Test Bank - Chapter 01

Q1: Which characteristic is indicative of a strengths-based approach in pediatric occupational therapy?

A. Focusing on specific impairments and weaknesses for intervention

B. Emphasizing children's strengths, individuality, and promoting growth (Correct)

C. Encouraging external rewards for positive performance

D. Having a fixed mindset about a child's abilities

Rationale: A strengths-based approach emphasizes a child's strengths and individuality, as everyone has strengths that support their own personal style. Children and youth with disabilities have unique strengths that, when identified and promoted, can lead to increased participation and confidence. Occupational therapy interventions build on a child's strengths.

Q2: What is the significance of the "just-right challenge" in pediatric occupational therapy?

A. It involves choosing activities that are too easy for the child to ensure success.

B. It requires focusing solely on a child's performance problems for intervention.

C. It elicits active participation and effort when activities match the child's developmental skills and interests. (Correct)

D. It discourages children from taking risks and attempting challenging tasks.

Rationale: The just-right challenge (1) matches the child's developmental skills and interests; (2) provides a reasonable challenge to current performance level; (3) engages and motivates the child; and (4) can be mastered with the child's focused effort.

Q3: According to the revised Core Competencies for Interprofessional Collaborative Practice (2016), which of the following is NOT one of the four core competencies?

A. Working with individuals of other professions to maintain mutual respect

B. Using knowledge of one's own role and those of other professions for collaborative care

C. Providing evidence of the effectiveness of one profession's intervention strategies (Correct)

D. Applying relationship-building values and principles of team dynamics

Rationale: In 2016, IPEC revised and updated its Core Competencies for Interprofessional Collaborative Practice. The current four core competencies include (1) working with individuals of other professions to maintain a climate of mutual respect and share values; (2) using the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations; (3) communicating with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease; and (4) applying relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable (Interprofessional

Education Collaborative, 2016, p. 10).

Q4: What is a significant barrier to interprofessional collaboration, particularly in pediatric practice?

A. Excessive contact time with clients and families
B. Lack of commitment to teamwork among practitioners (Correct)
C. Inadequate training in teamwork and a uniprofessional mindset
D. The integration of interventions and patient education from various disciplines

Rationale: While there may be an expressed value and commitment to working interprofessionally among practitioners (Bode, Giesler, Heinzmann, Krueger, & Straub, 2016), they often lack training in it. Without training in teamwork, and when practitioners have a uniprofessional mindset, disciplines tend to provide healthcare services parallel to one another. This may result in excessive contact time with providers for a client and family, as well as interventions or education from individual perspectives without consideration for how interventions or patient education may overlap, complement, or be integrated with other providers from other disciplines (Johnson, 2017). An interprofessional approach involves having one conversation together as a team with multiple providers to discuss the various ways to first assess and then treat inattention based on the various frameworks, theories, and principles that inform the practice approaches of different disciplines.

Q5: Which of the following is a key component of child- and family-centered practice in occupational therapy?

A. Focusing solely on the child's performance challenges
B. Making decisions without considering the family's expectations
C. Involving children and family in decision-making about goals and using meaningful activities (Correct)
D. Ignoring the family environment, expectations, and goals

Rationale: Occupational therapy practitioners following child-centered practice value and respect children by asking for their perceptions, including them in goal setting, listening to their feedback, and planning activities for which the child prefers. Family-centered practice involves understanding the family environment, expectations, and goals. Occupational therapy practitioners work closely with family members to support their children in doing meaningful activities within their environment. They celebrate the family's success and encourage members to engage in the process.

Q6: What does cultural humility in pediatric occupational therapy practice involve?

A. Ignoring the family's cultural values and beliefs
B. Remaining rigid in one's own cultural point of view
C. Demonstrating respect, active listening, and a non-judgmental stance (Correct)
D. Avoiding collaboration with families from different cultural backgrounds

Rationale: Occupational therapy practitioners who practice cultural humility seek to understand the beliefs, values, and cultural expectations of a child and their family to design effective intervention that enables children to engage in family and community occupations. By engaging in self-evaluation of their own biases and positions, they engage in lifelong learning and willingness to

change. They recognize the role of power in healthcare and work to fix or alter imbalances. For example, they acknowledge that parents are knowledgeable about their children and collaborate with them.

Q7: What distinguishes strengths-based approaches in pediatric occupational therapy?

A. Focusing solely on remediating weaknesses
B. Identifying and building on a child's strengths (Correct)
C. Ignoring the child's individuality
D. Emphasizing the fixed mindset

Rationale: A strengths-based approach emphasizes a child's strengths and individuality, as everyone has strengths that support their own personal style. Children and youth with disabilities have unique strengths that, when identified and promoted, can lead to increased participation and confidence. Occupational therapy interventions build on a child's strengths.

Q8: What outcome is achieved with active involvement of the child in occupational therapy?

A. Passive stimulation for the child
B. Intrinsic motivation and sustained engagement (Correct)
C. External rewards for participating
D. Isolation from social features during activities

Rationale: Children are more intrinsically motivated to take on skill challenges that they have designated as important and that the practitioner embeds in preferred activities. The child's engagement in activity is an essential component of a therapy session. This engagement funnels children's energy into the activity, helps them sustain full attention, and implies that they have adopted a goal and purpose that fuels performance in the activity.

Q9: What characterizes an activity that is considered a child's "just-right challenge" in occupational therapy?

A. Matching the child's developmental skills and interests (Correct)
B. Providing an unreasonable challenge to the current performance level
C. Discouraging the child's focused effort
D. Excluding the need for graded activities

Rationale: The just-right challenge (1) matches the child's developmental skills and interests; (2) provides a reasonable challenge to current performance level; (3) engages and motivates the child; and (4) can be mastered with the child's focused effort.

Q10: How do children show self-efficacy?

A. Limited belief in their own abilities
B. Negative self-esteem and self-doubt
C. Positive belief in their ability to achieve what they want to do (Correct)
D. External rewards as a primary motivator

Rationale: Self-efficacy refers to "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (Bandura, 1997, pp. 3). For children, one can think of self-efficacy as children's belief in their ability to do the things they want to do, associated with their perceived confidence. Children who have a positive self-efficacy believe they can achieve in school, have friends, and participate in social activities. They exhibit a positive self-esteem (i.e., I am able to do things well and have a variety of skills).

Q11: What is an essential characteristic of the therapeutic relationship in pediatric occupational therapy?

A. Lack of personal connection and interest in the child and family

B. Demonstrating mutual respect, positivity, and a nonjudgmental position (Correct)

C. Avoiding acknowledgment and validation of the child's and family's emotions

D. Minimizing the role of trust in the therapeutic relationship

Rationale: Pediatric occupational therapy practitioners establish therapeutic relationships with the child and family that encourages, supports, and motivates (D'Arrigo et al., 2020; Popova et al., 2022). In order to do so, the occupational therapy practitioner first builds rapport to create trust. This trust enables the child and family to feel safe and to be willing to take risks. The therapeutic relationship involves acknowledging, validating, and respecting the child's and family's emotions and creating a climate of emotional safety. Occupational therapy practitioners demonstrate a positive effect and seek opportunities for personal connection while conveying positive regard. They show interest in the child and family, make efforts to enjoy their personality, and value the child's and family's contributions to the therapy process.