

Chapter 01. Serving the Needs of Children and Their Families

Multiple Choice

Identify the choice that best completes the statement or answers the question.

- ____ 1. According to the ICF, impairments are:
 - a. problems in functional activities.
 - b. restrictions in activities.
 - c. problems in physiological functions of body systems.
 - d. limitations in functional skills.
 - e. limitations in participation.

- ____ 2. Evidenced-based practice should include:
 - a. expert opinion, continuing education, and personal experience.
 - b. intuition, unsystematic clinical experience.
 - c. explanations based on pathophysiology.
 - d. awareness, consultation, judgment, and creativity.

- ____ 3. When possible, an examination should:
 - a. start with tests and measures in the clinical setting.
 - b. start with observation done in the natural environment while gathering history.
 - c. never be done in the waiting room.
 - d. start with determining the child's strengths and weaknesses.

- ____ 4. When developing the plan of care for a child, it is important to:
 - a. Determine goals and objectives before talking with the child and family.
 - b. Prescribe interventions focused on the child's impairments.
 - c. Ensure goals and interventions address activity and participation.
 - d. Focus on measurable goals for the next 2 years.

- ____ 5. In pediatric practice, a top-down approach to assessment is preferred because:
 - a. weaknesses are identified first, and it is child-centered.
 - b. desired outcomes are identified first, and it is family-centered.
 - c. it is the most common model used in physical therapy practice.
 - d. it is a deficit-driven model.

- ____ 6. Chaining techniques work best:
 - a. with those with a cognitive impairment.
 - b. as negative reinforcement.
 - c. as continuous reinforcement.
 - d. with discrete tasks having a clear beginning and end.

- _____ 7. Reinforcing behaviors/skills that are increasingly closer to the desired behavior/skill are called:
- a. negative reinforcement.
 - b. behavioral programming.
 - c. positive reinforcement.
 - d. shaping.
- _____ 8. Collaborative teams:
- a. desire consensus decision-making in determining priorities for goals and objectives.
 - b. provide professionals with autonomy.
 - c. discourage role release because of liability issues.
 - d. prefer to provide intervention in special therapy rooms.
 - e. tell parents exactly what to do for their child.
- _____ 9. Physical therapists first started to work with children:
- a. in the 1940s for the treatment of children with cerebral palsy.
 - b. when Sister Kenny came to the United States to meet the needs of children with polio.
 - c. when Berta Bobath introduced a treatment for children with cerebral palsy.
 - d. during the polio epidemic in the early part of the 20th century.
- _____ 10. External factors that may affect a child's function include:
- a. cognitive ability, emotional stability, motivation, and language ability.
 - b. impairments of body structures and functions and limitations in activities.
 - c. family support, access to health care, financial resources, and accessible schools.
 - d. family and child's goals and objectives.
- _____ 11. If one embraces the ICF model, no matter what setting a pediatric therapist is providing interventions in (clinic, school, home, etc.), the primary long-term goal of physical therapy should be to:
- a. maximize the child's strength, range of motion, and posture in order to prevent secondary impairments.
 - b. minimize all physical impairments to improve the child's motivation and self-confidence when among peers.
 - c. maximize the child's participation in the home, school, and community.
 - d. walk up and down the stairs independently in less than 3 minutes while carrying two textbooks in order to change classrooms in the time allotted between classes.
 - e. eliminate all environmental and personal barriers to the child's community participation.
- _____ 12. A task analysis includes:

- a. determining the prerequisite body functions.
- b. the activities required to perform the task.
- c. the cognitive requirements to perform the task.
- d. understanding the motor planning requirements of the task.
- e. All of the above

_____ 13. The sequence of the hierarchy of response competence is first skill acquisition followed by:

- a. fluency, maintenance, and generalization.
- b. refinement of the skill, transfer, and attainment.
- c. generalization, maintenance, and refinement.
- d. transfer and performance in different environments.

_____ 14. Which model of team interaction is most commonly used in early intervention programs?

- a. Unidisciplinary model
- b. Multidisciplinary model
- c. Transdisciplinary model
- d. Hierarchical model

_____ 15. Determining the frequency, intensity, and duration of intervention is difficult; however, general guidelines have been developed for:

- a. cerebral palsy, myelomeningocele, and traumatic brain injury.
- b. pediatric hospitals and school-based settings.
- c. outpatient orthopedics and neonatal intensive care units.
- d. autism, Down syndrome, and muscular dystrophy.

