Occupational Performance Coaching for stroke survivors: A pilot randomized controlled trial protocol

Dorothy E. Kessler, Mary Y. Egan, Claire-Jehanne Dubouloz, Fiona P. Graham, and Sara E. McEwen

Key words: Goals; Occupation-based enablement; Participation; Problem solving; Self-efficacy.

Abstract
Background. Many stroke survivors report participation challenges. Occupational Performance Coaching for stroke survivors (OPC-Stroke) is designed to assist stroke survivors to develop the ability to plan and manage engagement in occupation. This approach combines emotional support, individualized education, and goal-focused problem solving to promote occupational engagement. Purpose. This study will explore the potential efficacy of OPC-Stroke and the feasibility of the research methods for use in a larger trial. Method. A pilot randomized controlled trial will be undertaken. Participants will be randomly assigned to receive 10 sessions of OPC-Stroke or usual care. Participation, perceived goal performance, satisfaction and self-efficacy, emotional well-being, and cognition will be measured at three time points. Implications. This research will test the potential usefulness of OPC-Stroke as well as the study methods, and thereby inform the continuing development of OPC-Stroke and further studies to measure its effectiveness.

Abridged Description. De nombreuses personnes ayant survécu à un accident vasculaire cérébral indiquent qu'elles ont des difficultés en matière de participation. L'approche Occupational Performance Coaching for stroke survivors (OPC-Stroke) a été conçue pour aider les survivants à acquérir la capacité de planifier et de gérer leur participation à des occupations. Cette approche combine le soutien émotionnel, l'éducation individualisée et la résolution de problème axée sur des objectifs, en vue de favoriser la participation occupationnelle. But. Cette étude examinera l'efficacité potentielle du OPC-Stroke et la faisabilité de la méthodologie de recherche dans le but éventuel d'effectuer un essai de plus grande envergure. Méthodologie. Un essai clinique aléatoire pilote sera réalisé. Les participants seront répartis de manière aléatoire afin de recevoir soit 10 séances du OPC-Stroke, soit des soins réguliers. La participation, le rendement perçu face à l'atteinte des objectifs, la satisfaction et l'auto-efficacité, le bien-être émotionnel et la cognition seront mesurés à trois intervalles dans le temps. Conséquences. Cette recherche permettra de tester l'utilité possible du OPC-Stroke, de même que la méthodologie de l'étude, ce qui permettra d'orienter le développement continu du OPC-Stroke et de poursuivre les études visant à mesurer son efficacité.

Trial registration: ClinicalTrials.gov NCT01800461 February 28, 2013

Funding: Dorothy Kessler was supported during development of this proposal by the following awards: Vanier Canada Scholarship, Canadian Occupational Therapy Foundation Doctoral Scholarship, Ontario Graduate Scholarship, and an Ontario Research Coalition Early Researcher Award.

Corresponding author: Dorothy Kessler, Bruyère Research Institute, 43 Bruyère St., Ottawa, ON, K1N 5C8, Canada. Telephone: 613-562-6262 ext. 1420. E-mail: dkessler@bruyere.org
Many stroke survivors report problems with participation or re-engaging in occupations, irrespective of disability level (Desrosiers et al., 2006; Mayo, Wood-Dauphinee, Côté, Durcan, & Carlton, 2002). Engagement in occupation relates to one’s involvement in individual or group activities that are deemed of worth and importance to the stroke survivor. This concept is closely related to the International Classification of Function, Disability, and Health (ICF) construct of “participation” (World Health Organization, 2002) since it describes multisteped acts carried out in real-life environments. Where engagement in occupation differs from the ICF concept of participation is that it explicitly considers that the extent to which a particular activity is personally valued may vary from individual to individual (Hemmingsson & Johnsson, 2005). For this research, the concept of participation is expanded to include the dimensions of value and meaning and is considered to be equivalent to engagement in occupation.

