CHAPTER 5

Human Occupation and Mental Health Throughout the Life Span

Most people live, whether physically, intellectually or morally, in a very restricted circle of their potential being. They make use of a very small portion of their possible consciousness, and of their soul’s resources in general, much like a man who, out of his whole bodily organism, should get into a habit of using and moving only his little finger. Great emergencies and crises show us how much greater our vital resources are than we had supposed.

William James (18)

CHAPTER OBJECTIVES

After studying this chapter, the reader will be able to:

1. Analyze the motivations for performance of occupation.
2. Outline changes in performance of occupation from childhood through late life.
3. Contrast involvement in work and play occupations at different ages.
4. Identify important achievements in occupational development at various life stages.
5. Recognize psychiatric disorders that typically appear in childhood, adolescence, adulthood, and later life.
6. Describe the effects of mental disorders on performance of occupation at different stages of life.
The desire to act upon the environment and to have an effect is a force that drives and shapes human behavior from birth to death. Occupation, or the expression of this urge through activity, is essential for human growth and development. The focus and specifics of occupation change throughout life as the playing child matures into the working adult, who later retires and is occupied with nonwork activities. The foundation of occupation-related habits and skills formed in childhood profoundly influences all later development. Without occupation, growth is frustrated and impaired.

This chapter considers how performance of occupation develops and changes as the person matures and ages. We will also look at some of the common mental health problems that arise in different life stages, with particular emphasis on the occupational aspects of these disorders and the role of occupational therapy in evaluation and treatment. It is important to remember that mental health problems do not always impair the ability to engage in occupation or to use occupation to further growth and development.

**Motivation Toward Occupation**

To understand how occupation develops and changes throughout life, we must first consider why humans engage in occupation at all. What are the reasons? And are the reasons always the same? Reilly (31) identified a sequence of three levels of motivation for occupation or action: exploration, competency, and achievement.

- **Exploration motivation** is the desire to act, to explore, for the pure pleasure of it. This is the primary, or first, motivation for action. Infants and small children do things because they are exploring what will happen, but adults do the same thing when they encounter new situations that arouse their interest.
- **Competency motivation** is the desire to influence the environment in a specific way and to get better at it. When motivated by competency, the individual will practice the action over and over again and seek feedback from the environment, including other people, about the effects of the action. Competency is the second level of motivation; it helps sustain actions that were initially motivated only by exploration.
- **Achievement motivation** is the desire to attain, compete with, or surpass a standard of excellence. The standard may be an external one or may be generated by the individual. Achievement is the third and highest level of motivation for occupation. When competent at the action, the person continues to perform it to achieve success according to a standard.

These three levels of motivation—exploration, competency, and achievement—form a continuum that gradually transforms playful exploration into competent performance and ultimately into achievement and excellence. The skills that the child learns through play are later practiced and refined and finally polished and combined with other skills to enable more sophisticated and complex behavior to emerge.

Whenever the individual encounters novelty in the environment, these three levels of motivation are reexperienced in sequence. New situations and unfamiliar environments bring out the urge to explore, then to become competent, and then to achieve. This is as true of the working adult and the retiree as of the preschool child.

Kielhofner (21) argues also that different levels of motivation predominate at different stages in life. He suggests that the child engages in occupation primarily because of a motive to explore, that the adolescent does so to become competent, and the adult, to achieve. He states that older adults are motivated by an urge to explore the past and their own life’s accomplishments and to explore their present capabilities through leisure. Let’s now take a closer look at this view of how occupation evolves as the individual grows and matures.
CHANGES IN OCCUPATION OVER THE LIFE SPAN

Human occupation traditionally has been divided into two main categories: work and play. Play consists of activities engaged in for pleasure, relaxation, self-exploration, or self-expression. Work includes all activities through which humans provide for their own welfare and contribute to the welfare of the social groups to which they belong. For the child, play is the dominant form of occupation; for the adult, work is the dominant form.

The balance and relationship between work and play change throughout life in certain predictable ways (Fig. 5-1).

The patterns of work and play illustrated in Figure 5-1 are based on an American notion of normal human life and activity. Although anthropological studies show many similarities in patterns of work and play across different cultures, persons who come from other cultural backgrounds may have expectations and experiences that differ from those illustrated. Keeping this possibility in mind, let us now look at the different life stages.

![Figure 5-1. The balance and interrelationship of work and play during the life span.](Modified with permission from Kielhofner G. A model of human occupation: 2. Ontogenesis for the perspective of temporal adaptation. Am J Occup Ther 1980;34:661. Copyright © 1980 by the American Occupational Therapy Association, Inc.)
Childhood

Play is the main occupation of the child. Figure 5-1 shows that in early childhood the child performs no work at all. Gradually, as children are assigned chores and other responsibilities at home and in school, they spend some of their time in activities that must be classified as work. The purpose of play and work in childhood is distinctive. As children play, they explore their environments, learn about reality, and develop rules that are used to guide actions. For example, the child learns that objects fall to the floor when dropped, that a stove is sometimes hot, that a favorite uncle will allow things that Mother will not. These rules about motions, objects, and people (32) are tools that the child uses to guide future action and to develop skills. This childhood learning about how the world works is a foundation upon which later accomplishments are built. Thus the playing child acquires knowledge and develops rules and skills that underlie and support the work of the student and the adult worker.

Research confirms that play is essential for later development (1). Studies of many species show that important neurological connections, such as cerebellar synapses and long fiber tracts, are formed in their greatest numbers during the period when play is most vigorous in the young animal. These connections establish a foundation for skillful, responsive motor actions. Another important function of play for young animals is to practice and rehearse the subtle social behaviors they will need as adults (1). Thus imitation and exploration of future occupational roles are enacted in play. Through fantasy and imitation, the child investigates and experiences various adult roles (mommy, doctor, teacher, and so on). This experience, known as the fantasy period of occupational choice, is the first step in the three-stage process of choosing a career or adult occupation (12).

During play, the child also learns the joy of having an effect on the world and on other people. This helps form an image of the self as personally effective and powerful, thus developing and enhancing a sense of personal causation. The pleasure that the child takes in one activity over another helps form interests that will motivate life choices.

Although the child is not expected to do much work, the productive activities of the child are very important for later development. Studies have shown that industriousness in childhood is associated with job success and personal adjustment in adult life (38). Chores and schoolwork are the major productive activities of childhood. By engaging in these tasks over time, the child acquires habits of industry and responsibility and learns to schedule activities so that time also remains for play. Some tasks, such as handwriting, have clear associations with work. Even very young children can describe the difference between work and play and may describe their time in school as “work” (23). Although play remains the major occupation throughout childhood, the maturing child spends increasing amounts of time in activities that lay a foundation for the future role of adult worker. Habits and routines are developed and established.