_____ 16. Collaborative teamwork does *not* include:

- a. role release to designated team members.
- b. consensus decision-making.
- c. motor and communication skills embedded throughout the interventions.
- d. professionals working in isolation on their own.
- e. equal participation on the team by the family.

_____ 17. Which statement *least* reflects a family-centered philosophy of physical therapy intervention?

- a. Asking the family what their concerns are.
- b. Providing the family a daily home exercise program to improve the child's muscle strength in preparation for ambulation.
- c. Identifying family caregiving routines and providing consultation to assist family members.
- d. Preparing for ambulation; discussing with the family play activities for supported standing that could provide opportunities for some sibling participation.

- _____ 18. When using a top-down approach to developing a plan of care for a child new to therapy, the physical therapist should proceed in which order?
- Evaluate child impairments, set goals for child, and develop a plan for intervention.
 - Develop collaborative goals, examine the child to determine physical therapy diagnosis, determine prognosis, and create a plan of care.
 - Perform standardized assessment, interpret results, discuss results with the child's family, and create a plan of care.
 - Determine patient impairments, perform standardized assessment, develop a plan of care, and discuss the plan with the child's family.
- _____ 19. The legislation that preceded the Americans with Disabilities Act in providing protection and access for individuals with disabilities is:
- Section 504 of the Rehabilitation Act.
 - Social Security Amendments of 1965.
 - Economic Opportunity Act of 1963.
 - State Children's Health Insurance Plan.
- _____ 20. Low-income, working parents whose children do not qualify for Medicaid because they work might qualify for health insurance under which federal program?
- State Children's Health Insurance Plan
 - Medicare
 - Health maintenance organizations
 - There is no insurance program available to them.
- _____ 21. If you suspect that a child you are serving is being abused:
- you can say nothing because your professional code of conduct requires confidentiality.
 - you must report the abuse using your state's procedures.
 - you should speak to the child's parent.
 - you must write a report and share it with the child's physician.
- _____ 22. When prescribing frequency of physical therapy intervention, which of the following children would be most appropriate for intensively scheduled physical therapy intervention (i.e., greater than 1 time per week)?
- A 6-year-old child who was just released from ICU/acute care following a bout of bacterial meningitis who was typically developing premorbidly but now requires maximum assist for ADLs and mobility.
 - A fifth-grade child with mild hemiparetic spastic cerebral palsy who can ambulate independently and participate in recreational sporting activities with peers but demonstrates asymmetry when sitting at his desk at school.

- c. A 3-month-old baby with a history of pregnancy complications, who was born at 34 weeks' gestation with mild respiratory difficulties (now resolved) and who is currently demonstrating age-appropriate motor skills despite noticeable low tone/generalized weakness.
- d. A 6-month-old baby with generalized weakness/low tone and an AIMS score in the fifth percentile who has supportive/attentive parents and who is not receiving any other services.

- ____ 23. When prescribing frequency of physical therapy intervention, which of the following children would be most appropriate for less frequently scheduled periodic rechecks (i.e., bimonthly, quarterly, etc.)?
- a. A 6-month-old baby with generalized weakness/low tone and an AIMS score in the fifth percentile who has supportive/attentive parents and who is not receiving any other services.
 - b. A 3-month-old baby with a history of pregnancy complications, who was born at 34 weeks' gestation with mild respiratory difficulties (now resolved) and who is currently demonstrating age-appropriate motor skills despite noticeable low tone/generalized weakness.
 - c. A fifth-grade child with mild hemiparetic spastic cerebral palsy who can ambulate independently and participate in recreational sporting activities with peers but demonstrates asymmetry when sitting at his desk at school.
 - d. A 6-year-old child who was just released from ICU/acute care following a bout of bacterial meningitis who was typically developing premorbidly but now requires maximum assist for ADLs and mobility.
- ____ 24. In contemporary pediatric practice, clinical reasoning entails synthesis of:
- a. the child's past history, medical diagnosis, and therapist-determined goals.
 - b. evidenced-based knowledge, findings from the PT evaluation, and contextual factors specific to the child and family.
 - c. a prioritized list of impairments specific to the child, past experience with children that have similar impairments, and personal intuition.
 - d. hypotheses about the child's medical diagnosis, knowledge of interventions available in the hospital or clinic, and recommendations from colleagues.
- ____ 25. When providing interventions for children, it is important to:
- a. be serious to ensure compliance.
 - b. ensure activities are educationally relevant in all settings.
 - c. educate the family and other team members as well as the child.
 - d. always focus on progressing the child through the development sequence.
 - e. All of the above
- ____ 26. Providing interventions in a natural environment is emphasized in which of the following models of service delivery?
- a. Integrated model
 - b. Consultative model
 - c. Monitoring

