

**The bio-psychosocial treatment needs of dual diagnosis patients:
Depressive episodes and alcohol misuse**

by

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A mini-dissertation submitted in partial fulfilment of the requirements for the
degree

MASTER OF SOCIAL WORK (HEALTH CARE)

in the Department of Social Work and Criminology

Faculty of Humanities

University of Pretoria

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November 2014

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Acknowledgements

I would like to acknowledge and extend my appreciation to the following individuals:

- My supervisor, Dr L.S. Geyer, for his professional guidance, mentorship and encouragement.
- My parents and loved ones for their patience, support and encouragement.
- My colleagues for their support and sound advice.

Abstract

The bio-psychosocial treatment needs of dual diagnosis patients:

Depressive episodes and alcohol misuse

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DEGREE: MSW (Health Care)
INSTITUTION: University of Pretoria

The goal of this study was to determine the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse. In order to achieve this goal, a qualitative research approach was adopted to gain a holistic understanding of dual diagnosis, as well as to explore and to describe the bio-psychosocial treatment needs of these individuals. This research study aimed to contribute towards solving a practical problem in practice by offering recommendations for a multidisciplinary team approach with regard to the treatment of patients diagnosed with depressive episodes and alcohol misuse in South African treatment centres.

To this end, the collective case study design guided the research study. A two-stage sampling strategy was implemented in the study. Firstly, purposive sampling was used to identify potential participants, and it was followed up with, secondly, volunteer sampling to recruit 10 individuals with co-occurring depressive episodes and alcohol misuse from a private psychiatric clinic in Pretoria, which formed the research sample. Furthermore, a semi-structured one-on-one interview, guided by questions contained in an interview schedule, was used as a data collection method. The researcher implemented the qualitative data analysis process of Creswell (1998, in Schurink, Fouché & De Vos, 2011) to extrapolate themes and sub-themes from the raw data through thematic analysis. The trustworthiness of the data interpretation was confirmed through peer debriefing, member checking, as well as the assurance of confidentiality.

An analysis of two different sources of data, namely the literature review and interviews, was used to answer the following research question: What are the bio-psychosocial treatment needs of dual diagnosis patients suffering from depressive episodes and alcohol misuse?

The key findings indicated that persons suffering from a dual diagnosis of depressive episodes and alcohol misuse have idiosyncratic biological, psychological and social treatment needs. On a biological level it was found that patients with a dual diagnosis lead a less active and an unhealthy lifestyle and are therefore more prone to the development of chronic illnesses, such as hypertension and cardiovascular disease. It was also found that these individuals exhibit addictive behaviours apart from the alcohol misuse. With regard to psychological needs, the research found that dual diagnosis patients experience difficulties in expressing their needs and emotions to others. In this regard the research indicated that these individuals have poorly developed coping mechanisms and limited resources for gaining an improved sense of well-being. Identified areas in which these individuals may need assistance on a psychological level include: general coping mechanisms, communication skills, problem solving skills, and conflict management. With regard to violent and aggressive behaviour, it was found that these individuals are more likely to internalise their frustration and aggress towards themselves. On a social level it was found that individuals with a dual diagnosis of depressive episodes and alcohol misuse experience more relationship breakdown and less social support. Additionally, on a social level these individuals experience difficulties in coping in the workplace, as well as having problems with financial management.

It is recommended that the multidisciplinary team participate in the development of psycho-educational groups that focus on the education of dual diagnosis patients regarding their needs on each level of functioning. Furthermore, it is recommended that effective clinical communication patterns are in place to prevent fragmented service delivery to individuals with a dual diagnosis. It is recommended that service delivery takes place in all forms of service delivery, including individual therapy, psycho-educational groups, group work activities, as well as family counselling.

Further research could focus on the following: 1) Extending the research population to areas outside the Gauteng Province, or even South Africa, in order to determine if these findings can be generalised to all patients with a dual diagnosis of depressive episodes and alcohol misuse; 2) Conducting the research in public health care centres to determine if the findings of this study are also prevalent in lower socio-economic classes (taking into consideration

that the present study was conducted at a private psychiatric clinic); 3) Repeating the study with different combinations of psychiatric illnesses, as well as substances of abuse, to determine if the conclusions drawn from this study can be made applicable to dual diagnosis in general, or only to dual diagnosis with depressive episodes and alcohol misuse in particular.

Keywords:

Dual diagnosis

Co-morbidity

Substance misuse

Addiction

Bio-psychosocial treatment needs

Depressive episodes

Alcohol misuse

Social work in mental health care

Gauteng province

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CHAPTER 1:

GENERAL INTRODUCTION

1.1 INTRODUCTION AND CONTEXTUALISATION

Dual diagnosis was first identified in the 1980s (Hryb, Kirkhart & Talbert, 2007:15) and denotes the co-occurrence of severe mental illness and substance use disorders (Drake, 2007:381). It is important, however, that a distinction is made between dual diagnosis and co-morbidity. “Co-morbidity refers to two or more diseases or conditions existing together in an individual at any one time” (Jeenah, 2010:4). Co-morbidity does not necessarily mean that the two conditions influence each other; however, dual diagnosis suggests that a complex relationship exists between the biological, psychological and social levels of the two disorders that co-occur (Jeenah, 2010:4). However, in literature these two terms are used interchangeably. Thus, for the purposes of this study, both dual diagnosis and co-morbidity refer to the complex relationship that exists between co-occurring disorders.

Substance misuse is a ubiquitous factor in mental health treatment programmes, since patients, along with their struggles to adjust to and overcome mental illness, also have to deal with and confront the effects of substance misuse (Drake, 2007:381). Substance misuse refers to “the use of any drug (chemical agent), usually by self-administration, in a manner that deviates from approved social or medical patterns” (Sadock & Sadock, 2005:79) that leads to addiction. In terms of this study, substance misuse refers to the misuse of alcohol. “Addiction is the repeated and increased use of a substance, the deprivation of which gives rise to symptoms of distress and an irresistible urge to use the agent again and which also leads to physical and mental deterioration” (Sadock & Sadock, 2005:79).

Epidemiological studies conducted in various developed countries have found that substance misuse is common amongst approximately 50% of persons with severe mental illness (Drake, 2007:381). In these studies, severe mental illness refers to “major mental disorders, such as schizophrenia, schizoaffective disorder, bipolar disorder and recurrent or unremitting depression, when they are persistent and accompanied by functional disability” (Drake, 2007:381). In this regard, depressive episodes, along with alcohol misuse, were found to be the most common dual diagnosis (Boden & Fergusson, 2011:906; Drake, 2007:381; Kessler, 2004:731; Wong & Patten, 2001:422). These depressive episodes refer to a mood disorder with manifestations of “a negative mood, subjective sense of sadness,

feeling ‘blue’ or ‘down in the dumps’ for a prolonged period of time” (Sadock & Sadock, 2005:148).

This study aims to identify the bio-psychosocial treatment needs of patients living with depressive episodes and alcohol misuse to streamline dual diagnosis treatment in treatment centres. The conceptualisation of the term bio-psychosocial is accurately captured by Borrell-Carrió, Suchman and Epstein (2004:576) as quoted below:

The term bio-psychosocial refers to both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular. At the practical level, it is a way of understanding the patient’s subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care.

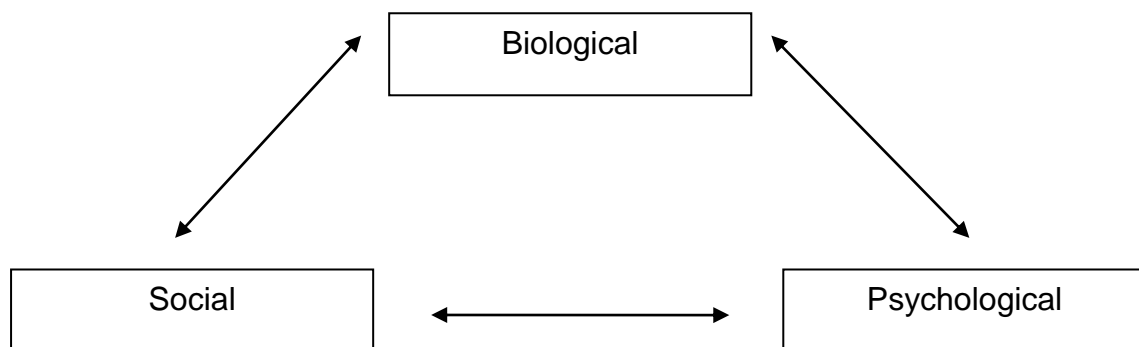
Treatment needs within the context of this study refers to what a dual diagnosis patient wishes to receive from treatment for either an adequate recovery, or to cope with their diagnosis. Currently in South Africa the treatment focus is on one of these diagnoses and seldom on both (Jeenah, 2010:9-11). Within the context of this study, dual diagnosis will refer to the complex relationship that exists between co-occurring depressive episodes and alcohol misuse.

Definitions of the two main focus points of this study, namely depressive episodes and alcohol misuse, correspond with the definitions as set out in the international classification of diseases (WHO, 2010). Depressive episodes: “Depressed or down mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity” (WHO, 2010). Alcohol misuse: “A pattern of psychoactive alcohol use that is causing damage to health. The damage may be physical or mental” (WHO, 2010).

1.2 THEORETICAL FRAMEWORK: BIO-PSYCHOSOCIAL APPROACH

The bio-psychosocial approach recognises that health care services must take a holistic approach on the treatment of dual diagnosis. In other words, they must take into account the physical or medical aspects of an individual (bio), the emotional or psychological aspects (psycho), and the sociocultural, socio-political, and socio-economic issues (social) in an individual’s life, when providing treatment.

In 1977, George Engel adopted the bio-psychosocial approach, originally developed by Roy Grinker in 1954 for use in psychiatry, and developed it into a model that can widely be applied in all medical practices (Alvarez, Pagani & Meucci, 2012:173). The approach draws from the strength perspective of social work practice and adopts parts from general systems theory and applies it to medicine and health care (Smith, Fortin, Dwomena & Frankel, 2013:226). It focuses on how each level of functioning influences the next (as demonstrated in Figure 1) and how these interactions have an impact on the person as a whole (Borrell-Carrió et al., 2004:576).



Source: Borrell-Carrió et al. (2004:576)

Figure 1: The bio-psychosocial approach

Furthermore, the bio-psychosocial approach is both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how a dual diagnosis is affected by multi-levels of organisation. From societal to molecular and *vice versa*. This study aims to explore how social practices such as work environment, social support, relationships, and financial aspects may contribute or exacerbate depressive symptoms and alcohol misuse on a molecular level, as well as how the changes on a molecular level, such as changes in neurotransmission due to depression or alcohol misuse, influence the social sphere of an individual's life. In undertaking this, the researcher was able to speculate, on a philosophical level, about the needs of dual diagnosis patients. On a practical level, the bio-psychosocial approach is a way of understanding the patient's objective experiences of living with depressive episodes and alcohol misuse in order to reach an accurate diagnosis, explore better health outcomes and plan for care (Borrell-Carrió et al., 2004:576).

Strengths associated with the bio-psychosocial approach are its contribution to the reverse of dehumanisation of medicine and disempowerment of patients in health care (Borrell-

Carrió et al., 2004:576); thus it encourages the patient to take more responsibility in dual diagnosis treatment. In other words, on a psychological level the dual diagnosis patient will receive information regarding depressive episodes and alcohol misuse. This information could in turn assist the patient on a social level to cope better with his or her social environment, leading to a decrease in depressive episodes and the need to self-medicate. Furthermore, improving the patient's social environment could increase psychological functioning.

The bio-psychosocial approach improves the knowledge base of medical practitioners and social workers, since this approach expects clinicians to be effective communicators and ethical practitioners of medicine who train themselves in the study of psychosocial aspects alongside biological determinants of health (Dogar, 2007:11). Biological aspects are therefore addressed by a psychiatrist by means of medication. The medication stabilises the dual diagnosis patient physically, making them able to concentrate on psychological and social interventions. However, education regarding biological determinants is also needed in order to ensure adherence to treatment; therefore, social workers need to educate patients or clients on the biological aspects of dual diagnosis (Van Daele, Hermans, Van Audenhoven & Van den Bergh, 2012: 474). Thus, in terms of dual diagnosis, the bio-psychosocial approach contributes to a better understanding of dual diagnosis for both patients and clinicians. It addresses all spheres affected by dual diagnosis and provides a suited structure in which integrated treatment can take place.

Furthermore, the bio-psychosocial approach contributes to the development of the multidisciplinary team approach implemented in most health care settings. In using this approach, it contributes to collaboration between physicians, social workers and other members of the health care team. However, in many instances the culture of the biomedical model is very much alive in the practice of most medical practitioners (Adler, 2009:609). This poses a problem in dual diagnosis treatment, if the psychiatrist, for example, does not include other members of the multidisciplinary team when developing treatment plans. The bio-psychosocial approach suggests a dialogue between clinician and patient, because the reality of each patient is not just interpreted by the clinician, as it is a continuous exploration of theories and expectations by both the clinician and the patient (Adler, 2009:609). Therefore, the bio-psychosocial approach expects the social worker to continuously be in dialogue with the patient but also with other members of the multidisciplinary team. For example, the social worker will need to be in communication with the psychiatrist in order to establish the severity of the diagnosis and capacity of the patient. With regard to the

psychological aspects, the social worker will provide education regarding dual diagnosis through group work, while the psychologist could give individual psychotherapy.

This approach enabled the researcher to develop a better understanding of dual diagnosis, as this approach encompasses information from all levels of functioning (Ghaemi, 2009:3; Smith et al., 2013:226). With the individual at the centre, the researcher could integrate information from the psychological level with information from the biological level and with data from the social level to develop a holistic understanding of dual diagnosis, e.g. “molecular integration at the cellular level, perception and cognition at the psychological level, and attribution of meaning at the social level” (Smith et al., 2013:226). By understanding that the integration of these action systems is a critical element in harmonic integration and health, the researcher could identify the bio-psychosocial needs of dual diagnosis patients (Smith et al., 2013:226).