Stroke survivors attempt to return to participation following hospital discharge, but this process can be stressful and challenging. Furthermore, when return to participation in occupations is successful, it occurs over several months (Davis, Egan, Dubouloz, Kubina, & Kessler, 2013). Several factors have been identified in the stroke literature as influencing participation after stroke. A few of these factors are potentially modifiable, including self-efficacy (as well as similar concepts of perceived control, choice, confidence; Asakawa, Usuda, Mizukami, & Imura, 2009; Kubina, Dubouloz, Davis, Kessler, & Egan, 2013; Reed, Wood, Harrison, & Paterson, 2012), functional ability (Beckley, 2006; Kubina et al., 2013), knowledge/information (Hammel, Jones, Gossett, & Morgan, 2006; Worrall et al., 2011), support (social contact, social resources, being listened to, guidance; Beckley, 2006; Kubina et al., 2013; Reed et al., 2012), apathy or depression (Asakawa et al., 2009; Rochette, Bravo, Desrosiers, St. Cyr-Tribble, & Bourget, 2007), and having goals (Reed et al., 2012; Wood, Connelly, & Maly, 2010). It is important that these factors are considered when developing interventions to promote participation following stroke.

Several interventions, specifically designed to enhance participation, have been tested with mixed results. Interventions tested have included leisure awareness, self-awareness, and competency development (Desrosiers et al., 2007; Nour, Desrosiers, Gauthier, & Carbonneau, 2002); home-based, client-centred approaches focused on goals (Egan, Kessler, Laporte, Metcalfe, & Carter, 2007; Gilbertson, Langhorne, Walker, Allen, & Murray, 2000); therapy that incorporates leisure goals and leisure activities (Logan, Gladman, Drummond, & Radford, 2003; Parker et al., 2001); a group lifestyle and physical activity program (Lund, Micheleit, Sandvik, Wyller, & Sveen, 2012); and a program of social, physical, and leisure activities (Bastien, Korner-Bitensky, Lalonde, LeBrune, & Matte, 1998). Some of these interventions have been found to be ineffective for enhancing participation (see Bastien et al., 1998; Logan et al., 2003; Parker et al., 2001) or effective for increasing satisfaction but not performance (see Egan et al., 2007). Others have been found not to have lasting effects (see Gilbertson et al., 2000), while the long-term effectiveness of others is not known (see Desrosiers et al., 2007; Lund et al., 2012; Nour et al., 2002). Among those interventions tested, the ones that were more successful included client goal setting, an emphasis on empowerment, competency development, and relevant information provision and support (Desrosiers et al., 2007; Egan et al., 2007; Gilbertson et al., 2000; Nour et al., 2002). None of the interventions tested to date have integrated all these elements.

Research suggests that an individualized approach is likely to be most effective due to the unique nature of each client’s occupations, stroke symptoms, personal characteristics, and environmental contexts (Egan et al., 2007; Desrosiers et al., 2007). Innovative approaches are required to help ensure that interventions to enhance participation are effective in meeting clients’ individual needs. As well, interventions must be designed to build competence and provide stroke survivors with the skills they need to allow them to plan and manage their own return to engagement in occupation following the completion of therapy.

Studies have found that stroke rehabilitation practice tends to focus on basic functional activities required for discharge (Duxbury, Depaul, Alderson, Moreland, & Wilkins, 2012), and participation needs have been reported to be underidentified by occupational therapists providing inpatient and community stroke rehabilitation (Korner-Bitensky, Desrosiers, & Rochette, 2008). A time-limited intervention that enables stroke survivors to address future participation challenges may provide therapists with a clinically feasible approach.

Occupational Performance Coaching (OPC) is an approach whereby individuals are guided to solve problems critical to the achievement of self-identified participation goals (Graham, Rodger, & Ziviani, 2010). With OPC, the occupational therapist guides the client to discover, implement, and evaluate his or her own solutions within a problem-solving framework. The primary objective of OPC is improvement in occupational performance, while the secondary objective is the development of self-efficacy and problem-solving skills to manage future occupational performance challenges (Graham & Rodger, 2010). While OPC was originally developed and found to be effective for parents of children with occupational challenges (Graham et al., 2010; Graham, Rodger, & Ziviani, 2013), this type of approach may be effective for people following stroke who are seeking similar outcomes.

