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A Study Exploring Parents' and Occupational Therapists Views on Facilitating Social and Emotional Development

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A Study Exploring Parents' and Occupational Therapists Views on Facilitating Social and Emotional Development

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in the department of Health and Human Sciences.

By

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Under the mentorship of Katy Gregg Ph.D

Abstract

This study examined how parents of a child with a disability and the child's occupational therapist each facilitate social and emotional development among children who have or are currently receiving occupational therapy services. This study first served to identify, through interviews, what social and emotional skills are important individually to the parent and the occupational therapist that the child gains. Through interviews, the researcher investigated the perceptions of how parents and occupational therapists facilitate social and emotional skills. The location of the therapy session was found to be a vital component among parent and occupational therapist interaction. Finally, this research noted how parents and occupational therapists are working together to better serve the child or how barriers can impede the relationship. The data exposes that even though occupational therapists view the holistic approach of their role as vital, this is not necessarily being implemented due to external factors. Based on the interviews with the participants in this study, data reduction points to a gap that is present between occupational therapist and parent interaction that can indirectly affect parent child interaction which in turn affects the child's social and emotional skill enhancement and development.

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Introduction

This research examined how social and emotional development is facilitated by parents and occupational therapists to children who have a delay or identified disability and who have received or are currently receiving occupational therapy services. This research focused on two components of comparison. One component concentrated on the parent's understanding and facilitation of social and emotional development while the other component refered to the occupational therapists' approaches on facilitating education and assisting in the development of social and emotional skills.

There are many misconceptions among child development that revolve around a child's social and emotional development. Newton and Thompson (2010) conducted a study that asked parents of typically developing children simple developmental questions in a questionnaire. The results showed that many parents underestimated their young infants' emotional and psychological day-to-day experiences. The parents then overestimated their toddler's social and emotional skill set. Zand et al. (2015, pp. 235) states, "Accurate assessment of developmental delays is dependent on an understanding of normative development." In regards to this study, it is of importance for the field to recognize the influence, or lack thereof, that parents as well as occupational therapists have on the child so that they can further assist the child in gaining social and emotional life skills.

Furthermore, parents and occupational therapists can work together with other specialists to develop the child's individualized education plan (IEP) if the child is receiving school services, an individualized family service plan (IFSP) if the child is receiving early intervention services, or a plan of action with goals and objectives if the child is only seeking occupational

therapy at an outpatient facility. Ray and colleagues (2009) said "working with families as partners in supporting the learning and development of the child is key" (p. 17).

Literature Review

Parental Knowledge and Misunderstanding

The knowledge of child development and understanding the typical patterns of development is important for all parents, caregivers, and personnel working with children. If one knows the typical patterns of development and what a child should be able to do around a given age, they are better able to support the child's development. Parent interactions with their child can affect their child's developmental outcomes. Zand et al. (2015) have suggested that parents with accurate knowledge of their child's development tend to recognize their child's developmental problems sooner as well as act in effective ways to help their child receive services. According to Zand et al. (2015), there are three identified ways that parents with greater developmental knowledge help their child when atypical patterns are noticed. First, these parents are generally aware of their child's mental and physical health. Second, parents are more aware of when it is an appropriate time to seek professional help. Third and finally, parents that are aware of patterns of development tend to better know how to receive and effectively use child services. It is necessary when looking at parent's knowledge on general development of their child to realize and be aware of the fact that the wealth of the parents' knowledge is varied by age, income, education, race/ethnicity, and parity (Zand et al., 2015).

A study done by Newton and Thompson (2010) also viewed the developmental misunderstandings that parents have of typical development. Newton and Thompson (2010) conducted a study that asked parents of typically developing children simple developmental questions in a questionnaire. The results showed that many parents underestimated their young

infant's emotional and psychological day-to-day experiences. Then in contrast, the parents overestimated their toddler's social and emotional skill set. Based on the findings by Newton and Thompson (2010), the majority of parents understand some important ways to promote development such as providing social experiences and using clear communication for setting limits. However, parents' understanding of typical developmental milestones and what is appropriate at a given age is less common knowledge. Parents of a child with a disability not only have to be aware of where their child is currently with their social and emotional skill set, but also what typically developing children of the same age range are able to do (Newton & Thompson, 2010). Zand and colleagues (2015) state that "accurate assessment of developmental delays is dependent on an understanding of normative development" (p. 235). In regards to this study, it is of importance for the field of occupational therapy to recognize the influence that parents as well as the therapists have on the child so that they can further assist the child in social and emotional life skills.

Theoretical Framework of Evaluation

According to the ecological systems theory developed by Bronfenbrenner (1986), the child is said to develop within a complex system of relationships that are affected by the different layers of the child's environment. The largest area of influence on the child is the macrosystem which is the cultural environment a child resides in (Allen and Cowdery, 2012). An example of the macrosystem that effects the child can included the laws that influence the child's environment such as the Individuals with Disabilities Education Improvement Act of 2004.

In regards to the family system, Bronfenbrenner (1986) said that even though the family is the main context where human development takes place, it is one of many settings where developmental processes occur. The microsystem is the child's innermost level which contains

the immediate environment that the child is exposed to. The family is a child's microsystem and the relationships between parents and the child directly influence the development and personality of the child (Swick & Williams, 2006). The parents directly influence social and emotional development through their parenting style and level of nurturance during infancy and childhood. In conjunction, following the parent's indirect influences as noted above, children respond to parents either positively or negatively which in turn leads to a bidirectional relationship between the parent and child.

When talking about the parental influence on children, it is important to note that parents are influenced by their own environments, including the work environment in which they are present. The work environment directly affects the parent, but indirectly affects the parent's child through their current demands and shift of time. Parent and child interactions that are positive help to facilitate developmental growth in the child within the six areas of development including social and emotional (affective) (Wakeford, 2016). Bronfenbrenner characterized these influences from indirect sources as the exosystem. Swick and Williams (2006), characterized the exosystem as contexts we experience vicariously through another person that have a direct impact on our lives. Swick and Williams (2006) went on to say that a parent's stress at work should be noted as a main source of an indirect effect on the child. The child can be subconsciously influenced by the stress of the parent's workplace through the parent's emotional state without ever physically being present in the parent's work environment (Swick and Williams, 2006).

Bronfenbrenner (1986) noted work completed by Prugh, Staub, Sands, Kirchbaum, and Lenihan (1953) which, while completed some time ago, is relevant within the context of this study. Prugh and colleagues observed and studied children within the hospital and care setting

which could in this study correspond to the therapeutic setting with the parents and the occupational therapist. In the study done by Prugh and colleagues, the control group of the study was the children's parents who were restricted to weekly visiting periods of two hours each. In contrast, the experimental group of children received visits from their parents at any time and parents were also encouraged and allowed to participate in ward care. This study showed greater emotional stress among the children whose parents could not visit their children when they pleased or could not be a part of the ward care. The emotional distress within the study lasted from months to as long as a year and half among the children in the control group. This study showed the relationship between increased parental influence in the hospital setting, and greater positive influences on the child's treatment and lasting outcomes. (Prugh et al., 1956). In regards to this study when looking in comparison to the study done by Prugh and colleagues, it is worth referencing that more parental involvement is a positive factor in regards to treatment.

