegel, & Paul (2008)

Effectiveness study
Level IV
Quantitative, 2 single-case studies with multiple baseline measures
2 participants: a 9 yr-old boy with Down’s syndrome who would only eat a limited number of pureed foods and a 5 yr-old boy with a gastrostomy tube.

Intervention
Intervention program designed to promote biting, chewing, tongue lateralization, lip closure, and increasing tolerance of food textures eaten. 2 types of meal sessions were included: chewing sessions and texture-fading sessions.

Instruments Used
Data were collected on children’s chewing and mouth cleaning. Behavioral data were collected about accepting or expelling food, negative vocalization, gaging, tongue lateralization, and biting. Dietary intake was recorded.

Statistics Used
Data were collected regarding chewing and mouth-cleaning behaviors. Dietary intake was measured for all meal sessions. Results were plotted on graphs.

Intervention package was effective in increasing the variety and texture of food eaten by both participants. At the end of the intervention, both participants were eating table foods and drinking from an open cup.

Small convenience sample, lack of randomization, no control group for comparison, potential for bias or subjectivity in data collection procedures.

Egilson & Trausta dottir (2009)

Efficacy study
Mixed methods: qualitative inquiry informed by grounded theory, semistructured interviews, and participant observations; rating scale used

Intervention
No intervention was provided.

Instruments Used
Children were observed for 4 hr at school. Children, teachers, and parents and the parents’ understanding of the concept of sensory experiences and the manner in which their children responded to such experiences. The most common unpleasant sensory experience for both groups involved sound. The most common pleasant sensory experiences involved touch and movement. Many parents had difficulty understanding the concept of sensory experiences.

The characteristics of each school setting influenced students’ participation. Settings with open spaces and limited structures such as school playground and field

No details about whether the data were triangulated through the use of reflective diaries or member checking reported. No demographic data were reported about.
**Supplemental Table 1. Summary of Child and Youth Practice Area Publications in the American Journal of Occupational Therapy in 2008 and 2009 (cont.)**

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<tr>
<td><strong>Engel-Yeger (2009)</strong></td>
<td>Participants were recruited from the Disability Records of the Icelandic State Diagnostic and Counseling Center. Participants were selected using purposeful sampling approaches. Parental consent was obtained. 14 students (9 boys, 5 girls) with physical disabilities, 17 parents, and 18 teachers took part. The students were between ages 6 and 12, and all had physical impairments. Children with intellectual disabilities were excluded.</td>
<td></td>
<td>parents were interviewed. The School Setting Interview was used for student interviews. The School Function Assessment was completed with children’s teacher.</td>
<td>trips presented more challenges. To promote students’ with disabilities school participation, therapists need to consider the overlap among the child, environment, and task factors.</td>
<td>the teachers or parents who were interviewed as part of the project.</td>
</tr>
<tr>
<td><strong>Engel-Yeger, Jarus, Anaby, &amp; Law (2009)</strong></td>
<td>Participants were recruited from the Disability Records of the Icelandic State Diagnostic and Counseling Center. Participants were selected using purposeful sampling approaches. Parental consent was obtained. 14 students (9 boys, 5 girls) with physical disabilities, 17 parents, and 18 teachers took part. The students were between ages 6 and 12, and all had physical impairments. Children with intellectual disabilities were excluded.</td>
<td></td>
<td></td>
<td>Differences in activity preferences were found between genders. Younger children preferred to participate in more PAC scales than did older children. Sociodemographic variables appear to affect children’s activity preferences.</td>
<td>Only healthy children were included in the study sample. PAC was developed in Canada, but the study was completed in Israel; hence, there may be some cultural differences in children’s activity preferences that the PAC might not have been sensitive to.</td>
</tr>
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</table>

**Intervention and Outcome Measures**

**Level/Design/Participants**

310 typically developing children (141 boys and 169 girls with a mean age of 8.86 yr [SD = 2.17]) from Israel were recruited. All children attended mainstream public school. The children were divided into 3 age groups: 5–8 (n = 140), 9–12 (n = 140), and 13–16 (n = 30) years. Inclusion criteria were being able to speak, read, and write Hebrew fluently. Children with known neurological, developmental, or learning disabilities were excluded.

**Intervention**

N/A

**Instrument Used**

Preferences for Activities of Children

Statistics Used

Cronbach’s α was used to estimate internal consistency

MANOVA

t tests

Spearman’s rank-order correlation

**Intervention**

N/A

**Instrument Used**

CAPE

Statistics Used

2-way ANOVAs were performed on each of the CAPE scores to test the significance of group and gender interactions. Post hoc Bonferroni procedures tested the significant

Healthy youths engaged in a broader range of activities and did so more frequently than youths with CP. Physical limitations associated with CP may affect the frequency of a child’s participation in activity outside of school. Youths with CP reported levels of enjoyment similar to those of typically developing peers.

