Occupational Profile and Intervention Plan

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**Occupational Profile**

The occupational profile provides a summary of the client’s history and past experiences identifying meaningful interests, values, and needs (American Occupational Therapy Association [AOTA], 2014). This allows the practitioner to collect information about the client and prioritize targeted outcomes that will support participation in life. Clients identify occupations and select the goals that provide significance to their lives. Practitioners are able to guide intervention efficiently to establish client-centered outcomes through consideration of the client's values (AOTA, 2014).

**Client of Interest and History**

The client is a 26 year old male who lives in Las Vegas, Nevada. The client was referred to an outpatient intensive rehabilitation program by a healthcare provider and reports being at home with his family for a month, prior to the start of treatment. Over the past three years, the client has lived with family and is indifferent about this situation. He spends most of his free time with family, but finds his life satisfactory. The client reports he has been sexual abused when he was 5 years old by a babysitter as well as when he was 6 years old by a drunk gay male. He states he is the youngest of two sisters and two half-brothers. The client reports his father was a leader of a very big gang that he joined when the client was 6 years old. The client states that his mother left and took the children to Las Vegas, Nevada and he did not see his dad until he was 16 years old. He remembers his father being mean to him and hitting his step-mom. The client has not been affected by family problems over the past 30 days prior to treatment.

**Medical and Psychosocial History**

 The client has been hospitalized two times for medical problems secondary to pancreas attacks caused by methamphetamine use. The client reports that hospitalization occurred due to the byproducts in the meth he was using. He states that this was several years ago and he has not had any problems since. The client has been treated for psychiatric problems one time in a hospital and one time in an outpatient setting. The client has had a significant period in which he experienced serious depression, anxiety, tension, hallucination and reports he has trouble understanding, concentrating or remembering. He has experienced these problems five out of the past 30 days. In the past, the client states he experienced thoughts of suicide and was prescribed medication for psychological and emotional problems. The client reports being diagnosed with Attention Deficit Hyperactive Disorder (ADHD) at 15 years old and bipolar disorder at 16 years old. Bipolar diagnosis is evidenced by a report from the State of Nevada Adult Mental Health Services (SNAMHS). Client reports symptoms are mostly manic however he gets emotional when his thoughts are oriented toward religion. Client checked all symptoms of post-traumatic stress disorder (PTSD), but reports these symptoms were caused by events related to his devil worship. He states he knows God is real and has seen things to validate his beliefs.

**Areas of Occupation**

The client has completed 11 years of education. At the present time he is unemployed. Over the past three years his usual employment pattern has been full-time. He experienced employment or school problems in 30 of the past 30 days prior to treatment, but client has not been troubled by these problems and consider treatment for them to be not be important at this time. The client reports that he can work in the restaurant industry and feels comfortable finding a job wherever he wants. The client states he has been a full or part-time employee since he was 16 years old.

The client is a father to a five year old boy and is unable to care for his son, due to his inability to manage his behavior. The client is not married and does not have a good relationship with the mother of his son. He would like to complete this program for the needs of his son and become employed to increase his quality of life. The client does not have many close friends, but states his relationship with his family is fair.

**Seeking Services**

The client reports substance abuse of methamphetamines for twelve years beginning at age 14. The client reports daily use except for six months at 16 years old, five months at 18 years old, and two months at 25 years old. Last use was reported five days before treatment started. He has been treated for drug abuse two times and has now been attending group for one month, with two months left to complete. The client states he is motivated to make a change and realizes he can be successful if he stays clean. The client considers treatment for his psychiatric problems important and appears to be in the preparation stage.

**Priorities and Desired Outcomes**

The client has lived in the controlled environment within the Alcohol/Drug Treatment Program for 1 month and has potential to graduate from the program in 2 months. He states he wants to be with his son and attending treatment services to prove to the judge he is capable to care for his son. The client wants a better life, but believes his social interaction skills need improvement, in order for a successful recovery.

**Areas of Success and Areas at Risk**

The client shows success through his motivation to want to change by attending meeting and participating in the conversation within the group. He completes all handouts and takes notes throughout the meeting showing interest to gain feedback during rehabilitation recovery. The client demonstrates adverse behavior and emotional outbursts upon opposing viewpoints throughout discussion. His inappropriate behavior and negative comments directed toward others is an area of risk that may lead to him being removed from the program.

