

# Parental Occupational Executive Training: Feasibility and Parental Perceptions

OTJR: Occupation, Participation and Health  
1–8  
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DOI: 10.1177/1539449220912191  
journals.sagepub.com/home/otj



Carmit Frisch<sup>1</sup> , Sara Rosenblum<sup>1</sup>, and Emanuel Tirosh<sup>2</sup>

## Abstract

Young children with attention deficit hyperactivity disorder (ADHD) cope with functional difficulties attributed to executive dysfunction. This study evaluates the feasibility of the Parental Occupational Executive Training (POET) intervention. Parents of 71 children (4–7 years) with ADHD attended 8 to 10 weekly, personally tailored intervention sessions with an occupational therapist. Quantitative and qualitative measures were used to examine feasibility in four indices: parental attendance, adherence, and acceptance, and therapist fidelity. Parental attendance and home-strategy use during daily activities rates were high. Parents identified the occupational performance coaching model's principles as supporting their ability to implement the intervention. Therapists demonstrated high fidelity to the POET's theoretical bases. The POET is a feasible intervention with high parental attendance (98.61%), parental adherence (80.56%–94.44%), and therapist fidelity (100.00%). It can be implemented within child development centers and occupational therapy clinics and leads to parents' increased adherence.

## Keywords

children, executive function, occupational performance, occupational therapy

## Introduction

By the age of 3 to 5 years, children with attention-deficit/hyperactive disorder (ADHD) experience various functional difficulties in all areas of their daily lives. Common difficulties include noncompliant and inappropriate behavior, problems performing activities with parents, and disruptive interactions with peers (DuPaul et al., 2001; Perez et al., 2014). They also may cope with aberrant eating behaviors (Leventakou et al., 2016) and problems accomplishing multistage tasks. For instance, during daily routines, children with ADHD may find it difficult to focus on a particular task, follow instructions, or organize their activities and objects in space. They may present messy eating behaviors and forget to clean up when they finish tasks. At school, they may ask irrelevant questions (Gol & Jarus, 2005) and experience difficulties with tasks that require language and mathematic skills (DuPaul et al., 2001). Finally, their play activities are more restricted than typical children of their age (Perez et al., 2014). Some evidence suggests that some of these functional difficulties are attributed to the children's compromised executive functions (EF). For example, difficulties in acquiring language and math skills and antisocial behaviors during peer-group interactions relate to delayed inhibition (Hughes et al., 2000; Thorell, 2007). According to Efron et al. (2014), varied functional difficulties often are associated with other psychiatric disorders, such as oppositional defiant disorder (54.2%), depression and anxiety (13.4%), or conduct disorder (10.1%).

Initiating primary evaluation for ADHD is recommended for preschool children who present functional difficulties and symptoms (Cortese, 2011). Evaluation and intervention at a young age potentially leads to a better developmental course and moderates later problem severity. The suggested counseling and intervention emphasis is improving children's everyday life functioning (Rosenbaum & Gorter, 2012). Among evidence-based intervention programs described for preschool children with ADHD (e.g., physical exercise or environmental enrichment), parental-behavioral training was found effective for teaching parents behaviors that strengthen relationships with their children and help manage problematic behaviors resulting from ADHD symptoms (American Academy of Pediatrics, Subcommittee on Attention-Deficit/Hyperactivity Disorder, 2019). Nevertheless, improving the children's behavior and ADHD alone seems insufficient to address the children's academic and daily functioning needs (Thorell, 2007). Although previous studies introduced positive executive-skills gains, they reported inconsistent

<sup>1</sup>University of Haifa, Israel

<sup>2</sup>Technion-Israel Institute of Technology, Haifa, Israel

### Corresponding Author:

Carmit Frisch, Laboratory of Complex Human Activity and Participation (CHAP), Department of Occupational Therapy, Faculty of Social Welfare and Health Sciences, University of Haifa, 199 Aba Khoushy Ave., Mount Carmel, Haifa 3498838, Israel.  
Email: carmitfr@gmail.com

relationships between improved developmental skills measured in testing conditions and daily function gains (e.g., Tamm et al., 2014; Thompson et al., 2009; Wilkes-Gillan et al., 2016). In addition, growing evidence suggests that compromised EF contribute to the functional difficulties associated with ADHD (e.g., Barkley, 2012).