No randomization was used in the selection or recruitment of participants. CAPE was developed in Canada, but study was completed in Israel; hence, there may be some cultural differences in children’s activity preferences that the CAPE might not have been sensitive to.
<table>
<thead>
<tr>
<th>Study Title and Authors</th>
<th>Study Type</th>
<th>Study Design</th>
<th>Population Characteristics</th>
<th>Intervention</th>
<th>Instruments Used</th>
<th>Statistics Used</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engel-Yeger, Nagauker-Yanuv, &amp; Rosenblum (2009)</td>
<td>Basic research</td>
<td>Quantitative 2-group nonrandomized case-control study using convenience sampling</td>
<td>Convenience sample: 42 children, 21 with dysgraphia (15 boys, 6 girls; mean age = 8 [SD = 0.62]) and 21 typically developing with no handwriting deficiencies (15 boys, 6 girls; mean age = 8 [SD = 0.47]) from mainstream schools in Israel. Children were recruited through an advertisement calling for participation in a study to evaluate children's handwriting performance and self-perception. Exclusion criteria included developmental delays, positive neurological findings, chronic diseases, learning disabilities, and vision impairments.</td>
<td>Intervention N/A</td>
<td>Instruments Used: ComPET, HHE, CHaP, PEGS</td>
<td>Statistics Used: T tests were used to test differences between HPSQ total scores for both groups. Mann-Whitney U tests were used to evaluate the significance of differences between the groups on the CHaP, PEGS, ComPET, and HHE. Spearman rank-order correlations were used to evaluate the correlations between the different measures.</td>
<td>Differences between the mean scores. Children are aware of their handwriting deficits and are able to report them. Children's reports may contribute to the identification of dysgraphia and facilitate their participation in occupational therapy intervention and in class.</td>
</tr>
<tr>
<td>Franklin, Deitz, Jirikowic, &amp; Astley (2008)</td>
<td>Basic research</td>
<td>Level I Quantitative retrospective 1-group cross-sectional study using convenience sampling</td>
<td>Data on 44 children (30 boys, 14 girls) were obtained via retrospective study using the Washington State FAS DPN clinical database. Inclusion criteria: (1) between ages 5 and 10 at the time of diagnosis, (2) having 1 of the FASD diagnoses, (3) having complete data available on the SSP and CBCL, and (4) being seen at the Washington State FAS DPN after 2000.</td>
<td>Intervention N/A</td>
<td>Instruments Used: SSP, CBCL,</td>
<td>Statistics Used: Pearson correlation coefficients, t tests, x², Fisher exact test</td>
<td>Children with FASD demonstrate problem behaviors and sensory processing impairments as reported by parents. Sensory processing deficits co-occur with behavioral problems at a high rate with children with FASD.</td>
</tr>
<tr>
<td>Hemmingsson, Lidstrom, &amp; Nygard (2009)</td>
<td>Efficacy study</td>
<td>Mixed methods; interviews and field observations</td>
<td>Intervention Children had received an assistive technology device 3–6 mo. The following themes emerged: (1) experiencing immediate benefits in terms of the functioning, (2) assistive technology device as</td>
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<td>How data were triangulated and how trustworthiness established was not clearly described. Parents were not included as a potential</td>
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| Hilton, Crouch, & Israel (2008) | Therapists who worked at 2 habilitation centers in a large city in Sweden identified students with physical disabilities on their caseload. Inclusion criteria for students were (1) had physical disabilities with motor limitations, (2) attended mainstream school, and (3) received an assistive technology device in school from a therapist within the past 3–6 mo. 20 students ages 10–19 yr and 17 occupational therapists took part in the study. | Quantitative 2-group nonrandomized case-control study using convenience sampling 52 children with HFASD were recruited from 5 US states and 53 healthy children via parent and professional contacts of the authors were the control group. Inclusion criteria for both groups of children were being born full term, having an IQ of ≥70, being proficient in English, having no history of neurological problems, and no history of hearing or vision problems. | **Intervention**  
No intervention was provided.  
**Instruments Used**  
• CAPE  
• Social Responsiveness Scale  
**Statistics Used**  
• Mann–Whitney U test  
• Kruskal-Wallis 1-way ANOVA  
• MANOVA | Findings indicate that out-of-school participation (in number of activities in which children participated, the number of people with whom they participated, and the variety of environments in which they participated) was significantly different for children with HFASD compared with typically developing peers. | Participants were recruited from limited geographic area. No randomization was used in the selection or recruitment of participants. Issues of inadequate power for data analysis are also present. |
| Hwang & Davies (2009) | Instrument development and testing                                                                                     | Convenience sample: 64 primary school children recruited from several school districts in western New York | **Intervention**  
No intervention was provided.  
**Instrument Used**  
SFA, completed by the students' classroom teacher  
**Statistics Used**  
Authors used Rasch modeling to examine the SFA's internal data source. | Most SFA items (255 of 266) within its 18 Activity Performance scales met the Rasch analysis goodness-of-fit statistics requirements. Item difficulty analysis yielded results similar to the hierarchical structure in the SFA manual. | Participants were recruited from limited geographic area. No randomization was used in the selection or recruitment of participants. Small sample size limits generalizability of results. |
The 64 children (39 boys, 25 girls) were between ages 6 and 15. Mean age = 9.37 (SD = 2.16). 35 students had a documented disability and 29 did not.