- d. Collaborative model
- e. All of the above

Chapter 1. Serving the Needs of Children and Their Families

Answer Section

MULTIPLE CHOICE

1. ANS: C

Rationale: The ICF-CY Definition of Impairments is as follows: Problems in body function or structure; body function is defined as physiological functions of body systems.

2. ANS: D

Rationale: In *Evidence-Based Rehabilitation*, Mary Law notes that awareness, consultation, judgment, and creativity are the four elements of evidence-based practice. It is noted that expert opinion, continuing education, and personal experience are subject to bias (Thomson-O'Brien & Moreland, 1998). The Evidence-Based Medical Working Group notes that we must de-emphasize intuition, unsystematic clinical experience, and explanations based on pathophysiology (1992).

3. ANS: B

Rationale: When possible, the examination should be done in the child's natural environment and should first include naturalistic observation.

4. ANS: C

Rationale: Because the focus of physical therapy with children should be on function and inclusion, the goals and interventions used in the plan of care should be at the ICF activity and participation level. Collaborating with the child and family as a first step in the evaluation process helps the therapist develop functional goals and judiciously using frequency criterion in goals helps to ensure the child's safety.

5. ANS: B

Rationale: Top-down approach to examination and evaluation involves determining the family and child's desired goals first before identification of obstacles/deficits and strengths.

6. ANS: D

Rationale: Chaining links related behaviors to accomplish a more elaborate goal with sequenced elements. Chaining works best with discrete tasks that have a clear beginning and end, such as most activities of daily living, or selected serial tasks that are strung together, such as performing a sliding board transfer.

7. ANS: D

Rationale: Shaping involves reinforcing behaviors that are increasingly closer to the desired behavior.

8. ANS: A

Rationale: Review Table 1.6. Collaborative teams desire consensus decision making in determining priorities for goals and objectives. Collaborative teams do not provide professional autonomy and prefer that professionals work together for common goals. Collaborative teams encourage role release; liability is not a major issue. Natural environments are preferred to clinical settings, and parents are not told what to do with their children. The parents and the team collaborate.

9. ANS: D
Rationale: Polio became a major health-care issue in the United States in 1917, and physical therapists began to work with those recovering from polio.
10. ANS: C
Rationale: All factors other than family support, access to health care, financial resources, and accessible schools are internal factors.
11. ANS: C
Rationale: In general, the goal of physical therapy and rehabilitation is to maximize the child's participation in the home, school, and community. The other options might be appropriate for a specific child, but the overriding goal would be to maximize participation.
12. ANS: E
Rationale: In a task analysis, the therapist determines the component parts of the task, including activity requirements and prerequisites. To perform an activity, the child requires the cognitive ability to understand the activity, the motivation to perform the activity, the motor-planning ability to execute the activity, and the muscle strength and ROM required to execute the activity.
13. ANS: A
Rationale: Review Figure 1.5
14. ANS: C
Rationale: The transdisciplinary model is the most commonly used, although interdisciplinary or collaborative models might also be used and therefore were not given as options.
15. ANS: B
Rationale: General guidelines have been developed to assist in determining intervention frequency and intensity for school-based practice by the state education departments in Iowa (2001) and Florida (2010) and for pediatric hospital settings (Bailes, Reder, & Burch, 2008).
16. ANS: D
Rationale: Review Table 1.6. Collaborative teamwork requires that professionals work together; it might not be physically together, but they need to communicate and not work in isolation.
17. ANS: B
Rationale: Whereas the family might eventually receive a home exercise program, you do not have enough information to determine whether such a program is something the family wants or thinks they need. All the other statements indicate collaborating with family members and asking the family what they care about, as is required in a family-centered approach.
18. ANS: B
Rationale: In a top-down approach, the goals are established first in collaboration with the child and family. The goals might change based on the examination, but they are first discussed, followed by the examination to determine physical therapy diagnosis, determine prognosis, and create plan of care.