The Parental Occupational Executive Training (POET) hybrid model was developed to address the needs of these children and their families, targeting specific daily functions and their underlying EF (Frisch, Tirosh & Rosenblum, 2020). Whereas Frisch et al. (2020) reported the effects of the POET on children's performance and EF, this article relates to the POET's theoretical basis, clinical protocol, and feasibility, as well as the therapist's fidelity and parental perspectives on factors that contribute to its feasibility. The POET provided to families in this study consisted of a written protocol based on the following three conceptual models.

### *International Classification of Functioning, Disability and Health (ICF)*

The *ICF* (World Health Organization [WHO], 2001) defines *health* according to a person's functional ability and describes factors that may promote it. When developing intervention programs to improve daily functioning and participation, the ICF recommends addressing health conditions or diagnoses, personal factors such as age and gender, anatomical structures, physiological/psychological functions, required activity characteristics, and the external environment (e.g., physical and social aspects) alongside health professionals' assessment and intervention processes. Considering these principles, the POET aims to facilitate children's engagement in occupations and reinforce participation in life activities while identifying which ICF dimensions promote or hinder performance (American Occupational Therapy Association, 2002).

### *Barkley's Hybrid Neuropsychological Model of EF*

Barkley's (1997) model demonstrates how EF emerge as early as infancy and affect daily functioning along the life cycle (Dawson & Guare, 2010). It includes six executive elements: self-behavioral inhibition, allowing children to manage distraction and delay responses; nonverbal working memory, which enables acting based on mental manipulations of events; verbal working memory, enabling self-talk; self-regulation of emotions, regulating strong positive and negative emotions and reinforcing motivation to complete boring tasks; reconstitution, enabling creative problem-solving and planning (Barkley, 2012; Barkley & Benton, 2010); and self-awareness of internal and external states, drives, wants, and actions required to initiate a change in automatic reactions (Barkley, 2012). Barkley's (1997) concepts enable establishing a new language for parents to interpret and

support their young children's challenges in daily functioning (Dawson & Guare, 2010; Levine, 2012).

### *Occupational Performance Coaching (OPC)*

The OPC's (Graham et al., 2009) unique approach incorporates coaching processes to resolve occupational performance issues. Parents learn to develop skills to support their children's performance by identifying and implementing effective solutions to daily occupational performance dilemmas in the children's natural environments (Graham et al., 2013). This process engages the three enabling domains incorporated into the POET intervention process: cooperative information exchange with parents about occupations and environmental elements; structured problem-solving processes; and connecting parents through emotional support aspects, such as listening, expressing empathy, and partnering to discover new strategies. Further OPC aspects integrated into POET were detailed throughout Graham et al.'s (2009, 2010, 2013) works.

### *POET*

In the POET intervention, parents participate in eight weekly face-to-face personal sessions (each approximately 45 min) and document home-strategy use during daily activities using standardized forms to enhance adherence (Supplemental Appendix A summarizes protocol components).

The POET weekly intervention plan is tailored to each child's personal functional needs and executive challenges while addressing the overall family's unique needs. During the first session, parents receive an illustrated model of Barkley's EF and identify two to six personal occupational intervention goals to focus their training (see Supplemental Appendix B for example goals).

In the following session, the occupational therapist coaches parents to prioritize those goals and identify performance-enabling or performance-challenging factors as they apply to the first goal. For each goal, the occupational therapist and the parents analyze together the occupational problem, the desired solution, and strategies that may help accomplish it. This process involves a range of coaching and training intervention styles (OPC uses only coaching). It provides parents more information regarding the nature of executive function challenges and coping strategies they themselves do not discover. Finally, for each goal, parents record which strategies they view as most appropriate to implement at home the following week. Their written plan contains up to five strategies and reflections on how addressing the identified challenges could improve the child's functioning.