1.3 RATIONALE AND PROBLEM STATEMENT

Although multiple research studies have recognised the importance of dual diagnosis research, the researcher has found that most of these studies are based in first world countries with limited research focusing on the southern hemisphere, and more specifically South Africa (Boden & Fergusson, 2011:906; Crum, Storr & Chan, 2005:72). Several databases, such as Ebsco Host, Google Scholar, Sabinet, NRF, and Science Premier were consulted, and it was confirmed that, up to date, limited South African studies have focused on the bio-psychosocial treatment needs of patients with depressive episodes and alcohol misuse. It was also found that most of the research on this topic is very dated, especially when it comes to intervention (Solomon, Zimberg & Shollar, 1993).

Stein, Seedat, Herman, Moomal, Heeringa, Kessler and Williams (2008:113) postulate that the most prevalent class of mental disorders in South Africa are anxiety disorders with a prevalence of 15.6%, followed by substance use disorders with a prevalence of 13.3%, and thirdly mood disorders, including depressive episodes with a prevalence of 9.8%, with an alarming co-occurrence of 32% (Pettinati, 2004:785) of alcohol misuse and depressive episodes (Wong & Patten, 2001:422).

In 2012, a private psychiatric clinic in Pretoria, South Africa, admitted a total of 3 261 psychiatric patients, of which 336 (10.3%) were admitted on their own accord for having a substance misuse problem, whereof 115 (3.5%) presented with alcohol dependence (Vista Clinic, 2014). These statistics, however, only reflect the number of patients that admitted to

having a substance abuse problem and were in a sober state at the time of admission to a psychiatric clinic. With regard to admission of dual diagnosis patients, Kessler (2004:730) is of the opinion that the prevalence of co-occurrence is much higher than reflected in these numbers, seeing that clinical samples are associated with professional help-seeking, which highlights the need for dual diagnosis research, specifically in South Africa.

Intervention research on co-occurring disorders have highlighted the need for integrated mental health and substance misuse services at a clinical level (Drake, O'Neal & Wallach, 2008:123). Research, however, has indicated that patients with co-occurring disorders were highly unlikely to receive treatment for both mental health and substance misuse problems (Drake et al., 2008:123). Instead, patients tend to seek treatment for only one diagnosis, and would be assigned to one system or the other, which would view the patient through its particular lens only (Drake et al., 2008:123; Hryb et al., 2007:15). This situation is further compounded when a multidisciplinary team, with different approaches to treatment, has to combine their efforts during the treatment of patients. It is therefore argued that dual diagnosis should be understood holistically to enable multipronged approaches, i.e. biological, psychological, and social, in rehabilitation and management. Most dual diagnosis patients need more structures than what a conventional psychiatric institution can provide, yet they are too fragile to withstand the rigours of a treatment centre or are excluded from such treatment due to their psychiatric needs (Case, 1991:69; Drake et al., 2008:123). The patient can also be excluded from both systems due to complicating factors (Granholm, Anthenelli, Monteiro, Sevick & Stoler, 2003:304), such as suicidal tendencies, withdrawal symptoms or psychosis. This statement is supported by the fact that treatment in South Africa is also known to be provided separately with only a limited number of institutions in South Africa providing both these services (Jeenah, 2010:17). Thus, by determining and understanding the treatment needs of dual diagnosis patients, specifically those suffering from the most prevalent co-occurrence, namely depressive episodes and alcohol misuse, specific treatment programmes can be developed to treat both problems adequately, or recommendations can be offered for multiprofessional teams working in this field of service delivery.

It is thus clear that substance misuse has diverse effects on mental health treatment programmes. Consequently these effects need to be taken into consideration when treating a dual diagnosis patient. Therefore, this research aims to explore and describe the biopsychosocial treatment needs of dual diagnosis patients in a private psychiatric clinic, in order to offer recommendations for more effective treatment programmes, especially within a

multidisciplinary context working from a bio-psychosocial theoretical approach. Thus, the research question guiding this study was: “**What are the bio-psychosocial treatment needs of dual diagnosis patients, specifically for patients with depressive episodes and alcohol misuse?**”

1.4 GOAL AND OBJECTIVES

The **goal** of the study was to determine the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse.

In order to achieve the goal, the following **objectives** were to be met:

- To conceptualise dual diagnosis and the various elements of treatment within the context of a developing world.
- To explore and describe the bio-psychosocial treatment needs of patients, diagnosed with depressive episodes and alcohol misuse, from the patient’s perspective.
- Based on the outcomes of the study, to make recommendations for a multidisciplinary team approach to the treatment of patients diagnosed with depressive episodes and alcohol misuse in South African treatment centres.

1.5 RESEARCH METHODOLOGY OVERVIEW

The researcher was interested in gaining a holistic understanding of dual diagnosed patients’ feelings and perceptions, as well as determining how these individuals make sense of their world. Therefore, a qualitative research approach was adopted (Willig, 2008:8). The research study was rooted in a constructionist approach because the researcher wanted to understand dual diagnosis as it is presented in the patient’s world (Fouché & Delport, 2011:63). Because this approach is interested in perceptions of individuals, the purpose of the study was exploratory in nature, but simultaneously descriptive, as the researcher also described the bio-psychosocial treatment needs of people living with alcohol misuse and depressive episodes.

Furthermore, the aim of the study was to contribute towards practical issues of problem solving, namely determining what the bio-psychosocial treatment needs of dual diagnosis patients are (Durrheim, 2006:45) and, therefore, the research was applied (Durrheim, 2006:46).

Due to the study being qualitative in nature, a case study design was considered to be the most appropriate research design, but more specifically, the researcher made use of the

collective case study design. This design offers a multiperspective analysis to the researcher, where the researcher considers more than one or two participants' views and opinions on their treatment needs within the context of dual diagnosis (Nieuwenhuis, 2010a:75).

For the purpose of this study the data collection procedure used was a semi structured one-on-one interview with guided questions contained in an interview schedule (see Appendix D). This data collection method was most applicable because it allowed the researcher to explore certain themes, as well as giving more flexibility to explore and gain a detailed picture of the participants' perceptions, ideas, beliefs or accounts of each topic (Greeff, 2011:351).

The study population included all individuals with a dual diagnosis on the case load of a private psychiatric clinic situated in Pretoria, from 1 January 2014 to 1 July 2014. By utilising purposive and volunteer sampling methods, a research sample of ultimately 10 participants was selected that met the following criteria: 1) Male and female patients who presented with depressive episodes and alcohol misuse. 2) Patients who voluntarily provided informed consent. 3) Patients on the case load of a private psychiatric clinic from 1 January 2014 to 1 July 2014. 4) Only participants who could speak and understand either Afrikaans or English. 5) No participants were considered if either the depressive episodes or alcohol misuse incapacitated them to communicate about their dual diagnosis. Ultimately 10 research participants were interviewed; however, the data reached saturation point after the sixth interview.

Confidentiality of the data collected was ensured by means of confidentiality agreements, as well as not referring to the participants by name, but rather by numbers (Gravetter & Forzano, 2003:107).

The raw collected data was analysed using Cresswell's (1998) qualitative data analysis process (Nieuwenhuis, 2010b:103), with the specific view to undertake thematic analysis. In this regard, the researcher ensured trustworthiness by means of prolonged engagement, triangulation, peer debriefing, member checking, as well as the assurance of confidentiality.

Before the empirical study was undertaken, its feasibility was ensured through, among others, ethical clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Appendix A). As well as obtaining permission from a private psychiatric clinic in Pretoria to make use of their patients to conduct the study (see Appendix

B). Furthermore, ethical considerations such as informed consent (see Appendix C), confidentiality, avoidance of harm, and debriefing of participants were taken into consideration in conducting this study. For a more detailed discussion of the research methodology and ethical considerations applicable to this study, see Chapter 3, Section 1.

The next section will highlight the limitations of the study.

1.6 LIMITATIONS OF THE STUDY

The following limitations must be taken into consideration when reading this research study:

- The research study was only conducted at one psychiatric hospital in the Gauteng Province. Therefore, the findings cannot be generalised to the entire population of dual diagnosis patients suffering from depressive episodes and alcohol abuse in the province, or South Africa.
- The study was conducted at a private psychiatric clinic. As a result, the research findings reflect only the private sector and not dual diagnosis in the public health sector.
- The research study only focused on a dual diagnosis of depressive episodes and alcohol misuse. Therefore, the findings may be different for other combinations of psychiatric disorders and substances of abuse.

1.7 CONTENTS OF MINI-DISSERTATION

The remainder of the mini-dissertation will consist of the following chapters:

- **Chapter 2: A literature review on the bio-psychosocial treatment needs of a dual diagnosis patients**

Chapter 2 will give a literature overview regarding the concepts of dual diagnosis, the prevalence of dual diagnosis, as well as the identified bio-psychosocial treatment needs. These needs will include those that have been identified in literature, namely physical health, coping mechanisms, violent and aggressive behaviour, relationships, and financial aspects.

- **Chapter 3: Research methodology, empirical research findings and interpretation**

In Chapter 3, the results obtained from the research study will be discussed and interpreted. In addition the chapter will outline the research methodology that was followed, as well as the applicable ethical issues.

- **Chapter 4: Conclusions and recommendations**

Chapter 4 will provide conclusions regarding the bio-psychosocial treatment needs of a dual diagnosis patient with depressive episodes and alcohol misuse. Furthermore, the chapter will offer recommendations regarding the bio-psychosocial treatment needs for the multidisciplinary team, specifically for treatment at treatment centres, and future research on dual diagnosis.

CHAPTER 2:

A LITERATURE REVIEW ON THE BIO-PSYCHOSOCIAL TREATMENT NEEDS OF DUAL DIAGNOSIS PATIENTS

2.1 INTRODUCTION

Most research completed on dual diagnosis does not dispute the fact that there is a link between alcohol misuse and depressive episodes (Canaway & Merkes, 2010:262), but as to how, why, and to what extent, an agreement cannot be reached by academia and practitioners. The inability to reach consensus consequently has a negative impact on treatment development for individuals suffering from co-occurring alcohol misuse and depressive episodes. The aim of this chapter is to explore the literature concerning treatment needs of dual diagnosis patients with co-occurring alcohol misuse and depressive episodes. Therefore, the main topics to be addressed include: the prevalence of dual diagnosis; a discussion of alcohol misuse and depressive episodes as separate entities; an exposition of the hypothesised treatment needs of dual diagnosis patients on the biological, psychological and social level and examining the role of the social worker.

2.2 UNDERSTANDING DUAL DIAGNOSIS

In order to understand dual diagnosis, the researcher will firstly provide an overview of the prevalence of dual diagnosis, secondly, discuss alcohol misuse and depressive episodes as two separate entities, and lastly, discuss the symbiotic relationship of the mentioned dual diagnosis.

2.2.1 Prevalence of dual diagnosis

Since dual diagnosis had first been identified in the 1980s it has become more and more prevalent in all societies (Drake, 2007:381). This section will discuss the prevalence of dual diagnosis globally, nationally, and specifically in the Gauteng Province where the research was conducted.

❖ Globally

According to the World Health Organization (WHO) (2013:5), at least 350 million people suffer from depressive episodes, with only one out of ten seeking help for their psychiatric

illness. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (WHO, 2013:5). A recent study conducted by the WHO (2013:5) has estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16.3 billion (\pm R147 billion) between 2011 and 2030. This excludes all other health care cost associated with psychiatric illnesses.

Hryb et al. (2007:15) are of the opinion that the low percentage seeking treatment may indicate that many individuals with psychiatric illnesses turn to self-medication, such as alcohol and other substances, in order to deal with the negative effects of their illness. Consequently, this often leads to a dual diagnosis. Drake (2007:381) estimates that the prevalence of co-occurring psychiatric illnesses and substance abuse is approximately 50%. An estimated 2.7 million adults (18 years and older) reported a co-occurring depressive episode and alcohol misuse. Clinical studies determined that the lifetime prevalence of substance abuse disorders in the general population was 16.7%, but was as high as 27.2% for individuals suffering from depressive episodes (Drake, 2007:382) with only between 50% and 60% seeking treatment (Hryb et al., 2007:15). Furthermore, it is estimated that between 76% and 85% of people with mental illnesses receive treatment in low-income and middle-income countries, which include most African countries, including South Africa.

❖ **Nationally**

According to Stein et al. (2008:112), there is no nationally representative data available on the prevalence of psychiatric disorders in South Africa. Their statement is supported by the *2011 General Household Survey Report* (Statistics South Africa, 2013), which stated that there are 95 000 individuals in South Africa suffering from depression or a mental illness, yet it did not elaborate on this fact. The lack of statistics makes it hard to determine the prevalence of dual diagnosis in South Africa. However, a study with 4 351 participants, conducted by Stein et al. (2008:114) in an attempt to gather more statistical information, found that the most prevalent lifetime disorders in South Africa are firstly alcohol abuse at 11.4%, and secondly, major depressive disorders with a prevalence of 9.8%.

A clinical study conducted by Fabricius, Langa and Wilson (2007:7) at a private rehabilitation centre in Johannesburg, South Africa, revealed that 57% of individuals admitted to the rehabilitation centre had a substance-related disorder, as well as one or more co-occurring psychiatric disorders. This statistically mirrors the findings from international research. Furthermore, a study conducted by Weich and Pienaar (2009:216) at Stikland Psychiatric Hospital found the prevalence of co-occurring psychiatric disorders and substance abuse to

be 79%. They proposed that, regardless of on which side of treatment the patient is, whether on the substance abuse treatment side or psychiatric treatment side, the prevalence of co-occurring substance misuse and psychiatric illness is between 50-80%.

❖ **Gauteng Province**

The above findings were also reflected by a private psychiatric clinic in Pretoria, South Africa. Out of a total of 4 929 admissions from 1 January 2013 to 1 April 2014, 3 487 (70.7%) of patients were admitted for some type of depressive episode, excluding bi-polar disorder. From this group of patients, 4.3% reported severe alcohol dependency, with a high indication for mild to moderate alcohol misuse (Vista Clinic, 2014).

In order to understand why the prevalence of dual diagnosis is so high, dual diagnosis, both as an illness and as the sum of its parts, must be understood. Therefore, the following section will examine depressive episodes and alcohol misuse as two separate entities, after which dual diagnosis will be examined in more detail.