Within the premise of this study, the role of the occupational therapist could fall within the microsystem and/or mesosystem of the child's development depending on the amount of therapy the child receives and the involvement of the occupational therapy in the child's day-to-day life. The occupational therapist has direct influence on the child within the session on a daily or weekly basis. However, the more the occupational therapist educates the parent on home therapeutic techniques, the more indirect influence the therapist has. The therapist, through teaching the parent techniques and the parent then implementing those techniques at home with the child, is influencing the child's development within the microsystem rather than in the mesosystem of a direct one-on-one therapy session. Because of the influence therapists can have in the child's microsystem and mesosystem, the therapists needs to work even more with the child's parents to devise a treatment plan as well as ways to implement those techniques. This

cooperative planning and implementation can influence the child's social and emotional skills which can better serve to enhance the child's developmental processes (Bronfenbrenner, 1986).

Children's Social and Emotional Development

Within previous literature, researchers have viewed social and emotional development as one category or entity. For the purpose of the study, social and emotional development will be broken into two different domains of development. The first thing to consider when referring to either social or emotional development consists of referring to typical developmental milestones and then assessing the current skill level of the child with a disability. When viewing social development specifically, it must be noted that it is a multifaceted area of development. According to Squires and Bricker (2007, p. 32), social development can include "attachment, temperament, self-image, self-control or behavioral regulation, empathy, social interactions, morality, and social knowledge (e.g. gender)." Within social development there are four "hows" related to the skill development. The four "hows" include "how to approach, to get included; how to interact, through sharing and cooperating; how to deal with differences, such as teaching, bullying, helping, and including others; and how to manage conflict by problem solving" (Allen & Cowdery, 2012, p. 386). These skills are important for all children for them to gain social and academic success in life (Duran, Hepburn, Kaufmann, & Le, n.d.). In collaboration with the four "hows" by Allen and Cowdery, Squires and Bricker (2007) address seven areas of social development that are important to recognize when trying to understand and categorize social interactions in children. The seven categories include "1) responding to and initiating interactions between caregivers, siblings, other adults, and peers; 2) meeting physical and social needs; 3) participating in cooperative and social activities; 4) managing behavior and resolving conflict; 5) knowing about self and others; 6) showing empathy; and 7) developing self-image

and self-worth" (p. 32). These seven categories can be used by parents and occupational

therapists to cohesively work together to in turn help the child meet their goal(s) within the social

domain.

As mentioned previously, emotional development falls cohesively with and is sometimes

combined into the developmental area of social development. Emotional development relies

heavily on the child's temperament and personality traits. According to Squires and Bricker

(2007), emotional development is heavily focused on emotional regulation and understanding

others emotions. Emotional regulation has characteristics involved in dealing with and

understanding elevated levels of positive and negative emotions including happiness, anger, fear,

excitement, and other emotions (Squires & Bricker, 2007). A child with a developmental

disability that includes an emotional component may find it hard to express emotions, understand

other people's feelings through verbal and nonverbal gestures, and understand jokes or sarcasm.

These emotional skills that typically developing children learn to navigate in childhood through

social interaction can be a hindrance to those with a disability. A lack of these emotional skills

can lead to possible social distancing, isolation, and challenging behaviors (Acredolo &

Goodwyn, 2005).

Occupational Therapists' Interactions

Occupational therapists use activities to help children receiving services be able to

perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Activities of daily living include eating, dressing, and performing hygiene routines whereas

instrumental activities of daily living include tasks such as meal preparation and shopping (Allen

& Cowdery, 2012). Occupational therapists not only consider how to help a child perform ADLs,

but they also look at different ways the parent or caregiver is involved in daily situations with the

child and in conjunction how this affects the child's participation. When looking at an occupational therapist's intervention it should not only serve to help the child perform these activities of daily living but it should also include focus on how to help the parent and child be able to make special life events that arise become meaningful experiences to both the child and family (Wakeford, 2016).

When looking at social and emotional learning (SEL) occupational therapists work on critical life skills such as being able to cope with a situation, build positive relationships, and behave in culturally appropriate and sensitive ways. The Collaboration for Academic Social and Emotional Learning (CASAL; 2016) has created five SEL competencies that occupational therapists use to help the children they are serving. The five competencies are self-awareness, self-management, social-awareness, relationship skills, and responsible decision making based on the child's age. According to CASAL's research, these five competencies that occupational therapists work on directly influence academic, social, and home participation. Occupational therapists can work with teachers and parents to create SEL opportunities for the child that are outside of the occupational therapists direct influence (The American Occupational Therapy Association, 2013).

Children receiving occupational therapy have short and long term goals, some of which relate directly or indirectly to social and emotional development. However, although social and emotional goals may be a part of the child's plan, the pediatric setting in which the occupational therapist works has a major influence on what the therapist focuses on and addresses with the child. Recent research has shown that hospital-based therapists focus more on the diagnosis and methods of meeting the goals while in contrast, occupational therapists serving children through early intervention focus on broader social and community aspects of development. With

occupational therapists working in early intervention there is more training on community life skills and more involvement of the parent within the therapy (Ideishi, O'Neil, Chiarello, & Nixon-Cave, 2010).

Interactions between Parents and Occupational Therapists

It is important that the occupational therapists and parents work together to facilitate social and emotional development. Even if the occupational therapist provides attentive and high quality services and therapy during the child's occupational therapy session, it is still critical to the child's intervention and outcome that the parents continue the implementation of the therapeutic practices outside of the sessions (Wakeford, 2016). Individualized family service plans (IFSP) and Individualized education plans (IEP) bring together the knowledge of an occupational therapist and parent as well as information from other professionals who work with the child. The IEP and IFSP are intervention plans that are mandated by the Individuals with Disabilities Education Act (IDEA) (Individuals with Disabilities Education Act, 2004). IDEA, modified in 2004, serves multiple purposes which include ensuring children have free and appropriate education offered to them, ensuring that the rights of children with disabilities and their parents are protected, and promoting educators and parents to have the necessary tools and components to better serve the child.

When choosing whether an IFSP or an IEP is created the professionals look to the child's age. An IFSP is created for children receiving services from ages birth to three. An IEP is established for a child ages three or older. For the process of creating intervention goals, the therapist will work with the family as well as professionals within the location where the child is receiving services such as through early intervention, outpatient therapy, or the school system. These professionals can include doctors, teachers, intervention specialists, and other school

personnel that influence the child's development. Regardless of what professionals are on the team to create the IFSP or IEP, collaborative approaches are the recommended practice (Wakeford, 2016).

In an article by Ray, Pewitt-Kinder, and George (2009), they emphasized the importance of listening to families in the process of developing a treatment plan. Ray and colleagues (2009) stated "working with families as partners in supporting the learning and development of the child is key" (p. 17). Also, it is important when working with families of the child with a disability that you try to understand the family's life and appreciate the extra work the parent is expected to do in order to support their child (Ray et al., 2009).