At subsequent sessions, the occupational therapist follows the POET's four main protocol components: discuss previous home-based strategies use and subsequent needed

modifications; determine the current session goal and identify current and desired functioning and how the goal relates to the children's executive challenges and performance-hindering factors; discuss implementation strategies for the following week; and prescribe a plan for the chosen strategies using standardized forms. Adhering to Graham et al.'s (2010) protocol for this process, the occupational therapist highlights the link between parents' actions and children's occupational achievements and prompts parents to generalize successes to other tasks, routines, and scenarios.

When parents report no change in the children's performance or difficulties, the occupational therapist looks for possible reasons for the strategy failure and suggests alternative strategies suitable to achieve the goal and support the parents' ability to support their child. Emotional support elements are used throughout all sessions. Families who need more time to promote their child's functioning attend (up to two) additional sessions. At the last session, the occupational therapist summarizes the intervention's achievements. Scheduling weekly sessions, explaining the nature of the strategies to the child, listing them on parents' structured take-home forms, and adapting the number of sessions (e.g., eight) for the Israel's Health Maintenance Organization are POET adjustments for the target population—children with ADHD (and their parents)—that the OPC does not include.

The initial evidence of the POET's value in addressing daily functions, parental perceptions, and understanding of the underlying EF and appropriate respective managements has been recently published (Frisch et al., 2020). The current study's objectives were to examine the POET's intervention feasibility and identify factors that affect parents' ability to implement the intervention at home.

## Method

### Study Design

This study used data from a broader study that examined the POET's efficacy related to children's EF and functioning and parents' knowledge about executive deficits and how to improve them. That broader study incorporated a comparative, quasi-experimental, crossover, and mixed-method design.

### Ethics

The University of Haifa Faculty of Social Welfare and Health Sciences and Maccabi Health Maintenance, Israel, approved the study (number 090/13). We followed procedures consistent with the approval institutions and the 2000 Helsinki Declaration. We informed all participants of the study's risks and benefits, their participation was voluntary, they could withdraw from the study at any time, and their personally identifiable data would remain confidential. All participants signed informed consent forms.

### Participants

We recruited families of children aged 4 to 7 years based on pediatrician referrals to child development centers and occupational therapy clinics in Israel. Parents completed a short interview and questionnaire based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) criteria and Revised Conner's Parent and Teacher Rating Scales (Goyette et al., 1978) to ascertain suitability for the study and intervention program. Only children who experienced ADHD in two functional settings (i.e., six positive items in the *DSM* questionnaires and a *t*-score greater than 65 on relevant Conner's scales) were included. Exclusion criteria were previous diagnosis (of child or parent) of emotional or parent-reported behavioral problems, neurodevelopmental disorders, or chronic medication related to neurobehavioral or psychiatric disorders. We then referred potential child participants for neurodevelopmental diagnosis at child developmental centers (if aged 4–5 years) or a Health Ministry–certified pediatrician/ADHD consultant (if aged 6–7 years). The medical assessment took place prior to or following an occupational therapy evaluation. The ADHD diagnosis was ruled out in one child, who was then excluded from the study.

During the 2.5 years of data collection, 116 children with ADHD were referred to the study; 72 (aged 3.67–7.00 years; 55 boys) met the inclusion criteria, including attendance at mainstream public schools and living with two-parent families who spoke Hebrew fluently. Participants' descriptive data were documented using a demographic questionnaire designed for the study (Table 1).

### Procedures

A trained occupational therapist evaluated the participating children and then allocated the parents to the study group (starting intervention immediately) or comparison group (with an 8- to 12-week waiting list; for more details, see Frisch et al., 2020). All families participated in the studied (POET) intervention but at different times. The intervention was covered by their health insurance.

Interventions were carried out in quiet rooms at different child developmental centers or private occupational therapy clinics. Both parents were asked to attend the weekly intervention meetings because the ability of both parents to develop resilience and patience toward their child had been demonstrated as the most salient aspect predicting success (Camden et al., 2015). Overwhelmingly (90.3%), families defined their primary caretaker as the mother. Thus, both parents' participation provided primary caretakers with emotional support vital to their ability to implement parental training (e.g., Medina-Mirapeix et al., 2017) and increased immediate intervention outcomes (Lundahl et al., 2008).