Adolescence

Adolescents, like children, continue to spend more time in play than in work. However, now motivated more by the desire to become competent than by the urge to explore, they choose activities in which practice and the habits of sportsmanship and craftsmanship make the difference between success and failure. Whether the activity is the track team, the chess club, or video games, the adolescent approaches it with determination to master and succeed. The biological changes of puberty interact with the adolescent’s use of occupation to motivate a growing interest in social activities that provide opportunities to explore and practice social and sexual behaviors.
The work of the adolescent, like the work of the child, consists of school and chores. School work becomes more rigorous and more time consuming, in keeping with the adolescent's growing cognitive capacity and discipline. Depending on the parents and the family situation, the chores may also be increasingly challenging. Many adolescents take on part-time jobs, which provide important experiences of what life is like in the adult working world and give feedback about the adolescent's readiness for work.

Adolescents are concerned about what they will do with their lives as adults, and occupational choice is generally viewed as one of the most important developmental tasks of adolescence. The process that began in the fantasy period of childhood enters a new stage, known as the tentative period. During this time, the adolescent considers possible adult occupations; this evaluation considers interests and likelihood of success. Finally, the adolescent weighs any choice in terms of personal values and achieved or expected place in the social system. From this overwhelming mass of factors, the adolescent must finally choose a career but may remake this decision several times throughout life.

Once the decision is made, the adolescent begins to work toward it, for example by enrolling in a training program or looking for a job. This begins the realistic period, in which the choice of career is examined in light of personal needs for achievement, satisfaction, status, and economic security. For example, if the chosen career is one in which jobs are scarce (e.g., acting) or the pay is low, the person may reconsider this decision and then must come up with alternatives and choose among them.

Thus occupational choice is crystallized and acted upon during adolescence, although for adolescent children of affluent parents the choice may be delayed into early adulthood. By contrast, adolescents from disadvantaged backgrounds may encounter overwhelming obstacles to realizing their occupational choice. In times of high unemployment, the adolescent with few skills may be denied employment or forced into a job that feels demeaning and unsatisfying. Ultimately, the process of occupational choice may be repeated by the adult who decides or is forced to change careers later in life.

**Adulthood**

The adult spends many hours in work, leaving little time for play. The work of the adult centers on the occupational role selected through the process of occupational choice. This work, which is not necessarily salaried (consider the homemaker), consumes much time and energy and allows for expression and gratification of the urge to achieve. For many adults, there is the additional work of parenthood.

Adults work to provide for their own needs and those of their families. Beyond this, they work to produce something of value to the rest of society. Having a productive work role is important for the self-esteem of the adult; it bestows a sense of identity, a place in the social hierarchy, and a reason for being. Adults who are unemployed or underemployed (working at jobs that are beneath their capacities) often have negative views of their own abilities and worth. They may see themselves as incompetent and helpless rather than as competent and achieving members of society.

Despite the fact that working adults have little time for play, the time they spend in leisure and recreation serves an important function: It restores and refreshes their energies to work again. The word recreation actually means “the creation (again) of the laboring capacity.” Different people feel different degrees of need for recreation; some people spend almost all of their time working, leaving only negligible amounts for play, and appear to be quite satisfied and happy. Others limit their work to a specific number of hours precisely because they want to make time for leisure pursuits.
In middle and later adulthood the individual looks toward the future and retirement and begins to explore and plan for this next stage. The major issue is the replacement of work with some other activity that will fill the hours, that will compensate for the loss of the worker role and of the social relationships with co-workers. Jonsson and colleagues (19) analyzed statements of people anticipating retirement and classified them as belonging to three types:

- Regressive (anxious and uncertain, dreading the future)
- Stable (expecting little change—may be either positive or negative)
- Progressive (may be either positive, focusing on new activities, or negative, focusing on getting rid of unpleasant work situation)

Examples of statements reflecting these three styles of response to retirement are shown in Box 5-1. Successful adjustment to retirement may require a reassessment of interests and the development of new hobbies and goals. Without this preparation, the transition from full-time work to retirement can be stressful, even devastating.

Later Adulthood

During the latter part of life and certainly after retirement, the number of hours spent in work dramatically decreases. Thus vast quantities of time suddenly become available, and decisions must be made about how to fill the hours. Leisure replaces work as the primary occupation, although many retirees continue to serve productive social roles (e.g., as volunteers) that can only be classified as work.

The loss of a work role or of the role of parent and homemaker represents not just the loss of activities that once filled one’s day but also of status and social identity. To adjust, the older adult needs goals and occupations that provide satisfaction and opportunities for success and that support a sense of self-worth. Older adults find particular meaning in maintaining leisure activities that have been lifelong interests (17). Each older person

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**BOX 5-1**

**SAMPLE STATEMENTS OF PERSONS ANTICIPATING RETIREMENT**

*Regressive:* “I can’t imagine not going to work. I don’t have a plan for how to spend the time.”

*Stable (positive):* “I do so many things now that I will be continuing [golf, volunteer at church], that I think very little will change except maybe I’ll have more time.”

*Stable (negative):* “Well, you know, I can’t say that life will be different. Just more of the same. The same old, dreary routine.”

*Progressive (positive):* “I have just been waiting so long for this. I’ll have more time for the botanical garden and the arthritis group and travel and just everything that I want to do more of.”

*Progressive (negative):* “Definitely retirement will be an improvement for me. My whole body aches after a long day at work, and frankly, I’m a little tired of the whole situation. It will be a relief.”

lives in a particular environment, has a particular occupational history, and has specific interests. The ability to continue living with maximum independence in the community is highly individual and requires client-centered support (16).

In the words of the 18th-century poet William Cowper, “Absence of occupation is not rest./A mind quite vacant is a mind distressed.” Thus one of the important tasks of this stage of adult life is to identify and develop interests and challenges that will sustain one’s sense of independence and self-worth.

**Occupational Development**

Because occupational therapy practitioners are concerned primarily with a person’s ability to develop and maintain satisfying occupational patterns, it is helpful to understand the functions, typical patterns, and development of occupation during the major life stages. The child samples and learns about the world through playful exploration, laying a foundation of motor and social skills. The adolescent, acting on the drive to become competent, practices and refines these skills and consolidates them into habits and roles. The adult, wishing to achieve and contribute, makes choices about career and life goals and selectively continues to develop and elaborate the skills and habits cultivated earlier in life. In later life, once career patterns are established and especially after retirement, the older adult may wish to integrate the long-abandoned interests of a younger self. Thus favored activities may be rediscovered and pursued again in later life. New occupations can be discovered and old interests reexplored.