Following review of the stroke literature, an adaptation of OPC for stroke survivors (OPC-Stroke) was developed. A multiple case study approach was used to further refine and develop the intervention (Kessler, Ineza, Patel, Phillips, & Dubouloz, 2014). Theoretically, OPC-Stroke is consistent with the ICF (World Health Organization, 2002) and the Canadian Model of Occupational Performance and Engagement (CMOP-E; Polatajko, Townsend, & Craik, 2007). Within the context of the ICF and the CMOP-E, OPC-Stroke is informed by coaching, metacognition theory, and models of support (direct effect models and the buffering model of support;
Uchino, 2004). Coaching, in general, draws on a variety of theoretical approaches, including humanism, cognitive and behavioural sciences, positive psychology, adult development, and adult learning theory (Ives, 2008). Of these approaches, OPC-Stroke draws primarily from humanism, cognitive and behavioural sciences (social cognitive theory, goal-setting theory, and solution-focused therapy), and adult learning theories. The adaptation of the OPC intervention for stroke survivors and the theoretical underpinning of OPC-Stroke are described in detail elsewhere (Kessler et al., 2014). Specifically, OPC-Stroke aims to address stroke survivors’ needs for emotional support, individualized education, and regaining a sense of control or self-efficacy through a collaborative process of goal setting and problem solving to attain set goals. Emotional support is provided to establish a therapeutic coaching relationship that creates a safe environment of trust, collaboration, and mutual respect for sharing information, exploring options, and taking the steps necessary to work toward goals (Hubble, Duncan, & Miller, 1999). Stroke survivors are thereby supported to develop the knowledge, skills, and self-efficacy required to take on future participation challenges. Secondary benefits of improved participation may include better emotional well-being and improved cognition due to the stimulation offered by taking part in the problem-solving process and by occupational engagement.

The purpose of this study is to explore the efficacy of OPC-Stroke with adults who have experienced stroke and to examine the feasibility of the research methods in preparation for a larger randomized controlled trial (RCT).

The primary hypothesis to be tested is that stroke survivors receiving OPC-Stroke will report increased participation compared with those receiving usual care. Secondary hypotheses to be tested are that (a) stroke survivors receiving OPC will report increased performance and satisfaction with individually identified participation goals, emotional well-being, goal self-efficacy, and cognition compared with those receiving usual care; and (b) a larger trial is feasible as indicated by recruitment and retention rates, respondent instrument completion rates, and attendance.

Method

Study Design

The pilot RCT will use an evaluator masked design to begin to test the efficacy of OPC-Stroke and to examine feasibility and acceptability of the research methods in preparation for a larger RCT. Ethical approval for this study was obtained from the related hospital and university research ethics boards.

Study Population

Twenty-four stroke survivors will be recruited after discharge from the acute stroke unit at the Ottawa Hospital, the Bruyère inpatient stroke rehabilitation unit, and the Bruyère outpatient stroke service. Services offered by hospital programs are time limited and are structured to address specific short-term goals, such as basic activities of daily living, upper-extremity function, and limited participation goals. Since return to engagement in occupation tends to occur over a longer time period (Davis et al., 2013), stroke survivors discharged from all of these settings are anticipated to have unaddressed participation goals.

Participants will be included in the study if they meet the following inclusion criteria: (a) first hospitalization due to diagnosis of stroke; (b) discharge from acute care hospital or inpatient rehabilitation to a non-institutionalized setting; (c) FIM™ (Keith, Granger, Hamilton, & Sherwin, 1987) scores at rehabilitation discharge of at least 3 (indicating capacity to engage in verbally based intervention) for expression, comprehension, memory, and problem solving; and (d) residence within the city of Ottawa. Stroke survivors referred to outpatient stroke rehabilitation for occupational therapy will be eligible following completion of their outpatient occupational therapy (due to potential overlap of client goals during outpatient occupational therapy). Participants will be excluded from the study if they (a) have other degenerative neurological diagnoses (such as Parkinson’s, multiple sclerosis) or (b) have a current major depressive or psychotic disorder.

