Theories of Motivation in Occupational Therapy: An Overview

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The motivational theories behind five theoretical approaches in occupational therapy that claim to be generic are explained. With the exception of the occupational behavior approach, the motivational perspectives are only implied features of the following other occupational therapy approaches discussed: object relations analysis, action consequence approach, recapitulation of ontogenesis, and developmental facilitation. These motivational explanations are developed and then applied to a case example. Finally, the occupational therapy approaches are analyzed in terms of the viability of their motivational perspectives to determine their adequacy as generic approaches for the profession.

This article analyzes five occupational therapy approaches that claim to provide generic (i.e., generally applicable) implicit and/or explicit explanations of human motivation. The purpose of this study is to clarify those theories' explanations of motivation with the purpose of facilitating a more critical analysis of theoretical approaches offered for use in occupational therapy. The frames of reference to be discussed are object relations analysis, action consequence approach, recapitulation of ontogenesis, occupational behavior, and developmental facilitation.

These approaches are discussed in reference to an actual case example. Since these approaches are often associated with psychiatry yet claim to be generic, a physical disability case was chosen because it represents a clinical and theoretical challenge to those claims of generic application.

Case Example

JF is a 25-year-old male who sustained a severe injury to his right dominant upper extremity while working as a freezer warehouseman. He sustained a compound fracture of the right elbow with loss of the elbow joint, loss of the distal half of the humerus, loss of the proximal half of the ulna and radius, and significant loss of soft tissue. At the time of injury, the patient was overweight, and he has remained so despite efforts to reduce. The patient also had a mild protein depletion at the time of the injury, which suggests a diet of junk foods.

JF underwent several debridements, along with an application of a Hoffman apparatus and split thickness skin grafting to the defect. He began receiving occupational therapy within the first couple of weeks after the injury to maintain the range of motion (ROM) of his wrist and fingers.

JF was rehospitalized more than once for pin tract infections. His Hoffman device and forearm cast remained on for 4 months. JF was
scheduled for major reconstructive surgery, which was to include osteocutaneous flap to fill the bony defect, joint fusions, possible muscle and/or tendon transfers, and possible nerve grafting. Major surgery was cancelled and rescheduled repeatedly at the patient’s request, apparently because he experienced anxiety about the upcoming surgery.

In the meantime, JF’s arm looked like a rope of soft tissue from the midhumerus to the midforearm, with atrophy of the forearm and hand. He had no functional motion in the hand. During this time, JF was not compliant with instructions to perform self-ROM techniques.

JF underwent an attempt at reconstructive surgery 7 months after the injury, following the previous postponements that he had initiated. This reconstructive surgery was aborted because of complications.

After the unsuccessful surgery attempt, JF was seen by occupational therapy personnel for positioning, maintaining ROM, dominance retraining, and monitoring signs of nerve return. During the next 12 months, JF demonstrated noncompliance with attendance and punctuality, self-ROM techniques, and positioning of the upper extremity. He would refuse to wear his splint and would let his arm dangle and remain edematous. JF often wore earphones and listened to music or read a book while being passively ranged. He avoided eye contact with staff members. His behavior varied from angry and defiant to “macho.” He disregarded clinic rules and used equipment unsafely.

Signs of nerve return gradually occurred with some sensory and motor gains. The major reconstructive surgery was rescheduled. JF continued to postpone the surgery dates suggested to him. Later, he began to consider an elective amputation, which was performed 19 months after the injury. JF has not worked since his injury. However, he has achieved independence in activities of daily living (ADL) relying on one-handed techniques and some assistive devices.

Object Relations Analysis

Object Relations Analysis is an approach defined by Mosey (1). Motivational theorists contributing to this frame of reference include Maslow (2), Freud (3), and Jung (4, 5). Mosey uses Freudian and Jungian theories of motivation and synthesizes them within the context of Maslow’s work. Therefore, the Freudian and Jungian theories of motivation are reviewed here to address Mosey’s implied view of motivation in her frame of reference.

Freud (3, 6, 7) views the human being as possessing limited psychic energy, which is housed in the id. The id is the primary source of motivation. Over time, the id differentiates into the ego and the superego. The function of the id is to reduce tension from unsatisfied physiological needs. The id accomplishes this in accordance with the pleasure principle, by creating an image that will satisfy the need and reduce the tension. The process is called object formation (3, 6, 7).