We have said that the ability to engage in occupation is one of the signs of mental health and that mental illness can interfere with a person’s ability to carry out daily life activities and to fulfill occupational roles. Let’s look now at other significant factors in mental health at various ages and the kinds of mental health disorders that tend to occur at different stages of life.

**MENTAL HEALTH FACTORS THROUGHOUT THE LIFE SPAN**

This section is an overview of the mental health needs of clients of various ages and the ways in which occupational therapy intervenes to help them. The section is divided according to six major life stages: infancy and early childhood, middle childhood, adolescence, early adulthood, midlife, and late adulthood and aging. For each stage, normal development and the kinds of mental health problems that sometimes arise are briefly described. The general goals and methods of occupational therapy are identified; and, where relevant, special intervention settings and evaluation and treatment methods are discussed. More detail on specific diagnoses and settings can be found in Chapters 6, 7, and 9.

While reading this section and after finishing the chapter, the reader should examine Table 5-1, which summarizes aspects of human occupation for each age group and lists major mental disorders that typically occur in the respective age groups. A case example later in the chapter illustrates the interactions among developmental tasks (10), the development of human occupation, environmental risk factors, and age-specific vulnerabilities to mental illness.

**Infancy and Early Childhood**

Babies start life with enormous needs and wants and absolutely no ability to satisfy them on their own. Parents have to be able to figure out what babies want—whether the infant is hungry or thirsty or needs to be burped or cuddled or changed—and then provide it. To be able to relate to other people later on and to engage in activities that involve others, infants and small children need to learn to trust their parents and then people in general. In addition, they need to learn to communicate their needs and feelings and to control their impulses. Thoughtful interaction and consistent
### TABLE 5-1 SOME ASPECTS OF DEVELOPMENT OF HUMAN OCCUPATION SUBSYSTEMS AND RISKS OF MENTAL DISORDERS BY AGE GROUP

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>VOLTION SUBSYSTEM</th>
<th>HABITUATION SUBSYSTEM</th>
<th>PERFORMANCE SUBSYSTEM</th>
<th>MAJOR MENTAL DISORDERS BY TYPICAL AGE OF ONSET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>Personal causation developing through social interactions and play; values of culture taught; interests enacted through choice of activity</td>
<td>Self-maintenance habits; routines established by parental scheduling; gradual shift to more control by child; student, friend roles learned</td>
<td>Tremendous development of skills transforming from helpless infant to active agent in worlds of family, play, school; age of exploration and increasing competence</td>
<td>ADHD, PDD, autism, Asperger’s syndrome, OCD, ODD</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Increasing drive for autonomy; considering choice of occupation; weighing parental vs. peer values; shifting interests affected by peer or environmental pressure</td>
<td>Exploration of roles; role experimentation; expanded; more independent student role; first enactment of worker role; increasing self-regulation; acquisition of habits of time management</td>
<td>Continued development of skills in motor, process, communication, interaction; social relations with peers fostering expanded communication and interaction skills</td>
<td>Schizophrenia, substance-related disorders, mood disorders</td>
</tr>
<tr>
<td>Adulthood</td>
<td>Maturation of personal causation, interests, values culminating in choice of occupation; values increasingly important in motivating behavior; interests possibly not addressed by work; avocational activities possibly especially fulfilling</td>
<td>Multiple roles (spouse, parent, worker, friend, volunteer, church member); despite role conflict, multiple role involvement satisfying; habits and routines influenced by need to manage time for multiple involvements</td>
<td>Peak abilities; mastery of many work-related skills; declining capacity may come from physical changes leading to reduced energy, need for eyeglasses, hearing aids; continued high level of involvement helping sustain greatest capacity and skill level</td>
<td>Schizophrenia, mood disorders, substance abuse</td>
</tr>
<tr>
<td>Later adulthood</td>
<td>Sense of efficacy possibly challenged by diminished physical capacity; importance (value) of work possibly declining as family and social values increase; opportunity in retirement to pursue interests more rigorously</td>
<td>Potential loss of major roles and role companions through retirement, physical disease, death (work role, spouse role, friend role); family roles and social roles increase in importance; habits of a lifetime well established; new habits hard to acquire</td>
<td>Age-related changes in musculoskeletal, neurological, cardiopulmonary systems varying in intensity; adjustments, adaptations to continue using skills (e.g., energy conservation, pacing, rest periods); adaptive equipment, environmental aids helping sustain skills</td>
<td>Alzheimer’s, vascular, and other dementias; depression; polysubstance abuse (prescription medications, alcohol)</td>
</tr>
</tbody>
</table>

ADHD, attention deficit-hyperactivity disorder; PDD, pervasive developmental disorder; OCD, obsessive–compulsive disorder; ODD, oppositional defiant disorder.

discipline by the parents help the child acquire these skills. A stable, secure, and predictable environment is one of the most important factors in helping the child at any age to develop trust in self, other people, and the world in general.

While all of this psychosocial development is going on, the child is developing in other ways too. Sensory abilities are becoming more refined, motor skills better coordinated, and perceptual and cognitive abilities more complex. The child constantly uses and refines developing abilities to learn more about the world and how to interact with it.

It is unusual for mental health problems to be diagnosed in infancy and the preschool years. Often problems that are brought to the attention of psychiatric professionals are quite severe. Some of these problems are believed to have biological causes, meaning that the behavioral or emotional disorder is caused at least in part by something physical within the body or the brain.

Attention deficit disorder (ADD), attention deficit-hyperactivity disorder (ADHD), and pervasive developmental disorder (PDD) are in this category. The child with ADD or ADHD has a shorter attention span than is normal for a child of similar age. Jumping from activity to activity, often with a high level of energy (hyperactivity) but with an apparent inability to concentrate long enough to finish many of the tasks attempted, the child leaves a trail of chaos and confusion. It is not hard to imagine how this can interfere with learning.

PDD is a cluster of disorders occurring in very early childhood and impairing the ability to develop in many areas. Infantile autism is one example. This is a disorder in which the very young child fails to respond to other people, often ignoring them completely. Autism is believed to have an underlying biological component, and research supports this view (30). Children with autism differ from other children in the way they process and understand sensation (39). The child is usually slow to develop language skills, the learning of which seems to rely upon interactions with others. In addition, children with autism may exhibit strange mannerisms, such as wiggling their fingers in front of their eyes, and bizarre interests, for example in bright lights or spinning objects.