Construct validity via its unidimensionality and hierarchical structure.

Jankovich, Mullen, Rinear, Tanta, & Deitz (2008) Instrument development and testing

Quantitative prospective, quantitative cross-sectional reliability and validity study

Convenience sample: 38 children recruited from the University of Washington Experimental Education Unit and 2 private preschools.

2 raters evaluated 38 typically developing children, ages 36–72 mo. Inclusion criteria were (1) typical development, (2) parental consent, and (3) child verbal assent. Typical development was defined as not having a clinical diagnosis (such as CP or ASD), not having received education or therapy services, and not using a mobility aid.

Interrater reliability of the 2 raters for the overall play age were within 8 mo of each other 86.7% of the time; for the 4 dimensions, they were within 12 mo of each other 91.7%–100% of the time; and for the 12 category scores, they were within 1 age level of each other 81.8%–100% of the time. Construct validity results showed a general match between children’s chronological ages and their overall play age scores.

Participants recruited from limited geographic area. Small sample size limits generalizability of results. The raters were entry-level Master of Occupational Therapy students and not qualified therapists.

Martin, Burtner, Poole, & Phillips (2008) Effectiveness study

Level V

Quantitative single-case study

Convenience sample: 35-mo-old child presenting with right spastic hemiplegia

Intervention

CMIT; child wore cast on nonaffected arm for 7–9 hr/day for 6 days/wk for a 2-wk period.

Instruments Used

- COPM
- Pediatric Evaluation of Disability Inventory
- Melbourne Assessment of Unilateral Upper Limb Function
- Grip and pinch strength

Statistics Used

Results were visually analyzed by graphing and comparing mean scores of all measures pre- and postintervention

COPM-identified goals of increased independence with bilateral hand play and participation in gross motor play with friends increased. Improvements in self-care, arm function, and grip strength were also noted.

Only 1 participant was included in study. Intervention period was brief, lasting only 2 wk. Hard to differentiate whether the change in upper-extremity function measured at 3 mo postintervention was truly attributable to CMIT or partially because of developmental gains made by the child.

Miller & Kuhaneck (2008) Basic research

Qualitative inquiry was informed by grounded theory; semistructured interviews

10 children (6 boys, 4 girls, ages 7–11) were recruited via

Intervention

No intervention was provided.

Instrument Used

Individual in-depth interviews were completed that focused on play

“Fun” emerged as the core category explaining the choice of specific play activities for children. 4 other categories of characteristics emerged as contributors to

The geographic area where children were recruited from was not reported. The method of recruiting/contacting the participants was not reported.
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<tr>
<td>Myers (2008)</td>
<td>Efficacy study</td>
<td>Quantitative mailed survey to respondents</td>
<td>Intervention No intervention was provided.</td>
<td>Participants reported that evaluation was the most frequently used strategy in the transition of children from early intervention or preschool to kindergarten. A minority of therapists received specialized training about transition.</td>
<td>No reliability or validity data were reported about the survey. Moderate response rate. Data analysis was largely descriptive. No comparison group was included.</td>
</tr>
<tr>
<td>Pfeiffer, Henry,</td>
<td>Effectiveness</td>
<td>Level I</td>
<td>Intervention Group used Disc 'O' Sit cushions throughout school day for a 2-wk period. Intent was to determine the effectiveness and impact of a dynamic seating system on improving attention to task for students.</td>
<td>Intervention group exhibited a statistically significant difference in relation to attention to task compared with the control group. Disc 'O' Sit cushions appear to be a helpful intervention strategy.</td>
<td>Only classroom teacher ratings on the BRIEF were used to measure potential changes. Participants were from 1 geographic region. Only children enrolled in 2nd grade were included, which limits generalizability of the findings.</td>
</tr>
<tr>
<td>Miller, &amp; Witherell (2008)</td>
<td></td>
<td>Quantitative 1-group pretest-posttest design with random assignment to either control or intervention group</td>
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</table>
61 2nd-grade students (45 boys, 16 girls) took part; 32 students were assigned to the control group, and 29 students were assigned to the intervention group. Student age ranged from 90 to 112 mo. Mean age was 99 mo.