2.2.2 Depressive episodes

Depressive episodes remain one of the most debilitating, and still most prevalent psychiatric disorders worldwide (Keedwell, Surguladze & Philips, 2009:353). Colbert (2003:63) refers to it as the “‘common cold’ of mental illness”. Therefore, it is understandable that the WHO (2013) estimated that there are more than 350 million people suffering from depression worldwide. Colbert (2003:63) claims that the reason for this high estimation is the lifestyle choices of depressed individuals, as these choices almost always result in poor nutrition, little exercise, smoking of cigarettes, use of alcohol or drugs, or the abuse of prescription medication. These bad habits result in decreased immune functions that eventually lead to disabling co-occurring illnesses.

Statistics on depressive episodes have fluctuated over the years but, on average, depressive episodes affect approximately ten per cent (10%) of men and nearly twenty-five per cent (25%) of women (Schlimme, 2002:1; WHO, 2013), with a lifetime prevalence of sixteen per cent (16%) (Keedwell et al., 2009:353). Further statistics have revealed that one in six individuals will be diagnosed with a depressive episode during their lifetime (Krishnan & Nestler, 2008:894).

Therefore, the need for the South African government to address neuropsychiatric disorders are on the increase, as it contributes to 6% of the total burden of disease in South Africa (Stein et al., 2008: 113). This high burden is mainly due to the debilitating symptoms that occur during depressive episodes.

The most common symptoms of depressive episodes are a pervasive lowering of mood, the loss of enjoyment in former pleasurable activities (Katona, Cooper & Robertson, 2008:22) or reduced ability to experience pleasure from natural reward (Krishnan & Nestler, 2008:894), and decreased energy (Katona et al., 2008:22). Krishnan and Nestler (2008:894) add irritability, difficulties in concentrating, and abnormalities in sleep and appetite to the core symptoms of depressive episodes.

In so many instances, when talking about depressive episodes or psychiatric illnesses, the socially acknowledged jargon used to explain depressive episodes is that depressive episodes are due to a 'chemical imbalance' in the brain. But what does this refer to? The brain is the central executive organ of the nervous system and is divided into various parts that perform different functions (Schlebusch, 2000:11). One of these parts, that are predominantly responsible for emotions, is the limbic system (Leaf, 2007:7). In order to explain the process of the limbic system better, Leaf (2007:7) compares the cells in the brain, known as neurons, to a forest. Human beings have an estimated 100 trillion 'trees' or neurons in their brain, and each 'tree' or neuron is capable of growing up to 70 000 'branches', known as dendrites. In order for the brain to communicate with the body it makes use of these 'branches' or dendrites to relay messages from one neuron or 'tree' to the next, by means of neurotransmitters (Leaf, 2007:7). Neurotransmitters are chemicals that transmit signals between neurons ('trees'), much like a monkey jumping from branch to branch and tree to tree carrying a message (Leaf, 2007:7). Schlimme (2002:1) add that these chemicals bind to receptors in order to excite or inhibit the firing of neurons. Therefore, a better understanding of not just depressive episodes and alcohol misuse, but also of dual diagnosis can be developed.

In the case of depressive episodes, if the limbic system is not producing the 'feel good' neurotransmitters, such as dopamine, norepinephrine and serotonin, negativity or pessimism is usually evident in the patient (Colbert, 2003:71). It is because of this that individuals with depressive episodes are drawn to self-medication, as the consumption of alcohol produces a moderate intoxication that potentiates the effects of serotonin, thereby making the depressed individual think that they are experiencing an improved mood (Colbert, 2003:71).

2.2.3 Alcohol misuse

Alcohol use is embedded in the social and cultural fabric of most societies and is actively promoted in many cultural, social and religious events (Rassool, 2011:48). Research conducted by the Royal College of Psychiatrists (2010:2) supports this statement, as they have found that more than nine out of ten people in the United Kingdom (UK) drink alcohol and view it as a normal aspect of social activities. However, figures made available by the Mental Health Foundation (2006:5) show that 38% of men and 16% of women in the UK are drinking above recommended limits and can be classed, according to World Health Organization standards, as having an alcohol use disorder. This is equivalent to 8.2 million people in England alone.

In South Africa it was estimated more than a decade ago that up to 89% of men and up to 77% of women drink alcoholic beverages (Maiden, 2001:66). These numbers, according to Seggie (2012:1), have significantly increased over the past decade. It is calculated that South Africans consume roughly 5 billion litres of alcohol per year. That is an average of 9 – 10 litres of pure alcohol per person per annum (Seggie, 2012:1). According to the World Health Organization's *Global Status Report on Alcohol and Health* (Poznyak & Rekve, 2014), this is among the highest per capita consumption rates in the world (Seggie, 2012:1).

Additionally, Rassool (2011:48) notes that alcohol is the fifth leading risk factor for the development of non-communicable diseases, such as cardiovascular disease, cirrhosis of the liver, and various cancers, as well as other neuropsychiatric disorders, including depressive episodes.

Therefore, the Mental Health Foundation (2006:5) postulates that far too little attention has been paid to the link between alcohol misuse and mental illness in general, but specifically to depressive episodes. There has also been comparatively little public exploration of why people drink and why alcohol forms such an important part of the social spheres of societies. Some suggested theories why people drink are that alcohol tastes good to most adults; there is a socially accepted norm that alcohol will help them to 'unwind' and relax; and it has the ability to lower people's inhibitions, making them more confident to talk to other people (The Royal College of Psychiatrists, 2010:3). Other theories suggested by the Mental Health Foundation (2006:6) include that alcohol "help us relax, feel brave, introduce ourselves, seal business deals, celebrate life events, we have forgotten how to do anything without alcohol".

However, one of the most prevalent theories is that people use alcohol as ways of coping with life or to self-medicate (Mental Health Foundation, 2006:6). According to some research (Mental Health Foundation, 2006:6; Rassool, 2011:48; Royal College of Psychiatrists, 2010:3) alcohol can be a very effective way of feeling better for a few hours. Therefore, in the case of treatment, it must be understood that alcohol is not just a chemical coping mechanism for dealing with the negative physical symptoms of illness, but also a social coping mechanism that has to be addressed in the social sphere too.

The reason why people use alcohol to feel better has to do with the biochemical changes in the brain, similarly to an earlier discussion regarding depression. When neurons (trees) are unable to produce certain chemicals (monkeys), like serotonin and dopamine, for whatever reason, people's moods are affected (Rassool, 2011:57). Because alcohol has the ability to modulate the activities of serotonin and dopamine, alcohol has the temporary effect of an improved mood (Tabakoff & Hoffman, 2004:7). Furthermore, alcohol also potentiates gamma-Aminobutyric acid's (GABA) effects in the brain and because GABA is the major inhibitory neurotransmitter in the brain tissue it affects the body's ability to respond to stimuli, creating a 'mellow' and relaxed feeling (Tabakoff & Hoffman, 2004:7). Therefore, alcohol promotes the desire through the serotonin and dopamine channels, but inhibits the performance through the GABA inhibitory channels (Tabakoff & Hoffman, 2004:7).

Continued exposure to alcohol may cause progressive changes in neuropsychological functions due to alterations in gene expression, neural remodelling, and neurotoxicity; therefore, these individuals will develop deficits in cognitive abilities, including special learning and memory, as well as response inhibition (Crews, Buckley, Dodd, Ende, Foley, Harper, He, Innes, Loh, Pfefferbaum, Zou, & Sullivan, 2005:1504). Rassool (2011:57) adds that, along with the effect alcohol has on mood and cognitive functioning, it also has detrimental effects on a human's physical well-being. This is because alcohol has a high calorific value and affects the body's ability to absorb and use nutrients, which ultimately results in malnutrition and immune suppression, making an individual more vulnerable for the development of physical, as well as psychological illnesses.

2.2.4 Dual diagnosis

After examining depressive episodes and alcohol misuse as two separate entities, it has become clear that the relationship existing between depressive episodes and alcohol misuse is very complex and symbiotic in nature (Brady & Malcolm, 2004:529). For many decades it was believed that there is a strong link between alcohol misuse and depressive episodes

and that a large number of substances may be capable of causing depression, therefore many psychiatric and pharmacological reference sources and contemporary textbooks of the late 80s and early 90s contain lists of substances, that are purported to cause depression (Patten & Love, 1993:96).

Brady and Malcolm (2004:529) challenged this viewpoint and were of the opinion that this phenomenon of dual diagnosis may manifest itself in several ways:

1) Alcohol misuse and depressive episodes may co-occur by coincidence, although there is not much proof supporting this, since alcohol misuse and depressive episodes co-occur by chance to a larger degree than expected (Mental Health Foundation, 2006:26);

2) Alcohol misuse may cause depressive episodes or increase the severity of symptoms (Brady & Malcolm, 2004:529). This assumption, to an extent, is supported. It is purported that problematic alcohol misuse may be associated with depression, not just because of the high amounts of ethanol intake that have detrimental effects on neurotransmission, but also because of other alcohol-related unhealthy lifestyle choices and social environments surrounding problematic drinkers (Gea, Beunza, Estruch, Sánchez-Villegas, Salas-Salvadó, Buil-Cosiales, Gómez-Gracia, Covas, Corella, Fiol, Arós, Lapetra, Lamuela-Raventós, Wärnberg, Pintó, Serra-Majem and Martínez-González, 2013:2). Haynes, Farrell, Singleton, Meltzer, Araya, Lewis and Wiles (2005:544) disagree with this viewpoint. They are of the opinion that excessive alcohol misuse is not associated with the onset of depressive episodes; however, their study did find that abstinence of alcohol was associated with a lower risk of presenting with depressive episodes. Further studies suggest that having a mental health diagnosis like depressive episodes may increase the risk of misusing alcohol to 4.1% (Rethink, 2009:1).

3) The above viewpoint suggests that depressive episodes may cause or increase the severity of alcohol intake (Brady & Malcolm, 2004:529). This viewpoint is supported by the self-medication and alleviation of dysphoria theories (Rethink, 2009:3). The self-medication theory suggests that individuals with depressive episodes may misuse alcohol to relieve a specific set of symptoms and to deal with the negative side effects of the illness or medication (Rethink, 2009:3). The alleviation of dysphoria theory simply means that individuals with depressive

episodes experience dysphoria or feeling 'bad' and this makes them more prone to using alcohol to alleviate these negative feelings (Rethink, 2009:1).

4) Brady and Malcolm (2004:529) mention that both depressive episodes and alcohol misuse are caused by an unknown external factor. The Mental Health Foundation (2006:7) supports this because they believe there is a likelihood that risk factors for poor mental health are also risk factors for alcohol misuse. Other theories supporting this is the multiple risk factor theory and the super sensitivity theory (Rethink, 2009:3-4). The multiple risk factor theory highlights the remarkable resemblance in risk factors between depressive episodes and alcohol misuse. These risk factors include social isolation, poverty, lack of structured daily activity, lack of responsibility, and genetic predispositions (Rethink, 2009:3-4). The super sensitivity theory says that some people may have biological and psychological vulnerabilities, which are caused by genetic and early environmental events in their life. It means that these individuals are vulnerable to stressful life events, so when they experience something stressful, it may trigger a mental illness or substance misuse disorders, or both (Rethink, 2009:3-4).

Understanding and reviewing these viewpoints and theories are of importance to this study because these views determine service delivery and treatment outcomes for dual diagnosis patients.

It is because of these viewpoints towards dual diagnosis that many individuals suffering from alcohol misuse and depressive episodes find themselves caught between different branches of mental health care (Wadell & Skarsater, 2007:1126). Mueser, Noordsy, Drake and Fox (2003:16) attribute these discrepancies in treatment views to the historical division of mental health and substance abuse treatment services. For many years, substance abuse treatment and mental health services have developed and evolved separately (Wadell & Skarsater, 2007:1126). Different perspectives, ideologies, and models underpin the various services (Wadell & Skarsater, 2007:1126). Education, training, and credentialing procedures also differ between these two systems, as do eligibility criteria for clients to receive services, making development of treatment programmes and service delivery almost impossible (Mueser et al., 2003:16). As a result of the bureaucratic separation between mental health and substance abuse treatment services, two general approaches to the treatment of co-occurring depressive episodes and alcohol misuse have been predominant up until early 2000. *Firstly*, the sequential treatment approach, where the one disorder will be addressed

first, usually the substance misuse, followed by the other mental health issues. *Secondly*, the parallel treatment approach, in this regard treatment for both disorders take place simultaneously, but are still viewed and treated as two separate entities (Meuser et al., 2003:16). However, each of these approaches is associated with a variety of difficulties including administrative and organisational problems (Meuser et al., 2003:16). Administrative and organisational problems may include duplication of administrative processes, miss communication between the twee sectors, drug regime confusion and logistical challenges. Therefore, the discerning need to develop guidelines for establishing expert practice and treatment programmes for dual diagnosed patients becomes apparent (Edward & Robins, 2012:551).

In this regard the Health Department of Victoria, Australia tried to remedy the problem by developing a policy which requires clinicians from both the mental health and the substance abuse sector to develop expertise in each other's fields, so that clients are able to obtain treatment via entry points from both services, the initiative is referred to as the 'no wrong door policy' (Edward & Robins, 2012:551). Despite this policy initiative, there has long been the acknowledgement that neither service area provides adequate clinical care for dually diagnosed patients (Edward & Robins, 2012:551). Thus, Rassool (2011:228) suggests the need to work towards an improved integrated approach by all relevant services, with one lead service coordinating the comprehensive care package.

Integrated treatment programmes can overcome many of the challenges faced by the traditional sequential and parallel approaches. Firstly, organisational and administrative challenges are effectively eliminated when using an integrated approach, because no coordination is needed between the different service providers; secondly, clinical issues regarding which disorder should be treated first is eliminated, as both disorders are viewed as 'primary' and receive treatment concurrently. Thirdly, conflicts over the use of different models, structures and philosophies regarding mental health and substance abuse are eliminated. This is not because conflicts regarding theories do not exist between clinical staff, but the need to work towards a collaborative team and to present a consistent treatment plan for patients often leads to a shift towards shared perspectives and a unified approach (Mueser et al., 2003:18). However, as Rassool (2011:228) has suggested, it is no longer about identifying which approach will be most effective, but taking the most effective treatment approach, as identified by years of research, i.e. the integrated treatment approach, and putting it under the microscope in order to move towards a more effective

integrated treatment approach for dual diagnosis patients. In order to do so the specific treatment needs of dual diagnosis service users need to be identified and further explored.