Psychic energy has its origin in the life and death instincts. Energy released to form object relations for biological needs is libido, and libido is associated with the life instinct. Energy released to return the organism to an inorganic state is associated with the death instinct (3, 6, 7).

At approximately age 2, id has evolved into id and ego. The ego functions in accordance with the reality principle to postpone immediate discharge of energy until an adequate tension-reducing object is located. The ego seeks an appropriate object that corresponds to the mental image created by the id and produces physiological need satisfaction (3, 6, 7).

The superego evolves from the id at approximately 5 or 6 years of age and represents striving for the ideal. The superego is the conscience of the individual and develops from the inculcation of parental notions of good and bad, which come into play during the phallic stage (3, 6, 7).

The ego mediates between the conflicts of the id and the superego. Through judicious use of defense mechanisms, the ego allows the organism to find a balance between the id and the superego by forming object relationships that satisfy the demands of both the id and the superego (3, 6, 7).

In summary, the Freudian view states that the human organism is motivated to form object relationships to satisfy the life and death instincts. These object relationships can reflect a tendency toward immediate, realistic, and ideal need gratification. In the normal human being, realistic need gratification is predominant and reflects success-
ful mediation between the extremes of the id and the superego.

Jungian theory differs from Freudian theory in three ways (4–6). The first difference is its rejection of the pansexualism endorsed by Freud. Jung states that human behavior is motivated by other factors in addition to sexual issues. The second difference is the notion of a teleological purpose. Inclusion of teleological motivation allows human beings to be viewed as organisms that are pushed by basic drives (as identified by Freud) and pulled by purpose (as described by Jung). To Jung, purpose is self-actualization or the process by which individuals become complete (4–6). This third difference, self-actualization, requires an understanding of one's existence and can only be attained when the organism comes to terms with features of the collective unconscious. These features are archetypes, specifically, the persona, the shadow side, the anima or animus, and the self. Archetypes are racial and ancestral heritages that form the basis for personality (4–6).

Mosey (1) uses Maslow's (2) work to synthesize Freudian and Jungian theory. She explains object formation as the attainment of need-satisfying objects in accordance with Maslow's hierarchy of need satisfaction.

Object relation formation is the way by which the organism progresses from physiological need satisfaction to the highest level of need satisfaction, self-actualization. Maslow's perspective identifies five levels of need: physiological, safety, love and belonging, esteem, and self-actualization.

The implied view of motivation in object relations analysis is that the human organism is pushed by life and death instincts and pulled by the need for self-actualization. The organism then forms object relationships that facilitate the satisfaction of needs.

Dysfunction in Mosey's (1) view is the presence of a complex that interferes with need satisfaction. A complex is the repressed gestalt of conflict between id and superego that exceeds the mediating capacities of the ego (1); that is, a person experiences conflict between the id's immediate procurement of an object for need satisfaction and the superego's moral injunction against that object. If the ego is unable to mediate the conflict, that conflict is repressed, yet it continues to negatively influence need satisfaction at the involved level of Maslow's hierarchy and thus negatively influences the progression to self-actualization.

Case Application

JF demonstrates immature object relationships. For example, he lacks the capacity to delay gratification, as shown in his inability to lose weight. He lacks insight and mature conscious willing, as shown in his inability to make decisions. He has inappropriate affects, which include machismo and heroism. JF demonstrates narcissistic object loss in his anger, defiance, and hostility. This object loss seems to be resolved with his having an increased interest in the alternative of amputation. JF's psychological dysfunction is postulated as an excessive response to the death instinct. He views himself as an aggressive object. This is deduced from the nature of the injury and his personality traits of machismo and heroism.

JF's self-destructiveness may be symptomatic of a complex centered around the conflict between the life and death instincts. An example of this complex is his denial, which is demonstrated by his refusal to take responsibility for his hand (e.g., refusal to perform self- ROM as instructed and refusal to wear his splint for protection and positioning). JF's lack of understanding of the implications of his noncompliance is further evidence of denial. JF's ego is unable to mediate between the life and death instincts, and the result is repression and self-destruction.