Based on this knowledge found in the study completed by Ray and colleagues (2009), parents and therapists can work together to develop goals that are developmentally and individually appropriate for the child. Developing goals begins with collaboration of the parent, occupational therapist, and other team members. The goals should reflect the parents' priorities for the development of their child as well as the needs of the child within their everyday environment (Wakeford, 2016). When developing therapeutic, educational, and in-home plans to help facilitate social and emotional skills, the plan centers on the child's characteristics and abilities. It is important to remember that short and long-term goals will look significantly different among various disabilities and the level of severity. The goals should focus on developmental appropriateness and move from the child's current developmental stage. If the child is not receiving therapy through either a state early intervention program or through the school system then the occupational therapist will develop a plan of care for the child that includes the short and long-term goals. Regardless of whether the child has an IFSP and IEP, both plans should include short and long-term goals in addition to objectives for the child's

future development (Ray et al., 2009). In addition specifically for an IFSP, goals may be included for the family or parents (Wakeford, 2016).

Research Questions

Social and emotional skills for children are promoted through interactions between the child and parent as well as the occupational therapist and child. When reviewing the literature of previous research, there have been studies that have viewed either parents or occupational therapists and their role in the child's social and emotional development. However, upon searching the literature there is a gap that involves how parents and occupational therapists interact and contribute together to the child's social and emotional development. The goals of this study include

1. To explore how parents and occupational therapists define social and emotional development along with how they describe it

2. To gain insight into what parents and occupational therapists view as important social and emotional skills for the child to have

3. To recognize how parents and occupational therapists are working together to support the child

4. To better understand how the occupational therapist is offering supports to the parent for them to be able to support their child within the areas of social and emotional development outside of the therapeutic setting

In regards to goal four, offering supports and strategies between the parent and occupational therapist can include, but is not limited to, providing guidance strategies, tips, and therapeutic home-based activities. This research has three main questions of study. The first question is what are occupational therapists' views on social and emotional developmental skills and what are the

goals they want for the children they serve? The second question is what social and emotional skills and goals are important to the parents that their child possesses? The third question is how do the parents and occupational therapists work together to support social and emotional development with the child receiving services?

Methods

Sample and Participant Selection

This study consisted of two groups of participants, occupational therapists and parents of children who are receiving or have received occupational therapy services. The first group of participants within the study were occupational therapists. Occupational therapists were recruited through the use of snowball sampling. Snowball sampling refers to getting new contacts of potential participants from each person that is interviewed (Patton, 2002). Contact was initially made with two occupational therapists who then made referrals to other occupational therapists. In total, four occupational therapists were interviewed who worked at facilities including pediatric outpatient services, the public school system, and early intervention.

The second group of participants were the parents of a child who is currently or was previously receiving occupational therapy services. Parents were recruited through occupational therapists. The researcher provided the occupational therapists with a letter of recruitment which was then given to the potential parent participants. The letter of recruitment provided details of the study and included what was required of the participant. If the parent was interested in participation they had the choice of either giving their contact information to their child's occupational therapist to relay to the researcher or they were able to call or email the researcher directly.

In regards to this study, the race, ethnicity, gender, and socioeconomic status of the parents did not determine participation in this study. The four parents that were interviewed were all female and Caucasian. While there was no demographic information gathered on the parents, there was however demographic questions that related to the child receiving occupational therapy services that the parent responded to in the interview (that were asked to the parents parents that were see Table 1). For the four occupational therapists that were interviewed all of them were female. Three were Caucasian and one was African-American. Demographic information was gathered from the occupational therapists on how long they have been working as an occupational therapist and what locations they have provided services in throughout their career (See Table 2).

Table 1. Child demographics as stated by the parent of the child receiving occupational therapy

Parent	Age of child	Age when beginning OT	How long receiving OT overall	Currently receiving OT	Any type of OT involvement now	Location of therapy (stated from most to least recent)
A	35 months	15 months	6 months	Yes	Yes; participation in a preschool intervention program	1) Preschool intervention 2) Outpatient
B	5 years	3 years	2 years	Yes	Yes; therapy through the school system	1) School system
C	3 years	9 months	1 year	No	No	1) Outpatient
D	6 months	Birth	4months	No	Yes; OT's check development every 2 months	1) In home therapy 2) Inpatient NICU OT

Note: OT= Occupational therapist; NICU= Neonatal intensive care unit

Table 2. Occupational Therapists demographics

Occupational Therapist	Years working as an OT	Pediatric work location (listed from most recent to least recent)
A	5 years	1) School system 2) Outpatient private setting
B	33 years	1) Early Intervention 2) School System 3) Outpatient private practice 4) Inpatient hospital setting
C	16 years	1) Outpatient private practice 2) Early intervention 3) Inpatient care
D	12 years	1) School System

Note: OT= Occupational Therapist

Data Collection

Data was collected through a set of interview questions for the occupational therapists (Appendix A) and a different interview protocol for the parents of a child who has or is currently receiving occupational therapy services (Appendix B). Interviews were chosen as the methodology based on previous studies that confirm the purpose and usefulness of utilizing interview. Interviewing takes interest into people's lived experiences which are defined as direct experiences with the subject of interest (Patton, 2002). Interviewing allows for interpretation of those meanings within the experiences (Seidman, 2006). According to Seidman's guidelines, he concluded that interviewing is a way of inquiring about a person's experiences. Similar to

Seidman, Patton (2002), says, "The purpose of interviewing is to allow us to enter into the other person's perspective" (p. 341).

When interviewing the occupational therapists', interview questions began with the occupational therapists' general definition of what they perceived social and emotional development to be. Next, the interview moved into more detailed questions of how the occupational therapist prepares for the session as well as the interaction (if any) that is done with the parent before or after the session with the child. Lastly in the interview, the occupational therapist was given a scenario that proposed a social and emotional developmental situation to better understand how the occupational therapist participants would handle that specific situation.

When interviewing the parents, a similar approach was taken by the interviewer. The interview questions for the parents began by asking the parent to explain what social and emotional development means to them. The interview questions then became more detailed by asking the parent questions such as the goals they have for their child within the two the domains of social and emotional, the activities they provided for their child to enhance social and emotional development outside of the therapeutic setting, and how they received information and interact with the occupational therapist. Lastly, the parent was given two different scenarios, instead of only one, that proposed social and emotional developmental situations to better understand how the parent would handle the situations.

Procedure

Before locating participants and beginning the interview process, the researcher completed the Institutional Review Board (IRB) approval. Once the study gained approval, an interview was conducted for each participant using either Appendix A for occupational therapists

or Appendix B for parents. The interview took place at a location convenient for the participant. These included a phone interview, meeting at the participant's home, at their place of work, or at a coffee shop. Before the interview began, rapport was built with the interviewee by asking them about their work if interviewing an occupational therapist or about themselves and their child if interviewing a parent. Also, before the interview began the Georgia Southern Informed Consent document was reviewed, clarified as needed, and signed by the participant. The interviewer then turned on the audio recording device and began the interview with the first question.

During each interview, questions were asked in the same order for each participant of either group. This allowed the interviewer to be consistent. The interviewer also provided follow up questions or clarification questions as needed with the interviewee. According to Ezzy (2002), checking for accuracy is important because the aim of a good interview is to obtain the story and the interviewee's interpretation as concisely as possible. Checking the interpretation with the interviewee also provides a way of developing a conversational approach to the interview (Ezzy, 2002).