**Environmental Effects on Participation**

The group setting supports the client’s goals through the social interaction and participation in group. This allows the client to acknowledge the behavior directed toward others before entering society. The handouts and activities presented in group provide the client with resources to utilize both currently and in the future. The client has to show compliance in this group setting before interacting with family, friends, and future employees. The group setting inhibits client participation due to the limited individual meetings that are arranged between the counselor and the client. This prevents the client from sharing stories and thoughts during group because of perceived judgments that may be placed on the individual. The group environment also does not address vocational skills to transition into society from the rehabilitation program. This may increase chances of relapse if the client does not learn the necessary skills for occupational performance.

**Occupational Analysis**

**Context of Services**

The client attends services at an intensive outpatient mental counseling center, participating in group meetings 5 days per week for 3 hours per session. The group consists of eight males ranging between 26-50 years old guided by a psychotherapist. All individuals are eligible for group with a diagnosis of a mental illness and substance abuse problem. If relapse occurs during treatment, the client will be considered for removal from the program as an entirety.

**Activity Performance**

The group began with check in which encompassed initial individual introduction leading to discussion to the areas of concern. Check in includes each group member explaining how they feel rating themselves between being indifferent and being excited on a scale of 1-10. This quickly opened up group dialogue highlighting personality traits as the conversations progressed. The discussion continued for 90 minutes and then clients took a 10 minute break. When the group returned, a handout was given for clients to discuss for the remaining 90 minutes. The worksheet focused on the therapeutic approach utilizing both the cognitive behavioral theory (CBT) and the dialectical behavioral theory (DBT). Trauma and emotions were addressed throughout the 90 minute session of group therapy to understand the connection between past and present events.

**Observation of Client Performance**

The client represented the dominator of the group within minutes as the dialogue carried over to him continuously, formulating an opinion on each topic. He shared how he is angry that he is placed in a group with people older than him expressing that he has nothing in common with them. The client overshadowed all participants in this group demonstrating poor social interaction, behavioral skills, cognitive thoughts and emotional regulation. The client failed to understand the importance of group due to his inflexibility of beliefs and continuous pessimistic outbursts. He was unable to recognize the commonality of the group and focused on the irrelevant characteristics of others. Negativity was articulated throughout the meeting using judgment and anger inflicted toward others. His narcissistic personality made it difficult to demonstrate active listening and reflect on topics presented throughout the session. The client expressed he wanted to make it through rehabilitation treatment so he could be granted custody of his son, maintain a romantic relationship, and spend time with his family. It was evident he was unable to determine the underlying problem and needed direction to understand the negative attitude and behaviors that were demonstrated within group.

His thoughts raced around in circles from positive to negative, contradicting his opinions from one sentence to the next. The client believed he was a strong active listener, but then explained how if he disagrees with the topic of conversation he will ignore the individual or act defensive. Life choices he made when he was younger reflect his demeanor and attitude toward his future. Frustration, anger, and anxiety were represented within his tone of voice and body language. Before improving personal and social relationships, the client will need to recognize his strengths and weaknesses to advance toward recovery without relapse.

**Domains Impacted**

Adverse behavior, distorted cognition, and the absence of social skills indicate that the client will have difficulty in occupational performance due to the bipolar traits carried with his illness. Nancy W. Spangler, the author of “Mood Disorders,” explains the areas that are frequently affected by individuals with mental illnesses, which include areas of cognitive, behavioral, social, and physiological aspects (Spangler, 2011). Cognition contains the ability to problem solve, make decisions, remember, and concentrate. This is essential to maintain for performance across the broad range of daily occupations such as work, educational pursuits, home management, play, and leisure (Spangler, 2011). Behaviors reflect the capacity to be motivated and complete tasks. This will impact the client’s performance patterns, including habits, routine, roles, and rituals (Spangler, 2011). Social aspects involve eye contact, listening skills, and managing interpersonal conflicts. This is imperative for participation in life activities within desired roles, context, and life situations. Lastly, the physiological aspect consists of sleep disturbance, restlessness, and fatigue, which may greatly impact all areas in occupational performance (Spangler, 2011).

