### 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>
<tr>
<td></td>
<td></td>
<td>28 children with ASD with average range IQ (24 boys and 4 girls) and 51 age- and gender-matched typically developing peers (43 boys and 8 girls) were recruited.</td>
<td><strong>Instruments Used</strong>&lt;br&gt;- Kaufman Brief Intelligence Test&lt;br&gt;- Gillian Autism Rating Scale&lt;br&gt;- Gillian Asperger's Disorder Scale&lt;br&gt;- Connor's Teacher Rating Scale-Revised Long Version&lt;br&gt;- Achenbach System of Empirically Based Assessment: Teacher Report Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children with ASD were included if they attended a regular classroom, were ages 6–10, and had a diagnosis of ASD. Children with ASD were excluded if they had additional intellectual, hearing, visual, or physical impairments. Where possible, matched controls were recruited from the same classroom as the child with ASD.</td>
<td><strong>Statistics Used</strong>&lt;br&gt;- Independent-sample <em>t</em>-tests&lt;br&gt;- Pearson correlation coefficients&lt;br&gt;- Spearman's correlation coefficient&lt;br&gt;- Stepwise backward-elimination&lt;br&gt;- Multiple regression analysis</td>
<td></td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td></td>
<td>20 trained occupational therapists were recruited through convenience sampling. Therapists were from Los Angeles, CA; were female; were ages 26–60; and had 1.5–20 yr clinical experience. All participants were qualified to administer the SIPT.</td>
<td><strong>Instruments Used</strong>&lt;br&gt;- SIPT&lt;br&gt;- Researcher-designed rating scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td><strong>Statistics Used</strong>&lt;br&gt;Interrater reliability was calculated through the percentage of agreement among the therapist's scoring for the 2 cases.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bazyk, Michaud, Goodman, Papp (2008)</td>
<td>Effectiveness study</td>
<td>Level III</td>
<td>Intervention&lt;br&gt;Children received direct and indirect occupational therapy services</td>
<td>Children made statistically significant changes in the fine motor and emergent literacy measures when</td>
<td>Small sample size was from 1 geographic region. No comparison group was included. No</td>
</tr>
<tr>
<td>Author/Year</td>
<td>Study Objectives</td>
<td>Level/Design/Participants</td>
<td>Intervention and Outcome Measures</td>
<td>Results</td>
<td>Study Limitations</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Hawkins, & Welch (2009)     | Quantitative, 1-group, pretest–posttest design | 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. The kindergarten curriculum also included an emergent literacy framework. | Instruments Used:  
- Peabody Developmental Motor Scales–2  
- Developmental Test of Visual Motor Integration  
- In-hand manipulation skills test  
- Pencil grasp rating scale  
- Observation Survey of Early Literacy Achievement: Letter Identification, Concepts About Print, and Hearing and Recording Sounds  
- Approximations of Text  | Descriptive statistics:  
- Pretest–posttest data were compared. | Randomization of participants or power analysis was included as part of study.                                                                                                                           |
| Bharadwaj, Daniel, & Matzke (2009) | Basic research        | 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. | Instruments Used:  
- Infant/Toddler Sensory Profile  
- Sensory Profile  
- MAP  
- SCPRNT  | Statistics Used:  
- A Pearson product–moment correlation was completed to determine whether duration of hearing loss and duration of cochlear implant use were related to the sensory processing scores.  | 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. |
| Bose & Hinojosa (2008)      | Efficacy study         | Intervention: No formal intervention was provided. Caregivers completed either the Infant/Toddler Sensory Profile or Sensory Profile, depending on the child's age. A subgroup of 6 children completed the MAP and the SCPRNT. | Statistics Used:  
- MAP  
- SCPRNT  | Nine children were classified as typical in all sensory categories, and the remaining 21 (70%) exhibited "at-risk" or "different" behaviors in ≥1 of 5 sensory categories: auditory, visual, vestibular, tactile, and oral processing. Findings suggest that children with cochlear implants may be at risk for sensory processing disorder. | Small sample of therapists recruited from 1 specific...
Qualitative inquiry informed by grounded theory; semistructured interviews

Purposive sampling; fliers were distributed to prospective participants.