Prompts were given to the interviewee if they did not understand the question, needed clarification, or had a long pause. If the participant did not understand the question, the question was then restated with more examples to provide the interviewee with more context. When the interviewee gave an answer, the interviewer wrote down key words and phrases for each question. Patton (2002) refers to four benefits of notetaking during an interview and these include:

1) notes taken during the interview can help the interviewer formulate new questions based on previous answers, 2) looking over field notes before transcripts are done helps

the researcher verify the direction the study is going as well as stimulate early insights into noticed themes, 3) taking notes about what is said facilitates later analysis by being able to "locate a specific piece of information, and 4) notes are a backup in the event that the recorder has malfunctioned (p. 383).

When the interview was complete, the interviewer stopped the recording. Conversation often continued briefly after the recording was stopped outside of the research context. The interviews of the occupational therapists ranged in time from seventeen to seventy-four minutes, while the interviews with the parents ranged from nineteen to thirty minutes.

Analysis

This study used content analysis as described in the context of grounded theory. Content analysis according to Patton (2002) is, "used to refer to any qualitative data reduction or sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (p. 453). By using the process of content analysis, it allowed for interpretation and extraction of meanings from the data collected during the interview process. Within content analysis, categories (e.g., patterns and themes) were developed by the researcher that were then connected to statements of the participants. Patterns are defined as descriptive findings such as, almost all participants reported the child understanding emotions to be important to emotional skill development. Themes are viewed more in a categorical form such as, understanding emotions (Patton, 2002).

As mentioned previously, the researcher performed inductive and deductive analysis through content analysis. Inductive analysis, refers to the researcher discovering the patterns and themes within the data of the interviews. Deductive analysis refers to the researcher generating

propositions as to the relevance and influential components of the data collected. However, although content analysis is a component of grounded theory, the actual methodology of grounded theory was not utilized within this research. This is due to the fact that the researcher had preconceived ideas about what social and emotional development should be and also had the understanding that parents are not always aware of what the academic definitions are of social and emotional development. Because of these preconceived notions, the researcher was not completely unbiased which is a component of the grounded theory methodology. Instead for this study, the researcher recognized the bias through performing inductive and deductive coding measures within content analysis.

While still in the field and conducting interviews, themes began to emerge between the parent and occupational therapist interviews. Then when transcribing began on the interviews that had been conducted, the interviews began to provide even more insight into patterns and themes by utilizing the process of inductive analysis. Remaining in the field while beginning transcription allowed for the interviewer to use the insights that are relevant to the study and peruse those topics in future interviews. This idea is embedded in the "emergent nature of qualitative interviewing." (Patton, 2002, p. 383.)

When viewing the process of transcription, according to Patton, transcribing offers a transition point between data collection of the interview and analysis which serves as part of data management and preparation for analysis (Patton, 2002). For this study, the program Express Scribe was used to transcribe verbatim the content of the interviews. The interviews were then copied and pasted into a Word document and saved onto a folder of a password protected computer.

When transcribing an interview, inductive analysis was used through utilizing memos to discover patterns and themes; which led to categories based on the findings. According to Strauss (as cited in Patton, 2002), a theoretical memo is "writing in which a researcher puts down theoretical questions, hypotheses, summary of codes etc.- a method of keeping track of coding results and stimulating further coding , and also a major means for integrating theory." Once all transcriptions were complete and memos recorded, the researcher did a first read through of the data, which began to reduce the data through the development of codes and eventually themes.

Once the interviews were transcribed and the first read-throughs were complete in the within inductive analysis, the transcriptions in Word documents were uploaded one by one into Atlas.ti, a qualitative research program used for data analysis. This software serves to merely assist in the analysis of the data. The researcher was actually performing the analysis (Patton, 2002). In order to reduce the data into meaningful codes, the researcher engaged with the data to find understanding in each participant's interview as well as discovered patterns of similarities and overt differences.

Inductive analysis continued through coding words and phrases stated by either the parent or occupational therapist or in some cases both. The content of the interviews were analyzed to determine what is significant to include when creating codes. When developing codes, the researcher performed convergence of the data which refers to figuring out what items fit together within the different transcriptions of the parents, occupational therapists, or within all transcriptions overall (Patton, 2002). The researcher examined the data for regularities which revealed patterns and were sorted into categories. Once convergence was complete, it was then analyzed for divergence which was done through building on known items and making connections between information from different transcriptions. Divergence also included

identification and understanding of data that did not fit into the overall patterns and themes of the data (Patton, 2002).

Because the researcher performed inductive analysis through memoing, performing read-throughs, and using the data analysis software Atlas.ti and deductive analysis through developing codes and finding divergence, it led to and enabled categories to be formed. After the researcher became aware of influential themes through these methods, the process of utilizing deductive analysis was conducted. Through deductive analysis, the researcher formalized results and conclusions by identifying relationships in the data from the categories and codes created during the previous process of inductive analysis.

Through graphic organization, the researcher with her research mentor discussed codes and reviewed potential themes. Code lists were collapsed into thematic groups, moved, and adjusted based on discussion and conversation regarding the interpretation of the data. Both inductive and deductive coding were used to compare and contrast personal definitions of terminology and definitions used in the child development field. As the conversations continued and codes combined, the researchers reduced the data to three themes which both believed represented the voices of the participants.

Results

Throughout the analysis of the data three themes emerged. The first theme included the important social and emotional skills that were stated by the occupational therapists and the parents. Parents and occupational therapists responded to what emotional and social skills they felt were important for the child to gain in order to promote their overall development. The second theme found within the data involved the occupational therapists' and the parents'

interaction across different settings. The amount of interaction and what was involved in the interaction varied between the locations including private outpatient, early intervention, and the elementary school system. The third theme found focused on the child interactions with the occupational therapist and the parent. These interactions with the child were based on increasing social and emotional skills and meeting social and emotional goals.

Defining Social and Emotional Skills

Within the first identified theme of important social and emotional skills stated by the occupational therapists and parents, it is imperative to note that social and emotional skills were displayed in the category of either social or emotional based solely on how the parent or occupational therapist categorized them. The working definitions provided in the interviews do not always align with the academic definitions of social and emotional development that were used to guide the framework of the research. However this qualitative research remained focused on the parent and occupational therapists' lived experiences, by reporting the parents' or occupational therapists' interpretation of social and emotional skills as they were noted by the participants.

For the purpose of reference, this study referred to the academic definition of social development which included "attachment temperament, self-image, self-control or behavioral regulation, empathy, social interactions, morality, and social knowledge (e.g. gender)" (Squires & Bricker, 2007, p. 32). The academic definition of emotional development used within this study was that emotional development relies heavily on the child's temperament and personality traits, and focuses heavily on emotional regulation and understanding others emotions (Squires & Bricker, 2007).

Table 3. Important Social and Emotional Skills

Important social skills stated by parents	Important social skills stated by occupational therapists	Important emotional skills stated by parents	Important emotional skills stated by occupational therapists
Smile appropriately	Problem solve	Express feelings	Show affection
Interacting with others	Ability to interact	Feelings link to words	Emotional coping
Engage appropriately with others	Engage appropriately with others	Knowing own feelings	Follow directions
Expressing themselves	Proper greetings	Can understand own needs	self-determination
Reacting to someone else	Interact in different settings	Communicate needs to others	Have appropriate responses
Acknowledging that a person is there	Comfortable to assert personality	Control emotions	Self-regulation of emotions
Communication	Participate in community	Confidence	Self-esteem
Confident in own locations	Self- advocacy	Differentiate between emotions	Comfortable with expressing themselves
Be able to transfer skills to different locations	Comfortably Express themselves	Understand emotions range in intensity	Taking responsibility
Respect			Understanding it's okay to be upset
Be themselves			Acknowledging when upset
Talk about emotions			Aware how to respond
Have eye contact			
Be able to cope			

In reference to Table 3 Important Social and Emotional skills, parents stated some of the social goals that they wanted their child to have as being confident in their own location, expressing themselves, and smiling appropriately. Parent B mentioned,

> I would like for him to be able to be confident in his own location wherever he is at…for example, if we were sitting in this house right now and it got completely quiet and he didn't see anybody, it would be very, very bad. Especially if he can't find anybody and that's a big problem because at some point he is not going to be around somebody and I want to make sure that is set.