Pierce, Munier, & Myers (2009)  Basic research Qualitative inquiry informed by grounded theory using videotaped sessions, in-depth interviews, and researcher observation records

18 typically developing White children (9 boys, 9 girls) and their mothers from Southern California were recruited. The children's ages ranged from 1 to 18 mo.

Intervention The video, interview, and observation record data were analyzed using a computer-assisted video analysis system, text-coding software, memo writing, visual modeling, theoretical sampling, and expert review.

Instruments Used A grounded theory of constant comparison was used. Several strategies were included to ensure trustworthiness, including a cross-class and gender-balanced sample, comparative use of a chimpanzee infant sample, piloting, peer debriefing, expert review, several data types, visual modeling, and theoretical sampling.

Statistics Used Data from 133 home visits included videotaped self-directed play sessions with usual objects, interviews, and observational records. Home data collection occurred monthly from ages 1–18 mo during morning hours.

Pizur-Barnekow, Kraemer, & Winters (2008)  Basic research Quantitative prospective 1-group pretest–posttest design using convenience sampling

Mothers' mean age was 30 yr, and most were White (95%). Infants consisted of 8 boys and 5 girls with a mean age of 15 wk ($SD = 0.97$).

Mothers were included if the child was their firstborn, they were married or living with a partner, Visual behavior did not differ between the synchronous and asynchronous slideshow conditions. Vagal tone was significantly lower during the asynchronous slideshow. Infants may discriminate synchronous from asynchronous stimuli changing visual behavior.

Participants recruited from limited geographic area. No randomization used in the selection or recruitment of participants. Small sample size limits generalizability of results. Issues of inadequate power for data analysis were also present.
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<tr>
<td>Pont, Wallen, Bundy, &amp; Case-Smith (2008)</td>
<td>Instrument development and testing</td>
<td>Prospective quantitative cross-sectional reliability and validity study</td>
<td>Intervention No intervention was provided.</td>
<td>The TIHM was found to have adequate construct validity and inter-rater reliability, but test-retest reliability was not supported.</td>
<td>Participants recruited from a limited geographic area. No randomization was used in the selection or recruitment of participants. Small sample size limits generalizability of results.</td>
</tr>
<tr>
<td>Randall, Imms, &amp; Carey (2008)</td>
<td>Instrument development and testing</td>
<td>Prospective quantitative cross-sectional validity study</td>
<td>Intervention No intervention was provided.</td>
<td>All children ages 2.5–4 scored as expected on the Modified Melbourne Assessment for Children, and it may be used with children without neurological impairment in the 2.5- to 4-yr age group with confidence.</td>
<td>Participants were recruited from a limited geographic area. Small sample size limits generalizability of results. The construct validity of the Melbourne Assessment for Children has not been well established.</td>
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<tr>
<td>Rechetnikov &amp; Maitra (2009)</td>
<td>Meta-analysis</td>
<td>16 studies that met inclusion criteria were included. Independent variable for the study was the presence or absence of speech-language impairments. Dependent variables were performance scores on motor skill tests. Data were collected from studies.</td>
<td>Intervention N/A</td>
<td>The 16 studies yielded 110 effect sizes. Children with speech and language impairments made more motor errors than children without impairments, with a statistically large effect size. Deficits in specific speech and language disorders were associated with motor impairments. To identify children at risk, researchers used meta-analysis.</td>
<td>Gray literature was not included in the search strategy. Inclusion of old studies back to 1960 may not have the rigor required. The inclusion of motor scores from nonstandardized motor skill tests may cause data with poor validity to be included in the meta-analysis.</td>
</tr>
</tbody>
</table>

* Level of evidence:* I-Prospective quantitative cross-sectional reliability and validity study; II-Prospective quantitative cross-sectional validity study; III-Meta-analysis.