Participants will be recruited at the time of discharge from hospital or outpatient stroke rehabilitation. Health professionals employed at each hospital will screen and refer interested clients who meet the inclusion and exclusion criteria to a research assistant, who will then seek informed consent.

Randomization. Following consent to participate in the study, initial outcome measures will be completed. Participants will then be allocated to the treatment or control group using block randomization stratified by timing of recruitment, that is, post-inpatient hospital stay or post-outpatient rehabilitation services. The randomization sequence will be computer generated by a statistician and then concealed prior to allocation using opaque sealed and numbered envelopes. The envelopes will be kept by research staff not associated with the study who will open the envelopes and reveal the allocation to the first author and the occupational therapist who will be providing the intervention following completion of the initial outcome measures.

Description of the OPC-Stroke Intervention

Domains of OPC-Stroke. The OPC-Stroke comprises the following components defined as the domains of OPC-Stroke: emotional support, individualized education, and a goal-focused problem-solving process (see Table 1).

Emotional support is conveyed to the client through use of active listening, empathizing, reframing, guiding, and encouraging (Graham & Rodger, 2010). Individualized education occurs through a reciprocal exchange of information between the occupational therapist and client that is grounded in adult learning principles (Collins, 2004). This individualized education involves exchange of information that is relevant to the...
individual needs of the stroke survivor and his or her participation goals. Education can be related to health conditions and impairments, specialized strategies, provision of information about community resources and entitlements, typical development related to the person’s stage of life, and teaching and learning strategies (Graham & Rodger, 2010).

Goal-focused problem solving consists of processes to facilitate goal setting and problem solving to promote goal achievement. Identification of participation goals is facilitated through the use of personal projects analysis (PPA; Little, 1998) to promote reflection during goal setting. Personal projects are activities carried out over time within a particular social context to achieve an end that is named and given meaning by the doer (Little, 1998). In this way, personal projects reflect occupations. During the process of PPA, participants are facilitated to reflect on specific aspects of goals, such as importance, support available, and degree of challenge.

Once goals have been identified, a structured problem-solving process of (a) set goal, (b) explore options, (c) plan action, (d) carry out plan, (e) check performance, and (f) generalize is presented (Graham & Rodger, 2010). The occupational therapist guides the participant through this process as he or she strives to achieve set goals. During the explore options step of a particular goal, collaborative performance analysis (CPA) is used. In CPA, the client is guided to analyze different aspects that contribute to his or her performance using the Person-Environment-Occupation (PEO) model (Law et al., 1996). The PEO model facilitates the examination of the interaction between the person, the environment (including social support), and the demands of the occupation that promote or inhibit participation. In conjunction with use of the PEO model, CPA involves the following four steps: (a) identify what currently happens, (b) identify what the client would like to happen, (c) explore barriers and bridges to enabling performance, and (d) identify client needs in planning and taking actions to achieve goals. Throughout these steps, the emphasis is on finding solutions as opposed to focusing on problems (Berg & White, 2010; Graham & Rodger, 2010). Although the problem-solving process is depicted as a linear progression (see Figure 1), a step may be revisited at any time.

During exploration of options and planning, the occupational therapist guides the client to select actions steps that present challenge yet are achievable. This guidance helps to promote persistence in working toward goals (Bandura, 1977).

---

### Table 1

<table>
<thead>
<tr>
<th>Emotional support</th>
<th>Individualized education</th>
<th>Goal-focused problem solving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen</td>
<td>Health conditions and impairments</td>
<td>Set goal</td>
</tr>
<tr>
<td>Empathize</td>
<td>Specialized strategies</td>
<td>Explore options; collaborative performance analysis</td>
</tr>
<tr>
<td>Reframe</td>
<td>Community resources and entitlements</td>
<td>Plan action</td>
</tr>
<tr>
<td>Guide</td>
<td>Typical development</td>
<td>Carry out plan</td>
</tr>
<tr>
<td>Encourage</td>
<td>Teaching and learning strategies</td>
<td>Check performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generalize</td>
</tr>
</tbody>
</table>

Note. Adapted from Graham and Rodger (2010).