Occupational therapy for children with these disorders often focuses on sensorimotor or sensory integrative treatment approaches, which are believed to affect the underlying biological problem. Occupational therapy assistants (OTAs) may carry out such treatment only under the direct supervision of occupational therapists (OTs) who have special training in these approaches. Psychoanalytic (object relations) methods are sometimes used instead, but these also require direct supervision and special training. A more behaviorally oriented treatment approach focuses on the development of self-care skills (e.g., shoe tying) through direct instruction and reinforcement.

Building a trusting relationship and modifying the environment to enable success are often the twin foundations of intervention with children. Baron (3) presented a case study of a 4-year-old boy who had oppositional defiant disorder (ODD). A structured play experience with the occupational therapist over many weeks helped this child give up his resentful and argumentative behavior and develop a more spontaneous and genuine approach to play. Key elements of this treatment included a slow and careful building of trust through brief, frequent, one-on-one play with activities selected by the child from a limited choice given by the therapist; modification of the social play environment so that competition was reduced; and teaching and reinforcement of social skills such as taking turns.

Another serious mental health problem of early childhood is reactive attachment disorder, in which the child stops responding to other people because he or she has been neglected or ignored; this sometimes leads to failure to thrive, a condition in which the child may stop eating and withdraw totally. In such cases, the most intensive work is with the parents, teaching them how to provide more affection and better care.
Very small children with mental health problems are seldom treated as inpatients. Because of the important role of parents and family life in a child’s development, the philosophy is to keep the child with the family whenever possible. Therefore, children may attend day treatment centers, special preschools, or programs at community mental health centers or may be treated at home, often with the parents participating. Chapter 9 contains more information on this topic.

Occupational therapy for infants and small children with mental health problems is considered a very demanding and complex area of practice (6). In addition to emotional and social deficits, it seems that children with mental health problems are more likely than other children to have developmental motor delays (22). The occupational therapist uses special developmental assessments and data collection instruments, such as the play history (4, 36), to evaluate the child’s abilities, interests, and needs. Treatment programs are usually highly individualized, although they may take place in groups. Groups provide an experience of working with others, sharing, waiting, and taking turns—skills that prepare the child to succeed during the school years.

Some of the goals of treatment with this very young population are developing trust and social interactions, increasing gross and fine motor coordination, improving sensory processing and perceptual skills, and facilitating spontaneous play. In addition to sensorimotor and sensory integrative methods, play therapy and expressive art activities are sometimes used to help children develop and express their fantasies. OTAs who wish to work in this area need training beyond their basic education and should receive extensive supervision from a qualified OT.

**Middle Childhood**

During the grade school years, the child refines growing abilities in many areas. The roles of student and contributing family member are gradually adopted. The child develops a more sophisticated awareness of social norms and expectations and of the needs of others, learning to delay gratification for increasingly long periods. In addition, the child becomes physically better coordinated and more intellectually sophisticated. Vast amounts of knowledge and increasingly complex skills are acquired through schoolwork and peer relationships.

The child continues to need the love, support, and encouragement of parents and family to feel secure enough to attempt new challenges. Some mental health professionals believe that the family has such an effect on the mental health of the child that it may be the cause of emotional and behavioral problems. Others believe that the family is a factor but that other factors, such as biological predisposition and experiences at school and elsewhere, are also involved. Yet others suggest that the peer group is the most influential factor (14).

Fortunately, mental health problems in middle childhood are infrequent, although more common than in early childhood. Among the problems that are seen in children during these years are conduct disorders, in which the child behaves in an antisocial fashion (e.g., stealing, cutting school), and other disorders that show up in physical behaviors (eating problems, stuttering, bedwetting, and so on). These behaviors may merit a diagnosis of ODD. Drug and alcohol problems may also appear at this age. ADHD often continues into middle childhood or makes its first appearance at this time. Some children have difficulty learning in school and may be diagnosed with learning disabilities.

Symptoms of obsessive–compulsive disorder (OCD) may appear in middle childhood. The child with OCD may be fearful and anxious and may use ritual behaviors (such as ordering, checking, or touching things) to cope with these feelings. The ritual behaviors interfere with success in school and may prevent the child from making friends. This disorder is generally treated with medication.

Asperger’s syndrome may be first diagnosed in middle childhood. This is considered a higher-functioning autistic disorder on the spectrum of PDD. The person with Asperger’s syndrome is
typically highly intelligent but socially awkward. The person has great difficulty learning how to communicate with others, does not understand how other people feel, and cannot understand social cues. Figure 3-1 illustrates this disorder in an adult. The good to excellent academic skills and high level of analytical intelligence associated with Asperger's syndrome are assets for the person. Children with this disorder can achieve success in school and on the job provided they learn to compensate for their difficulties with social cues. Like children with autism, those with Asperger's show clear sensory processing deficits (9).

Children of school age are treated on an outpatient basis and hospitalized only when they are so out of control that they may harm themselves or someone else. They may be seen in school settings, in day treatment settings, or in after-school programs. The Occupational Therapy Psychosocial Assessment of Learning (OT PAL) may be used to observe and measure the child's ability to function appropriately for his or her age in the classroom (28, 37). Typically, the occupational therapy staff works with other professionals, such as the special education teacher, the speech therapist, the child life specialist, and the school psychologist. The goals of treatment may include increasing trust and social relatedness; developing cooperation; improving self-esteem and self-awareness; enhancing self-control; developing body awareness and sensorimotor skills; and improving coordination, perceptual skills, and cognitive abilities.

Occupational therapy assessment and intervention for school age children logically should first address the occupational roles of the child: family member, friend, player, student, and so on (7). Children and their families can learn how to better use the environment to make it easier for the student to do homework and chores successfully. Segal and Hinojosa (33) point out that families and situations require individual analysis and individualized support.

Occupational therapy treatment models vary with the setting and its philosophy but may involve sensory integrative, behavioral, psychoanalytic, and environmental approaches. Children with ADD or learning disabilities may be taught progressive relaxation and stress management techniques. Computer games have been used to evaluate cognitive and perceptual problems and as rewards or reinforcers for participating in other treatment activities (11). As with the treatment of small children, occupational therapy intervention in middle childhood is considered a complex specialization, and one in which the OTA will benefit from additional training and supervision.