6 occupational therapists took part in the study. Inclusion criteria were:
1. licensed U.S. occupational therapist,
2. ≥ 2 yr of work experience,
3. working ≥ 20 hr,
4. ≥ 4 hr/wk spent in an inclusive classroom,
5. regular interactions with teachers,
6. agreement to participate in study.

Instruments Used
In-depth interviews 1 hr in length were conducted. Interview questions focused on the therapists’ experiences when delivering services in inclusive schools and when interacting with teaching staff.

Statistics Used
All interviews were audiorecorded and transcribed into a text format. Data were collected until saturation was achieved. Open coding, axial coding, and selective coding were used to identify themes.

In the study, rewarding experiences. 4 themes emerged: (1) It’s Not Like I Don’t Value Collaboration (the benefits of collaboration), (2) Collaboration—I Can’t Do It Alone (the challenges of interactions), (3) My Opinion, Please Ask for It (attachment to the expert status), and (4) Is This Collaboration (interactions in practice)?

Brown, Rodger, & Davis (2008)
Instrument development and testing

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

Convenience sample: 356 healthy, school-age children recruited from Ottawa, Canada, ranging in age from 5 to 11 yr

Inclusion criteria were:
1. parental consent,
2. between ages 5 and 11,
3. proficient English-language skills,
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.

Convenience sampling used. Participants were recruited from specific geographic region, which limits the generalizability of the results.

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 videotaped play segments pre- and postintervention. Teachers who did

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.
<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>Case-Smith &amp; Arbesman (2008)</td>
<td>Quantitative</td>
<td>Systematic review</td>
<td>Playground duty were interviewed regarding changes in play.</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. Only studies published after 1986 were included. Qualitative studies were excluded. No gray literature was included as part of search.</td>
<td></td>
</tr>
<tr>
<td>Cope, Forst, Bibis, &amp; Liu (2008)</td>
<td>Effectiveness study</td>
<td>Quantitative single-case study</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. Only studies published after 1986 were included. Qualitative studies were excluded. No gray literature was included as part of search.</td>
<td></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>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. Only studies published after 1986 were included. Qualitative studies were excluded. No gray literature was included as part of search.</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 mCMT or partially because of developmental gains made by the child.</td>
<td>Only 2 questions were posed to parents about their children's sensory experiences. The parents...</td>
</tr>
</tbody>
</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.

---

**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, gagging, 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.

---

**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

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

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.)

<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>Engle-Yeger (2009)</td>
<td>Basic research</td>
<td>Quantitative 1-group nonrandomized cross-sectional study using convenience sampling</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. Parents were interviewed. The School Setting Interview was used for student interviews. The School Function Assessment was completed with children's teacher.</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>Trips presented more challenges. To promote students' with disabilities school participation, therapists need to consider the overlap among the child, environment, and task factors. The teachers or parents who were interviewed as part of the project.</td>
</tr>
<tr>
<td>Engel-Yeger, Jarus, Anaby, &amp; Law (2009)</td>
<td>Basic research</td>
<td>Quantitative 2-group nonrandomized case control study using convenience sampling</td>
<td>Convenience sample: 52 Israeli children ages 12–16: 22 with CP (10 boys, 12 girls; mean age = 14, SD = 1.4) and 30 typically developing children (9 boys, 21 girls; mean age = 13.43, SD = 1.11).</td>
<td>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.</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. 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.</td>
</tr>
</tbody>
</table>
All participants attended school and did not have mental disorders or chronic diseases in addition to their diagnosis.

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.

Participants were recruited from 1 geographic region, which limits generalizability of study findings. Small sample size for comparison of instrument scores. No randomization used in the selection or recruitment of participants. Multiple data comparisons using the same sample increased the risk of Type I errors.