**Table 1.** Parents' and Children's Characteristics.

Characteristic	n (%)		
Responder			
Mother	65 (90.28)		
Father	7 (9.72)		
Suspected ADHD			
Mother	14 (19.44)		
Father	21 (29.17)		
Both parents	9 (12.5)		
Siblings	5 (6.94)		
No one	20 (27.78)		
		<i>M (SD)</i>	<i>Range</i>
Responders' age, years		37.56 (4.21)	28.08–44.92
Mother education, years		16.28 (2.42)	12.00–23.00
Children's age, years		5.34 (0.95)	3.83–7.08
Gender			
Male	55 (76.39)		
Female	17 (23.61)		
Medical diagnosis of child			
Distractibility	7 (9.72)		
Impulsiveness and hyperactivity	5 (6.94)		
Combined	28 (38.89)		
No diagnosis yet	28 (38.89)		
Childhood ADHD (before 6 years old)	4 (5.56)		

Note. Table includes data for the entire sample ( $N = 72$ ); one included family completed the demographic questionnaire but did not attend the intervention. ADHD = attention deficit hyperactivity disorder.

The first author trained and guided 16 occupational therapists, each with at least 5 years of pediatric clinical experience, to conduct the intervention. The therapists attended a 24-hr course and used a uniform protocol, followed by ongoing consultation, throughout the intervention. We ascertained fidelity among the (17 total) occupational therapists by documenting standardized reports following every session. The first author reviewed these reports and provided written feedback to assist the occupational therapists adhere to intervention principles.

## Measures

As in previous reports addressing intervention feasibility for children and youth with ADHD, we used the weekly standardized reports to analyze participants' attendance rate, adherence to home-strategy use during daily activities, and acceptance (e.g., Levanon-Erez et al., 2019; Tamm et al., 2014), as well as therapist fidelity (Hogue et al., 2016). Therapist fidelity relates to therapists' ability to focus on the intervention's essential elements and avoid implementing incompatible elements (Dunn et al., 2018). The following paragraphs detail the four feasibility measures produced from the weekly standardized two-page forms.

**Attendance.** The therapists reported participant attendance rates. Based on results of similar previous studies (e.g., Bor et al., 2002), we defined acceptable attendance as 75% or more of all participants fully adherent to the schedule.

**Adherence to home-strategy use during daily activities.** The first author reviewed the occupational therapists' weekly forms following the interventions. In Part A, the therapists circled answers that best described parent-training characteristics during the week preceding the session, using a six-item multiple-choice questionnaire (more than one answer could be circled). Example questions included, "Did the parents implement the intervention?" Answers could be yes, only one parent, only for 1 or 2 days, partially applied, or no. If parents reported they did not implement home-strategy use during daily activities, then the therapists were asked to identify the reason for nonadherence (e.g., a busy week, did not agree with the plan, unclear strategies, child did not cooperate, an identified parental need prevented implementation, another child's identified need, or other). To determine parental adherence rates, we examined reports for the third (documenting the first training implementation) and seventh (toward the end of training) sessions. An acceptable rate was defined arbitrarily as 75% or more participants following the written program between intervention sessions and at least partially implementing chosen goal-related principles.

**Acceptance.** We used three open-ended questions at the last intervention session to examine parental acceptance—that is, factors parents identified as possibly affecting their ability to implement the intervention. The questionnaire was developed according to qualitative research principles (Braun et al., 2019) and subject to critical proofreading by an expert investigator in the field who otherwise did not participate in the study. Any suggested modification was discussed until mutual agreement was achieved. The questions asked parents their impressions of the intervention process, what they gained from it for themselves and for their child, and factors affecting their ability to implement the program.