- **Intervention:** No intervention was provided.
- **Instrument Used:**
  - TIHM
  - Modified Melbourne Assessment for Children Ages 2 to 4
  - Quality of Upper Extremity Skills Test
- **Statistics Used:**
  - Descriptive statistics
  - Analysis of variance (ANOVA)
  - Repeated-measures ANOVA
  - t-test
  - 2 statistic
  - Scatter plots

- **Participants:**
  - Convenience sample: 45 healthy children ages 5.5–6.5 recruited from 1 independent and 4 government-run primary schools.
  - 30 children (5 boys, 5 girls for each of 3 age groups) were recruited via random identification from a hospital-based child care center. Age groups were (1) 24–35 mo, (2) 36–47 mo, and (3) 48–59 mo.
- **Study Limitations:**
  - Participants were recruited from a limited geographic area. No randomization was used in the selection or recruitment of participants. Small sample size limits generalizability of results.
  - All children ages 2.5–4 scored as expected on the Modified Melbourne Assessment for Children, and it may be used with children without neurological impairment in the 2.5- to 4-yr age group with confidence.
  - Gray literature was not included in the search strategy.
that compared speech–language-impaired children and healthy children on motor tests. A total of 42 studies were located, but only 16 met inclusion criteria.

Inclusion criteria: (1) published in English between 1960 and 2006, (2) included children ages 2–21 with diagnosed speech and language problems, (3) presence of healthy control group, (4) motor performance assessed using standardized and nonstandardized motor skills testing, and (5) test scores (means and SDs) available for effect size calculation.

Statistics Used
Effect size (d) and Fisher’s Z were computed using Comprehensive Meta-Analysis software. Heterogeneity was evaluated by obtaining Q and I² values that represent the presence and the extent of the heterogeneity.

risk for motor developmental delay, assessments of motor performance should be added to assessments of specific language disorders.

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Reynolds & Lane (2009)

Basic research

Quantitative 2-group nonrandomized case-control study using convenience sampling

Convenience sample: 48 children (24 with ADHD and 24 without ADHD) between the ages of 6 and 10

Typically developing group included 13 girls and 11 boys with a mean age of 102 mo (SD = 18.1). ADHD group was divided into 2 groups, 1 group with ADHD and sensory overresponsivity (n = 13; 5 girls and 8 boys; mean age 107.9 mo [SD = 17]) and 1 group with ADHD only (n = 11, 4 girls and 7 boys; mean age 110.8 mo [SD = 19.8]).

Inclusion criteria included the children having normal intelligence (IQ > 70).

Intervention
N/A

Instruments Used
- RCMAS
- SOR
- Demographic form that asked questions about child’s age, race, gender, and current medication regimen

Statistics Used
Anxiety and SOR scores were examined using ANOVA and Fisher’s exact test to detect differences between group means and compare scores to a clinical cutoff standard.

Children presenting with ADHD and sensory overresponsivity were more anxious than both the ADHD-only group and the non-ADHD control group. Children with ADHD and sensory overresponsivity were more likely to have clinically significant anxiety as determined by total scores on the RCMAS.

Participants were recruited from 1 geographic region, which limits generalizability. Sample size was small for comparison of RCMAS and SOR scores. No randomization was used in the selection or recruitment of participants. Multiple data comparisons using the same sample increased the risk of Type I errors occurring.

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Instrument development and testing

Prospective quantitative cross-sectional reliability and validity study using convenience sampling

49 typically developing children ages 8–12 participated in the study. Mean age was 10.4 yr (SD = 1.12). Children were

Intervention
No intervention was provided.

Instruments Used
- CKTA
- Parent BRIEF
- Delis–Kaplan Executive Function System Color–Word

Interater reliability of the CKTA was 0.96. Internal consistency of the CKTA was moderate with a Cronbach’s α of 0.68. Support for the CKTA’s discriminant validity and concurrent validity were obtained. The CKTA was able to differentiate between low- and

Participants were recruited from a limited geographic area. No randomization used in the selection or recruitment of participants. Small sample size limits generalizability of results. Only 1 ethnic group was represented in the study participants.