<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Research Design</th>
<th>Intervention</th>
<th>Instruments Used</th>
<th>Statistics Used</th>
<th>Findings</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>Intervention: N/A</td>
<td>Instruments Used: ComPET, HH, 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 HH. Spearman rank-order correlations were used to evaluate the correlations between the different measures.</td>
<td>Participants were recruited from 1 geographic region, which limits generalizability of study findings. Small sample size for comparison of instrument scores. No randomization used in the selection or recruitment of participants. Multiple data comparisons using the same sample increased the risk of Type I errors.</td>
</tr>
<tr>
<td>Franklin, Deitz, Jirikowic, &amp; Astley (2008)</td>
<td>Basic research</td>
<td>Level I</td>
<td>Intervention: N/A</td>
<td>Instruments Used: SSP, CBCL</td>
<td>Statistics Used: Pearson correlation coefficients, t tests, χ², 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 behavior 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</td>
<td>The following themes emerged: (1) experiencing immediate benefits in terms of the functioning, (2) assistive technology device as</td>
<td>How data were triangulated and how trustworthiness established was not clearly described. Parents were not included as a potential</td>
<td></td>
</tr>
<tr>
<td>Author/Year</td>
<td>Study Objectives</td>
<td>Level?Design/Participants</td>
<td>Intervention and Outcome Measures</td>
<td>Results</td>
<td>Study Limitations</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
<td>---------------------------</td>
<td>-----------------------------------</td>
<td>---------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Hilton, Crouch, &amp; Israel (2008)</td>
<td>Basic research</td>
<td>Quantitative 2-group nonrandomized case-control study using convenience sampling</td>
<td>Intervention No intervention was provided.</td>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Hwang &amp; Davies (2009)</td>
<td>Instrument development and testing</td>
<td>Quantitative prospective and quantitative cross-sectional validity study</td>
<td>Intervention No intervention was provided.</td>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Instrument development and testing</td>
<td>Interventions</td>
<td>Instruments Used</td>
<td>Statistics Used</td>
<td>Results</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>------------------------------------</td>
<td>---------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>Jankovich, Mullen, Rinear, Tanta, &amp; Deitz (2008)</td>
<td>64 children (39 boys, 25 girls) were between ages 6 and 15. Mean age = 9.97 (SD = 2.16). 35 students had a documented disability and 29 did not.</td>
<td>Construct validity via its unidimensionality and hierarchical structure.</td>
<td>Intervention No intervention was provided.</td>
<td>Revised Knox Preschool Play Scale; each rater observed two 15-min free-play sessions.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Martin, Burtner, Poole, &amp; Phillips (2008)</td>
<td>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.</td>
<td>Instrument development and testing</td>
<td>Level V</td>
<td>Quantitative prospective, quantitative cross-sectional reliability and validity study</td>
<td>Descriptive statistics were computed for all variables. Interrater reliability was calculated through percentage agreement between the raters.</td>
<td>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.</td>
</tr>
<tr>
<td>Miller &amp; Kuhaneck (2008)</td>
<td>10 children (6 boys, 4 girls, ages 7–11) were recruited via individual in-depth interviews.</td>
<td>Intervention No intervention was provided.</td>
<td>Individual in-depth interviews were completed that focused on play.</td>
<td>“Fun” emerged as the core category explaining the choice of specific play activities for children. 4 other categories of characteristics emerged as contributors to.</td>
<td>The geographic area where children were recruited from was not reported. The method of recruiting/contacting the participants was not reported.</td>
<td></td>
</tr>
</tbody>
</table>
### 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>
<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>Myers (2008)</td>
<td>Efficacy study</td>
<td>Quantitative mailed survey to respondents</td>
<td>No intervention was provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Instrument Used</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A researcher-generated survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>consisting of 33 items was used</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>that focused on the role of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>occupational therapists with young</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>children with special needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>transitioning from 1 service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Statistics Used</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Descriptive statistics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Frequencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Percentages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pfeiffer, Henry,</td>
<td>Effectiveness study</td>
<td>Level I</td>
<td>Intervention group used Disc ‘O’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miller, &amp; Witherell</td>
<td></td>
<td></td>
<td>Sit cushions throughout school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2008)</td>
<td></td>
<td></td>
<td>day for a 2-wk period. Intent was</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>to determine the effectiveness and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>impact of a dynamic seating system</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>on improving attention to task</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>for students.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Instrument Used</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● BRIEF</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Statistics Used</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● ANOVA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Myers (2008), purposeful sampling methods. All children were White, from middle-class homes, and resided in suburban to semirural areas. Inclusion criteria were (1) between ages 7 and 11, (2) typically developing, (3) spoke fluent English, and (4) did not have any medical diagnosis.