**Fidelity.** Therapist fidelity was assessed using the therapist's session reports, Part B, including items that examined whether the therapists implemented the required knowledge and followed the intervention's exact structure (Thijssen et al., 2017). For example, therapists circled targeted functional domains (self-care, morning routine, dressing, eating, participating in meals, playing and self-employment, leisure, social functioning, evening routine, and learning functions); up to two EF (inhibition, nonverbal/verbal working memory, emotional regulation, planning/problem-solving) they determined as underlying the targeted goal; and additional factors affecting the child's performance (problems in child's nonexecutive skills, challenges attributed to parental characteristics or cultural context, task characteristics, or none); and estimated

their emotional support (listening, empathy, reframing, guidance, encouragement) using a binary response of yes or no.

The first author systematically reviewed the reports and documented comments for identification and definition of the child's and parents' needs, type of strategies chosen for the problems the parents raised, and proper implementation of the three theories upon which the intervention is based—the ICF (WHO, 2001), Barkley's (1997, 2012) terms for EF, and OPC three domains (Graham et al., 2009). If needed, she then offered the therapists alternative concepts and approaches to implement in the next session.

### Data Analysis

The data were analyzed using SPSS Version 21.0. We calculated the sample size using the G-Power program, considering effect size = .30, significance = .05, and power = .80. Demographic nonparametric data were presented with means and ranges. Categorical variables and adherence rates were calculated using percentages. Finally, the first author and two additional researchers analyzed parents' answers to the open-ended questionnaire, extracted codes with descriptive labels, and then discussed and merged them into themes.

## Results

### Attendance

Of the 72 participating families, 71 (98.61%) completed all (8–10) intervention sessions. One family completed questionnaires but withdrew from intervention participation. In 63 (87.50%) families, both parents attended all sessions; in eight (11.11%), both parents attended the first session, but one parent dropped out during the remaining appointments.

### Adherence

Following the third intervention session, 68 (94.44%) families adhered to the home-strategy use and 58 (80.56%) adhered in the last session. Reasons for nonadherence included parental difficulties setting boundaries (10%); parental executive difficulties, especially creative planning/problem-solving (75%); and unclear strategies (15%). For the seventh session, therapists did not complete 11 reports (15.49%).

### Acceptance

Questionnaire responses raised four themes affecting parents' abilities to implement the intervention: intervention characteristics, occupational therapist's support, parental factors, and limiting factors. Of 45 (61.5%) families who completed questionnaires related to their experience with the intervention program, 33 (73.33%) addressed the intervention structure and/or the emotional support elements as enabling factors (Graham

et al., 2009). Eighteen parents (40% of respondents) called the POET “very professional,” describing it as organized, consistent, sharing, and accessible. For example, one stated,

My impression of the intervention process: professional and practical, orderly and consistent. The weekly training included reports addressing implementation challenges and the respective reasons, and ways to handle the related difficulty in several stages, which greatly helped to further implement the program on a daily basis.

Twenty parents (44.4% of respondents) emphasized emotional support elements derived from the OPC model: listening, empathy, guidance, and encouragement. One stated,

The occupational therapy strengthened my abilities, my successes; emphasized again and again how much I contribute to my child. This is something that was very meaningful for me, because sometimes one needs to be reinforced in order to change habits, and she [the therapist] greatly helped me.

Few parents mentioned parental factors that enabled them to implement the POET intervention (e.g., both parents need to create a collaborative environment or their own motivation and beliefs). However, some parents reported limiting factors such as vacations, holidays, and the intervention process intensity. They preferred longer sessions or longer intervals between sessions. All responding parents indicated three themes of gains from attending the POET intervention: new knowledge/understanding, practical tools, and child's and parents' functional improvements.

### Fidelity

Review of the occupational therapists' postsession reports revealed that all adhered to the POET's theoretical bases. For example, All therapists assisted parents to define intervention goals which were functional identified the children's executive deficits using Barkley's (2012) model, suggested appropriate strategies, when needed and incorporated Graham et al.'s (2009) emotional support elements.

## Discussion

The POET is a personally tailored intervention that provides an opportunity for young children with ADHD to improve daily functioning in a variety of life areas. It exposes parents to specific knowledge of Barkley's terms in the EF realm and their relevance to the child's functioning. Therapeutic-coaching elements facilitate the parents' success in promoting it.