Specific needs that have been identified and which will be the further focus of this study include biological treatment needs, with specific focus on physical health and well-being and suicide, psychological treatment needs, highlighting coping mechanisms and violent and aggressive behaviour, as well as social treatment needs, exploring relationship needs and financial difficulties.

2.3 TREATMENT NEEDS OF DUAL DIAGNOSIS PATIENTS WITH CO-OCCURRING DEPRESSIVE EPISODES AND ALCOHOL MISUSE: A BIO-PSYCHOSOCIAL PERSPECTIVE

Through literature the researcher has identified some hypothesised treatment needs of dual diagnosis patients with co-occurring depressive episodes and alcohol misuse. These needs will be discussed on the biological, psychological and social levels.

2.3.1 Biological treatment needs of dual diagnosis patients

The biological dimension refers to an individual's internal and physiological functions. It includes factors such as genetic and familial influences (Zunker, 2008:100). On this level of intervention the social worker is less involved and the main responsibility of care falls on the health practitioner (Psychiatrist). However, Nelson (2012:157) is of the opinion that social workers play an important role in psycho-education and family support on this level (Van Daele et al, 2012:474).

❖ Physical health and well-being

Individuals with co-occurring depressive episodes and alcohol misuse cause considerable harm to themselves, due to the many aspects of depressive episode and addictive behaviour that have an impact on the individual's physical health (Rassool, 2011:224). As mentioned earlier, individuals with co-occurring depressive episodes and alcohol misuse make lifestyle choices that result in a decreased immune system and have a greater risk of developing cardiovascular disease, diabetes, and more frequent infectious diseases (Colbert, 2003:64). These individuals also tend to have generally poor health habits, which leave them vulnerable for developing most types of diseases (Colbert, 2003:63).

According to Brick (2008:9), the number of systems affected by alcohol misuse, both in the scope of medical consequences and in terms of the economics of medical treatment of

alcohol related disorders, is phenomenal. Research results have found that 79% of dual diagnosis patients misusing alcohol had at least one chronic health problem, and 59% had two or more co-occurring chronic illnesses (Rassool, 2011:224).

Brick (2008:9) argues that the reason for this is because chronic alcohol misuse damages the heart muscle, elevating blood pressure and increasing the risk of heart failure and stroke. Furthermore, chronic alcohol consumption can injure various tissues, produce diverse physiological changes, and impair and interfere with the hormonal and biochemical regulation of a variety of cellular and metabolic functions. It may also significantly increase the risk for the development of certain forms of cancer. Due to alcohol's ability to impair balance, motor functions, and judgement, alcohol misuse increases the risk for accidental injuries and impairs the body's natural ability to recover from these injuries in a timely fashion (Brick, 2008:9; Rassool, 2011:224).

In terms of depressive episodes, negative thinking patterns, due to the lack of neurotransmitters in the brain, may cause structural and biochemical changes of the cells, thereby weakening the immune system, and diminishing its ability to protect the body from infectious diseases (Leaf, 2007:5). It can also change the shape of the receptors on cells lining the heart, increasing the susceptibility to cardiovascular illness, heart palpitations, aneurysms and strokes with 60 – 80 % (Leaf, 2007:5; Whited, Wheat, Appelhans & Pagoto, 2011:124).

In this regard Whited et al. (2011:124) argue that the increased risk for the development of cardiovascular disease in terms of depression can more often be attributed to external causes than internal changes. Depressive episodes are associated with several life style risk factors for cardiovascular disease, including being mostly sedentary, poor diet, being more likely to smoke and less likely to quit, and in general having less healthy habits. Individuals suffering from depressive episodes are also more prone to self-harm and suicide due to their complicated health statuses (Rassool, 2011:224).

After considering health consequences of both alcohol misuse and depressive episodes, it can be concluded that individuals with a dual diagnosis of co-occurring alcohol misuse and depressive episodes are more likely to have a diminished immune system, will be more vulnerable for the development of cardiovascular disease, are at an increased risk for developing infectious diseases, are generally less active, de-motivated, and at a higher risk for self-harm and suicide, all of which contribute to the complexity of dual diagnosis treatment.

Therefore, treatment needs likely on this level include providing psycho-education regarding dual diagnosis as an illness and the consequences thereof. After the psychiatrist has provided the patient with anti-depressant medication to reduce the level of acute psychiatric symptoms to the point where he is able to cognitively and physically participate in treatment (Wallen & Lorman, 2008:579), will then explain to the patient the importance of adherence to medication and psychosocial treatment. Along with psycho-education, the role of the social worker includes providing the needed social support for detoxification and withdrawal symptoms by means of introducing the patient to new support systems (Crews, 2008:153).

The social worker will most likely not be actively involved in the medical process needed to address these needs, but will fulfil tasks on the psychosocial level of treatment, for example, education and support.

2.3.2 Psychological treatment needs of dual diagnosis patients

The psychological dimension of dual diagnosis treatment is a very broad concept and includes all internal, perceptual, cognitive, emotional and personality factors that affect development (Zunker, 2008:101). In this regard Leaf (2007:5) denotes that the psychological dimension is predominantly about thoughts and perceptions as it is not so much what an individual experiences, but the individual's interpretation of the meaning of an event. Therefore treatment on this level moves away from the biological and more into the cognitive realm (Zunker, 2008:101).

According to Bieling, McCabe and Antony (2013:40) cognitive behavioural therapy is superior when compared to several other treatment options, when working with depression and alcohol misuse. Therefore, a cognitive behavioural treatment approach will be more effective when addressing the psychological needs of dual diagnosis patients. Psychological needs of dual diagnosis patients identified through literature include coping mechanisms and addressing anger and aggressive behaviour.

❖ Coping mechanisms

Coping mechanisms can be described as strategies people use to deal with stresses, pain, and natural changes experienced in life (Bieling et al., 2013:4). Unfortunately people neglect to develop and adapt their coping mechanisms on continuing bases; therefore, many find themselves in extremely stressful and traumatic situations they simply cannot cope with and turn to negative coping mechanisms, such as alcohol misuse in an attempt to self-actualise.

A study completed by the Mental Health Foundation (2006:23) found that one third (33%) of 2000 participants taking part in the study relied on alcohol consumption to “get through” the Christmas holidays; furthermore, the survey reflected that up to 12 million adults in the UK drink to help them relax or to overcome feelings of depression. Thus, the research reflects the self-medication theory, namely, that individuals with depressive episodes use alcohol as a means to cope with the negative symptoms and traumatic life events, in turn becoming dependent on the alcohol. Using alcohol as a coping mechanism poses two potential problems. *Firstly*, self-medicating with alcohol can become circular and self-perpetuating. Underlying depression leads to increased alcohol use, which changes the physiology of the brain and leads to a depletion of the neurotransmitters needed to reduce depressive symptoms, therefore more alcohol consumption is needed to numb the depressive symptoms. The *second* problem with using alcohol as a coping mechanism is that it is difficult to maintain the amount of alcohol required to reduce these negative feelings as the individual becomes tolerant to the alcohol and needs to use more to achieve the same effects as previously (Mental Health Foundation, 2006:23).

Thus, from the literature it can be concluded that individuals with co-occurring depressive episodes and alcohol misuse most likely do not have the ability to adapt and deal with life stressors, and subsequently make use of inadequate coping mechanisms. Therefore, the development of coping mechanisms is identified as one of the treatment needs of dual diagnosis patients in treatment programmes.

Coping mechanisms are learned behaviour, therefore Burnett, Porter, and Stallings (2011:853) are of the opinion that individuals with dual diagnosis can be taught new and more effective coping mechanisms through psycho-education. In this regard the most effective psychosocial approach in psycho-education is cognitive behavioural therapy (CBT). CBT in psycho-education is focused on providing information in order to modify thought patterns to bring about emotional and behavioural changes (Burnett et al., 2011:853).

Prost, Musisi, Okello and Hopman (2013:267) found that psycho-education intervention was positively associated with improved patient knowledge of mental illness, alcohol misuse, and compliance with prescribed medication, as well as an increase in functionality in terms of coping ability. Burnett et al. (2011:851) agree with this statement and add that psycho-education in group therapy is a very common and effective intervention in the management of dual diagnosis, when the patient can understand the link between the biological and the psychosocial aspects of their lives, patients are more compliant and involved in the

treatment process. Van Daele et al. (2012:478) do not dispute that psycho-education is an effective tool in teaching coping mechanisms and ultimately as an intervention approach, but do highlight that the initial results were positive, however, with follow up interviews six months later the results were relatively weak and most of the participants found it hard to keep up with these changes. This is contrary to the idea that psycho-educational interventions provide patients with skills to continually improve their mental health. Mueser et al. (2003:23) attribute these findings to dual diagnosis patients often dropping out of treatment due to the chaos in their lives, cognitive impairment, low motivation and hopelessness. Therefore, Burnett et al. (2011:850) suggest that psycho-education and support structures should be implemented over a longer period of time and should be made available to both patients and their families after the patient has been discharged.

Due to patients' inability to effectively cope with life stressors they often feel immense anger and express themselves through aggressive behaviour.

❖ **Anger and aggressive behaviour**

Alcohol misuse has long been associated with high levels of aggression, frustration and violent behaviour (Rhule-Louie & McMahon, 2007:53) because of its ability to weaken a person's inhibitory mechanisms (Gruenewald, 2004: 1247). Heinz, Beck, Meyer-Lindenberg, Sterzer and Heinz (2011:400) even go as far as to argue that alcohol is the most potent agent for eliciting aggression. Therefore, it is no surprise that in the past 50 years there has been a significant growth in the prevalence of alcohol-related aggressive crimes (Dutton & Karakanta, 2013:311). Heinz et al. (2011:401) suggest that this has to do with the acute effects of alcohol on brain functions. As noted earlier in the discussion regarding alcohol misuse, ethanol stimulates serotonin and dopamine release by means of modulating the activities of these chemicals, as well as exerts an inhibitory effect by inducing GABA release (Heinz et al., 2011:401). Alcohol misuse affects executive functions associated with the pre-frontal cortex with marked changes in behaviour, including emotional ability and aggression, apathy, deficits in anticipating, planning and sequencing, deficits in initiating behaviour, adapting and stopping behaviour, and deficits in abstract reasoning (Heinz et al., 2011:401).

For many years it was believed that alcohol is the culprit when it comes to aggressive behaviour in dually diagnosed patients. The reason for this is that depression connotes lethargy and sluggishness, making a person too listless to aggress; therefore, aggressive behaviour was seen as a side effect of alcohol misuse and treated chemically (Dutton & Karakanta, 2013:311). Furthermore, the attribution biases of depressed and aggressive

individuals seem contradictory. Depressed individuals attribute negative life events and situations to an internal cause and will most likely blame themselves for negative events and will not aggress towards others, but may aggress towards themselves. This is an explanatory style that is stable across the depressed individual's life. On the other hand, aggressive people externalise blame, viewing negative events as produced by traits in others and seeing others as having hostile intent (Dutton & Karakanta, 2013:311).

However, Van Dorn, Volavka and Johnson (2012:490) do not fully support the notion that alcohol is the sole cause of anger and aggressive behaviour in dually diagnosed patients. Over the past 20 years consensus has emerged among most researchers that there is a modest, yet statistically significant relationship between psychiatric disorders, like depression and aggression. This may be the reason why sequential and parallel treatment is less successful in this regard, as most treatment options in these structures only address aggression as it is understood from an addiction point of view. Further studies done by Dutton and Karakanta (2013:310) indicate that the presence of depression elevates the risk for general aggression as well as intimate partner aggression and self-aggression.

Thus from research it can be concluded that anger and aggressive behaviour in dual diagnosed patients are not due to just one element but may be exacerbated by the presence of both disorders. Therefore, the need that exists in the psychological dimension for a dual diagnosis patient is to provide treatment and education on how to effectively manage anger and aggression.

2.3.3 Social treatment needs of dual diagnosis patients

According to Zunker (2008:103), marital relationships, social support, family, cultural and religious beliefs, as well as socialisation of financial aspects form part of the social dimensions. In this study relationships, socialisation, social support, cultural aspects and financial aspects will be addressed as components of the social dimension.

❖ Relationships

Relationship breakdown in dual diagnosis is very common as the illness does not just have an effect on the patient but may have detrimental effects on the family system as a whole, as well as on other social relationships (Tiet & Mausbach, 2007:513). Boden, Fergusson and Horwood (2013:1) are of the opinion that this has to do with the effects of alcohol misuse on a range of social life outcomes, including skills needed to obtain a healthy relationship. A

number of studies have shown that alcohol misuse is associated with an increased risk of relationship problems and breakdown; from a range of surveys it was found that the odds of divorce for individuals with alcohol misuse problems were 1.8 times higher than for individuals without substance misuse histories (Boden et al., 2013:1).

Horsfall, Cleary, Hunt and Walter (2009:25) agree with Boden et al. and add that the mixture of strong emotions, an inability to cope with everyday situations and the continuing resort to alcohol, exacerbate social alienation and increase the potential for violent and aggressive behaviours in social and romantic relationships. Furthermore, patients with dual diagnosis also place high demands on the individuals in their lives; therefore, friends and family members of dual diagnosis patients experience distress, tension and conflict in these relationships. Interpersonal conflicts are often associated with dual diagnosis relationships. According to Burnett et al. (2011:851) dual diagnosis patients do not possess the needed skills to resolve conflict in their relationships. Conflict in these relationships may be due to family and friends' frustrations with low motivation levels, negative interactions and ongoing substance misuse, which may ultimately lead to these individuals dissolving the relationship with the dual diagnosis patient (Horsfall et al., 2009:25).

In this regard Thoits (2011:145) and also Peirce, Frone, Russell, Cooper, and Mudar (2000:28) argue that positive social ties and social support, or at least the perception thereof, are related to better treatment outcomes and a decreased need for self-medicating. Furthermore, the quality of social relationships predicts general better health, better treatment outcomes and mortality (Kendler, Myers & Prescott, 2005:250).

Therefore, a need that exists in the social dimension in terms of relationships may be to teach dual diagnosis patients skills that can be used effectively in their relationships, for example, communication skills, conflict management skills, and problem solving skills. In this regard Thoits (2011:145) adds that family intervention in this dimension may be a very helpful treatment approach. By changing and improving support and social networks, it is likely to increase positive treatment outcomes. Mueser and Fox (2002:255) are of the opinion that the role of the social worker, when working with the dual diagnosis family, is 1) to provide information about dual diagnosis, 2) decrease stress in the family, 3) help with solving problems, 4) collaborate with the treatment team, and 5) to increase social support.