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.

For Pfeiffer, Henry, Miller, & Witherell (2008), 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.

No reliability or validity data were reported about the survey. Moderate response rate. Data analysis was largely descriptive. No comparison group was included.

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.
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.

**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.

Infant Space Theory provides a perspective on infant–toddler interactions with the spaces and objects of the home. This view of infants–toddlers with their contexts describes progressions in gaze and visual play, in mapping and ranging home space, in stationary object play, and in the described development of mobile object play. The study findings may assist therapists in creating and modeling naturalistic interventions with infants and their families.

A sample of 18 mother–infant dyads from a White background residing in the Southern Californian region has limited generalizability. The authors also reported that the data were gathered in the mid-1990s but were not analyzed until after 2007; therefore, it questionable whether data more than a decade old are viable to complete such an analysis on.

---

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.

**Intervention**

13 infants watched computer-generated synchronous or asynchronous slideshows of auditory and visual stimuli. Infants were tested between the ages of 14 and 17 wk.

**Instruments Used**

Visual behavior was recorded via videocamera, and vagal tone data were collected via an

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.
### 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>
<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>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>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>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>
</tr>
<tr>
<td>Rechetnikov &amp; Maitra (2009)</td>
<td>Meta-analysis</td>
<td>16 studies that met inclusion criteria were included.</td>
<td>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, the meta-analysis suggests that speech and language impairments should be considered.</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>

* Overview of occupational therapy impact area publication statistics in the *American Journal of Occupational Therapy* in 2008 and 2009. The table highlights various studies, their methodologies, and relevant observations.
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.

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.

---

**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).

**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.

**Intervention**
- N/A

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

---

**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 high-functioning participants.

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.
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>
<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. 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. 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>
<td>Interference Test and Sorting Test  - Wechsler Intelligence Scale for Children–IV Digit Span  Statistics Used  - Student’s t tests  - χ² analyses  Interrater reliability was computed using intraclass correlation coefficients. Internal consistency was evaluated using Cronbach’s α. 1-way ANOVA was used to assess discriminant validity.</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>
</tr>
<tr>
<td>Sachs &amp; Nasser (2009)</td>
<td>Efficacy study</td>
<td>Naturalistic qualitative method based on a phenomenological approach; interviews and participatory observations. 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>Intervention  Parents and children took part in ≥10 monthly family occupations held in the Snoezelen.  Instruments Used  Semistructured in-depth interviews and participatory observations were used for data collection. Interviews were audiotaped and transcribed for further analysis. Observations were videotaped and transcribed. Field notes were recorded by a 2nd researcher.</td>
<td>Internal consistency was .90, interrater reliability was .92, and test–retest reliability was .84. Concurrent validity correlations ranged from 0.52 to 0.65. Construct validity confirmed a 2-factor structure accounting for 67% of the variance.</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>
</tr>
</tbody>
</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 consecutively 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.

### 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.

### 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

**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 may contribute to the challenges that people with autism have when attempting to communicate with others and to develop meaningful relationships.