This study's purpose was to establish the POET's feasibility in four domains (parent attendance, adherence, acceptance, and therapist fidelity). Parents' adherence, defined as clinic attendance and home implementation documented weekly as in former studies (e.g., Wilkes-Gillan et al., 2016),

showed an attendance rate (98.61%) higher than or comparable with that reported in other studies on parental training for preschoolers (3–6 years) with ADHD. For example, Bor et al. (2002) reported 72% completion of a weekly (60- to 90-min) 10- to 12-session intervention. In Thompson et al.'s (2009) study, 95.12% of participants attended all eight sessions. Finally, Tamm et al. (2014) reported 91% of families in their research attended at least six of the eight sessions. Given these findings, the POET's full-schedule attendance rate is satisfying. We expressed both-parent attendance as an inclusion criterion and, in 87.5% of the families, both attended. Data from the parents' qualitative questionnaires suggest this requirement contributed to this study's high attendance rates.

The second indicator of the POET's feasibility is the high percentage of parents who implemented the intervention strategies at home, as the occupational therapists documented in their weekly reports. A high rate (94.44%) of parents fully implemented the first consolidated plan; at least 80.56% implemented the last. This home adherence may appear to compare satisfactorily with other studies related to training/coaching parents of children with ADHD (Bor et al., 2002; Tamm et al., 2014; Thompson et al., 2009), but different methodology and inclusion criteria do not allow a valid comparison.

The 80% rate of adherence to planned weekly activities represents a feasible high parental commitment (Wilkes-Gillan et al., 2016). Because parental practice of the learned skills optimizes treatment outcomes, adherence is vital to the intervention's success (Ros et al., 2016). Parents play a key role in assisting children to generalize strategy use in the home and environments beyond it (Wilkes-Gillan et al., 2016). Earlier studies reported variables that helped overcome barriers to home-strategy use during daily activities and increase adherence included parents' information about the child's progress and knowledge of the exercises' usefulness and ways to incorporate them into daily life (Medina-Mirapeix et al., 2017). These variables were also implemented during the POET's intervention process.

Regarding acceptability, the qualitative findings indicate additional important factors influenced parents' ability to implement the POET. First, operationally, the intervention was structured, consistent, and implemented by highly cooperative therapists. Second, occupational therapists provided parents emotional support in implementing the program (e.g., mentioning four of five OPC emotional support elements). The structured process is an essential OPC domain because it allows parents to focus on goals and promotes their understanding of how their specific actions affect their child's functioning. It also encourages parents to develop a sense of competence by promoting their decision-making and consequently improve their children's functioning (Graham et al., 2013). Emotional support has been described as helping parents move from being emotionally challenged in fulfilling their parental roles to being empowered to problem-solve. These dimensions, together with the process's

collaborative nature, have potential for parental success in improving their children's functioning (Graham et al., 2010). Implementing the major OPC principles appears to contribute significantly to the POET's feasibility by building a parent-therapist alliance.

### **Limitations and Future Research**

This study had some limitations. First, the occupational therapists did not complete 15.49% of the seventh-session reports or verify whether all parents completed qualitative questionnaires. Research coordinators can help overcome this disadvantage in future studies. Second, the intervention was implemented only in Israel and included volunteer families who shared the same cultural background. Third, after-session reports were not structured to facilitate quantitative scoring; thus, we used only qualitative analysis to assess therapist fidelity. Assessment of the POET's feasibility is warranted in other communities/cultures, in families with alternative structures (other than two-parent), and particularly in those with parents who themselves cope with ADHD.

### **Conclusion**

This study's results suggest the POET is a feasible intervention that leads to parents' increased satisfaction with their children's daily functioning. Notably, our study included more (17) clinical occupational therapists than other investigations related to parent-coaching. For example, Dunn et al. (2012) included two occupational therapists; Graham et al. (2013) included one. Our results demonstrate that many occupational therapists could implement the POET with high parent attendance, adherence, and acceptance, and with acceptable fidelity to the intervention principles. The structured documentation of each objective, task, and parental behavior, as well as the underlying principles guiding such behavior, presumably enhances the intervention's fidelity. Our findings also suggest that the POET can be implemented within child development centers and occupational therapy clinics.