Within the interviews, parents went on to talk about important emotional skills that they want their child to be able to have. Parents stated that they want their child to be able to understand and differentiate between emotions, understand that feelings link to words, and be able to understand that emotions range in intensity. While parents mentioned many emotional skills, all parents mentioned at some point the want for their child to be able to differentiate between emotions. Parent A mentioned the most important emotional skill she wanted her child to have as,

> Probably knowing her own feelings, cause the screaming, she didn't know what was wrong and neither did we but mostly I want her to be able to figure out what feelings she is having.

Parent D also mentioned wanting her 6 month old child to be able to differentiate between emotions by stating,

> So I guess like the emotion of him being sleepy or tired or something is hurting him or something, all of those emotions he confuses with eating right now. So

him being able to differentiate between that would definitely make both of our

lives easier.

As noted in Table 3 Important Social and Emotional Skills, occupational therapists stated some important social goals that they want the children they are serving to gain as being able to problem solve, being able to engage in proper greetings, and participate in self-advocacy. Occupational therapists consistently mentioned throughout the different locations of outpatient therapy, early intervention, and the school system that they want for the children to have proper greetings. Occupational therapist A stated in response to working with a child,

One of those goals was to initiate proper greetings like saying hello and saying

goodbye because he never would do it without a prompt so just learning those

just social greetings is a good goal to have.

Occupational therapist D also mentioned the importance of the social skill of greetings within the location of the school system. Occupational therapist D stated,

So if we are walking down the hall, it is important to me that when another

person greets them, that they stop, look them in the face, and greet them back.

And we work on that just in transitions to and from therapy basically.

Occupational therapists, just as parents, went on to talk about important emotional skills that they want the children they are serving to be able to have. Occupational therapists stated that they want their children to be able to be comfortable in expressing themselves, have increased self-esteem, and be able to acknowledge when they are upset. Occupational therapist B mentioned the

importance she places on a child's ability to be comfortable in expressing themselves.
Occupational therapist B noted,

> When a child typically hasn't said anything or acted out or done anything
> negative and does like, for the first time, I'm smiling while everybody else is
> having an uproar. But to me I'm kind of proud that he took the risk to actually do
> something that was out of character for himself.

The occupational therapist went on to give an example of this as,

> When they actually, when somebody tries to do that and they say "stop" or
> "don't do that" well I'm very proud of that.

In reference to Table 3 Important Social and Emotional Skills, parents and occupational
therapists both referred to three social skills and one emotional skill that they viewed as
important skills for the child to have. The three social skills both groups mentioned were
responding appropriately, interacting with others, and be able to transfer social skills to different
locations. When viewing the child's ability to respond appropriately Occupational Therapist C
noted:

> So, you know once again being able to manage emotions and have appropriate responses
> or compensatory strategies to be able to participate and addressing tasks, the toileting
> task, a walking down the hallway task, whatever it may be.

Responding appropriately also extended to the child having appropriate interactions and
responses to playing and toys. Parent A acknowledged,

> Socially I wanted her to be able to engage with other kids or with me or appropriately
> with a toy or with puzzles instead of throwing them behind her or getting frustrated.

The second commonality in social skills stated between the occupational therapist and parents referred to interacting with others. Parent C mentioned her definition of social development as,

> Social development would mean interacting with the world, other children, adults,
> just society in general.

Similarly occupational therapist C gave her definition of social development for the children she serves as:

> I think it's their ability to interact and developmentally grow with their parents,
> their siblings, their peers in a variety of settings whether that be in the home, in
> the community, daycares, schools, churches, playgrounds.

Occupational therapist C mentions in the definition not only the importance of the child's ability to interact with others, but also to be able to transfer those social abilities to multiple settings which was the final commonality found between parents and occupational therapists. Parent A responded in reference to the second scenario as seen in Appendix B with,

> I guess I'm an odd ball but I would say to her, because even though we are out at
> a place that's public, she needs to have the same ways that she does at home. So I
> would do the same thing and if people stare at me oh well. She has to be able to
> do the same thing somewhere else that's not home.

Both parents and occupational therapists went on to note an important emotional skill they wanted the child to have was being able to control and regulate their emotions. In response to emotional skills the parent wanted for their child within the next year (Appendix B), parent C noted,

Learning how to tolerate and control her, things that she does, emotions… When

she is really upset…you know just learn how to control her own emotions in

public.

In response to the question asking what the most important emotional skills the occupational

therapist wants for the child they are serving (Appendix A) occupational therapist D mentioned,

Just to self-regulate to a point where instead of us getting a behavior…I mean if

it's during class they can raise their hand and say you know I need a minute to go

in the hall or whatever we have worked out for them to do or whatever versus

pushing and kicking… which is a lot of behaviors that they have because they

are overwhelmed.

Effects of the Setting on Interaction

The second theme found in the data relates to the occupational therapist and parent

interaction across the settings of pediatric outpatient practice, early intervention, and the

elementary school system. It was deducted that the first location was between the parent and

occupational therapist within outpatient therapy. Outpatient, within the context of the

participants' experiences, referred to private practices. Occupational therapists that worked in

outpatient therapy mentioned interacting with parents in three different manners. The first type of

reported interaction between the occupational therapist and parent included informing the parents

on how the session went with the child. Occupational therapist A noted,

But you always do just kind of give them a run down and tell them what you

worked on…You kind of save those last couple of minutes to talk to the parent.

Occupational therapist C provided specific information on what she may tell a parent regarding how the session went with the child. Occupational therapist C mentioned that she would inform the parents of,

> …how they tolerated those transitions today or maybe transitions were a lot harder and they were a little bit more emotional but this is how we handled it and dealt with those fears or things that may have come up. So addressing them just like anything else that may or may not have happened in the session.

The second way occupational therapists mentioned interacting with parents was through encouraging the parent to participate in social activities with their child. Occupational therapist C stated,

> We always encourage our families in the clinic to attempt participation in a variety of activities whether it be music or a play group or going to the park just to allow for socialization.

The third way occupational therapists responded on how they interact with parents is by providing the parent with strategies and activities to do at home. An example occupational therapists mentioned was providing parents with strategies to help their children manage their emotions and cope with situations that arise outside of therapy. It is important to remember that comments mentioned by the parents provided cohesive support to the statements of the occupational therapists that centered around the three main methods of interacting with the parents. For example, parent A mentioned in talking about her child's therapy,

> Most of the time I was with her because of her age, but after a rapport was met with her therapist, I'd say about a month in, is when I would wait in the waiting

room and then she would come out and tell me or she would give me a sheet to

say like what we worked on today.