Focus of Therapy

In this approach, therapy should focus on the physical component as it is affected and effected by the psychoanalytic component, specifically, through symbol interpretation, which is achieved by conscious association and the development of insight. The latter will facilitate an awareness of the imbalanced influence of the death instinct. Theoretically, this conscious recognition of the death instinct as the causative factor in his injury and personality will result in a strengthening of ego functions in that it will help the patient to reject an excessive reliance on denial. Increased ego functions will mediate more appropriately the conflict between the life wish and the death wish. The result will be greater need satisfaction at the affected hierarchical levels, probably safety and love and belonging, and a progression toward self-actualization. Greater compliance with the therapeutic regimen will be seen. This compliance will be achieved via increased maturity in object relationships, for example, mature conscious willing and appropriate affectual response.

Action Consequence Approach

The action consequence approach (1) is based largely on op-
The action consequence approach explains learning as acquisition or extinction of behaviors in response to the presence or absence of reinforcement.

Function, or adaptive behavior, is defined as a high frequency of adaptive behaviors and a low frequency of maladaptive behaviors in ADL, avocational pursuits, and work that allows individuals to function competently in tasks expected of them in their environment. These behaviors have individual task and shared task behaviors as their basis (1).

Conversely, dysfunction is defined as a high frequency of maladaptive behaviors and a low frequency of adaptive behaviors that interfere with adequate performance in ADL, avocational pursuits, and work required in the expected environment. These behaviors have individual task and shared task behaviors as their basis (1).

The foundation of stimulus response learning theory. Operant conditioning literature is the primary theoretical base of action consequence (1). Stimulus response theories pay little attention to intraorganismic integrating principles (e.g., cognition, ego, phenomenology). Stimulus response theories ignore cognitive functions and focus on readily quantifiable and observable extraorganismic events to explain behavior; for example, they stress external reinforcement and environmental cues (6).

The action consequence approach includes their work and Skinner's (11). Dollard and Miller identify the following four elements in their model: (a) drive; (b) cue or discriminative stimulus; (c) response or operant response; and (d) reward. Skinner depicts operant conditioning as follows: The discriminative stimulus leads to the operant response and the reinforcing stimulus by an external agent. These two models are similar. The differences are the terminology and the identification of drive by Dollard and Miller in their model. Drive is the organism's motivation for response. Drive initiates behavior. It is internal. Drives may be primary or unlearned, as in hunger or shock, or they may be secondary or learned, as in fear. Motivation is a function of drive. Drive is any internal stimulus that compels the organism to respond in an effort to reduce the stimulus (10).

Action consequence does not specifically address rehabilitation efforts such as exercise for the patient with a physical disability. However, physical capacities are dealt with implicitly and underscore performance in the five areas identified earlier.

In treatment, the occupational therapist would provide the discriminative stimulus; for example, the therapist might make a polite

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request to engage in a therapeutic task to foster the response of engagement. Reward (e.g., praise) would be provided after emission of the response. This treatment approach would be used on an optimal schedule, probably ratio as opposed to interval. Focus would first be on physical capacities or incapacities within the context of individual and shared task behaviors. Focus would then shift to ADL, avocation, and work.

**Occupational Behavior Approach**

Occupational behavior provides a theoretical framework the authors interpret as follows: Occupational therapy’s task, as identified by Reilly (12), is to prevent or reduce incapacities resulting from illness. In its early theoretical writings, this approach was aligned exclusively with chronic disability (12, 13). The ultimate focus of therapy in the occupational behavior perspective is occupational role performance (12, 13). Occupational role performance is viewed as a systems, hierarchical, and developmental phenomenon with supporting theory drawn from the social and behavioral sciences and philosophy of science, specifically general systems theory, theories of socialization, culture and adaptation, and role theory (12–17). The generators of the occupational behavior approach are Reilly (12, 18–21) and associates, including Kielhofner and Burke (15) Burke (22), Kielhofner (23, 24), Heard (13), Robinson (25), Florey (26), Matsutsumi (16, 27), and more recently, Webster (17), Cubie and Kaplan (28), and Barris and associates (14).

Effectance (or intrinsic) motivation is defined as a biologically inherent or innate urge to explore and master the environment. It is characterized by the desire to be a cause, and it accounts for the engagement in behavior that is in itself satisfying (26).