### **Acknowledgments**

We thank the participating children, their families, and the research team for carrying out this study. We also thank the Health Care Services of Maccabi and the child development centers for their collaboration, and especially Tsofia Deutsh-Castel, MD, and Susana Berman, MD.

### **Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### **Funding**

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This

work was supported by the Department of Graduate Studies of the University of Haifa and by Health care Services. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

### Ethical Approval

The Haifa University Faculty of Social Welfare and Health Sciences and Maccabi Health Maintenance, Israel, approved the study (Approval No. 090/13).

### ORCID iD

Carmit Frisch  <https://orcid.org/0000-0001-5068-9991>

### Supplemental Material

Supplemental material for this article is available online.

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## POET FEASIBILITY AND PARENT PERCEPTIONS

### Appendix A: *POET Protocol Summary*

Meeting	Content
Pre-intervention	<ul style="list-style-type: none"><li>• Gather initial information of child's occupational needs and clues for ADHD symptoms</li><li>• Collect family characteristic data</li><li>• Using standardized questionnaires and occupational performance analyses, observe child's ADHD symptoms, EF, and occupational performance of target goals</li></ul>
1	<ul style="list-style-type: none"><li>• Interview parents about child's daily functioning (based on the COPM), set intervention goals, and rate importance levels of child's performance and parental satisfaction</li><li>• Formulate therapeutic contract (describe intervention characteristics and requirements of parents)</li></ul>
2	<ul style="list-style-type: none"><li>• Set priorities with parents for intervention goal to focus</li><li>• Perform structured problem-solving process: identify main EF and other challenges, explore solutions, plan action for parents during the following week. Encourage parents to summarize the meeting and the (up to five) strategies to implement.</li><li>• Implement emotional support elements throughout the session</li></ul>
3–7	<ul style="list-style-type: none"><li>• Check performance systematically: review each strategy, parents' efforts to implement them, and occupational implications</li><li>• If parents are challenged, assist them to understand their needs and find alternative/additional strategies</li></ul>

## POET FEASIBILITY AND PARENT PERCEPTIONS

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- When parents experience success, assist them to generalize successes to additional contexts/occupations
  - If possible, conduct structured problem-solving process for a new intervention goal
  - Implement emotional support elements throughout the session
- 

- 8 (last)  
If needed, 2  
more  
meetings  
can be  
conducted
- Check performance systematically: review each strategy, parents' efforts to implement them, and occupational implications
  - Summarize intervention achievements: occupations and behaviors in which the child improved self-control, child's main identified EF challenges, and main identified affective strategies for coping with them
  - Assist parents to think of their child's possible occupational challenges in the near future and how their new knowledge can assist them to cope with new challenges
  - Measure the intervention's achievements
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*Note. POET = Parental Occupational Executive Training; ADHD = Attention Deficit Hyperactivity Disorder; EF = Executive Functions; COPM = Canadian Occupational Performance Measure.*

## POET FEASIBILITY AND PARENT PERCEPTIONS

### Appendix B

#### *Examples of Personal Occupational Intervention Goals*

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Domain	Goal: My child will . . .
ADL	<ul style="list-style-type: none"><li>• settle down in the morning independently with up to two reminders from his parents</li><li>• sit 10–15 minutes during supper /finish his/her meal before leaving the table</li><li>• remember to eat with knife and fork</li><li>• remember to open the candies clapboard only with permission</li></ul>
Self-play/leisure	<ul style="list-style-type: none"><li>• return toys to their place in the evening, with parent's assistance</li><li>• entertain him/herself (activity with target) in the presence of an adult for 10–30 minutes a day</li></ul>
Learning	<ul style="list-style-type: none"><li>• finish a multistage work assignment (coloring, cutting, or pasting)</li><li>• complete short learning tasks/homework independently</li></ul>
Social function	<ul style="list-style-type: none"><li>• play with young siblings in organized play / play with a purpose</li><li>• respond moderately when frustrated and avoid harming people or objects</li><li>• notice simple instructions and complete them with up to 2 reminders</li></ul>

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*Note. ADL= Activities of Daily Living*