**Problem Statements**

1. The client is unable to manage behavior due to inappropriate impulses.

2. The client is unable to regulate emotions due to distorted cognitive beliefs.

3. The client is unable to conceptualize opinions due to irrational cognitive thoughts.

4. The client is unable to care for his son due to decreased self-management.

5. The client is unable to maintain relationships due to decrease social skill interaction.

**Priority and Justification of Reasoning**

These problem areas negatively impact the client’s performance and participation in society affecting his quality of life. The client’s frequent impulses and misunderstanding of maniac behavior, impact all domains of performance. The client’s distorted cognitive thinking influences his inability to manage and regulate his behaviors. If the client is unable to maintain acceptable behavior and manage his beliefs appropriately, all areas in occupational performance and participation will be impacted negatively. It is important to improve this aspect as one’s thoughts control the mind, influencing behavior. If goals are achieved, the client may identify goals regarding community participation or a vocational training program to increase the chance to reach success. The client will have difficulty building social and romantic relationships if he continues to be unaware of his behavior, preventing the client from achieving the desired outcome. Court orders explain how the client will need to graduate from this program before custody of his son is granted to him. This distinguishes the need to improve cognition and behavior, to provide stability throughout performance in activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

**Intervention Plan & Outcomes**

**Long Term Goal 1**

The client will manage behavior during group discussion by controlling impulses and recognizing manic episodes using coping strategies 75% of time in 2 months.

**Short term goal 1.** The client will manage behavior during group discussion by controlling impulses utilizing coping strategies 50% of the time in 1 month.

***Intervention*.** The intervention will take place during group meetings 5 times a week for 90 minutes of the 3 hour session. This will begin with client check-in and group discussion of experienced problems for the first 90 minutes of group. After the 10 minute break, the group will return back together and participate in an activity titled “Who Am I?” for the remaining 90 minutes. The activity that will take place is called “Who Am I?” which will be played to promote social interaction and participation with group activities. Participants will take turns choosing a card that has a famous name written on the back of the card. The card will be taped to the individual’s back so that the name will only be revealed to the group members. The individual with the name card will ask the group questions to determine what famous person they are and will be given candy to encourage participation. Questions can only be used that can be answered with either yes or no by the group. The client will be allowed to ask the group for hints if the client is stumped for more than three minutes. The intervention will conclude with a group discussion relating the game to real life situations. This will consume the 90 minutes permitted for intervention, addressing the impulses controlled during the game.

***Grade up/down*.** If the individual needed help, a handout was provided with questions for further assistance to grade this activity down. To grade this activity up, the client would not be allowed to ask the group for hints and would have to become creative with questions to determine the correct answer.

***Intervention approach***. The intervention approach focused on specific strategies to modify, adapt and maintain behavior. The means of modify suggest that the client will decrease the rate of impulses by adapting the current behavior to support performance in the natural settings. This includes utilization of verbal cuing and promoting to adjust behavior appropriately. The client will also have to maintain appropriate behavior in order to be allowed to participate in the group activity (AOTA, 2014).

***Evidence***. The *American Journal of Psychiatry* conducted a study using a functional MRI to detect the neural effects correlated of emotional distraction, and whether such deficits are a consequence or a precursor of the disorder (Kanske, Heissler, Schönfelder, Forneck, Wessa, 2013). Participants included both bipolar patients and healthy individuals to test the effect of emotional distractors on cognition when completing a task. Outcomes displayed that all participants exhibited slower responses when emotional distractors were present, although results significantly inflated within bipolar patients (Kanske et al., 2013). The results suggest that emotional dysregulation leads to exacerbated neuropsychological deficits in bipolar patients, as evidenced by behavioral slowing and task-related hyper activation (Kanske et al., 2013). This justifies the need for emotional distractors by participating in a game that redirects the mind. Distractions allow the mind to reroute, eliminating the burden of inappropriate thoughts and behavior that encompass one’s concentration.

***Outcome***. Acknowledging impulses will help achieve participation in desired occupations by meeting the expectations of society. By coping with frustrations when stumped by answers or questions, the client will achieve improved occupational performance. This intervention will help manage impulses by following the demands of the task of only answering yes or no to questions presented. Positive participation as an active member in group will increase his health and wellness and overall quality of life. (AOTA, 2014).