❖ Financial difficulties

A holistic philosophy of counselling suggests that patient concerns are inseparable and intertwined. Therefore, clinicians providing psychosocial treatment should not limit their ability to only understanding the patient's belief system and interests but also be alert to personal concerns that may interfere with the patient's ability to adequately process information and make optimal decisions (Zunker, 2008:95). One of the concerns identified in the social dimension that may influence the patient's ability to recover is financial issues (Beaumont, Friedlander & Ndetei, 2011:169; Granholm et al., 2003:307; Hryb et al., 2007:15; Prince, Patel, Saxena, Maj, Maselko, Philips & Rahman, 2007:846).

Financial difficulties in dual diagnosis patients can be attributed to multiple factors including financial mismanagement, difficulties with employment, and high cost of treatment.

Money management affects daily independent living and can be viewed as an essential component of psychiatric rehabilitation and recovery (Elbogen, Tiegreen, Vaughan & Bradford, 2011:223). Individuals with psychiatric disorders consistently rank better financial management and improved money management skills as their most important personal goals. Furthermore, Lewis, Keefe and Curphey (2013:6) have found that nearly half (44%) of individuals with mental health problems have severe debt. According to a 2011 survey by MoneySavingExpert.com, nine out of ten individuals who have severe debt also have a co-occurring mental health problem.

Furthermore, Beaumont et al. (2011:169) are of the opinion that problems with money management in dual diagnosed patients are due to a lack of neurotransmitters and effects of alcohol on the prefrontal cortex of the brain, inhibiting the higher cognitive functions needed to effectively manage money. In this regard Elbogen et al. (2011:224) argue that individuals with greater debt are significantly more likely to develop mental health problems; thus they believe that the debt was present before the mental illness. Lewis et al. (2013:6) agree with both these statements and are of the opinion that it is a symbiotic relationship: when debt mounts, so does stress and anxiety, contributing to depression. The increased negative neurological effects of depression in turn contribute to ineffective money management, leading to more debt.

Problems with employment further contribute to financial issues. Dual diagnosed patients have difficulty in processing information and the meaning associated with life events that are critically important to the decision-making process. Diminished ability in information

processing affects interactions in the workplace and the ability to perform appropriately (Zunker, 2008:105; Strickler, Whitley, Becker, & Drake 2009:261). Adding absence from work due to sickness associated with alcohol misuse and depressive episodes aggravates an already unstable work environment and may lead to dismissal, suspension, demotion and more financial crisis (Peltzer, Ramlagan, Mohlala & Motseke, 2007:18).

In this regard Elbogen et al. (2011:224) have found that a better financial status is associated with higher quality of life, greater self-efficiency, fewer psychiatric symptoms and a decrease in self-harm behaviour, whereas financial instability is linked to a higher relapse rate.

Therefore, from the literature it can be concluded that addressing money management is definitely one of the needs of dual diagnosis patients. This need can be addressed through psycho-education, by teaching patients basic money management skills.

From all of these needs that have been identified, it is clear that the social worker working with dual diagnosis patients have to take many aspect into consideration when implementing dual diagnosis treatment. In the next section the researcher will discuss the role of the social worker when working with dual diagnosis.

2.4 ROLE OF THE SOCIAL WORKER WHEN WORKING WITH DUAL DIAGNOSIS

According to the National Association of Social Workers Standards for Social work Practice in Health Care Settings (NASW, 2005:5-7), social workers have been involved in the health care setting since the early 20th century, with the main focus of making health care services available to the poor and improving social conditions. Currently social workers in health care provide services on multi-levels and are present in public health, acute and chronic care settings, providing a wide range of services. These services may include health education, crisis intervention, supportive counselling and case management.

In this regard Nelson (2012:15) adds that social workers play a pivotal role in the mental health sector, but highlights that co-existing problems and complex needs associated with mental health issues and problematic substance use may contribute to difficulties in service delivery. Olckers (2013:31) is of the opinion that, because of South Africa's diverse and political background, more social workers find themselves with client loads that include co-occurring mental health and substance abuse disorders. However, they are unable to provide adequate treatment due to substance abuse and psychiatric disorders still being treated linearly or consequently (Rassool, 2011:228). Rassool (2011:228) suggests that the

inability to adopt an integrated treatment approach is due to the complex needs of dual diagnosis patients and the compounded pressures of stigma, prejudice, and previously implemented ethnocentric intervention strategies. Olckers (2013:32) disagrees and is of the opinion that the inability to provide integrated dual diagnosis treatment is due to the clinical and non-clinical divide of social workers and the lack of training in generically trained social workers.

Social work in mental health is divided into the public sector and the private sector, where the private sector has an obligation towards investors and the motivation of the public sector is for social responsibility and environmental awareness, thus making the focus of each sector very different in terms of funding and training (Olckers, 2013:33-34). These different goals may explain the differences in the role of the social worker in each of these sectors.

In Olckers' (2013:35) research she highlights two very important aspects that have an impact on the role of the social worker in mental health and therefore in dual diagnosis treatment. The first is that the South African Council for Social Service Professionals (SACSSP) and the South African Association of Social Workers in Private Practice (SAASWIPP) do not recognise clinical social work or any other specialised master's degree as a separate specialised form of social work. Thus there is no integrated training and guidelines for social workers to work effectively in the field of dual diagnosis. Therefore, it is the role of the social worker to be involved in the development of policies in which these aspects are addressed and effective guidelines for service delivery are developed. Secondly, a representative of the Clinical Social Work Interest Group was quoted as saying: "Generically trained social workers are out of their depth" when it comes to mental health and that only clinically trained social workers are able to operate in mental health settings and with mental health issues (Olckers, 2013:35).

With substance abuse treatment mainly being addressed by generically trained social workers (Setlalentoa, Thekisho, Ryke & Loots, 2010:13), the expectation that mental health issues should exclusively be addressed by clinically trained social workers (Olckers, 2013:35), and the SACSSP's inability to compile a scope of practice for specialised social workers, it is understandable that most attempts in providing integrated treatment programmes for dual diagnosis patients have continually failed in South Africa.

Therefore, the role of the social worker in dual diagnosis may include developing a workable integrated treatment approach for dual diagnosis patients in both psychiatric and substance abuse treatment settings, as well as implementing these treatment programmes in such a

way that it decreases stigma and prejudice. Along with the development and implementation of integrated treatment programmes, the social worker has to contribute continuously to his own knowledge as well as to the knowledge base of this particular field and other social workers.

The researcher will further discuss the required social work roles in order to provide adequate dual diagnosis treatment in South Africa in both the public and private sector.

After consulting the literature, such as NASW (2005:15-21), Bogenschutz, Geppert and George (2006:50), NASW (2011:1), Olckers (2013:47) and Ray, Pugh, Roberts and Beech (2008:6), it is evident that the role of the social worker in mental health and substance abuse, and therefore also dual diagnosis, include:

- Determining the patient's eligibility for services by means of conducting a bio-psychosocial assessment and evaluating social histories. Assessment of the patient may also include severity of substance use, evaluating support systems, physical and emotional functioning, financial stability, and self-harm and suicidal behaviour.
- The social worker is also involved in developing and implementing treatment plans that address both the depressive episodes and alcohol misuse as well as discharge plans that adhere with the client's self-determination.
- Helping dual diagnosis patients obtain tangible services, and establishing initial links between patient and resources. These services may include support groups, the obtaining of social grants and housing services.
- Participating in legislative processes to improve service delivery to dual diagnosis patients.
- One very important role highlighted in all of the research is providing direct therapeutic services, such as individual and group therapy, to dual diagnosis patients.

According to Ray et al. (2008:6), the role of the social worker in individual therapy with dual diagnosis patients is promoting independence and self-directed support. In other words, the social worker has to assist the patient to identify his or her strengths and use these strengths in order to improve the patient's environment. In this regard the person centred approach and the strengths perspective are the most applicable when working with dual diagnosis patients.

❖ **Person centred approach**

The person centred approach (PCA) was developed by Carl Rogers in 1959 and is based on the central hypotheses “that the individual has within him or herself vast resources for self-understanding, for altering the self-concept, basic attitudes, and his or her self-directed behaviour – and that these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided” (Rogers, 1979:1). PCA works from the assumption that every individual has the ability to change and grow. It is the social worker’s responsibility to help empower and develop the individual living with dual diagnosis in conjunction with a process of economic development to reach his or her goals. This process is known as social development and has been adopted by South Africa since 1997 (Patel, 2005:29). In order to promote social development in dual diagnosis patients the social worker may need to provide education and support through group work services.

❖ **Strengths perspective**

The strengths perspective requires from a social worker to view and define individuals by their values, strengths, hopes, aspirations and capacities, regardless of their illness or antisocial behaviour (Peacock, Forbes, Markle-Reid, Hawranik, Morgan, Jansen, Leipert & Henderson, 2010:642). The strengths perspective, however, does not ignore or dismiss negative experiences or the person’s shortcomings. These shortcomings and negative behaviours are rather acknowledged as one part of an individual’s personal and psychosocial experiences (Peacock et al., 2010:643). It is the role of the social worker to help dual diagnosis patients identify and explore their strengths, as the fundamental premise is that individuals will do better in the long term if they are able to identify, recognise and use the strengths and resources available in themselves and their environment (Peacock et al., 2010:643).

The role of the social worker in treatment groups for dual diagnosis patients is to contribute to support, education, growth, therapy, socialisation and self-help (Toseland & Rivas, 2009:20). Olckers (2013:47) is of the opinion that the role of the social worker in group work is maintaining, restoring and improving psychosocial functioning by means of creative activities, improving problem solving skills, teaching functional, healthy relationship skills, vocational activities, recreational activities, social activities, and helping patients enhance and utilise their own problem solving and coping capacities more effectively. However, Olckers (2013:43) is contradicting herself in saying this, as earlier in her research she

explains how the occupational therapist is accepted in the multidisciplinary team as the person responsible for conducting the majority of mental health groups, adding that social workers have far less knowledge of mental health than their colleagues. Northen and Kurland (2013:1) disagrees with Olckers (2013:43) and is of the opinion that the enhancement of the psychosocial functioning of people and the improvement of their environment are the primary concerns of social workers. Northen and Kurland (2013:1) further add that the first socialisation group with mentally ill patients was conducted in the mid-1930s and the first field work placement in schools of social work in psychiatry was in 1939, therefore the field of social work has been adding knowledge of groups in mental illness since the 1930s and was one of the first disciplines providing group work in psychiatric settings.

From literature it can be concluded that the role of the social worker when working with dual diagnosis patients would be to 1) provide education regarding alcohol misuse, depressive episodes, and coping mechanisms. In doing so the patient is empowered to effectively manage his social environment, in turn reducing depressive episodes and the need to self-medicate. 2) Provide support to both the family members and the patient; this may include implementing family intervention approaches in order to resolve conflicts in the family. Further education may be needed for the family to help them understand dual diagnosis and to develop more effective coping mechanisms for themselves. 3) Developing and implementing integrated treatment programmes for dual diagnosis patients. 4) Contributing to the knowledge base of dual diagnosis through research. 5) Reintegration of the patient into the work and family environment through case management. 6) Post integration guidance by means of support groups.

2.5 SUMMARY

From the literature it can be concluded that depressive episodes and alcohol misuse do have a symbiotic relationship, making consequential and parallel treatment options outdated. However, in order to move towards an integrated treatment approach, more research needs to be done regarding the specific and unique needs of dual diagnosis patients with co-occurring depressive episodes and alcohol misuse. These needs should be addressed on a biological, psychological and social level. From the literature it can be concluded that, from a biological standpoint, these patients are most likely making unhealthy lifestyle choices that exacerbate their depression. Therefore patients with dual diagnosis will need information on how to improve their health. An increase in depressive symptoms may also lead to an

unstable psychological environment for the patient, putting even more strain on already unstable coping mechanisms. Therefore the literature has identified that it is important for these patients to receive support as well as learn more effective coping mechanisms in dealing with their social environment. Other aspects highlighted through the literature study are the support systems available in the social environment. Patients who receive support from family members tend to do better in therapy compared to patients that do not feel they are being adequately supported. From the literature study it can be concluded that, in order to treat individuals with dual diagnosis, a holistic approach needs to be adopted. Furthermore, research is required regarding the role of the social worker in the multidisciplinary team when providing treatment to dual diagnosis patients.

Chapter 3 will focus on research methods used, and the empirical findings.

CHAPTER 3:

RESEARCH METHODOLOGY, EMPIRICAL RESEARCH FINDINGS & INTERPRETATION

3.1 INTRODUCTION

In Chapter 1 of this study, the researcher identified a gap in knowledge and research regarding the bio-psychosocial treatment needs of dual diagnosis patients suffering from depressive episodes and alcohol misuse, which resulted in the following research study. The goal of the study was to determine the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse. This chapter will, therefore, explore and describe the bio-psychosocial treatment needs of dual diagnosis patients. The aim of data collection is to identify the predominant bio-psychosocial needs of patients who are dual diagnosed with depressive episodes and alcohol misuse. The research findings are reported through themes and sub-themes, so as to contribute to the development of more effective treatment plans for dual diagnosis patients with depressive episodes and alcohol misuse.

This chapter will be divided into two sections: Section A: Research methodology and Section B: Data analysis and interpretation.

3.2 SECTION A: RESEARCH METHODOLOGY

Section A of this chapter will discuss the research methodology used in the execution of this study. Firstly, the research question will be outlined and secondly, the research methods used during data collection will be discussed.

3.2.1 Research question

This study was guided by the following research question: **“What are the bio-psychosocial treatment needs of dual diagnosis patients, specifically for patients with depressive episodes and alcohol misuse?”**

3.2.2 Research methods

The research methods employed include the research approach, type of research, research design, population, sampling, data-collection method, and data analysis.