(Continued)
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Objectives</th>
<th>Level/Design/Participants</th>
<th>Intervention and Outcome Measures</th>
<th>Results</th>
<th>Study Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosenblum (2008)</td>
<td>Instrument development and testing</td>
<td>Prospective quantitative cross-sectional reliability and validity study using convenience sampling</td>
<td>Interference Test and Sorting Test. Wechsler Intelligence Scale for Children–IV Digit Span.</td>
<td>High-scoring groups on the Parent BRIEF. Discriminant validity and concurrent validity for the CKTA were supported.</td>
<td>Participants recruited from limited geographic area. No randomization was used in the selection or recruitment of participants. Multiple data comparisons using the same sample increased the risk of Type I errors.</td>
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<td>230 children were recruited via convenience sampling from 4 public schools in northern Israel. A letter was sent home to parents requesting that their child take part in the study.</td>
<td>Statistics Used: Student's t tests, x^2 analyses. Interrater reliability was computed using intraclass correlation coefficients. Internal consistency was evaluated using Cronbach's $\alpha$. 1-way ANOVA was used to assess discriminant validity.</td>
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<td>Children were ages 7–14 with no documented history of developmental delay or neurological or physical impairment. 54% were boys, and 46% were girls</td>
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<tr>
<td></td>
<td></td>
<td>Intervention: No intervention was provided. Instruments Used: ComPET, HHE, Handwriting Proficiency Screening Questionnaire</td>
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<tr>
<td>Sachs &amp; Nasser (2009)</td>
<td>Efficacy study</td>
<td>Naturalistic qualitative method based on a phenomenological approach; interviews and participatory observations</td>
<td>Intervention: Parents and children took part in ≥10 monthly family occupations held in the Snoezelen.</td>
<td>2 themes emerged: the Snoezelen environment was experienced as another world by parents and facilitated being together as a family. The Snoezelen provided a sense of intimacy and relaxation, which is important in facilitating family occupations.</td>
<td>Children lived in an institutional residential environment and Snoezelen is not a real-world living environment in which occupations take place. Member checking with parents was not completed, therefore, 1 triangulation source was not used.</td>
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<td>Participants were identified by an occupational therapist or social worker who worked at the residential facility; parents provided consent to take part in the study. Participants were 10 families of children with mental retardation living in a long-term residential facility from Haifa, Israel. 6 families were Jewish and 4 were Arab.</td>
<td>Instruments Used: Semistructured in-depth interviews and participatory observations were used for data collection. Interviews were audiorecorded and transcribed for further analysis. Observations were videotaped and transcribed. Field notes were recorded by a 2nd researcher.</td>
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</table>
Parents’ ages ranged from 31 to 53. Children’s ages ranged from 4 to 17.

Inclusion criteria were (1) family had ≥1 children with diagnosis of severe or profound mental retardation, (2) family had no other children with disabilities living in other institutions, and (3) family members had participated in ≥10 mo consecutive family occupations held in the Snoezelen.

**Statistics Used**

Interview data were analyzed line by line, and codes were developed. Then data were analyzed in an integrative cycle approach in which themes were identified. Observations were analyzed and coded. Trustworthiness was ensured by comparing data from field notes, observations, and interviews. Confirmability and audit of the research process was established by retention of the data collection materials.

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**Schoen, Miller, & Green (2008)**

**Instrument development and testing**

Prospective quantitative cross-sectional reliability and validity study using convenience sampling. 2 separate samples were recruited. Sample 1 consisted of 125 people, and Sample 2 consisted of 92 people via convenience sampling. Age of participants ranged from 3 to 55.

In Sample 1, 60 were typically developing, and 65 were referred for symptoms of sensory overresponsivity. Sample 2 included 44 healthy participants and 48 with signs of overresponsivity. For healthy participants, inclusion criteria were (1) no history of sensory sensitivity, (2) no disability diagnoses, (3) no history of therapy intervention, and (4) no prescription medication. For inclusion in the overresponsivity group, participants had to exhibit signs of sensory sensitivity that interfered with their daily life activity.

**Intervention**

No intervention was provided.

**Instruments Used**

- Sensory Over-Responsivity Scales
- SSP

**Statistics Used**

- Descriptive statistics were computed for all variables.
- Exploratory principal-components analysis using an orthogonally rotated component matrix
- Internal consistency using Cronbach’s α
- Interrater reliability using Pearson correlation coefficient
- Discriminant validity using t tests
- Concurrent validity using Pearson correlation coefficients

Sensory Over-Responsivity Scales exhibited high internal consistency reliability and discriminant validity. The scale was reduced from 21 subtests to 15 and from 90 items to 53. The scale also significantly correlated with the SSP.

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**Shoener, Kinnealey, & Koenig (2008)**

**Basic research**

Case report using quantitative and qualitative data collection methods. Personal narrative completed by 18-yr-old boy diagnosed with pervasive developmental disorder not otherwise specified, apraxia of speech, and dyspraxia; concurrent difficulties with sensory processing and regulation, praxis, and communication may contribute to the challenges that people with autism have when attempting to communicate with others and to develop meaningful relationships.

**Intervention**

The client attended a private school for children with expressive language problems and autism. Standardized tests revealed difficulties in the areas of balance, strength, gross and fine motor skills, visual motor skills, and communication. For the speech and language component, communication was difficult. Standardized tests revealed difficulties in the areas of balance, strength, gross and fine motor skills, visual motor skills, and communication. For the speech and language component, communication was difficult.