Adolescence

The most important task of adolescence is to develop an identity separate from one's parents—a social and sexual identity that will support an independent life. Occupational choice (discussed earlier) is a process that contributes to the development of identity in adolescence. Other important experiences center around the peer group of other adolescents. Through a variety of interactions and relationships with others of similar age, the adolescent explores values and interests and develops social skills. It is not unusual for an adolescent to experience insecurity, mood swings, loneliness, depression, and anxiety in response to hormonal and physical changes and the increasingly demanding expectations of others. These are normal responses to a challenging life adjustment. Sometimes, however, the problems are severe.

Major psychiatric disorders such as schizophrenia and mood disorders (mania and depression) often make their first appearance in adolescence. Schizophrenia (see Chapters 3 and 6) is a disorder that is poorly understood but that manifests itself in extreme personal disorganization. Its psychotic symptoms, hallucinations and delusions, can usually be controlled only with prolonged use of powerful medications. But even with medication, many people who have schizophrenia have difficulty setting goals or structuring their time; their sense of self-identity is frequently impaired. The newer, so-called
Section I / History and Theory

Atypical antipsychotic medications are more effective in helping with these problems. However, these more expensive drugs are not always prescribed to persons who receive health care through Medicaid. When schizophrenia occurs as early as adolescence, it interferes with further psychosocial development; in other words, the developmental task of forming a separate identity is extraordinarily difficult, and later development suffers as a consequence.

Mood disorders (mania and depression) may also first appear in adolescence. They have a better prognosis, or predicted outcome, than does schizophrenia. Nonetheless, they are serious disorders, and suicide is a growing risk among adolescents, especially those with mood disorders.

Substance-related disorders are mental health problems that arise from use or excessive use of drugs, alcohol, inhalants, or other mind-altering substances. Adolescents may fall into substance abuse after experimenting with drugs or alcohol to be accepted by their peers. Some adolescents who have other mental health problems use these substances as self-medication to deaden their feelings of anxiety or depression.

Because forging a personal identity is the major task of the adolescent, gender identity may be a source of confusion. Experimentation with various sexual roles can be an expression of personal preference but may also be a way of acting out against one’s parents.

Eating disorders affect some adolescents. Anorexia nervosa (abnormal loss of appetite and thinness) and bulimia nervosa (purging after binging) are more common in girls than boys. Real or perceived social pressure to look thin is a contributing factor. These conditions are discussed in Chapter 6.

Although adolescents may be treated in outpatient or community settings, it is not unusual for them to be hospitalized, especially when they are psychotic and in need of medication. Separate wards or adolescent services are provided wherever there are sufficient numbers of adolescent clients to justify the expense. Most adolescent inpatient services use milieu therapy (see Chapter 7). The adolescent who is trying to develop a separate identity will often act out or rebel against authorities (e.g., treatment staff). If the staff is too permissive or inconsistent, the adolescent fails to grasp the boundaries of reasonable behavior; on the other hand, if the staff is too punitive and restrictive, the adolescent may become withdrawn and confused. Staff who work with adolescents are usually trained on the job to support the adolescent’s independence while setting firm limits on unacceptable behavior.

Occupational therapy for adolescents is a specialized practice area. The therapist may use specialized evaluation instruments such as the Adolescent Role Assessment (5) to learn how the adolescent is adjusting to school, family life, and friendship. The Adolescent Leisure Interest Profile (ALIP) is a newer evaluation to assess leisure interests (15). Goals of treatment may include development of self-esteem and self-identity skills, development of occupational choice, training in daily living skills, development of sensorimotor skills (especially in relation to body image), and acquisition of prevocational and leisure behaviors.

In selecting activities for adolescents, occupational therapy staff must consider current fashions in activities and technology. Franklin (11), for example, reported that adolescents responded more favorably to a computer-based values clarification program than to a traditional paper-and-pencil version. Baron (2) incorporated computers for word processing and graphics design into the tasks available to adolescent members of a newspaper treatment group. In this group, the variety of job tasks and the structure and limitations provided by the leader helped members acquire and develop a sense of internal control and direction.

In working with adolescents who have mental health problems, the OTA may lead self-care and other activities of daily living (ADLs) groups, provide sessions on sex education and birth control, or run vocational programs such as work groups and assembly lines. Because adolescents are still in school most of the day, occupational therapy and
other clinical services are scheduled around consumers’ schoolwork. Students with mental health problems may present behavior problems in school; occupational therapy practitioners can help identify the cognitive deficits and other factors responsible and can work with the student to develop less-disruptive and more appropriate ways of coping (8).

In general, the OT or OTA working with the child or adolescent who has mental illness will focus on the young person’s “occupations and interests of choice rather than the disorder” (13, p. 2). This is a client-centered practice in which the occupational therapy practitioner asks the young person to identify goals that are personally important. The OT or OTA then creates strategies and interventions to work toward those goals; the young person is continually involved in evaluating whether the plan is working and in determining future goals of interest.

**Early Adulthood**

The years from 18 to approximately 40 are filled with challenges and opportunities. Young adults, having completed the process of occupational choice, strive to obtain employment and succeed in their chosen careers. Having attained a sense of identity as a separate person, young adults are able and eager to develop friendships and intimacies with others. The search for a marital or intimate partner is a primary task of this age group. Young adults with children are faced with the new role responsibilities of parenthood. Thus early adulthood is a period characterized by a search for intimacy with others and a desire to achieve and contribute to the future in some way, whether through a career, raising children, or both.

Many of the clients seen in mental health settings fall into this age range. Young adulthood is the period during which many of the major psychiatric disorders of adult life are first noted. Also, for those who are insecure in their jobs or in their personal and sexual or family lives, this can be a period of severe stress and difficult adjustment. Varying levels of employment and uncertain job security can impede occupational success. The fact that there are more women than men in the population means that more women cannot find marriage partners. This is compounded by fears of infection by human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs). The rise in infertility problems, some a consequence of prior STD infection, in this age group means that many couples cannot have their own biological children. Persons who are HIV positive may fear rejection on the job and in society. All of these factors are potentially stressful and may lead to mental health problems. Individuals with limited coping skills and limited exposure to effective role models may act out their stress and anxiety through domestic abuse and violence, substance abuse, or road rage (aggressive driving).