This is in contrast to extrinsic motivation, which accounts for the engagement in activity to satisfy external demands with resulting external reinforcement (29). Reilly (21), Florey (26), and later Kielhofner and Burke (15) discuss the concept of intrinsic motivation as it relates to occupational therapy. These works rely in part on the theoretical views developed by psychologists DeCharms (30), White (31, 32), McClelland (33, 34), and Erikson (35).

The perspective these occupational behavior theorists have developed is as follows: The normal human being (and therefore by implication the disabled human being) is always characterized by the presence of effectance motivation. In early childhood, effectance motivation is predominantly expressed as exploratory behavior. In such behavior, the child explores and manipulates the human and nonhuman environment out of curiosity and because of the pleasure derived from such an exploration (15, 22, 25, 26). Through this exploratory behavior, rules of motion, objects, and people are acquired that form the basis for eventual role performance (25).

In adolescence, effectance motivation occurs primarily in the form of competence motivation. This form of motivation accounts for engagement in practice to master a skill even at the risk of social disapproval (15, 26).

In adulthood, effectance motivation is primarily characterized by a desire for achievement, which explains engagement in activity to meet standards of excellence. The adult approaches these standards of excellence to obtain the intrinsic pleasure associated with performance at that level and to successfully meet social expectations regarding behavior. Competence motivation accounts for skills acquisition, whereas achievement motivation accounts for role performance designed to meet personal and social requirements for becoming a participating member of society (15, 26).

Effectance motivation seems to be a necessary concept for an approach that focuses on role-related behaviors rather than tension-reducing behaviors (the latter is the case in the psychoanalytic perspective discussed earlier). Effectance motivation offers an explanation for participation in such non-tension-reducing behaviors as rule and skill acquisition, habit formation, and goal setting, all of which make up ADL, leisure, and work.

Dysfunction in the occupational behavior perspective may be viewed as incompetent role performance or incompetent occupational behavior. In the authors’ opinion, two criteria should be used to assess role performance as competent or incompetent: (a) sat-
satisfaction to self and (b) satisfaction to society. When one or both of these criteria are not met, a person may be viewed as dysfunctional. This dysfunction may account for a lack in valued goals, interests, personal causation, rules acquisition, skills acquisition, habit formation, and/or internalization of roles. Additionally, dysfunction may be the result of the imbalance between the person’s internal characteristics, such as those listed earlier, and an excessively demanding external environment.

Case Application

Occupational behavior literature identifies four occupational roles: preschooler, student, worker, and retiree (13). Cultural and developmental expectations indicate that JF should be enacting a worker role. However, because of the medical course of his injury, JF has developed no disposition toward enacting the worker role. Thus it is premature to facilitate the acquisition of worker skills specific to any worker role. General work skills and ADL (the latter being identified by Kielhofner, Burke, and Igi (38) as a basic form of work skills) can be addressed theoretically. For example, it would be possible to work on dominance retraining, independent one-handed ADL, attention to detail, and other task-related behaviors. However, it is the authors’ judgment that JF may not resume a working role for the following reasons: (a) the length of time he has been unemployed; (b) uncertainty about when he will return to work; (c) his lower-level job skills in a competitive market; (d) his poor work history; (e) his lack of skills in attendance and punctuality; and (f) his difficulties with authority. In light of the probability that JF will not resume a worker role, therapy should expand the traditional scope of occupational roles (14) and foster the enactment of alternative developmentally appropriate roles, such as the roles of volunteer and hobbyist. To do this, the patient must form habits, acquire skills, and accept rules to support such role enactment. Deficiencies in JF’s case are seen in connection with habit formation, specifically his temporal disorganization (his recurrent tardiness) and in connection with his acceptance of rules, specifically the rules of social conduct (JF’s avoiding eye contact, his difficulties with authority, and his inappropriate socialization). He also needs to accept the rules relating to objects and, for example, learn to use power equipment safely.

Focus of Therapy

To help JF accept these rules, the therapist should create an environment that supports exploratory behavior. Such an environment includes people and objects. It facilitates exploration, repetition, and imitation. This environment must be free of stressors such as hunger, anxiety, fear, isolation, and pain (26). Goals of treatment, choice of activities, objects, and support for learning are provided by the therapist (28).