**Methodology of study**

Methodology of study was not well described or formatted. No methods were used to ensure trustworthiness mentioned. The progress made by participant made over a 5-yr period was not well documented. No dates or time lines of when the typed quotes were

(Continued)
Supplemental Table 1. Summary of Child and Youth Practice Area Publications in the *American Journal of Occupational Therapy* in 2008 and 2009 (cont.)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Silva, Ayres, &amp; Schalock (2008)</td>
<td>Effectiveness study</td>
<td>Level III</td>
<td>Prospective 1-group pretest-posttest design</td>
<td>Delivery of 2-mo/80-hr Qigong Sensory Massage Protocol</td>
<td>Findings indicated that children exhibited significant short-term improvements in sensory impairment and social development after receiving the Qigong Sensory Massage Protocol.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Convenience sample: Recruitment letters were sent to parents of children between ages 3 and 6 receiving autism services from 1 Education Service District serving 2 counties in Oregon.</td>
<td>Instruments Used:</td>
<td></td>
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</tr>
<tr>
<td></td>
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<td>Inclusion criteria were (1) age &lt;6 with a diagnosis of autism, (2) enrolled in early intervention services, (3) no medical diagnoses or medication, and (4) parental consent. 26 children ranging in age from 31 to 84 mo were diagnosed with autism; 15 therapists were</td>
<td>Instruments Used:</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Motor planning–praxis skills. An intervention program using sensory integration, a relationship approach, and principles of motor learning and motor control was implemented.</td>
<td>Instruments Used:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Methods description written by therapist who provided intervention for client 6 hr/day over a 5-yr period</td>
<td>Instruments Used:</td>
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<tr>
<td></td>
<td></td>
<td>Method of recruitment was not mentioned by authors.</td>
<td>Instruments Used:</td>
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</tbody>
</table>

*Sensory Profile*<sup>C15</sup>  
*Sensory Integration and Praxis Tests*<sup>C15</sup>  
*Bruininks–Oseretsky Test of Motor Proficiency, 2nd edition*<sup>C15</sup>  
*DTVP*<sup>C15</sup>  
*Vineland–II Adaptive Behavior Scales*<sup>C15</sup>  
*Autism Behavior Checklist*<sup>C15</sup>  
*Sensory Profile*<sup>C15</sup>  
*Informal parental questionnaire*<sup>C15</sup>  
*Change scores were calculated*<sup>C15</sup>  
*Wilcoxon Sign test*<sup>C15</sup>  
*t test for independent samples*<sup>C15</sup>  
*Confidence intervals*<sup>C15</sup>
**Silva, Schalock, Ayres, Bunse, & Budden (2009)**

**Effectiveness study**

**Level I**

Quantitative 1-group pretest–posttest design with random assignment to a waiting list control group or an intervention group

Convenience sample: Recruitment letters were sent to parents of children between ages 3 and 6 receiving autism services from 2 Education Service Districts serving 8 counties in Oregon.

Inclusion criteria were (1) age <6, (2) eligible for intervention services for autism, (3) no complicating medical diagnoses, and (4) parental consent. 46 children (37 boys and 9 girls) with a mean age of 59 mo participated; children were randomly assigned to an intervention or a waiting-list control group.

**Intervention group received 20 sessions of Qigong Sensory Training; parents received training and completed the follow-through massage given daily to the child.**

**Instruments Used**
- Pervasive Developmental Disorders Behavior Inventory
- Teacher and Parent versions
- Autism Behavior Checklist
- Sense and System Checklist

**Statistics Used**
- MANCOVA
- Post hoc univariate analysis of covariance
- t tests for individual samples with Bonferroni adjustments

**Results** indicated that Qigong Sensory Training reduced the severity of autism as measured by the tests of behavior and developmental disabilities. Teacher and parent evaluations indicated that children had significant classroom improvement of social-language skills and reductions in autistic behaviors.

**Tsai, Lin, Liao, & Hsieh (2009)**

**Instrument development and testing**

Quantitative reliability study using convenience sampling

Children were recruited from mainstream classrooms by special education teachers and from rehabilitation departments by occupational therapists in Taipei, Taiwan.

52 children with CP consisting of 31 boys and 21 girls ranging in age from 5 to 8. Inclusion criteria were (1) a diagnosis of CP, (2) between ages 5 and 8, and (3) an ability to follow general oral instructions.

Exclusion criteria were (1) an inability to follow the instructions of the MVPT-R or TVPS-R, and (2) poor visual acuity as indicated by the Teller Acuity Cards assessment at 38 cm < 6.50 cycle/cm.

**Intervention**
- No intervention was provided.

**Instruments Used**
- MVPT-R
- TVPS-R

**Statistics Used**
- Intraclass correlation coefficients and SRD were used to examine the test–retest and interreliability.
- Cronbach’s α was used to estimate internal consistency.