19. ANS: A

Rationale: The Rehabilitation Act of 1973 (93-112) guaranteed rights to individuals with disabilities. Included in the Act is Section 504, which is viewed as the first civil rights statute for persons with disabilities; this preceded the 1990 American with Disabilities Act (PL 101-336) (review Appendix 1.A).

20. ANS: A

Rationale: The State Children's Health Insurance Plan is state health insurance coverage for uninsured, low-income children. Children whose parents earn too much to qualify for Medicaid but cannot afford private health insurance are eligible for state-run insurance programs.

21. ANS: B

Rationale: The Federal Child Abuse and Prevention and Treatment Act (PL 93-247) indicates you must report the abuse. The procedures for reporting the abuse vary state by state, so you must follow your state's reporting mechanism. Although the professional code of conduct says that the therapist/patient relationship is confidential and that information can be given only with written consent, child abuse mandates a breach of confidentiality that is supported by federal law.

22. ANS: A

Rationale: The child with the most obvious present need for physical therapy is the child recovering from a recent acute injury and requires maximum assistance for ADLs. If it was not immediately post-injury and the parents had been dealing with the child's limitations for a year, this child would not be a high priority for intensive therapy. This topic of frequency and intensity is also addressed in Chapter 12: Schools, and Chapter 14: Pediatric Acute Care Hospitals. This question is not directly addressed in this chapter. It requires decision making on the part of the student and knowledge of different pediatric conditions.

23. ANS: B

Rationale: The 6-year-old child with an acute injury requires intensive physical therapy; all of the others might require periodic checks; however, a 3-month old demonstrating age-appropriate motor skills requires less frequent periodic checks than a 6-month old with probable gross motor delay and a 5th grader with a known medical diagnosis. This question is not directly addressed in this chapter. It requires decision-making on the part of the student and knowledge of different pediatric conditions.

24. ANS: B

Rationale: Sound clinical reasoning requires profession-specific knowledge including current research evidence, clinical expertise and collaboration with the child and family to understand context and promote mutual decision-making.

25. ANS: C

Rationale: Because families and other team members assist children with functional activities and practicing interventions, it is critical to include them when educating a child during interventions. Being playful during interventions is more motivating than being structured and serious. Educational relevance is indicated when providing interventions in school settings and emphasizing the developmental sequence is not indicated for older children.

26. ANS: E

Rationale: PT interventions for children should occur in a natural environment, regardless of service model or type of team interactions. Natural environments, which are best for achieving participation, include the child's home, classroom, or community. Direct interventions may occur in a restrictive environment, such as a clinic or hospital, when specialized equipment is needed.

Chapter 02. Child Development

Multiple Choice

Identify the choice that best completes the statement or answers the question.

- _____ 1. Which developmental theory has had the most long-term impact on the practice of pediatric physical therapy?
 - a. Dynamic systems
 - b. Genetic-oriented view
 - c. Cognitive view
 - d. Neuromaturational view
 - e. Ecological view

- _____ 2. Which developmental theory enlightened us regarding the importance of early learning?
 - a. Maturational view
 - b. Behavioral view
 - c. Ecological view
 - d. Cognitive view
 - e. Genetic-oriented view

- _____ 3. When working with a teenager having a developmental disability, which theory would probably guide your work today as a physical therapist?
 - a. Dynamic systems
 - b. Genetic-oriented view
 - c. Cognitive view
 - d. Maturational view

- _____ 4. Your best friend from high school expresses concern that there is something wrong with his 12-month-old son. At this age, a typical 12-month-old can:
 - a. gesture.
 - b. change from sitting to creeping independently.
 - c. walk with hands held.
 - d. rise to stand through $\frac{1}{2}$ kneel.
 - e. All of the above

- _____ 5. Your best friend from college expresses concern that there is something wrong with her 4-month-old son. At this age, a typical 4-month-old can:
 - a. roll over independently.
 - b. change from sitting to crawling independently.
 - c. drink from a cup.