JF’s lack of attendance suggests that he is not motivated to participate in therapy. Therefore therapy should assess his personal causation to determine if he has external, balanced, or internal locus of control. If he has an external locus of control, therapeutic efforts should be directed primarily at fostering a balanced locus. This can be achieved by generating an environment that supports exploratory behavior and by following the clinical guidelines put forth by Burke (22).

In such a controlled environment the patient is confident that he or she can successfully perform the tasks presented by the therapist. Furthermore, these tasks must require the acquisition and/or utilization of skills that the patient finds valuable or meaningful. Finally, the environment must include avenues for feedback so that the patient can be reassured that he or she is efficacious in performing these tasks (22).

These guidelines for creating a controlled environment ensure that the therapist appreciates the powerlessness experienced by such a patient (i.e., the patient’s perceived loss of control and his or her loss of opportunity to make choices) (22).

However, if the patient’s locus of control is balanced or internal, an environment should be created that provides (a) exploratory elements allowing for the acceptance of rules of people and (b) competency elements allowing for the acquisition of skills necessary for a new occupational role. Environments that provide systematic instruction, an opportunity to make things, role models, and association with peers support competency-based behaviors (26).

Once the patient has acquired the necessary roles and skills, the therapeutic effort should be directed toward the acquisition of habit patterns to support and internalize the desired occupational role.

Recapitulation of Ontogenesis

Recapitulation of ontogenesis, a synthesis of action consequence and object relations analysis as seen from a developmental perspective, provides a frame of reference also generated by Mosey (1). Human function is viewed as a product of...
seven adaptive skills, which occur in a stage-specific, interdependent, and qualitative developmental progression. Individuals are considered functional when they can meet the requirements placed on them in their expected environment.

The major theorists of this frame of reference are those of the object relations analysis and action consequence approaches: Freud (1, 3), Jung (4–6), Maslow (2), Dollard and Miller (10), Hull (8, 9), and Skinner (11). Additional theorists include Ayres (37) and Piaget, as described by Flavell (38). The major concepts are the seven adaptive skills with their corresponding subskills: (a) perceptual-motor skills; (b) cognitive skills; (c) drive-object skills; (d) dyadic interaction; (e) group interaction; (f) self-identity; and (g) sexual identity (1).

In this frame of reference, motivation is the desire for mastery. However, the explanation of mastery in the theoretical base of this approach is insufficient for a clear understanding of the motivational concept. Subskill acquisition is explained in terms of learning, and the postulates regarding change are those reflected in action consequence (operative conditioning principles). Thus, one can infer that another major motivational explanation is the drive theory explained in reference to action consequence. Additionally, in light of the inclusion of psychoanalytic concepts drawn from object relations analysis, a traditional psychodynamic explanation of motivation may be also inferred.

Function and dysfunction are relative to the individual’s expected environment and the social roles required of him or her within that environment. The individual is functional when there is integrated learning of those adaptive subskills that are needed for successful participation in his or her environment (1).

Human function is viewed as a product of seven adaptive skills, which occur in a stage-specific, interdependent, and qualitative developmental progression.

Case Application

JF is dysfunctional in subskill number five of the drive-object skill. This subskill is the ability to invest libidinal energy in appropriate abstract objects and to control an aggressive drive. JF is using himself as an inappropriate aggressive object as evidenced by his inordinate risk taking, which may have resulted in his injury.

The drive-object skill refers to an individual’s learning to satisfy needs through the control of drives and through object formation (1). A variety of behaviors indicate dysfunction, including impulsive behavior, the inability to delay gratification, minimal problem solving, and a lack of concern for or awareness of another person’s needs (1).

JF demonstrated these features. He appeared disinterested in therapy, usually avoiding eye contact. As mentioned previously, he would wear a walkman headset or intently read a book while the therapist performed passive ROM. He stated he did not have time to perform ROM on himself. He had conflicts with a staff member who would not meet his request for inappropriate wound debridement. JF became angry at this refusal and then refused to stay for ROM exercises.

As mentioned earlier, JF is dysfunctional at the subskill level of the drive-object skill that requires the ability to control an aggressive drive. Dysfunction at this level “is indicated by sociopathic or psychopathic behavior, maltreatment of aggressive objects... anxiety or guilt arising from the contemplation or actualization of an aggressive act, and diffuse and poorly directed aggressive drive” (1, p. 194).