Among the mental health problems and psychiatric disorders often seen in young adults are adjustment reactions, alcohol and drug abuse, schizophrenia, mood disorders, eating disorders, anxiety disorders, and various personality disorders (see Chapter 6 for more information on diagnoses). Adjustment reactions or disorders are maladaptive or ineffective reactions to life stress; instead of dealing with the stress in a positive way (i.e., by trying to solve problems and rise above the situation), the individual may feel depressed or anxious or function poorly at work or in social situations. It is believed that these people do not have an underlying psychological problem, but rather are reacting to stress. Occupational therapy intervention for people who have adjustment disorders focuses on helping them identify and work toward specific goals. A crisis intervention approach (described in Chapter 7) may be used.

Alcohol and drug abuse is more prevalent among young adults than among adolescents. Alcoholism is a disease that has many definitions; what all of these definitions have in common is excessive or uncontrolled use of alcohol, whether daily or episodically. Alcoholics typically deny that they have a drinking problem; denial prevents them from seeking help or accepting it when it is
offered; and this is considered part of the disease. Another problem alcoholics have is with their use of time, they spend their leisure hours drinking and often have no other consistent leisure pursuits. Alcoholics tend to become increasingly dependent on alcohol and are likely to have job problems and end up losing their jobs and relationships.

The goals of occupational therapy for alcohol and drug problems usually include development of self-awareness and self-responsibility, identification of personal goals, vocational assessment and work adjustment, and development of time-management and leisure-planning skills. In particular, recovering alcoholics need to learn new activities and routines for their spare time to replace the empty hours once filled with drinking. Frequently, the occupational therapist and assistant work with a treatment team that may include medical staff, creative arts therapists, psychologists, and alcohol counselors. Programs and occupational therapy approaches to persons with alcoholism and other substance abuse disorders are discussed in more detail in Chapters 6 and 9.

Eating disorders include anorexia and bulimia. Anorexia is a disorder in which the person (usually female) literally starves herself, believing that she is fat even though she is emaciated. Bulimia, also mainly affecting women and girls, is a disorder in which the person goes on eating binges and then makes herself vomit. It is believed that anxiety about self-control versus control by others is one of the factors in both of these conditions. Occupational therapy usually includes assessment and modification of the person’s habits and beliefs related to eating and food, education in nutrition and cooking, sensorimotor and expressive activities for development of a more positive body image, and training in daily living skills. Chapter 6 contains more information on these disorders and on occupational therapy approaches to treatment.

Many of the young adults seen in mental health settings have a diagnosis of either schizophrenia or mood disorder. For some this is a continuation of a disease first diagnosed in adolescence, with multiple hospitalizations since then. Others have their first episode during their 20s or 30s. Some individuals are controlled with medication, so that the person leads a fairly normal life free of severe episodes that require hospitalization. However, most cases of schizophrenia and mood disorders become classified as chronic, meaning that the disease continues throughout life. These conditions are commonly viewed as serious and persistent mental illness (SPMIs).

Clients with a SPMI are considered very challenging. Some have alcohol and drug disorders and borderline and other personality disorders in addition to schizophrenia or an affective disorder. Although such individuals may have limited skills for independent living, they are usually street smart, able to survive on their own in a marginal way. Large numbers of the homeless are in this group. Many of these people reject the stigma or label of mental illness, refuse to identify themselves as ill, and move in and out of treatment on personal whim. Involvement in criminal activities is not unusual; these clients may as easily be imprisoned as hospitalized (34).

Obviously, not all young adults with SPMIs share these characteristics. Some respond well to a structured environment and accept the role of patient or client. The challenge is to motivate such clients to do their best within the limits of the disability. Others are very difficult to manage and hard to keep in a program. These clients decide what to do based on what they want at the moment. If the therapist will not give in right now, the client is likely to walk out and not come back until no other option remains.

High-functioning young adults with SPMIs are more receptive to help as long as it is provided in a manner that meets self-esteem needs and aspirations. The person is likely to be well educated and to hold very specific career goals. Such individuals do not want to be identified as patients but will actively participate in a treatment program if it is provided somewhere that is not identified as a hospital or part of the mental health system,
A psychoeducational approach is often used with these consumers. When skills are presented in this format, the person can perceive them as education rather than therapy, thus supporting the identity of self as a person rather than a patient (34).

Occupational therapy goals for young adults focus on the development of adult life skills and the fulfillment of personal aspirations. Typical goals include completing one’s education, identifying vocational interests and aptitudes, acquiring pre-vocational and vocational skills, obtaining and maintaining employment, developing daily living skills, improving social skills, developing coping skills, identifying and developing leisure interests, and structuring leisure time. The therapist performs the evaluations and formulates the treatment goals and plan, working closely with the client.

The OTA may provide tutoring or academic assistance while the person works toward a general equivalency diploma (GED) or other educational goal. Other roles for the OTA include running classes or training programs for daily living skills, social skills, leisure skills, and job search skills and day-to-day supervision of work-oriented programs.

**Midlife**

Ferol Menks, an occupational therapist, defines midlife as “the point in the life cycle when the individual realizes that time is limited and that he or she cannot accomplish everything hoped and planned for” (26). The goals that were selected and pursued during the early adult years may have been reached or may seem unattainable. Around age 40 the adult begins to reevaluate life’s direction, feeling that this may be the last chance to make major changes.

Erikson (10) conceptualizes the major task of the middle adult years somewhat differently, terming it the crisis of generativity versus stagnation. Generativity is a “concern in establishing and guiding the next generation.” Adults in the middle years who are unable to direct this energy successfully will feel stagnant or purposeless, cut off from the stream of human achievement that extends into the future.

One obvious avenue for achieving generativity is through one’s children, but this path is not open to everyone and for many does not by itself satisfy this urge. For those who are working, this need may be transformed into a concern with nurturing the careers of younger workers. Some adults seek out ways to contribute their expertise and energies through church or community organizations.

The adult at midlife assesses whether work has been satisfying and worthwhile. If the work is found lacking either in opportunities for further achievement or in personal satisfaction, the individual may move into a second career. This may necessitate a return to school, a transition that some find stressful.

Additional developmental stresses center around the process of aging. During this period, the adult undergoes a decline in physical capacities, a change in sexual energies, and significant cosmetic deterioration (wrinkles and so on). Women go through menopause, and men’s sexual potency declines. All of these changes signify that one is no longer young. Different people react differently to this. Some seek cosmetic surgery, subject themselves to intense exercise programs, look for younger sexual partners, and attempt to stay the forces of time. Others accept these changes gracefully as a condition of life and move on to other concerns.