**Short term goal 2**. The client will regulate maniac behavior during group discussion by practicing self-awareness skills 50% of time in 1 month.

***Intervention***. The intervention will take place during group meetings 5 times per week for 90 minutes of the 3 hour session. This will begin with client check-in and group discussion of experienced problems for the first 90 minutes of group. After the 10 minute break, the group will return back together and participate in an activity that related to the four horsemen of the apocalypse (McKay, Wood, & Brantley, 2007). This handout will provide definitions of criticism, contempt, defensiveness, and stonewalling. A discussion will take place during the second half of group, where the group will share examples of incidents of denial. The therapist will ask a series of questions that will allow information to be brought to the client’s attention. This will encourage the client to recognize his behavior through self-reflection and awareness. Recognition of behavior will lead to future interventions directed towards self-management.

***Intervention approach*.** The approach to intervention was selected based on the idea of establish and restore, to help the client understand the underlying problem of his illness. Guided discovery will encourage self-reflection and encourage remediation of behavior. This will allow the client to establish and recognize inappropriate behavior when he is in the maniac stage and collaborate with the therapist to develop self-management skills (AOTA, 2014).

***Evidence*.** The *British Journal of Psychiatry* by Scott (2001) explained the impact of cognitive behavioral therapy as an adjunct to medication with patients with bipolar disorder. Findings indicated that cognitive therapy may be beneficial for patients with bipolar disorder showing both long term and short term benefits. The educational style of cognitive therapy uses techniques of guided discovery, which entails asking a series of questions that allows information to be brought to the client’s awareness. Understanding bipolar disorder and its impact on the individual requires conceptualization, which involves cognitive, behavioral, affective, biological, and environmental areas of the individual’s life (Scott, 2001). This confirms that the client needs to have an understanding of the stages through self-awareness techniques, before utilizing mechanisms for coping during manic bipolar episodes.

***Outcome***. The outcome of this intervention encourages prevention of outbursts in maniac stages through recognition of symptoms. If the client recognizes the behaviors he presents to others, occupational performance will be enhanced and improved through management of behavior. This intervention may increase the client’s health, quality of life, participation, and well-being if he is able to recognize these symptoms with the motivation to change (AOTA, 2014).

**Long Term Goal 2**

The client will manage and regulate distorted cognitive beliefs appropriately during group discussion with verbal prompting less than 25% of the time in 2 months.

**Short term goal 1**. The client will manage distorted cognitive beliefs during group discussion with verbal redirection 50% of the time in 1 month.

***Intervention***. The intervention will take place during group meetings 5 times a week for 90 minutes of the 3 hour session. This will begin with client check-in followed by group discussion of experienced problems for the first 90 minutes. After the 10 minute break, the group will return back together and participate in an activity titled the “Wall of Defenses” for the remaining 90 minutes (McKay et al., 2007). This is a worksheet consisting of defensive words that individuals use to protect themselves. The handout identifies the person at the top of the wall and the defense mechanisms below. These words include: justifying, protecting, silence, blaming, analyzing, judging, arguing, hiding, switching, joking, agreeing, withdrawing, evading, rationalizing, minimizing. The client will mark an X on the defenses that are most often used and provide an example that is relevant to his life. Discussion will then take place to identify any misplaced judgments, philosophies, and ideas that pertain to the client’s statements.

***Grade up/down***. To grade this activity down, the group will read and discuss the definitions before placing an X on the specific word. This will allow the client to fully understand the word and how it is used as a defensive strategy. To grade this activity up, the group will write a positive strategy of how they can avoid defensive thinking for each example given.

***Intervention approach***. The OTPF approach to intervention focuses on the idea to establish and restore the client’s cognitive processing. This is an approach designed to change client variables that establish skills or an ability that has not been yet developed. This will guide cognitive thinking to ensure appropriate thoughts are in place and eliminate all judgments. The intervention also focuses on the notion to modify the current context or activity demands to support performance in the natural settings. This includes compensatory techniques to reduce other features that impact cognition. Simplifying the task sequence will to initiate the ability for problem solving while modifying philosophies and opinions that constitute basic values (AOTA, 2014).