Based on the statements provided by the parents and occupational therapists within outpatient

therapy the research suggests that there is an active relationship between the occupational

therapist and parent. However, it is worth noting two key points that show divergence within the

research. When talking about relaying information to the parent and providing activities for the

parents to do at home, occupational therapist A stated,

You can give them some things to do at home and sometimes they do them and

sometimes they don't it just depends on the parent.

On the other hand, when asked if they wanted to add anything else, parent A and the researcher

had the following dialogue. Parent A mentioned,

I think…giving the parents more information or more ways on how they can

cope with their child as opposed to always focusing on the child. Maybe? I

mean.

Interviewer: So building, you think that building more of a relationship between

you and the therapist would've been helpful. Is that what you are saying or just

receiving more information like a pamphlet or something like that?

Parent: For me it would probably be, I guess as much as they learn about a child

and how, what works with the child to also see what works with the parent. I

guess at home.

These statements point out, first, that even if the occupational therapist guides the parent on specific strategies or informs the parent of how the session went, those interactions and suggestions may not be put into place outside of the therapeutic setting. Second, the data suggests that the parent wants the occupational therapist to get to know the family and what works and doesn't work, just as they do with the child during a session.

The second context was parent and occupational therapist interactions within the setting of early intervention. When asking the occupational therapist what guidance strategies or tips they offer to the parents, they mentioned providing the parents with encouragement as well as activities and guidance strategies to use in the home. Both providing encouragement and providing activities and guidance strategies were mentioned by occupational therapists within outpatient therapy as well. However, when occupational therapists were asked about how they inform the parent on how the occupational therapy session went (Appendix A) and then when asking parents how they received information about how the session went (Appendix B), there is one key distinctive point within therapy in the early intervention context. The researcher concluded from the data that within the context of early intervention parents are more often than not involved in the occupational therapy session with their child and the therapist as it is being conducted. Due to the fact that parents are coached to complete therapeutic tasks with their children, parents are helped to feel "confident and competent" in working with their child on a specific task after the occupational therapist leaves. This is seen when Occupational therapist B noted,

> That's what that session would be based around and making that parent feel
>
> confident and competent to be able to do what it was we were asking and that
>
> could be kind of imbedded into what we were doing.

In relation parent D mentioned,

> Yeah I mean I would always watch her so I'd kind of see how she did things and
> then I could try to mimic it. Whatever it was to show my husband, you know
> what she did, if he wasn't here at the time but she would also give me pointers
> and everything on things to do with him after she left or the next day.

This provides the opportunity for the occupational therapist and parent to have an active relationship within the context of early intervention.

The third context that became apparent through data analysis was parent and occupational therapist interactions within the public elementary school system. Occupational therapists within the school system stated different things relating to how they try to connect with the parents. A few of the things occupational therapists reported doing included sending out progress notes every nine weeks, sending emails to parents regarding the session, and providing their phone number to allow the parents to call and talk through a situation with the occupational therapist. When Parent B was asked how they receive information from the occupational therapist they stated,

> We get to see them twice a year and that's when we get assessments from those
> extracurricular ones, but for the most part, I feel like we are pretty informed
> about everything. The sessions are about almost an hour long and we sit down
> and each teacher goes through there therapy and what they have been going
> through with him and it is pretty evident to what he does do when he comes
> home so it's not a big surprise.

In contrast, when asking the occupational therapist how they interact with the parents, the occupational therapists consistently mentioned that they encourage the parent, which was previously stated by occupational therapists in both outpatient and early intervention therapy. Occupational therapist D noted,

> Sometimes you don't even lay eyes on parents in the school system even when you're working with their kids for years. And sometimes some parents, you have parents who you know you see on a regular basis. It really varies and it's not like you can penalize the kids whose parents aren't, who aren't available or aren't present…So it widely varies and so you just keep encouraging them. You just keep encouraging them to, you know, to do the things that they need to do.

The statement previously mentioned by parent B and the statement above from occupational therapists D connect back into the key point previously mentioned. Even if the occupational therapist provides information to the parent on specific strategies or informs the parent of the session, it may not be implemented outside of the therapeutic setting. The research suggests that it really relies on the parents want to be involved or apart of their child's therapy. However, according to the parents' statements if they are involved in receiving notes, meeting with occupational therapists at meetings, and working with their child at home, then they felt that they are being informed on their child's occupational therapy. Therefore, when looking at the data across different contexts, it is suggested that whether the relationship between the occupational therapist and parent is active or inactive depends highly on the parent's want or interpretation of involvement in their child's therapy.

Interactions with the Child

The third and final theme that the researcher exposed from the data focused on the child interactions with the occupational therapist and the parent. Based on participants' responses, the interactions with the child were based on increasing social and emotional skills and meeting social and emotional goals. First when looking at occupational therapists, there was consensus that was indirectly mentioned through examples, that other activities such as fine motor activities are more widely emphasized within occupational therapy. Even when occupational therapists were asked questions directly relating to social and emotional development they often mentioned non-social and emotional activities. Occupational Therapist A mentioned,

> Yeah for the most part what I'm working on is just increasing their success in the classroom? So handwriting skills, some visual motor, visual perception, things going on in the classroom.

This was very similar when asking parents about goals that the occupational therapist had for their child within the areas of social and emotional development. When parents were asked about goals that the occupational therapist had or worked on with their child, social and emotional goals were consistently not mentioned first, if at all. Instead items such as teeth brushing and fine motor activities were repeatedly mentioned. The researcher often had to prompt the parents by asking "Did the therapist mention specific things about social or emotional development?" After parent C was prompted by asking if there was any specific social emotional goals that the therapist had, she tried to remember and then stated,

No not really. I feel like that was more in Speech. Like I always felt like they did

that more in speech than in OT. OT was more like you know working on

brushing teeth you know.

However in contrast to the examples mentioned above that were provided by occupational

therapists and parents, occupational therapists consistently pointed out the importance of the

using the holistic approach which refers to looking at the whole child and every area of their

development when working with them during a therapy session. Occupational therapist C

specifically mentioned the importance of utilizing a holistic approach by stating,

I would just say that as OTs it is really important that we do look at the whole

person. I think sometimes with limitation of clinical settings or insurance or

diagnoses that, you know, we're focusing on specific goals but if we leave out

the social emotional then it will be hard to target that. And as OTs the holistic

approach is so important for ultimate success and continued independence.

Discussion

Facilitation of social and emotional skills with children comes from interactions between

the child and parent as well as between the occupational therapist and the child. When referring

to the literature of previous researchers, there have been no studies conducted that focus on how

the parents and occupational therapists work together to influence the child's social and

emotional development. This research study focused on three main questions of inquiry which

will be discussed in relation to the results found.

The first question asked within this research was "what are the occupational therapists'

views on social and emotional developmental skills and goals they want for the children they

serve?" The social skills listed by occupational therapists included but were not limited to initiating proper greetings, being able to problem solve, and being able to interact in different settings. The emotional skills listed by occupational therapists included but were not limited to emotional coping, being able to regulate emotions, and being comfortable expressing themselves.

The second research question asked was "what social and emotional skills and goals are important to the parents that their child possesses?" The social skills listed by parents included but were not limited to being confident in their own location, expressing themselves, and engaging appropriately. The emotional skills listed by parents included but were not limited to linking feelings to words, being able to control their emotions, and being able to differentiate between emotions.