Test–retest reliability of the MVPT–R and TVPS–R were .96 and .97. The TVPS-R subscale correlations ranged from .76 to .92. The SRD for the MVPT–R was 3.9 (9.6 of the total score) and 13.5 (12% of the total score) for the TVPS–R. Intrarater reliability correlation for the MVPT–R was .93 and .92 for the TVPS–R. Cronbach’s α for the MVPT–R was .87 and .98 for the TVPS–R. At the subscale level, the TVPS–R Cronbach’s αs ranged from .87 to .94.

Participants were recruited from a limited geographic area. No randomization was used in the selection or recruitment of participants. Small sample size limits generalizability of results. Revised versions of MVPT–R and TVPS–R have been published by their authors in recent years. A major limitation is that the versions of the MVPT–R and TVPS–R used in this study are now out of date and irrelevant for use in practice.

(Continued)
The rationale for using neurodevelopmental treatment with children exhibiting mild retardation is not valid. The 1978 version of the Bruininks–Oseretsky Test of Motor Proficiency was used to collect version should have been used. No data were collected on motor-free visual perception, school-related skills, or occupational performance integration group exhibited skills. Multiple data comparisons using the same sample increased the risk of Type I errors occurring.

### Supplemental Table 1. Summary of Child and Youth Practice Area Publications in the *American Journal of Occupational Therapy* in 2008 and 2009 (cont.)

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Wuang, Wang, Huang, &amp; Su (2009)</td>
<td>Effectiveness study</td>
<td>Level I</td>
<td>Intervention Children were randomly assigned to 1 of 3 intervention groups that were based on either sensory integration, neurodevelopmental treatment, or perceptual-motor principles. Another 40 children served as controls. Each intervention group received 3 1-hr sessions/wk for a 40-wk period.</td>
<td>All 3 intervention groups significantly outperformed the control group on all measures. The sensory integration group exhibited a greater change on fine motor, upper-limb coordination, and sensory integrative functioning. The perceptual-motor group exhibited significant gains in gross motor skills, and the neurodevelopmental treatment group had the smallest amount of change.</td>
<td>The rationale for using neurodevelopmental treatment with children exhibiting mild retardation is not valid. The 1978 version of the Bruininks–Oseretsky Test of Motor Proficiency was used to collect data when the more recent 2006 version should have been used. No data were collected on motor-free visual perception, school-related skills, or occupational performance skills. Multiple data comparisons using the same sample increased the risk of Type I errors occurring.</td>
</tr>
</tbody>
</table>

**Note:** *N* = 39. **Level 1** = systematic reviews, meta-analyses, and randomized controlled trials; **Level 2** = two-group nonrandomized pretest–posttest designs (e.g., cohort designs, case control studies); **Level 3** = one-group, nonrandomized, noncontrolled trial; **Level 4** = single-subject designs, descriptive studies, and case series; **Level 5** = expert opinion, case study, not based on systematic research methods. ADHD = attention deficit hyperactivity disorder; ANOVA = analysis of variance; AOTA = American Occupational Therapy Association; ASD = autism spectrum disorder; BRIEF = Behavior Rating Inventory for Executive Functioning; CAPE = Children's Assessment of Participation and Enjoyment; CBGL = Child Behavior Checklist; CHAP = Children's Questionnaire for Handwriting Proficiency; CMIT = constraint-induced movement therapy; ComPET = Computerized Penmanship Evaluation; COPM = Canadian Occupational Performance Measure; CKTA = Children’s Kitchen Task Assessment; CP = cerebral palsy; DTVP–2 = Developmental Test of Visual Perception (2nd ed.); FASD = fetal alcohol syndrome disorders; FASDPN = Fetal Alcohol Syndrome Diagnostic and Prevention Network; HFASD = high-functioning autism spectrum disorders; HHE = Hebrew Handwriting Evaluation; MANOVA = multivariate analysis of variance; MAP = Miller Assessment for Preschoolers; mCIMT = modified constraint-induced movement therapy; MVPT–R = Motor-Free Visual Perception Test–Revised; N/A = not applicable; PAC = Preference for Activities of Children; PEGS = Perceived Efficacy and Goal Setting System; RCMAES = Revised Children’s Manifest Anxiety Scale; SCRINT = Southern California Post Rotary Nystagmus Test; SD = standard deviation; SFA = School Function Assessment; SIPT = Sensory Integration and Praxis Tests; SR = Sensory Over-Responsivity Inventory; SRD = smallest real difference; SSP = Short Sensory Profile; THM = Test of In-Hand Manipulation; ToP = Test of Playfulness; TVPS–R = Test of Visual Perceptual Skills–Revised.

*Level of evidence reported only for effectiveness studies.*

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