***Evidence***. The *Canadian Journal of Psychiatry* investigated the changes in the use of coping styles in response to maniac symptoms and compared this to individuals who received psych education (Parikh, Hawke, Zaretsky, Beaulieu, Patelis-Siotis, MacQueen, & Cervantes, 2013). The results of this study showed that both CBT and psych education showed similar improvements in symptoms. Equivalent results of improvement were also shown in stimulation reduction and problem-directed coping styles in both groups (Parikh et al., 2013). CBT and psych education have similar impacts on coping styles for mania, although denial and blame only impacted CBT toward success. This study shows the justification for intervention by educating the client of the mental illness and acknowledging the aspects of denial and blame that are frequently used within the mental health population. The client will learn to recognize appropriate versus non-appropriate behavior and understand how denial and blame impacts the overall recovery. As the client is able to understand the behavior presented, coping strategies can be learned so problems discontinue.

***Outcome***. This intervention allows the client to acknowledge past judgments placed on others and guide their understanding toward the negativity that clutters the mind. Understanding that cognitive thoughts will affect the client holistically will improve the client well-being and overall quality of life. This will trigger changes that will enrich participation through acceptance and communication with others (AOTA, 2014).

**Short term goal 2**. The client will regulate emotions appropriately during group discussion using DBT techniques 50% of the time in 1 month.

***Intervention***. The intervention will take place during group meetings 5 times a week for 90 minutes of the 3 hour session. This will begin with client check-in followed by group discussion of experienced problems for the first 90 minutes. After the 10 minute break, the group will return back together and participate in an activity that is facilitated toward the client of interest. The client will learn distraction techniques when maniac episodes occur. A handout will be given titled “Distract Yourself by Counting” to understand simple skills that keep one’s mind busy and help focus on something other than the negative thoughts that fill the mind (McKay et al., 2007). This will consist of counting breaths, counting objects, count or subtract by increments of seven, or identifying a counting method that is individualized for the client. A distraction plan will be made for the client during group, to utilize in discomforting situations. This plan will be written on a note card and carried in the client’s wallet as a resource to distract, relax, and cope. The client will have these techniques as a tool to cope with upcoming distressing situations to utilize as a reminder. Discussion will take place if time permits within the 90 minute group treatment session to identify other areas to utilize this distraction technique.

***Intervention approach*.** The OTPF approach to intervention focuses on the idea to establish and restore the client’s cognitive processing. This is an approach designed to change client variables that establish skills or an ability that has not yet developed. This will guide cognitive thinking to ensure appropriate thoughts are in place and eliminate all judgments. The intervention also focuses on the notion to modify the current context or activity demands to support performance in the natural settings. This includes compensatory techniques of using distraction techniques to reduce emotions that impact cognition. Simplifying the task sequence will to initiate the client’s ability to solve problems, while modifying philosophies and opinions that constitute basic values (AOTA, 2014).

***Evidence*.** The intervention focused on the DBT using distracting strategies to cope with distress. The *Journal of Affective Disorders* directed a preliminary study of a DBT-based psychoeducational group in treating euthymic, depressed, or hypomanic Bipolar I or II patients (Van Dijk, Jeffrey, & Katz, 2013). Twenty six adults were randomized to an intervention consisting of 12 weekly 90 minute sessions of learning DBT skills, mindfulness techniques, and general bipolar disorder psychoeducation (Van Dijk et al., 2013). This introductory evidence shows that DBT skills reduce depressive symptoms, improve affective control, and improve mindfulness self-efficacy in bipolar disorder (Van Dijk et al., 2013). Further trials are needed given the small sample size however evidence reflects that DBT skills have been proven to be effective in treatment of bipolar disorder (Van Dijk et al., 2013).

***Outcome***. The achieved outcome will improve the client’s occupational performance, quality of life, and overall well-being. The client will utilize this note card in preparation for social events or when involved in disagreements. This will help guide the client directly to proper steps to prepare him for society. He will achieve life satisfaction through self-concepts and coping strategies learned within group, which will promote occupational performance. Physical, mental, and social aspects of well-being will be supported with the implementation of this compensatory strategy. He will have the education and tools to emotionally regulate through managing the thoughts that cloud his mind (AOTA, 2014).