JF could view himself as an aggressive object but yet be unable to invest appropriately into himself as such. JF would be interfering with his own need satisfaction. He may have invested self-destructive energy and that would explain his injury. He may also have been investing self-destructive energy throughout the course of therapy, which would explain his abuse of his arm’s positioning needs, his refusal to do self-ranging, and his overall noncompliance.

Focus of Therapy

Treatment requires teaching this subskill by first establishing a primary object relationship with the patient. Then the therapist fosters and provides reinforcement for gradual conformity to cultural norms, specifically, the identification of culturally appropriate aggressive objects and ways of handling aggressive drive toward one’s self and others (1). Factors such as improved attendance, eye contact, and increased patient compliance with the home exercise program would be reinforced via action consequence treatment techniques.

Developmental Facilitation

Developmental facilitation (the authors’ term) is a theory generated by Llorens (39) that identifies various developmental dimensions.

The following theorists have
contributed to the knowledge base of this approach: Ayres (40, 41); Gesell, as reported by Knobloch and Pasamanick (42); Erikson (35); Freud, as reported by Gram (43) and Hall (44); Havighurst (45); Mosey (1); Pearce and Newton (46); and Piaget, as reported by Maier (47). The dimensions identified by developmental facilitation allow for the acquisition of skills and behaviors in sensorimotor integration, affective responses, and object relationships. Such skills allow the individual to function in work, education, play, self-care, and leisure, which are referred to as areas of occupational performance.

Occupational performance should be consistent with the cultural requirements of the human being at given ages and stages of development. Dysfunction is disruption in any of the developmental dimensions that prevents engagement in successful occupational performance.

There is no explicit discussion of motivation in this approach. However, Llorens’ (39) view of human motivation may possibly be derived from statements made in the explanation of the theory and from an identification of the motivational explanations that accompany the various theoretical perspectives incorporated into the knowledge base of this approach.

Llorens (39) uses the three concepts of mastery, achievement, and social acceptance to explain briefly how growth occurs. These concepts may reflect the perspective in occupational behavior of effectance (or intrinsic) motivation and extrinsic motivation as being the primary movers of the human being. The inclusion of Piaget’s work may also be interpreted as an endorsement of effectance motivation (47). Since Ayres (41) explains motivation as internal drive mediated through the limbic system and in light of Llorens’ inclusion of her work, one can infer that Llorens would endorse that view as well. One can also infer that Llorens acknowledges a psychodynamic motivational propensity because of her inclusion of psychoanalytic theories.

The authors emphasize the fact that their identification of motivation concepts in this approach is purely conjectural based on vague references to motivational explanations. Furthermore, if the authors’ identification of motivation theories is correct, the possibility is high that several of these theories are incompatible (e.g., psychodynamic and effectance motivation). If this is the case, the developmental facilitation approach may be found to be invalid because of internal inconsistencies among its major concepts.

Whatever the situation may be regarding explanations of motivation in this approach, the authors find it academically and clinically unwieldy to account directly for motivation in such an eclectic approach. Therefore, because the possibility exists that this approach encompasses incompatible motivational explanations and thus renders a theoretically sound analysis of motivation in the case example impossible, a case application shall not be attempted.

Conclusion

In summary, JF was the kind of patient for whom anything that could have gone wrong did go wrong. He had the kind of injury that in a highly motivated patient could have had a more successful clinical outcome. Theories in occupational therapy, whether they claim to encompass all motivational explanations, do not explicitly address motivation. Therefore, treatment geared toward increasing the patient’s motivation is often not attempted. In cases such as JF’s, to treat the hand injury without addressing his motivation would have been less than ideal.

The authors have attempted to outline the motivational theories inherent in the five generic approaches presented. The conclusion is that only occupational behavior has an adequate motivational perspective to serve as a generic approach, because it has three features: (a) an explicit discussion of motivation in its theory base; (b) a utilization of a motivational theory that leads to the patient’s engagement in activities (occupations) that are not tension reducing or drive satisfying in the Hullian sense; and (c) a theoretical base that includes biological, psychological, and social dimensions of human function with a discussion of their interrelationships. In other words, of the approaches analyzed, the occupational behavior approach is the only one that has a motivational explanation and a scope compatible with the perspective and breadth required by occupational therapy’s definition and philosophical base (48).

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