Typically, the children of adults in this age group are teenagers. Dealing with the rebellion and turmoil of adolescent children can be a challenge and joy or a significant stress, depending upon the adult’s coping skills. Eventually these children mature, leave home, and create lives and families of their own; some adults find this prospect alarming because it means the end of their own roles as parents. Midlife adults also are frequently faced with the needs of their own aging parents, who may be dependent in some way on their care and whose deterioration is a reminder of the inescapability of death. Adults caught between the demands of their aging parents and
demands of their own children have been named “the sandwich generation.”

Thus the stresses on the midlife adult are multiple. Successful negotiation of this stage entails understanding and accepting the aging process and identifying and pursuing goals in work or family or community life that enable one to contribute to the future in a way that feels significant to the individual.

It is helpful to categorize midlife adults who have mental disorders into three groups. The first group consists of those who have had mental health problems for many years—problems that have continued and often worsened as they aged. The second group comprises persons with various adjustment disorders, those who are unable to master or resolve the crises and stresses of adult life and who resort to maladaptive behaviors such as drug and alcohol abuse, overeating, or withdrawal. The third group consists of individuals who are developing dementias such as Alzheimer’s disease. Each of these groups has different treatment needs.

Many of the middle-aged adults who have had mental health problems for many years are somewhat burned out. This means that they have little energy and seem passive and almost indifferent to what goes on around them. They will go along with treatment programs but do not seem to have much invested in their own progress; getting through each day seems enough of a challenge. Not every person in this category is burned out, however. Some are career patients who have come to identify themselves in the patient role; they use the mental health system to meet their needs for physical safety, food, shelter, and economic assistance. Occupational therapy interventions for adults with chronic disorders of long standing focus on improving and maintaining daily living skills, providing opportunities for productive work in a sheltered environment, and facilitating as much independent function as the person can manage.

The second group, those with adjustment reactions to the crises and stresses of adult life, need assistance in identifying and resolving the issues that confront them. As was mentioned earlier, crisis intervention is a widely used approach. Menks (25) has described a conflict resolution model in which the occupational therapist guides the client through five steps that begin with identifying the problem and end with implementing a plan of action. The problems addressed are varied, ranging from how to use leisure time to how to compensate for a career that feels demeaning and pointless to how to cope with divorce or the death of a spouse.

In the third category are people with primary degenerative dementia, a kind of organic brain syndrome that is progressive. Alzheimer’s disease, which is in this category, may show its first signs as early as age 40. Memory impairment or forgetfulness is usually the first symptom; the person first has trouble remembering details (dates, names, facts), and the memory loss becomes more profound as the disease progresses. Gradually so much of the memory is lost that the victims cannot complete simple activities because they do not remember that they started them. There are personality changes as well; though these are not always noticeable in the early stages, the behavior of persons with dementia becomes less social and more inappropriate over time. Ultimately, they lose physical neuromotor control over their bodies, become incontinent and less mobile, and die.

Because the symptoms of Alzheimer’s disease progress slowly at first, the person in the early stages of the illness can usually continue customary activities with a few minor adjustments. For example, at work the person may have to be supervised more closely than before or switch to duties that require less attention to detail. Similarly, family members have to compensate for cognitive deficits in the home. The patient who is the cook in the family needs supervision to make sure he or she does not cause a fire. Occupational therapists and assistants work with these early-stage individuals and their families in the home wherever possible. The goals of intervention are to assess what areas and activities are causing difficulty for the person,
to evaluate current strengths and deficits, and to help the family adapt the environment and provide the social support the person needs.

It is important that persons with Alzheimer's disease remain at home or in the accustomed environment for as long as possible, because they are better able to function in familiar environments than in new ones (24). In the later stages of their illness, these individuals cannot remain in the community because they need either medical care or round-the-clock supervision. They are most frequently placed in nursing homes, although some are hospitalized in large public institutions. Occupational therapists and assistants provide services that help them remain alert and function to the best of their present capacities. These might include reality orientation (described in Chapter 22), sensory stimulation (e.g., olfactory and tactile stimulation), and physical activities (exercise, ball play, dancing). Memory training is sometimes used with those who are higher functioning—that is, are in the early or middle stage of the disease.

Late Adulthood and Aging

The most important psychosocial task of older adults is believed by many experts to be the development of an understanding and appreciation for what they have accomplished during their lives. Erikson (10) has called this the crisis of ego integrity versus despair. Erikson believed that in order to feel that life has been worthwhile, the older adult needs to see the self as only a small part of the human community, which will endure beyond one's own death.

In addition to this major developmental task, the older adult often must deal with significant life stress. One's aging body, retirement and the loss of a career role, the deaths of spouses and cherished friends, economic worries, and the loss of one's home are just a few of the stresses that may press on the older adult's diminished energies. New hobbies, new friendships, and new roles as volunteer or grandparent may compensate for some of these losses, but many older adults find it difficult to make these adjustments.

Shimp (35) reminds us that many of our cherished "truths" about older people are in fact myths. While many retirees are satisfied and relieved to give up their productive roles, many others happily undertake volunteer and paid jobs into their 90s. Also, the notion that the aged cannot adapt to life stresses needs careful examination in each case. Even a severe stress such as acute-care hospitalization can be endured and managed successfully, given sufficient motivation and hope.

Depression is the most common psychiatric diagnosis in the elderly population. A person in a very deep or severe depression can become so withdrawn and self-involved as to appear demented (cognitively impaired); for this reason, the condition is sometimes misdiagnosed as an organic mental disorder. In some cases, the depression is masked by multiple physical complaints—aches and pains, stomach problems, and so on—that may cause physicians to completely miss the underlying depression. When the depression is finally recognized and properly treated, usually with medication, the person's attention and cognitive functions return to normal. After depression, Alzheimer's disease and other organic mental disorders are the psychiatric conditions most commonly diagnosed in the aged population. Coincidentally and confusingly from a diagnostic point of view, depression is often a symptom of organic mental disorder.

Occupational therapy may be provided to the older adult in the home, in a geriatric day center, or in a hospital or nursing home. The purpose of occupational therapy is to help the older adult maintain or achieve a feeling of competence or self-reliance and to prevent further deterioration in functioning. Environmental adaptations made by the occupational therapy practitioner can allow higher-functioning individuals to continue living in their own homes; this is very important for maintaining
their sense of self-identity and a personal daily routine. In addition, the therapist or assistant may provide leisure counseling, assist in the development of hobbies, and facilitate social involvement.