3.2.2.1 Research approach

The main focus was gaining a first-hand, holistic understanding of people's feelings, perceptions and interpretations of the particular phenomenon, namely dual diagnosis (Fouché & Delpont, 2011:63). Therefore, a qualitative, rather than a quantitative, research approach was adopted to explore, from a bio-psychosocial point of view, how people living with a dual diagnosis make sense of their world and experience it (Willig, 2008:8 & Fouché & Delpont, 2011:63). To do this, a constructionist approach was used as the research paradigm in order to understand dual diagnosis as it is presented in the patient's or participant's world. The purpose of the research was exploratory in nature, in order to establish the way in which people being studied understand and interpret their social reality of living with dual diagnosis (Lietz & Zayas, 2010:189). In addition, the research was also descriptive in nature, as it aimed to describe the bio-psychosocial treatment needs of dual diagnosis patients (Lietz & Zayas, 2010:189)

3.2.2.2 Type of research

The aim of the research is to contribute to the practical issues of problem solving, namely answering what the bio-psychosocial treatment needs are of a patient diagnosed with a dual diagnosis. Therefore, this study was applied (Durrheim, 2006:46).

3.2.2.3 Research design

The case study itself is not a research method but constitutes an approach to the study of singular entities (Willig, 2008:74). By implementing this the focus is towards a comprehensive (holistic) understanding of how participants relate and interact with each other in a specific situation as well as how they attach meaning to the phenomenon, namely, the treatment needs of dual diagnosis patients (Nieuwenhuis, 2010a:75). Furthermore, this design offers a multiperspective analysis since it considers more than one or two participants' views and opinions on their treatment needs with regard to dual diagnosis (Nieuwenhuis, 2010a:75; Lietz & Zayas, 2010:190). More specifically, this design is interested in exploring and describing the opinions of multiple participants on bio-psychosocial treatment needs, making it the most applicable design for the research study.

The benefit of using a collective case study design was that it gave the researcher the opportunity to spend more time with each individual when collecting the data. This made it possible to ask the individual to elaborate on a point and really get a holistic view. The

downside of using this method is that it was very time consuming and could easily become more therapeutic in nature (Fouché & Schurink, 2011:322). Nevertheless, the researcher limited her role to that of research and did not assume the position of a therapist.

3.2.2.4 Research population, sampling and sampling method

The study population included all individuals (Welman, Kruger & Mitchell, 2005:53) with a dual diagnosis on the case load of a private psychiatric clinic situated in Pretoria from 1 January 2014 to 1 July 2014. The focus of the research was to determine characteristics of this specific study population (Bless, Higson-Smith & Kagee, 2006:84).

In order to select a sample a non-probability sampling method was utilised, which is often the case with a qualitative research approach, as each unit in the sampling frame did not have an equal chance of being selected (Strydom & Delpont, 2011:391). More specifically, in order to achieve this both purposive and volunteer sampling was used (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2013:3).

In terms of purposive sampling, the researcher coordinated with the unit managers, in close contact with psychologist or psychiatrists of the wards, in order to select participants. The identified criteria were made know to the unit managers who purposively recruited potential participants for the study. When the unit manager identified a patient who fit the criteria for the study, the unit manager provided the patient with an information leaflet. Thereafter patients who were willing (i.e. volunteer sampling) to participate in the research study contacted the researcher as per contact details on the information leaflet or indicated to the ward staff that they were interested in participating, and the ward staff informed the researcher.

Purposive sampling methods have received criticism that it cannot be accurately generalised, as the sample is based entirely on the judgement of the researcher (Palinkas et al., 2013:3; Strydom & Delpont, 2011:392). The researcher took note of this; however, the characteristics chosen were in correlation with theoretical and applied standards and therefore the research was able to reflect the needs of dual diagnosis patients accurately (Palinkas et al., 2013:3; Strydom & Delpont, 2011:392). The researcher utilised volunteer participants until data saturation point. Data saturation was reached with the sixth participant, however in total ten interviews were conducted.

Participants who met the following criteria were informed by the unit managers that they fit the criteria for participation in this research study. More specifically, the following criteria were used to guide the recruitment of research participants:

- Male and female patients who presented with depressive episodes and alcohol misuse.
- Patients who voluntarily provided informed consent.
- Patients on the case load of a private psychiatric clinic for 1 January 2014 to 1 July 2014.
- Only participants who could speak and understand either Afrikaans or English.
- No participants were considered if either the depressive episodes or alcohol misuse incapacitated them to communicate about their dual diagnosis.

3.2.2.5 Data collection

The predominant method of collecting data in qualitative research is interviews as it gives the researcher the opportunity to explore the perceptions of an individual (Greeff, 2011:342). For the purpose of this study the researcher made use of a semi-structured one-on-one interview with questions in an interview schedule exploring the following themes: physical health, coping mechanisms, possible violent and aggressive behaviour, relationships, financial matters and work-related issues. A semi-structured interview schedule (see Appendix D) is a set of predetermined themes that guides the interview and does not dictate it. It gives the researcher more flexibility in order to explore and gain a detailed picture of the participants' perceptions, ideas, beliefs or accounts of a specific topic (Greeff, 2011:351). In this regard Babbie (2008:335) adds that it is based on a set of subjects to be discussed in depth, which made it more applicable in exploring and describing the bio-psychosocial treatment needs of a dual diagnosis patient, rather than the use of standardised questions. One of the disadvantages of using this method was that it was time consuming and intense (Greeff, 2011:353). The researcher was careful not to get too involved and lose focus of the aim, which was research. The researcher avoided this by making it clear to the participant what the aim of the session is and referred the participant for therapeutic intervention, if needed.

In order to establish the effectiveness of the interview schedule a pilot study was conducted beforehand with two participants; however, these participants do not form part of the main study.

3.2.2.6 Data analysis

Data analysis, according to Creswell (in Schurink, et al., 2011:397), is the process of bringing order, structure and meaning to the collected data. Terre Blanche, Durrheim and Kelly (2006:321) add that the purpose of analysis is to provide a thorough description of the characteristics, processes, interactions, and contexts that contribute to the phenomenon being studied. Creswell (in Schurink et al., 2011:397) has identified eight steps in the process of data analysis. This process was executed as follows in this study in order to do thematic analysis.

Step 1: Planning for recording of data

This step refers to how the researcher plans to “save” the information gathered for later analysis. For this reason it is important that the researcher plans for the recording of data in a systematic and appropriate manner (Schurink et al., 2011:404). For the purpose of this study the researcher made use of process notes and, if the participants agreed, an audio recorder to record the interview.

Step 2: Data collection and preliminary analysis

For the purpose of qualitative data analysis it was imperative to make use of a twofold approach, which involves data analysis at the research site during data collection, as well as data analysis away from the site, following the period of data collection (Schurink et al., 2011:405). During the interview the researcher developed impressions and understandings of the participant’s perceptions of the subject matter. These preliminary understandings were analysed after each interview.

Step 3: Managing data

According to Schurink et al. (2011:408) this is the first step in data analysis away from the site. This is where the researcher used the gathered data and converted them to appropriate text units and sorted the data into data files (Schurink et al., 2011:408). The researcher transcribed each interview and made use of computer files to save and organise the information gathered from the participants as transcripts.

Step 4: Reading and writing memos

It was important for the researcher to constantly make notes and memos as people, events and quotes were processed in the researcher's own mind (Schurink et al., 2011:409). The researcher read and re-read the memos to get better acquainted with the data. Continuous interactions with the data lead to better understanding of the data (Schurink et al., 2011:409). The researcher constantly made notes and read the transcripts a few times in order to familiarise herself with the data.

Step 5: Generating categories and coding the data

Schurink et al. (2011:410) postulate that category formation is the most centred and most difficult part of qualitative data analysis, requiring complex and creative thinking. It is in this phase where the researcher had to identify recurrent themes, ideas, beliefs or patterns in order to link people and settings together (Schurink et al., 2011:410). In this regard the researcher made use of a process of open coding, which entails naming and categorising of the phenomena through close examination (Schurink et al., 2011:412). Thus the researcher broke down, examined, compared, conceptualised and categorised the data, distinguishing between categories, themes and patterns by making use of a colour coding system (Schurink et al., 2011:412).

The researcher therefore, applied a coding scheme to the themes and categories that were identified, by marking certain passages, ideas or ways of thinking that is constantly present clear (Schurink et al., 2011:411). These codes are in several forms: abbreviations of key words, coloured dots or numbers (Schurink et al., 2011:412). The researcher made use of colours in the coding process, using green for themes, blue for ideas and pink for categories.

Step 6: Testing emergent understandings and searching for alternative explanations

This phase entails a search through the data during which the researcher starts to challenge the understandings, searches for negative instances of the patterns and incorporates these into larger constructs in order to evaluate the data to establish their usefulness (Schurink et al., 2011:415). It was in this step that the researcher evaluated the information and determined how useful the information would be to the study. It is also in this phase that the researcher did not just accept the categories and patterns that seemed so apparent, but challenged these very patterns and search for other plausible explanations for these data findings and correlations between them (Schurink et al., 2011:415). The researcher also

studied other literature concerning this topic to be able to identify alternative explanations for the phenomenon being studied.

Step 7: Interpreting and developing typologies

Interpretation entailed making sense of the data that the researcher had collected. The researcher then developed typologies and systems for the categorising of concepts (Schurink et al., 2011:416). “A typology may be defined as a conceptual framework in which phenomena are classified in terms of the characteristics which they have in common with other phenomena” (Schurink et al., 2011:416). The researcher explained the findings in terms of the bio-psychosocial approach as theoretical framework.

Step 8: Presenting the data

Moving to the final phases, Schurink et al. (2011:418) are of the opinion that “ the researcher should present the data and findings as well as make recommendations and present this in the form of a formal written research report” (Schurink et al., 2011:418).

3.2.2.7 Trustworthiness in qualitative research

“Trustworthiness is established when research findings, as closely as possible, reflect the meanings as described by the participants” (Lietz, Langer & Furman, 2006:444). To minimise the threat to trustworthiness, the researcher engaged in a variety of strategies to ensure that the research findings reflected the meanings as described by the participants. These strategies include: (1) Peer debriefing, referring to a process where the researcher engages with peers in order to explore aspects from a different aspect (Cohen & Crabtree, 2006). With regard to this study the researcher regularly interacted with psychologists and psychiatrists specialising in dual diagnosis. (2) Member checking or respondent validation refers to the process where the researcher rephrased the information and evaluated whether the respondent was truthful. The researcher used this method by referring back to statements the participant made earlier on in the interview to see if the patient’s recollections are consistent. (3) And lastly reflexivity where the researcher partook in a continuous process of reflection, both on the research and the researcher’s own conceptual views (Cohen & Crabtree, 2006; Lietz et al., 2006:444).

3.2.3 Ethical considerations

Ethics can be defined as: “conforming to the standards of conduct of a given profession or group” (Babbie, 2008:67). The researcher secured permission from the private psychiatric clinic to conduct this study. Furthermore, the following ethical aspects were applicable:

- Informed Consent

The general concept of informed consent refers to the fact that human participants should be given complete information about the research and their roles in it before agreeing to participation (Gravetter & Forzano, 2003:107). The researcher informed the participants about the subject of the research and obtained informed consent by means of a consent letter. It was the responsibility of the researcher to make sure that the participants understood:

- What the term dual diagnosis means.
- That they will have to answer personal questions regarding their mental health status and drinking patterns.
- They will have to discuss topics from their personal lives.
- The information the participant provides will be used in a research study that may be published.
- The information provided will be recorded and transcribed.
- Data collected from the participants will be saved for up to 15 years at the University of Pretoria (Gravetter & Forzano, 2003:107).

- Confidentiality

Researchers in the social sciences collect information that can be considered private or personal by some participants, and it is reasonable that some participants would not want this to be made public (Gravetter & Forzano, 2003:113). Therefore, the ethical guidelines required from the researchers to ensure the confidentiality of the research participants (Gravetter & Forzano, 2003:107). The researcher upheld confidentiality by not discussing any information related to the study with anyone except the research supervisor. The researcher could, however, not assure anonymity.

- Avoidance of harm

In the social sciences subjects may experience emotional harm. It was therefore an ethical obligation of the researcher to protect participants within reasonable limits, from any form of emotional discomfort that may emerge from the research project (Strydom, 2011:115). The

researcher attempted to minimise harm by means of informing participants about the emotional impact the study may have. Emotional issues that may arise include feelings of worthlessness, irrational guilt, anger and anxiety. The researcher addressed these issues by means of encouraging the participants to be aware of their emotions and debriefing the participants after the interview. The researcher also identified participants who could prove vulnerable and did not recruit them for this study. The researcher debriefed each participant after data collection and determined whether any emotional harm had occurred. If the researcher found that there may be more emotional stress than what can be dealt with in the debriefing session, the researcher referred the participant back to Erwin Lass, a clinical psychologist.

- Deception

Deception refers to the withholding of information, or offering inaccurate information to participants of the study. In the context of this study the researcher eliminated the threat of deception by means of informing the patients of the intent and purpose of the study, and identified herself as a researcher.

- Debriefing of respondents

Debriefing refers to a session where participants get the opportunity, after the study, to work through their experiences and its aftermath (Strydom, 2011:122). The researcher debriefed each participant after their interview.

Section B will present the qualitative findings and provide interpretations thereof.

3.3 SECTION B: QUALITATIVE FINDINGS AND INTERPRETATION

This section will focus on the research findings and interpretation of the collected data. In Section 1 the demographic information of the research participants will be presented, followed by the qualitative data and interpretation thereof in Section 2.

3.3.1 SECTION 1: Demographic profile of the research participants

The demographic information of research participants were collected during the interviews by means of an interview schedule. There were a total of ten research participants, five male and five female, which indicates that there is a contradiction of the traditional view that only men use substances to mask or deal with depressive episodes (Addis, 2008:154). In this

regard Kendler et al. (2005:250) support this concept and are of the opinion that the incidence of females presenting with dual diagnosis has increased over the past decade.

Furthermore, with regard to racial grouping, seven of the participants were Caucasian and three were African. This reflects the notion of a general stigmatisation of psychiatric disorders among black South Africans, as postulated by Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams and Meyer (2009:2), providing a possible explanation for the low incidence among black participants.

Demographically, dually diagnosed patients tend to be younger, male and from a lower socioeconomic class (De Bernardo, Newcomb, Toth, Richey & Mendoza, 2002:45; Weich & Pienaar, 2009:216). However, this study revealed that this is not the case, as the average age of the participants were 39 years of age and most belonged to the working middle class. However, it should be noted that the research study was done at a private psychiatric clinic; therefore, these socioeconomic findings may not be a true reflection of the wider population.