---

**OPC-Stroke intervention structure.** The OPC-Stroke intervention consists of up to 10 one-to-one visits with an occupational therapist trained in OPC-Stroke over a 16-week period. Visits last approximately 1 hr and take place in the participant’s home or location of his or her choice. During the first visit, the occupational therapist will use the PPA tool (Little, 1998) in combination with the Canadian Occupational Performance Measure (COPM; Law et al., 2005) to facilitate discussion of and reflection on current engagement in occupation. Three personal projects will be identified by each participant as intervention goals, and the following nine OPC-Stroke sessions will be focused on these projects. Three goals will be selected to ensure adequate time to address each goal within the time frame of the intervention.

A manual for OPC-Stroke that includes the domains and structure of the intervention was developed to promote consistency of application of the intervention while allowing for the flexibility required for an individualized approach. Occupational therapists with strong interpersonal skills will be selected for training. Training in the intervention will be provided by the first author and will comprise review of the manual, overview of coaching principles, and feedback following review of audiotapes.
Control Group
The purpose of the control group in this study is to control for change that may occur with the passage of time in the estimate of the efficacy of the intervention (Freedland et al., 2011). This is particularly relevant following stroke as the course of natural recovery and adjustment may lead to changes in performance. The control group will receive usual care. Usual care may consist of outpatient therapy (excluding outpatient occupational therapy) and/or personal support services for activities of daily living.

The choice of a usual-care control group is considered to be appropriate for early stages of testing where the goal is to determine preliminary efficacy (Freedland et al., 2011). A control intervention that provided the same amount of attention was considered for this study but was not feasible given that emotional support is considered to be a key active ingredient in the OPC-Stroke intervention and that it would be difficult to avoid providing emotional support in an approach that adequately controlled for attention. This dilemma is shared by researchers in the area of psychotherapy (Freedland et al., 2011).

Data Collection

Quantitative data. At baseline, a research assistant, who will be masked to group assignment, will obtain consent and complete the following pretest outcome measures: Reintegration to Normal Living Index (RNLI), Hospital Anxiety and Depression Scale (HADS), and Montreal Cognitive Assessment (MoCA).

At baseline, the occupational therapist providing the intervention (the “coach”) will administer the COPM and the Goals Systems Assessment Battery–Directive Function Indicators (GSAB-DFI) to participants in both groups. For this study, the COPM will be administered as part of the PPA process. Both groups will receive the initial goal-setting session with the coach to promote consistency of application and the ability to capture outcome measures related to selected goals (i.e., COPM and GSAB-DFI). The administration of these measures is the first step of the coaching process.

Following the intervention (for the intervention group) or 14 weeks following completion of initial outcome measures (for the control group; T2) and at 6-month follow-up (T3), a research assistant will complete all post-intervention evaluations (RNLI, HADS, COPM, GSAB-DFI, and MoCA) to minimize bias (see Figure 2).

To maintain masking of the research assistant, the first author will track timing of evaluations, and the intervention occupational therapist will not communicate directly with the research assistant after allocation. To evaluate effectiveness of masking, the research assistant will be asked to guess the group of each participant following the T3 evaluation.

The primary outcome measure will be overall participation measured using the RNLI. The secondary outcomes will be performance of and satisfaction with participation goals (COPM), emotional well-being (HADS), goal self-efficacy (GSAB-DFI), and cognition (MoCA). All outcomes will be measured at all three time points (pretest, post-intervention, and 6-month follow-up).