Among the skills listed, the parents and occupational therapists both stated three of the same social skills and one common emotional skill. The three important social skills both groups wanted the child to have were responding appropriately, interacting with others, and be able to transfer social skills to different locations. The social skills of responding appropriately and interacting with others aligned directly with the social development definition used for this study which was that according to Squires and Bricker (2007), social development can include "attachment temperament, self-image, self-control or behavioral regulation, empathy, social interactions, morality, and social knowledge (e.g. gender)" (p. 32). Being able to transfer social skills to different locations was not something mentioned within a definition that framed the research, but is however important and consistently found as a wanted social skills among parents and occupational therapists. The emotional skill that was mentioned by both parents and occupational therapists was being able to control and regulate their emotions. This aligns with the definition of emotional development used for this study which was that emotional

development is heavily focused on emotional regulation and understanding others emotions

(Squires & Bricker, 2007).

The third research question was "how do the parents and occupational therapists work together to support social and emotional development with the child receiving services?" Parents and occupational therapists expressed different ways of working together. Their level of interaction was often informed by the location of the therapy which was either outpatient, early intervention, or within the school system. Within the three locations, occupational therapists and parents all had the potential for active interactions and relationships. However, two key points of divergence were found. The first was that even if the occupational therapist guides the parent on specific strategies or informs the parent of the session, it may not be put into place outside of the therapeutic setting. This piece of divergence has a direct link to the prior literature which states that even if the occupational therapist provides attentive and high quality services and therapy during the child's occupational therapy session, it is still critical to the intervention and outcome of the child that the parents are continuing the implementation of the therapeutic practices outside of the session (Wakeford, 2016). The second piece of divergence found suggested that the parents want the occupational therapist to get to know the family and understand what works and doesn't work with the family, just as they do with the child during a session. This is a new finding that has not been reported within previous literature reviews that were conduct by the researcher for this study but is present in some early intervention literature.

Finally the researcher concluded from the interview data from occupational therapists, that other activities such as fine motor activities, for example, are more widely emphasized within occupational therapy sessions with the child. Even when occupational therapists were asked to talk specifically about social and emotional goals they had for the child they serve, the

occupational therapists often mentioned non-social and emotional activities. This is not surprising given that within the definitions of what occupational therapists do through their work, social and emotional skill development is not always directly stressed. Instead, for example, activities of daily living and instrumental activities of daily living are emphasized which include eating, dressing, and performing hygiene routines whereas instrumental activities of daily living include tasks such as meal preparation and shopping (Allen & Cowdery, 2012).

It was found during the interview that occupational therapists mentioned having a holistic approach, or looking at the whole child, when implementing an occupational therapy session. This would include having activities that focused on the child's goals but also allowed the child opportunities to develop in all developmental domains including social and emotional (affective). However, even though occupational therapists in this study want their activities with children to target all developmental domains at some point during the session, there seems to be a gap between what the occupational therapists wants to include in the therapy, such as activities that focus on social and emotional skill development, and what is actually being implemented.

According to the data analyzed, there are external influences mentioned by multiple occupational therapists that included limitations among the settings of the occupational therapy session as well as limitations within insurance. It was mentioned that within the external factor of insurance that sessions must be directly representative of the child's goals and not vary. If a child does not have a specific social and/or emotional goal, but the occupational therapist feels there is a need to address a certain skill, it must be done indirectly.

This gap was reported by participants as having a direct effect on the occupational therapist and parent interaction and how each person serves the child. Because of the restrictions of time and insurance, occupational therapists may struggle incorporating these social and

emotional goals. Due to this struggle, parents noted that occupational therapists may not always provide social and emotional activities for them to work on with the child because that social or emotional skill may be outside of the child's specific documented goals. Due to less information being passed regarding social and emotional skill development by the occupational therapist, parents can be less informed of the goals that are being worked on with their child. They may also be less informed on how to work with their child on social and emotional skills or life skills that are difficult for the child outside of the context of occupational therapy. An exception to this was when the parent specifically talked to the occupational therapist about a social or emotional difficulty at home and asked for guidance. However, in general because the parents are not always receiving information on social and emotional activities to do with their child unless specifically asking, they are not implementing strategies outside of the therapeutic setting to help their child gain the social and emotional skills that they may currently be lacking. Part of the difficulty in this communication is whether or not parents realize the link between occupational therapy and social and/or emotional development.

Due to the parent being less informed on how to help their child gain social and emotional skills, this can then in turn affect the child in gaining those necessary social and emotional skills that the parents and occupational therapists previously listed as important in Table 3. Important Social and Emotional Skills. Finally, this finding links directly back to Wakeford (2016), where the child's therapy then lacks the critical piece of intervention where the parent is working on the skills in areas such as social and emotional development outside of the therapeutic session (Wakeford, 2016).

Reflective Critique

Since completing a thesis through the Georgia Southern University Honors Program, I have learned within many different areas that have expanded overall what I have gained from my college experience. I have learned valuable skills to not only help me succeed in further education, but also just throughout my future career. The main thing I feel that I have gained from this process is a new style of writing along with a new range of vocabulary. Through talking with my mentor, reading journal articles and books, and having to parse out relevant information, I gained the skills to be able to communicate better in a written format. I am able now to verbally communicate what my research has found and translate it within my writing. Also, I have gained such valuable skills in how to read journal articles and find relevant information. The first obstacle within the process of gaining this skills set was how to search the databases to produce information that is relevant. Learning this was very impactful to my education thus far and I believe it will continue to assist me in my future academia. Within this skill, I was able to learn how to take relevant information and then apply it systematically into my research. Finally, when doing a long-term research project such as this one, I have learned that it is so valuable to continue searching the literature because there are new journal articles produced routinely. By doing this, it allowed me to be fully emerged in the research and verify that I had not missed any recently published information that could have been critical to this study.

Limitations and Future Directions

Within this qualitative study, there was a small sample size of 4 parent participants and 4 occupational therapist participants which may be posed as a limitation. However, even though

the process of qualitative research through interviewing can be more time consuming and thus limiting the amount of participants, interviewing allows us to enter into the other person's perspective (Patton 2002). For future research, it would be of use to interview more people and incorporate people of different demographics or focus specifically on occupational therapists in one context to draw more delineated conclusions. In regards to demographics, it would also be beneficial to incorporate both male and female occupational therapists and parents. Due to the finding that occupational therapists wanted to but were not reporting the implementation of a holistic approach because of outside factors such as insurance, it would be beneficial for further research this finding to include parents of different socio-economic factors and different insurance providers. In conjunction, when recruiting occupational therapists and parents to be participants, recruiting from different geographical locations could be beneficial. Within this research, the participants lived only in the southeastern region on the United States. With that being said, the goal of qualitative research is not meant to generalize across settings but to provide a window into the world of individuals' personal experiences. The benefit of this research in particular promotes other occupational therapists and parents to consider their inclusion of social and emotional developmental skills when planning a child's goals. Occupational therapists working with children can compare their experiences to those reported and honored through this research.

References

Acredolo, L. & Goodwyn, S. (2005). *Baby hearts: A guide to giving your child an emotional headstart*. New York, NY: Bantam Dell.

Allen, K. E. & Cowdery, G. E. (2012). *The exceptional child: Inclusion in early childhood education*. Belmont, CA: Cengage Learning.