On average the severity of alcohol misuse varied between participants. Some participants misused alcohol on a daily basis, whereas others did not consume large amounts of alcohol during the week, but had episodes of binge drinking over the weekend.

More demographic information is presented in Table 1.

Table 1: Demographical information of research participants

Participants	Gender	Age	Racial grouping	Province of origin	Highest qualification	Occupation	Religion	Marital status	Number of children	Number of alcoholic drinks consumed per day
Participant 1	Female	35	White	Gauteng	MBCbB	Medical Doctor	Christian	Single	0	3960 ml of cider per day
Participant 2	Male	47	White	Mpumalanga	Grade 10	General assistant	Christian	Widow	0	1500 to 2250 ml of whiskey per day
Participant 3	Female	51	White	Mpumalanga	Diploma in Marketing Management	Marketing	Christian	Divorced	5	100 ml Vodka per day, binge drinking over weekends
Participant 4	Male	46	White	Gauteng	Grade 12	Senior personnel clerk	Christian	Divorced	3	750 ml of whiskey per day
Participant 5	Male	36	White	Free State	Grade 12	Business integration manager	Christian	Married	3	100 ml of beer per day, binge drinking over weekends
Participant 6	Male	41	Black	Mpumalanga	N3	Maintenance Planner	Christian	Married in Traditional Law	3	2250 ml – 4500 ml of beer per day

Participant 7	Female	33	White	Gauteng	Honours degree in Geography	Technical assistant	None	Civil union	0	750 ml of whiskey per day
Participant 8	Male	40	Black	North-West	Diploma in Public Management	Senior administration clerk	Christian	Married in Traditional Law	2	4500 ml of beer per day
Participant 9	Female	36	White	Gauteng	NQF4	Car sales, caretaker	None	Civil union	0	750 ml of whiskey per day
Participant 10	Female	22	Black	Limpopo	Grade 12	Student	Christian	Single	1	Binge drinking, 18 bottles (5940 ml) of beer in one sitting

3.3.2 SECTION 2: Qualitative data and data interpretation

During the data analysis process recurring themes and sub-themes were identified, exploring the opinions of the ten research participants regarding their dual diagnosis. In Section 2 the data interpretation will be presented in these themes and sub-themes. In order to voice the views, perceptions and experiences of the participant living with dual diagnosis, verbatim quotations will be used where applicable. It should also be noted that the participants interviewed were receiving treatment and were under the influence of antidepressants, therefore, some of the responses were blunt; in these instances extracts from the interviews will be provided in order to contextualise the quotes. Furthermore the researcher also gave an indication of how many of the participants were of the same opinion or made the same statements. This was done to illustrate the strength and degree to which the data can be generalised (Maxwell, 2010:476).

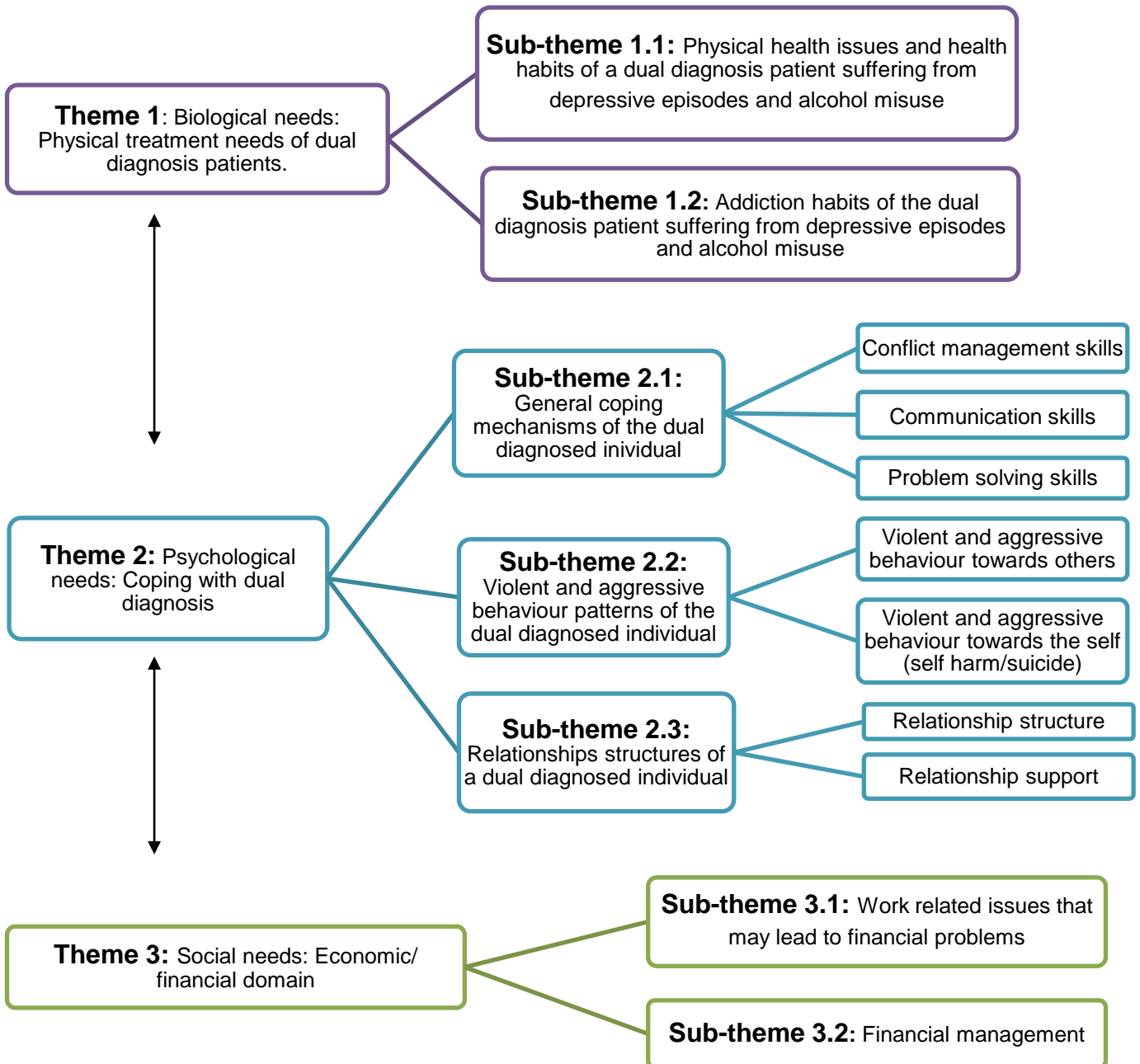


Figure 2: Visual presentation of themes and sub-themes

THEME 1: BIOLOGICAL NEEDS: PHYSICAL TREATMENT NEEDS OF DUAL DIAGNOSIS PATIENTS

Working within the context of health care, one cannot ignore the physical manifestations of dual diagnosis and the effect it has on the individual's functioning. Under the umbrella term

of Theme 1 “Biological needs: physical treatment needs of dual diagnosis patients”, two sub-themes were identified. Firstly, physical health issues and health habits of a dual diagnosis patient suffering from depressive episodes and alcohol misuse. Secondly, addiction habits of the dual diagnosis patient suffering from depressive episodes and alcohol misuse.

Sub-theme 1.1: Physical health issues and health habits of a dual diagnosis patient suffering from depressive episodes and alcohol misuse

From the interviews it was evident that good physical health is not compatible with a dual diagnosis of depressive episodes and alcohol misuse. In this regard six of the ten participants indicated that they did not think that they were in good physical health. Furthermore, four of the ten participants were of the opinion that they were in good physical health, however, all four of these participants were active smokers, not physically active, consumed large amounts of alcohol and did not follow a healthy diet.

This is supported by Prince et al. (2007:864), who have found that mental disorders, such as depressive episodes, are associated with risk factors for chronic diseases, such as smoking, reduced activity, poor diet, alcohol consumption and hypertension, although 20% of participants did not consider these behaviours as harmful to their physical well-being, contributing to further deterioration of health (Scott & Happell, 2011:589).

From the interviews it appears that individuals with a dual diagnosis do not follow a healthy diet or active lifestyle. In this regard six of the ten participants indicated that they did not follow a healthy diet, the remaining four participants were of the opinion that they did follow a healthy diet, however, two of these four individuals were, if medically interpreted, overweight or obese. These findings are supported by Scott and Happell (2011:593) who have found that the diet quality of individuals suffering from a mental illness is poor. It is stated that these individuals are more likely to consume high fat and low fibre foods, higher amounts of saturated fat, higher amounts of sucrose and sweetened drinks, and in general add more salt to their food and are 30% more likely to eat only one meal a day.

Furthermore, all ten of the participants indicated that they did not exercise or follow an active lifestyle; three however, felt that it was not needed as they thought they were active at work. In this regard research indicated that individuals with a dual diagnosis may have lowered perceptions of adequate physical activity levels (Scott & Happell, 2011:594) and are in general less active (Saatcioglu, Yapici & Cakmak, 2008:83).

Therefore, the combination of alcohol misuse with symptoms of depressive episodes and unsatisfactory health habits have a profound effect on a person's quality of life and physiological well-being, as this may give rise to other chronic disorders, such as hypertension and cardiovascular illnesses (Saatcioglu et al., 2008:83; Prince et al., 2007:864). The research concurs with this statement since three of the participants indicated that they suffered from hypertension and seven participants indicated that they were experiencing some physical health concerns at the time.

The following quotations reflect the participants' views regarding their physical well-being.

P4¹: "Last year February I had a stroke. In August I had a heart attack and in October I had a second heart attack and they put in two stents. Heart problems, high blood pressure, cholesterol, you name it. Everything came down in one year."

P6: "I--When I started having--Knowing about that I had problems with my feet, my feet were very sore. Were very painful and the heart rate was--Actually I would feel the heart pains, in most cases, yeah."

From a bio-psychosocial perspective, the biological manifestations are usually the first indicators to the individual that there may be a psychosocial problem that needs to be addressed (Alvarez et al., 2012:175). In this regard many depressive symptoms may present themselves as symptoms of other chronic illness, prolonging the process of accurate diagnosis (Saatcioglu et al., 2008:83).

These already existing health problems are escalated by further addictive habits that will be discussed in sub-theme 1.2

Sub-theme 1.2: Addiction habits of the dual diagnosis patient suffering from depressive episodes and alcohol misuse

Individuals suffering from a dual diagnosis of depressive episodes and alcohol misuse tend to have other addictive habits apart from alcohol misuse.

¹ Refer to the participant number.

In this regard seven of the ten participants indicated that they were active smokers. Participant one indicated that she suffered from an eating disorder along with abusing Benzodiazepines. Participant eight alluded to the fact that he partook in risky sexual behaviour. Whereas participant six indicated that he had experimented with dagga.

The following quotations reflect the participants' experimenting with other harmful substances and behaviours.

P1: "Ek sal ontrek van mense en het ook baie geslaap want dan kan ek vergeet en as ek by die huis was dan sou ek n benzo gedrink het. Die eerste keer wat Attivan vir my voorgeskryf is, was ek 17 en dit was deur 'n huis dokter vir my voorgeskryf" / ["I withdraw from people and sleep a lot, because then I forget and if I am at home I would have taken a benzo. I was 17 years old, when for the first time, a general practitioner prescribed Ativan."].

P6: "... the using of substances, the dagga, started just for fun, and that was in 1986. I was selling cigarettes, mostly selling to people who were smoking dagga, and then when they didn't have money I would take the dagga in exchange for the cigarettes. And with that, I would sell the dagga and then I eventually started smoking dagga."

It could be postulated that because alcohol has the ability to modulate the activities of serotonin and dopamine, the neurotransmitters the depressed individual lacks, it can also improve an individual's mood. Because alcohol has the capability of achieving the desired effect of a temporarily improved mood, it makes alcohol use more alluring to individuals with mood disorders (Tabakoff & Hoffman, 2004:7). Furthermore, Tabakoff and Hoffman (2004:7), as well as Sussman, Lisha and Griffiths (2011:3), are of the opinion that individuals who misuse alcohol as a way to achieve an improved mood, most likely participate in other addictive behaviours to sustain this effect.

Research has indicated that psychiatric disorders in dual diagnosis patients normally precede substance misuse disorders. Therefore, alcohol misuse is used as a coping mechanism for dealing with the depressive episodes (Szerman, Lopez-Castroman, Arias, Morant, Babin, Mesias, Basurte, Vega & Baca-Garcia, 2011:1).

Thus, from a bio-psychosocial point of view, the need to deal with a problem occurring on the psychological level may spill over to the biological sphere and manifest as physical symptoms (Cabib, Campus & Colelli, 2012:659). Research has proved that when individuals are unable to cope with problems presenting on one sphere, i.e. psychological level, it creates a ripple effect and spills over to the physical and social spheres, reinforcing the notion that dual diagnosis should be treated biologically, psychologically and socially (Ghaemi, 2009:2).

Psychological needs and coping mechanisms will be discussed further in the next theme, Theme 2: Psychological needs: Coping with dual diagnosis.

THEME 2: PSYCHOLOGICAL NEEDS: COPING WITH DUAL DIAGNOSIS

Individuals with psychiatric diagnoses, like depressive episodes, are thought to have poorly developed problem solving skills (Bieling et al., 2013:4). Therefore, many individuals suffering from depressive episodes may not have the adequate coping mechanisms to deal with their problems and life stressors, and using alcohol becomes their primary coping mechanism (Crum et al., 2005:72). This is postulated to be caused by the lack of neurotransmitters in the frontal cortex of the brain impairing cognitive functioning (Carrillo, Ricci, Coppersmith & Melloni, 2009:349-350). Furthermore, these individuals may have limited resources for gaining an improved sense of well-being, with the consequence that they resort to using readily available, cheap and not unduly stigmatising substances, i.e., alcohol (Horsfall et al., 2009:26).

All of the research participants reiterated that they found it difficult to cope with conflict, emotionally charged situations and everyday stressors. This research study echoes a literature review done by Horsfall et al. (2009:26-27) that indicated that individuals with a dual diagnosis have narrow repertoires of coping skills. Furthermore, dual diagnosis patients may also have deficits in attention, concentration, and abstract thinking, caused by depression and alcohol misuse. Deficits in attention, concentration and abstract thinking lead to inappropriate coping mechanisms with the result of dysfunction in psychosocial aspects (Horsfall et al., 2009:27).