Occupational therapy interventions for the older adult in a nursing home or geropsychiatric unit are similar to those described earlier for the midlife adult with Alzheimer’s disease. The OTA may use reality orientation and remotivation or reminiscence techniques and life-review activities (described in Chapters 20 to 22) or instruct nursing staff and volunteers to do so. Other aspects of occupational therapy intervention for this group are described in Chapter 9.

Because not all residents in a nursing home function at such a low level, the occupational therapist must plan programs that allow people with different capacities to participate and that provide challenges to each person at his or her own level. The therapist begins by assessing how well each person functions in terms of social, physical, and cognitive functioning and self-care skills. The Parachek Geriatric Rating Scale (27, 29), which is sometimes used for this, may be administered by the OTA. The Parachek scale allows the observer to rate 10 functions in the three categories of physical capabilities, self-care skills, and social interaction. The scoring system and treatment manual that accompany the scale assist the therapist in assigning residents to groups based on functional level as determined by their scores on the rating scale. Parachek recommends that crafts and cognitive activities like games and puzzles be provided for higher-functioning residents, simple group activities and self-care for those with scores in the middle range, and sensory stimulation for those with the lowest scores. She recommends physical activities for all three groups and adapts the activities to compensate for more limited function in the low-scoring group. Allen Cognitive Level tests, described in Chapter 3, may also be used, along with the Allen approach to cognitive disabilities.

The OTA who works with the geriatric population must be very receptive to the needs and concerns of the older individual. It is important to respect and accommodate the habits and beliefs that the person has built up over a lifetime. Because they have lost so many of the things that were once important to them, older people often fear the loss of their identity and self-direction and may feel threatened when a health professional pushes them too far too fast. Also, because of a general slowing of physical capacities, older people may respond less quickly and usually need more time to answer questions and learn new things. Finally, the older individual thinks often and deeply about the past and enjoys telling stories about it; this recounting is an important psychological process for establishing a sense of ego integrity. It is important for the OTA to recognize the value of this reminiscence and encourage it.

**SUMMARY**

We can think of life as a puzzle or a project that can be worked out only by traveling down a path that is not always clear. A turn in the road may bring us face to face with obstacles that must be dealt with before we can proceed. As the quotation from William James at the beginning of this chapter suggests, obstacles and crises often stimulate us to reach deeper into ourselves and thus grow and develop. We each have our own tools (our native talents and acquired skills) to help us work out the puzzle and to clear the path. Sometimes, though, the obstacle seems unconquerable, and this is when mental health problems arise.

Problems can occur at any age at any point along the path; some individuals are more vulnerable to these problems than are others. The role of the mental health professional is not to solve the problem or clear the path but to enable people to tackle and master their own obstacles so that they can clear their own way and proceed. To do this well, we must know as much as we can about human development, because this forms the underlying structure of each person’s path;
knowledge of major developmental milestones and tasks helps us predict a person’s capabilities at each point in the life span and alerts us to possible stresses and vulnerabilities.

We must also know as much as possible about occupation and its development in the human being, and we must value it highly. Occupation is an essentially human tool for tackling the puzzles of life. It gives us a sense of purpose and competence, channels our energies, and sustains our forward movement. Without occupation there is no progress; everything stops. When occupation is disordered and when occupational roles are poorly grasped and weakly lived, life becomes chaotic. Disability or disease may impair the ability to use occupation, depriving the individual of a vital link to living ordinary life. The role of occupational therapy is to restore this ability, to enable and support each person’s ability to use this powerful tool to solve life’s puzzles, to master stresses and obstacles, and to propel the self on the path to the future. The following case example illustrates the interactions among developmental tasks, the development of human occupation, environmental risk factors, and age-specific vulnerabilities to mental illness and provides an opportunity for the reader to explore these issues further.

CASE EXAMPLE

Ericka

Ericka is a 17-year-old black, single student in a large city high school. She was recently arrested for a felony, charged with putting a younger girl in a choke hold while two others tore the gold chains from the victim’s neck.

Ericka is the 6th of 14 children of an unmarried drug-addicted mother. Ericka was born addicted to crack cocaine. She received therapy in the neonatal intensive care unit (NICU) and later through several early intervention (EI) programs. At one time, Ericka attended a school for emotionally disturbed (ED) children; but at age 11 and in the 5th grade, she was mainstreamed into a public school, where she received special services outside the normal classroom in which she was placed. At present, she is in 10th grade in a special education classroom. She is a poor student but attends school consistently. Teachers report that she does not sit still easily and that she is quickly distracted. She has limited social skills (has trouble negotiating, enters situations without trying to understand them first, interrupts, and so on), and has no close friends. The female police officer who arrested her said that Ericka indicated that the girls from the gang were her “friends” but that Ericka also said they had been friends for just a couple of weeks, during which time the other girls encouraged Ericka to bully and overpower victims for them.

Ericka is tall for her age (5 feet, 11 inches). She lives with her great-grandmother because both her parents are now deceased. The great-grandmother, aged 62, says she has tried to keep Ericka under control and that she is afraid Ericka has begun, with her new friends, to use marijuana and drink beer.

Case Study Questions
• Discuss the developmental task(s) of Ericka’s age group.
• Identify the environmental risk factors for Ericka.
• For what mental disorder(s) does Ericka seem to be at risk?
• Based on the information provided, discuss Ericka’s mastery of the occupational roles that are normal at her age.
• Following from the model of human occupation, what else would you like to know about Ericka?
• How would you begin to engage Ericka in a discussion of goals she might value or want to work toward?
### REVIEW QUESTIONS AND ACTIVITIES

1. **Contrast the motivations for exploration, achievement, and competency.**
2. **Define work–play balance and discuss the amount of time spent in work and play at different stages of life.**
3. **Briefly describe the occupations of the child, the adolescent, the adult, and the late-life adult.**
4. **Identify important achievements in occupational development at each of the following life stages: childhood, adolescence, adulthood, and late adulthood.**
5. **Trace the development of the worker role from childhood through retirement.**
6. **For each of the major life stages identified in the chapter, list the psychiatric diagnoses that are common to that stage.**

For each diagnosis on your list, write down the effects of the disorder on the ability to function in performing occupations of play, work, education, leisure, ADLs, instrumental activities of daily living (IADLs), and social participation. Where the information is provided, also note the occupational therapy intervention that is recommended.

7. **Ericka, introduced in the case study, is now 17 years old. Write a description of her as you imagine she might be at 27, 47, 67, or 87 years of age. Emphasize her occupational functioning. Write a best-case and a worst-case scenario.** (This may be done as a class project, with different groups taking different ages.)
# References


SUGGESTED READINGS