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.

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
## 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>
<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>Silva, Ayres, &amp; Schalock (2008)</td>
<td>Effectiveness study</td>
<td>Level III</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>
<td>Small convenience sample; lack of randomization; no control group for comparison; lack of control for other treatments that children might have received concurrently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospective 1-group pretest-posttest design</td>
<td>Instruments Used:</td>
<td></td>
<td></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>• Vineland-II Adaptive Behavior Scales</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<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>• Autism Behavior Checklist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Sensory Profile</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Informal parental questionnaire</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Statistics Used:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Change scores were calculated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Wilcoxon Sign test</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• t test for independent samples</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confidence intervals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Method of recruitment was not mentioned by authors.

Instruments Used

- Sensory Profile
- Sensory Integration and Praxis Tests
- Bruininks–Oseretsky Test of Motor Proficiency, 2nd edition
- DTVP

Statistics Used

- Change scores were calculated
- Wilcoxon Sign test
- t test for independent samples
- Confidence intervals

Motor planning–praxis skills. An intervention program using sensory integration, a relationship approach, and principles of motor learning and motor control was implemented.

Instruments Used

- Sensory Profile
- Sensory Integration and Praxis Tests
- Bruininks–Oseretsky Test of Motor Proficiency, 2nd edition
- DTVP

Statistics Used

- Change scores were calculated
- Wilcoxon Sign test
- t test for independent samples
- Confidence intervals

Findings indicated that children exhibited significant short-term improvements in sensory impairment and social development after receiving the Qigong Sensory Massage Protocol.

Small convenience sample; lack of randomization; no control group for comparison; lack of control for other treatments that children might have received concurrently.
 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**  
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.
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>
<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>Huang, Su (2009)</td>
<td>Effectiveness study</td>
<td>Level I</td>
<td>Quantitative quasi-experimental design; 1-group pretest-posttest design with random assignment to control group or 1 of 3 intervention groups</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 data when the more recent 2005 version should have been used. No data were collected on motor-free visual perception, school-related skills, or occupational performance.</td>
</tr>
</tbody>
</table>

Convenience sample: Participants were recruited from a pediatric occupational therapy unit, Department of Rehabilitation Medicine in a university-affiliated medical center in Taiwan.

Inclusion criteria were (1) between ages 7 and 8, (2) a diagnosis of mild mental retardation (e.g., IQ of 50–70), (3) absence of serious emotional or behavioral disturbances, (4) not receiving therapy treatment, and (5) ability to follow test instructions. Exclusion criteria included children presenting with coexisting autism, CP, blindness, deafness, or previous history of neurological disorders. Sample size included 160 children, 40 of whom were assigned to a control group.

Instruments Used
- Bruininks–Oseretsky Test of Motor Proficiency
- MVPT–R
- Test of Sensory Integrative Functioning

Tests were administered by therapists who were blinded to the children’s group involvement.

Statistics Used
MANOVA; if significant group effects were found, then follow-up F tests were performed with Scheffe post hoc comparisons; effect sizes were calculated as well.

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; RCMA = Revised Children’s Manifest Anxiety Scale; SCPRNT = Southern California Post Rotary Nystagmus Test; SD = standard deviation; SFA = School Function Assessment; SIPT = Sensory Integration and Praxis Tests; SRD = Sensory Over-Responsivity Inventory; SSD = smallest real difference; SSP = Short Sensory Profile; THM = Test of In-Hand Manipulation; TVPS–R = Test of Visual Perceptual Skills–Revised.

*Level of evidence reported only for effectiveness studies.

This table is a product of AOTA’s Evidence-Based Practice Project and the *American Journal of Occupational Therapy*. Copyright © 2010 by the American Occupational Therapy Association. May be freely reproduced for personal use in clinical or educational settings as long as the source is cited. All other uses require written permission from the American Occupational Therapy Association. To apply, visit [www.copyright.com](http://www.copyright.com).