Primary outcome measure. The RNLI (Wood-Dauphinee, Opzoomer, Williams, Marchand, & Spitzer, 1988) is an 11-item scale with proven reliability, validity, and responsiveness (Stark, Edwards, Hollingsworth, & Gray, 2005; Wood-Dauphinee et al., 1988). The RNLI has been widely used in stroke rehabilitation research (e.g., Mayo et al., 2000; Tooth, McKenna, Smith, & O’Rourke, 2003; Wood-Dauphinee et al., 1988). The RNLI includes questions regarding daily functioning (i.e., mobility in the home, mobility in the community, taking trips, self-care), work activities (i.e., volunteering, housework and studying, recreational activities, social activities, and family role), and perception of self (i.e., comfort with others, comfort with self, ability to deal with life events). All questions are worded to take into consideration the satisfactoriness of the present situation to the individual. A 10-point Likert scale will be used in lieu of the original visual analogue scale as it is more appropriate poststroke (Price, Curless, & Rodgers, 2012).
Secondary outcome measures. The COPM (Law et al., 2005) is a reliable, valid, and responsive tool (Carswell et al., 2004; Cup, Scholte op Reimer, Thijsen, & van Kuyk-Minis, 2003) for measuring performance and satisfaction with personally identified participation goals. Participants are asked to identify goals and then rate their performance and satisfaction with current status on a scale from 1 to 10, where 10 indicates optimal performance or satisfaction. Numbers are summed and divided by the number of goals. This tool has been widely used as an outcome measure in stroke rehabilitation research (e.g., Cup et al., 2003; Jansa, Sicherl, Angleitner, & Law, 2004; Jenkinson, Ownsworth, & Shum, 2007).

The HADS (Zigmond & Snaith, 1983) is a brief, psychometrically sound measure of depression and anxiety (Aben, Verhey, Lousberg, Lodder, & Honig, 2002; Johnston, Pollard, & Hennessey, 2000) that can be used in a variety of settings. The HADS consists of 14 items that reflect the client’s mood in the past week.

The Goals Systems Assessment Battery (Karoly & Ruehlman, 1995) is based on the multiple-function model of behaviour and personality (Ford, 1987) and consists of four function indicators subscales: Directive, Regulatory, Control, and Arousal. The Directive Function Indicators subscale (GSAB-DFI), which will be used in this study, provides a valid and reliable measure of goal value and self-efficacy (Karoly & Ruehlman, 1995). Each goal is rated on four questions regarding goal value (e.g., “This goal is worthwhile”) and four questions regarding self-efficacy (e.g., “I possess the necessary skills to attain this goal”) for that specific goal. Each of the goals identified using the COPM will be rated individually using this measure.

The MoCA (Nasreddine et al., 2005) is a quick screening tool designed to detect mild cognitive impairment that has been tested with people who have experienced stroke (see Cumming, Bernhardt, & Linden, 2011; Toglia, Fitzgerald, O’Dell, Mastrogiovanni, & Lin, 2011). It involves assessment of a broad range of cognitive skills, including attention and concentration, executive functions, memory, language, visuo-constructual skills, conceptual thinking, calculations, and orientation.

In addition to the above scales, descriptive data, including date of stroke, type and location of stroke, stroke severity (discharge FIM score; Keith et al., 1987), age, gender, living situation, services received postdischarge, and comorbidities, will be collected. To examine feasibility and acceptability of the research procedures, recruitment, retention, and attendance rates will be tracked. As well, data missing from outcome measures and effect sizes will be examined.

Treatment fidelity. The occupational therapist will keep notes and will digitally audio-record each session to document the process, frequency, duration, and content of the coaching intervention. These data will be used to examine the treatment fidelity of the OPC-Stroke intervention.

Data Analysis

Quantitative data. Means, standard deviations, and proportions will be calculated to summarize the characteristics of the participants in the experimental and control groups. T-test and chi-square statistics will be used to test for between-group baseline differences.

To test the primary and first secondary hypotheses—that is, to determine whether following receipt of OPC-Stroke the participants in the intervention group demonstrate increased participation, performance, and satisfaction with identified goals, emotional well-being, goal self-efficacy, and cognition compared to the control group—change in RNLI, COPM, HADS, GSAB-DFI, and MoCA scores will be compared using repeated-measures ANOVA (Park, Cho, & Ki, 2009). These analyses will use intention to treat principles. That is, data from all participants will be analyzed based on their initial group assignment. If a participant drops out of the study, his or her most recent outcome scores will be used for subsequent time points (Gupta, 2011).