The American Occupational Therapy Association (2013). *Occupational therapy's role in mental health promotion, prevention, and intervention with children and youth: Social and emotional learning (SEL)* (Information sheet). Retrieved from: https://www.aota.org/-/media/Corporate/Files/Practice/Children/SchoolMHToolkit/Social-and-Emotional-Learning-Info-Sheet.pdf

Berk, L. E. (2012). *Infants, children, and adolescents* (7th ed.). Boston, MA: Pearson Education.

Brofenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*, 723-742.

The Collaboration for Academic Social and Emotional Learning. (2016). What is SEL? Retrieved from: http://www.casel.org/what-is-sel/

Case-Smith, J. (2013). Systematic review of interventions to promote social-emotional development in young children with or at risk for disability. *American Journal of Occupational Therapy, 67,* 395-404. http://dx.doi.org/10.5014/ajot.2013.004713

Durnan, F.B., Hepburn, K.S., Kaufman, R.K., Le, L.T., Allen, M.D., Brennan, E.M., & Green, B.L. (n.d.) *Early childhood mental health consultation.* Nashville, TN: Center on the Social and Emotional Foundations for Early Learning. Retrieved from: http://csefel.vanderbilt.edu/documents/rs_ecmhc.pdf

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation.* New York, NY: Routledge.

Ideishi, R. I., O'Neil, M.E., Chiarello, L. A., & Nixon-Cave, K. (2010). Perspectives of

    therapist's role in care coordination between medical and early intervention

    services. *Physical & Occupational Therapy in Pediatrics, 30*, 28-

    42. doi: 10.3109/01942630903337478

Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2004). Newton, E. K. &

    Thompson, R. A. (2010). Parents' views of early social and emotional development:

    More or less than meets the eye. *Zero to Three, 30*(4), 10-16. Retrieved from:

    http://main.zerotothree.org/site/DocServer/30-4.pdf?docID=11584

Patton, M. Q. (2002). *Qualitative research & evaluation methods.* Thousand Oaks, CA: Sage

    Publications.

Prugh, D., Staub, E., Sands, H., Kirschbaum, R., & Lenihan, E. (1956). A study of the emotional

    reactions of children and families to hospitalization and illness. *American Journal of*

    Orthopsychiatry, 23(1), 70-106. doi: 10.1111/j.1939-0025.1953.tb00040.x

Ray, J. A., Pewitt-Kinder, J., & George, S. (2009). Partnering with families of children. *NAEYC:*

    Young Children, 64 (5), 16-22. Retrieved from:

    naeyc.org/files/yc/file/200909/FamiliesOfChildrenWithSpecialNeeds0909.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education*

    and the social sciences. New York, NY: Teachers College Press.

Squires, J. & Bricker, D. (2007). *An activity-based approach to developing young children's*

    social emotional competence. Baltimore, MD: Paul H. Brookes Publishing Co.

Swick, K.J. & Williams, R. D. (2006). An analysis of Bronfenbrenner's bio-ecological

    perspective for early childhood educators: Implications for working with families

    experiencing stress. *Early Childhood Education Journal, 33,* 371-378. doi:

    10:1007/s10643-0060078-y

Wakeford, L. (2016). Occupational therapy in early intervention and early childhood special

    education. In B. Reichow, B. A. Boyd, E. E. Barton, & S. L. Odom (Eds.), *Handbook of*

    early childhood special education (pp. 385-401). Switzerland: Springer.

Zand, D. H., Pierce, K. J., Bultas, M. W., McMillin, S. E., Gott, R. M., & Willmott, J. (2015).

    Accuracy of knowledge of child development in mothers of children receiving early

    intervention services. *Journal of Early Intervention, 37,* 226-240. doi:

    10.1177/105381515610633

Appendix A

Occupational Therapists' Interview Questions

Introduction script:

Thank you for being here today. We are going to discuss social and emotional development in children who receive occupational therapy. In order to maintain confidentiality of your clients, please do not refer to any children by name. If at any time you do not feel comfortable answering a question or wish to skip a question please inform me. I want to remind you this is voluntary and you can withdraw at any point in the interview process. Great, let's begin.

- Tell me what social development means to you for children.

    o Prompt if needed: What are social skills that are needed for children?

- Tell me what emotional development means to you for children.

    o Prompt if needed: What are emotional skills that are needed for children?

- Tell me about how you prepare for a child's Occupational therapy session within their social and emotional goals.

    o If they do not answer: Do you set aside specific goals to work on that day? How do you determine what goals to work on during that session?

- Tell me about important social skills and goals you want the children you are serving to meet before being discharged.

- Tell me about important emotional skills and goals you want the children you are serving to meet before being discharged.

- How do you inform the child's parent about how the occupational therapy session went regarding social and emotional skills after the session is complete?

- Tell me about what you may tell a parent regarding if the child met a social and/ or emotional goal. Can you provide me with an example of this?

- After the session is complete with the child, what guidance strategies or tips do give the parent(s) on therapeutic social and emotional activities to do at home? Can you provide me with an example of this?

- What's the most important thing related to social and emotional development you want a child to get out of Occupational therapy?

- I'm going to give you a scenario and I would like you to reflect honestly on what you would do with the child in this situation.
    - Your child is alone with you during an occupational therapy session and becomes physically and emotionally upset. They are crying and screaming. How would you handle and the situation?

- Is there anything I haven't asked you that you would like to talk about?

Appendix B

Interview Questions for Parents of children receiving occupational therapy

Introduction script:

Thank you for being here today. We are going to discuss social and emotional development among children who receive occupational therapy. In order to maintain confidentiality of your clients, please do not refer to any children by name. If at any time you do not feel comfortable answering a question or wish to skip a question please inform me. I want to remind you this is voluntary and you can withdraw at any point in the interview process. Great, let's begin.

- What is the age of your child?
- Tell me what social development means to you for your child.
    - Prompt if needed: What are social skills you want for your child?
- Tell me what emotional development means to you for your child?
    - Prompt if needed: What are emotional skills you want for your child?
- How long has your child been receiving Occupational Therapy services?
- Tell me about the social skills you would like your child to be able to accomplish within the next year.
- Tell me about the emotional skills you would like your child to be able to accomplish within the next year.
- Tell me about the long-term goals you have regarding your child within social skills.
- Tell me about the long-term goals you have regarding your child within emotional skills.

- Tell me about what you know about the social and emotional occupational therapy goals set for your child when thinking both short and long term.

- How do you receive information about how the occupational therapy session went regarding the social and emotional goals after the session is complete? What does the therapist tell you regarding if your child met a goal the social or emotional goal? Example?

- After the session is complete, what guidance strategies or tips do you receive from the Occupational therapist on therapeutic social and emotional activities to do at home with your child? Examples?

- What's the most important social and emotional skill you want your child to get out of Occupational therapy?

- Tell me about social activities your child participates in outside of therapy.

- I'm going to give you two different scenarios and I would like you to reflect honestly on what you would do with your child in this situation.
  - Your child is alone with you at your home and becomes physically and emotionally upset. They are crying and screaming. How would you handle and the situation?
  - Your child is grocery shopping with your child and they become physically and emotionally upset. They begin crying and screaming in the middle of the aisle. How would you handle the situation?

- Is there anything I haven't asked you that you would like to talk about?