**Precautions and Contraindications**

Theories are directed toward client specific characteristics, however may not be suitable for explicit populations. According to Substance Abuse and Mental Health Service Administration (SAMHSA), CBT is generally not appropriate for certain clients who have psychotic or bipolar disorders and are not stabilized on medication (Substance Abuse and Mental Health Service Administration [SAMHSA], 2006). In addition, clients who do not have stable living arrangements and are not medically stable would not be suitable for CBT interventions. Because treatment takes place in an intensive outpatient treatment center with sufficient housing and medication management, this eliminates these factors and allows this theory to guide interventions. The client would be receiving treatment within the program counseling group that consists of a population meeting the mental illness and substance abuse standards to allow treatment. The goals target the client directly with the intervention and activity choice guided by psychotherapeutic theories, although considerations will be granted upon days filled with distress. Emotional outbursts will be documented accordingly to consider daily conditions and measured by the maniac stage of symptoms.

**Primary Framework Utilized**

The Cognitive Behavioral Theory (CBT) is highly utilized in psychosocial treatment and throughout interventions. This theory is based on work by Aaron Beck, who described depression as being related to distorted beliefs and faulty thinking patterns, which affect emotions and behaviors (Beck, 1999). He theorized that humans develop core beliefs through early life experiences and centered CBT on uncovering distorted beliefs and faulty thinking patterns (Spangler, 2011). Practicing alternative cognitive and behavior patterns may adjust the thoughts and emotions that occur prior to disruptive behaviors in people with mental illness. By establishing these connections, individuals may identify triggers that interrupt appropriate rationale and establish changes to negative thought patterns. This may help identify the behaviors associated with one’s illness and determine what triggers these reactions.

In conjunction with the cognitive behavioral approach, interventions were also guided through dialectical behavioral therapy (DBT). This technique stems from CBT and both theories have been shown to effectively treat borderline personality disorder, a condition also marked by prominent affective disturbances (Van Dijk et al., 2013). This is a protocol that focuses on behavioral and problem-solving characteristics utilizing acceptance based strategies. It is involved in treating patients with multiple disorders targeting various thought processes and behavioral styles used throughout intervention. Five components are addressed with DBT including skills training, motivational enhancement, generalization, structuring of the environment, and the motivational enhancement of therapists. The primary goal of DBT is to balance behavioral change, problem-solve, and emotionally regulate with validation, mindfulness, and acceptance of patients (SAMHSA, 2006). These components correspond to the interventions developed to serve the client and enhance the awareness of inappropriate behavior as well as distorted thoughts.

**Client Training and Education**

Health promotion and wellness is addressed throughout group meetings relating the psychological feelings to the physiological signs. The stressors that take up space in our mind deplete energy impacting one’s immune system and overall wellbeing. Exhausting one’s mind with negative emotions including judgment, anger, resentment, and fear will build up internally affecting the body’s organs as well as externally affecting the environmental surroundings. It is important for the client to be educated upon their illness to terminate these problems and live a peaceful life. Progress continues at a steady incline through individual’s cognitive processing and awareness of reactions. Activities and interventions provide the client with useful tools to transfer over into social relationships. If the connection is made between the cognitive behavioral strategies learned in group and how it may be practiced outside of group, the client will have a greater success rate to manage their mental illness and maintain future independence.

**Client Responsiveness**

The client’s responsiveness will be monitored and assessed towards goal outcome during each treatment session by daily progress notes and clinical reasoning. If verbal cues, cognitive redirection, behavioral strategies and verbal prompting are exceeded well beyond the level suggested, goals and interventions will be modified appropriately. Intervention takes place in a group setting to help the client become aware of his social interactive behavior toward his peers. Because behavior and cognition are related to the client’s bipolar mental illness, client factors will be considered throughout each treatment session. Activities will be graded up or down in response to the client’s behavior and will be documented to verify the outcome of treatment. It is hopeful the client responds to the connection between treatment services and how this will affect his performance and participation in society. If the client responds to treatment with an open mind to change, the potential for relapse will be eliminated, granting the opportunity for outcome success.

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