The second secondary hypothesis, whether a larger trial is feasible, will be determined based on examination of recruitment, retention, and attendance rates and percentage completion of the outcome measures. Recruitment rates will be used to examine recruitment strategies and for planning the time frame of a larger trial. Retention rates will be used to assist with determining the total number of participants to recruit in a larger trial. Attendance rates will be based on number of sessions completed within 16 weeks. These data will assist with refining the number and timeframe of sessions for future studies.

Power calculation. As this is a pilot RCT, the goal is to identify trends. Significant findings are not expected. However, it is noted that a group size of 11 participants will provide an 80% chance of detecting a statistically significant 12-point difference on the primary outcome measure, the RNLI (scale range 11 to 110 points), given a standard deviation of 10 with an α of .05. A 12-point difference on the RNLI is half the difference we observed on uncontrolled testing (Kessler et al., 2014). Twenty-four participants will be recruited due to randomization in block sizes of four. To decrease the likelihood of attrition, the control group will be offered the OPC-Stroke intervention following completion of the study as an incentive to remain in the study.

Treatment fidelity. Digital audio recordings of coaching sessions along with the coach’s field notes will be used to monitor treatment fidelity. Recordings of the first five sessions of the first 5 participants and then three sessions, selected randomly, for the remaining participants receiving OPC-Stroke will be monitored. The first author and a different research assistant will review the session recordings and will score them using a treatment fidelity checklist that was developed based on the OPC-Stroke manual and that is geared toward assuring that the intervention follows the essential aspects of OPC-Stroke.
(i.e., emotional support, information exchange, and goal-focused problem solving).

Discussion

The aim of this study is to begin to test the efficacy of OPC-Stroke and examine the feasibility of the study design in preparation for a larger RCT. OPC-Stroke has an excellent fit with occupational therapy values and commitment to client-centered practice. Pentland (2012) highlights that coaching provides occupational therapists with tools to promote client awareness of meanings associated with occupations and to enable choices with regard to participation. These types of tools are important for promoting client autonomy. Client autonomy, or responsibility for decision making in rehabilitation and involvement of clients in goal setting, is promoted in the literature but is often challenging in practice (Rosewilliam, Roskell, & Pandyan, 2011). This challenge is due to differing knowledge, expertise, and views of recovery between the clinician and the client as well as to client psychosocial factors (Rosewilliam et al., 2011). Even in occupational therapy, a profession committed to client-centred care, goals are more likely to reflect the expectations and constraints of the health care system as opposed to the client’s true wishes (Rosewilliam et al., 2011). OPC-Stroke specifically promotes client goal setting and responsibility for planning and decision making to achieve goals. The testing of OPC-Stroke will provide insight into the process and outcomes of a client-centred goal-setting approach, which may begin to address perceived barriers to autonomy and client-directed goal setting.

Occupational therapists have the potential to address issues related to participation among individuals poststroke, yet there tends to be minimal time spent addressing participation issues and greater emphasis on basic function and environmental adaptation to enhance safety (Moulton, 1997; Walker, Drummond, Gatt, & Sackley, 2000). OPC-Stroke provides an approach to treatment that could potentially be incorporated with other approaches in stroke rehabilitation and thereby provide stroke survivors with tools to address participation challenges when these services are terminated.

Pilot work to examine feasibility and efficacy is considered an important component when developing and testing complex interventions (Medical Research Council, 2008), such as OPC-Stroke. Results of this study will be used to determine if a larger RCT is warranted based on the potential efficacy, and if so, what adaptations to the design may be required to ensur successful implementation.

Study Limitations

As with any study, this pilot RCT contains limitations. The first limitation is lack of masking of the participants and providers. In an ideal situation, participants, providers, and evaluators are masked to treatment allocation. In this study, only the evaluators will be masked. Consistent with many RCTs conducted in rehabilitation, it is not possible to mask the person administering the intervention, and delivery of an inactive sham treatment to mask participants is problematic both from an ethical and a feasibility standpoint.

The second limitation is that this study excludes stroke survivors with more severe cognitive and communication deficits. This is deemed advisable during the initial stages of collecting empirical evidence on the efficacy of an approach. Another limitation is that the process of goal setting itself may be beneficial, and therefore both groups may show improved participation. This situation cannot be avoided as the COPM, which is also a goal-setting tool, is being used as an outcome, so it must be administered to both groups at baseline. Finally, participants in the intervention group may achieve benefits, such as decreased depression, simply through receiving increased attention. At this stage of testing, use of an attention control was deemed too expensive to justify. Future testing of OPC-Stroke should include an attention control.

Key Messages

- More effective interventions to improve participation following stroke are needed.
- Occupational Performance Coaching for stroke survivors, with its combined approach of emotional support, individualized education, and goal-focused problem solving, is a promising method of promoting occupational engagement among stroke survivors.

References


Author Biographies

**Dorothy E. Kessler**, MSc, OT Reg. (Ont.), is Doctoral Candidate, University of Ottawa, and Research Trainee, Bruyère Research Institute, Ottawa, ON, Canada.

**Mary Y. Egan**, PhD, OT Reg. (Ont.), is Professor, School of Rehabilitation Sciences, University of Ottawa, Ottawa, ON, Canada.

**Claire-Jehanne Dubouloz**, PhD, OT Reg. (Ont.), is Professor, School of Rehabilitation Sciences, University of Ottawa, Ottawa, ON, Canada.

**Fiona P. Graham**, PhD, is Senior Lecturer, Rehabilitation Teaching and Research Unit, Department of Medicine, University of Otago, Wellington, New Zealand.

**Sara E. McEwen**, PhD, is Scientist, Sunnybrook Research Institute, St. John’s Rehab Program, and Assistant Professor, Department of Physical Therapy, and Associate Member, Graduate Department of Rehabilitation Science, University of Toronto, Toronto, ON, Canada.

Book Review


DOI: 10.1177/0008417414526858

This is an important book for community-based occupational therapists. This second edition aims to present a well-developed discussion of current occupational therapy practices in a variety of community-based settings. In textbook format, it focuses on the United States and specifically aims to support the American Occupational Therapy Association’s Centennial Vision. However, ideas and concepts are well enough articulated that they could be adapted to, and tried out, in other contexts and countries. Several new chapters have been added in this second edition, deepening and broadening the scope from the first edition, to include topics such as health promotion in faith-based settings and academic communities.

This is a big book: nine sections, with 39 chapters. The information in each chapter is presented clearly with relevant definitions, charts, and tables. An editor’s job is to ensure cohesion in the overall work, and Scaffa and Reitz have done so. Each chapter is strong enough to be read alone as an introduction, while there is also integration throughout the book between chapters. The table of contents and the index are well laid out to assist the reader to cross-reference within the book. For example, those interested in developing a new program for children would be able to select and use chapters on basic principles, program development, and primary care settings as well as draw from chapters specifically focused on children.

The main strength of this book is that it pulls together evidence about well-established theories and practices of community-based occupational therapy while also providing ideas about innovative, new practices. It provides answers to the question: How can occupational therapists contribute to the creation of more just, healthy, and peaceful societies? These perspectives are vital in current socioeconomic and political climates, globally, where solutions to complex social problems are so very needed. One concern is it does not reach far enough into human rights and justice perspectives to encourage advocacy for structural change. For example, *human rights and political* are key words in current occupational therapy discourses but are not found in the index, perhaps because these perspectives are implicitly woven through the book.

This book not only asks occupational therapists to move beyond traditional health and educational settings but offers road maps for getting there. The editors and authors see their occupational therapist readers as part of their own practice community and provide a guide for creating projects and initiatives that have the potential to significantly progress both the profession of occupational therapy and communities as a whole. In summary, it provides an overview of possibilities for occupational therapy’s contributions to the common good.

Lynn Cockburn