Several sub-themes were identified which the participants indicated they had difficulty coping with. These sub-themes include general coping mechanism with reference to conflict

management, communication skills and problem solving, as well as violent and aggressive behaviour and relationships.

Sub-theme 2.1: General coping mechanisms of the dual diagnosed individual

The data analysis revealed that almost all of the research participants had suffered a traumatic event prior to the escalation of their negative affect. When the participants were asked how they dealt with these traumatic experiences, most of them indicated that they had not dealt with these events. When the participants were further probed in this regard they were of the opinion that they did not know how to deal with these events. With regard to these findings, other research done on mice by Cabib et al. (2012:659) indicated that stress is the main non-genetic source of psychopathology, therefore with regard to this study, individuals who do not possess the necessary mechanisms capable of moderating the pathogenic effect of stress or who are not resilient to environmental risk experiences are more vulnerable to developing psychological illnesses, such as depressive episodes (Cabib et al., 2012:659).

Furthermore, this study revealed that all of the participants used alcohol as a coping mechanism for dealing with their negative emotions. However, the alcohol misuse leads to deficits in other areas of coping, such as conflict management, communication, problem solving, and relationship aspects. Each of these aspects will be discussed.

The following quotations reflect participants' traumatic experiences.

P1: "Ek is seksueel gemolesteer toe ek 14 was en ek is verkrag op 17. Ek het al in standard 9, toe ek 17 was, 'n bottel wyn in my kas weg-gesteek.

Y: sal jy sê die alkohol misbruik is ook 'n "coping mechanism"?

P1: Ja ek sal sê definitief ek het die eerste keer op 15 alkohol gedrink."

[I was sexually molested when I was 14 and I was raped when I was 17. In St 9 when I was 17 I was already hiding a bottle of wine in my closet]

[Y: would you say the alcohol misuse was a coping mechanism?]

[P1: Yes, I would definitely say that I use alcohol as a coping mechanism, I drank alcohol the first time when I was 15.]

“P4: When my wife left with another man. I lost it completely. And then I started just drinking. The depression, I don’t know when it started. I didn’t even know I had depression. I was informed here [referring to Clinic], as well as Post Traumatic Stress, so that combined. Well, everything just went for a ball, immediately. I permanently felt depressed. I was in the Bush War, so from the Bush War until now there are a lot of times that I feel down. Then I feel happy, and then I feel down again. Sometimes it goes on for two, three weeks; sometimes it just goes on for one or two days.”

Understanding coping mechanisms from a bio-psychosocial point of view, one has to understand that when an individual experience difficulties at one level, it almost always spills over into other domains of functioning (Ghaemi, 2009:5). Therefore, if individuals cannot cope with a traumatic event in a social domain it will cause psychological and emotional turmoil in the psychological domain (Ghaemi, 2009:5). The build-up of these emotions, due to not effectively addressing emotions in a psychological domain, may lead to ineffective conflict management.

❖ **Conflict management skills**

From the data it is noted that individuals with a dual diagnosis of depressive episodes and alcohol misuse, do not possess the needed coping mechanisms to manage conflict effectively. In this regard most of the research participants reiterated that they had a tendency to avoid conflict situations as far as possible. When the participants were asked how they would handle a conflict situation, nine of the ten participants indicated that they would suppress the negative emotions arising and not deal with it. Furthermore, these participants indicated that they would rather just walk away.

Research done at Cambridge University on emotional bias and executive control in major depression indicates that the findings of the present study are not uncommon, due to functional abnormalities in ventral and dorsal neural systems, which are present during depressive episodes and alcohol misuse (Keedwell et al., 2009:353). Therefore, patients with dual diagnosis may experience abnormalities in emotional processing and consequently in effective conflict management (Keedwell et al., 2009:352).

The following quotations reflect the participants’ views regarding how they handle conflict.

P6: "With my wife. As I said before, I used to beat her and I used to threaten her and--But all that stopped, because I've seen it was taking a toll on me, on my kids, on my wife. And I stopped that. The only thing I would do it's--Just move away from her, if she will start with her noises, I will go away. And the other thing that I would do, it's to find a lady friend of which--When she--Not many lady friends, but one specific lady friend, of which when I have problems with my wife I would simply go to her, spend time with her, come back. And then just sleep at home, like nothing has happened."

P9: "Yes. I'd rather walk away. Unless I am--Look, I can get, especially road rage. I'm one of those people that will get out and--. You know what I'm saying? So, in certain situations, it's a more fight than flight scenario. But, in personal [sic], like in dealing with spouses, it's more like a retreat than a fight. If it comes to that--I used to be very fired up and started screaming back, but now it's just like uh-uh [indicating no]."

When approaching this from a bio-psychosocial viewpoint, it is found that, when individuals experience conflict they will respond to it in a physiological way (Biological level); either they would want to get away from the conflict or will prepare to confront the situation or person responsible for the conflict situation. Consequently, there are two broad categories of coping responses: the first is targeting the source of the stress on a social level (problem focused) and the second is targeting the emotional arousal that sustains stress responses on a psychological level (Cabib et al., 2012:660). Therefore, the key to handling a conflict situation effectively is determined by the individual's ability to differentiate when to use what response. Thus, when stressors are susceptible to action on a social level, problem focused coping strategies are most successful (Cabib et al., 2012:660). However, when conflict situations are not susceptible to action, the most effective strategies are those aimed at regulating emotional arousal on a psychological level.

Unfortunately, as was reflected in the literature (Horsfall et al., 2009:27) and research findings, most of the research participants did not possess the desirable problem solving abilities to manage their conflict by means of problem focused coping strategies on a social level, or possess the emotional insight to solve the problem on a psychological level. Complicating effective problem solving for individuals with a dual diagnosis is ineffective communication skills.

❖ Communication skills

The dual diagnosis patients revealed that they often present with ineffective communication as, according to Del Piccolo, Danzi, Fattori, Mazzi & Goss, (2014:151), they find it difficult to identify and manage emotional states. In this regard eight of the participants indicated that they found it difficult to communicate their emotions and needs to those around them. Many of the participants indicated that they would only talk about their emotional needs when they were drunk; however, this normally leads to more problems in their relationships.

Additionally, a study on communication patterns in this regard has found that, when individuals experience psychological discomfort, they show an increase in laden expressions (Del Piccolo et al., 2014:151; Gabriel, Beach & Bodenmann, 2010:306). In other words, communication patterns become so emotionally charged that the patient finds it impossible to identify and verbalise these emotions in an accurate and understandable way (Del Piccolo et al., 2014:151). Interpersonal problems and social deficits are strongly associated with the development, intensity and course of depression. These statements are supported by the research findings, as many participants indicated that they became so emotionally overwhelmed when talking about their emotions, they found it easier to keep their emotions to themselves.

The following quotations reflect the research participants' opinions regarding their communication skills.

P4: "No, I'm struggling. I'm really struggling. I told my psychologist this morning as well. They asked me to write stuff; I'm not good at writing. And what I feel inside is difficult to explain to people, what I feel because they don't --. If you were there with me, then you will understand. Then I know I don't have to say too much, you will understand what I'm saying. The problem for me is to explain it to somebody so that they can understand and to not judge me. At this stage, it feels like everybody's judging me. You did stupid things, why did you do it? But now to explain to them why did it, that's my problem, I just can't explain it, I don't know why."

P5: "Generally I would, yes. Recently, when the depression in the last six months, not so much. What I thought I used to be able--Was good at, seems now So it's almost like a humble experience, type of,

thought I was really great at this thing and this thing and this thing and then there's some feedback that's negative feedback or, let's say, criticism that knocked me a little bit. So I was probably over confident in certain aspects and then got feedback that . . . "Mmm, actually I'm not so good at that [referring to communication skills]."

Deficits in communication patterns are just one of the problems experienced in the social domain of the bio-psycho-social approach when dealing with a dual diagnosis. Several studies have identified that a lack of verbal and non-verbal interactions, as well as high levels of passivity, withdrawal and negative statements, including complaints and negative self-statements, contributes to a decrease in communication patterns on a social level and may lead to negative relationship patterns (Gabriel et al., 2010:306). Literature has indicated that depressed persons display a higher frequency of interruptions, expression of negative feelings, criticism, defensiveness and lower levels of non-verbal positivity in their communication patterns with others (Gabriel, et al. 2010:306), leading to more and increasingly negative social interaction, as well as dissatisfaction in the social domain (Alvarez et al., 2012:175; Dogar, 2007:13).

Individuals with a dual diagnosis of depressive-episodes and alcohol misuse also have limited skills with regard to problem solving.

❖ **Problem solving skills**

More than 20 years ago Carey and Carey (1990:247) conducted a study with 65 men and women of whom 25 were dual diagnosis subjects. The goal of the study was to evaluate the problem solving abilities of dual diagnosis patients. Their study found that dual diagnosis patients demonstrate significantly poorer problem solving skills than other participants in the control group. The study also found that, when dual diagnosis patients gave responses towards problem solving, the responses were less elaborated and generally less effective (Carey & Carey, 1990:247).

Research 24 years later still reflects that individuals with a dual diagnosis have diminished problem solving skills (Wadell & Skarsater, 2007:1126). In this regard eight of the participants indicated that they were able to solve problems at work and in their everyday life; however, all ten of the participants indicated that they were unable to solve interpersonal problems in their relationships and were more likely to avoid the situation.

The research findings concur with Nezu and Nezu (2012:159) who, in their book, indicated that a differentiation needs to be made in terms of impersonal and interpersonal problem solving. Problem solving refers to problem solving within a more impersonal context, whereas social problem solving relates more to problem solving on a more interpersonal level. As they are of the opinion that individuals may not experience problem solving issues in their normal interactions, but will experience severe impairment in problem solving in situations where they are emotionally involved.

The following statements reflect the participants' opinions regarding their problem solving abilities:

P3: "I think I am going to say no, on both accounts solving problems in my work situation and in my personal life because I do not enjoy problems, I tend to try and get away from them. I tend to ignore them. If I were good in problem solving, I would take the problem and sort it out, but I tend to ignore it and ignore it until it becomes a massive problem, and only then when I absolutely have to do something about it that is when I will look at it, so no I am not good at problem solving."

P 10: "It depends on what it is. If it's emotional and if it's not physiological, I don't think I can do it well. But when it comes to maybe fixing a kettle or making sure my egg is in a perfect circle, I can do that. Like, real problems that I can do physically, I can do."

On a bio-psychosocial functional level, all people strive to maintain a homeostatic state between all the different levels of functioning including biological, psychological and social levels (Dogar, 2007:13). According to Grobler and Schenck (2009:2) this is a process of self-actualisation, meaning that an individual will always try to find a way to "go on" or cope and it is no different in a social environment with regard to emotional problem solving. Social problem solving is a process where individuals attempt to identify or discover adaptive means of coping with the wide variety and range of stressful problems, both acute and chronic, encountered during the course of everyday living (Nezu & Nezu, 2012:159). However, if an individual does not possess the required skills to solve interpersonal problems the individual will find an alternative way to cope with the problem, i.e., alcohol misuse. Excessive alcohol misuse along with an individual's inability to cope with problems on a social level may lead to violent and aggressive behaviour.

Sub-theme 2.2: Violent and aggressive behaviour patterns of the dual diagnosed individual

The link between alcohol misuse and aggression or violent behaviour has been well documented over the past decades (Bendall, 2010:101; Boden, Fergusson & Horwood, 2012:134; Pihl & Sutton, 2009:1188). Furthermore, literature has indicated that the increasing misuse of alcohol is associated with higher rates of violent offences, aggression and victimisation (Boden et al., 2012:134) because alcohol is arguably the most potent agent for eliciting aggression and reducing behavioural control (Heinz et al., 2011:400). These aspects, combined with symptomatic aggressive outburst in depressive episodes (Blackbeard, 2010:85), may cause a dual diagnosis patient to aggress towards others and even themselves.

With regard to this research study, the data analysis process revealed two sub-themes regarding violent and aggressive behaviour, namely violent and aggressive behaviour toward others and violent and aggressive behaviour towards the self (self-harm and suicide).

❖ Violent and aggressive behaviour towards others

Alcohol misuse is associated with high levels of aggression (Rhule-Louie & McMahon, 2007:53). This, along with the research done by Van Dorn et al. (2012:490), in a national survey of over 78 000 households, states that depression is a contributing factor to aggressive behaviour, and alludes to the fact that individuals with dual diagnosis will most probably exhibit aggressive behaviour towards others. However, the research findings are unique when compared with these statements as it found that this is not always true. When participants were asked whether they considered themselves to be aggressive, most of the participants said no. The participants also indicated that they did not experience bouts of aggression towards others. In this regard five of the participants indicated that they did experience aggressive outburst, but not necessarily towards other people. However, three of the participants did indicate that they had become physically aggressive towards others, and one of these participants indicated that he had become violent towards his spouse.

The following quotations reflect the research participants' opinions regarding their violent and aggressive behaviour:

P2: "Well, then I do get very angry with them. Okay, I wouldn't say I will become physical, you know, even physical fighting, I try to avoid those things, but I do get very angry."

P4: "Yes, I'm a very aggressive person. I can get very, very angry very quickly. I've got a big anger problem."

P6: "Conflict with my children. I also, the kids, I used to be harsh. In the manner that--I would--Started beating them, with my hand on their buttocks, and then the older one, I even slapped him once or twice because of not listening and then eventually I started to tell him that whatever--If he's--Feel aggressed with, he must write it down so that I can have it."

Although half of the participants indicated that they did have trouble controlling their aggressive behaviour, the other half indicated that they did not experience themselves as being aggressive. These findings are supported by Dutton and Karakanta (2013:311) who are of the opinion that aggressive behavioural traits may be more linked to the intensity of alcohol intake and internal or external locus of control and cannot be generalised to dual diagnosis. Furthermore, individuals experiencing depressive episodes are most likely to internalise their aggression and frustration (Dutton & Karakanta, 2013:311), highlighting the next sub-theme: violent and aggressive behaviour towards the self (self-harm and suicide).

❖ **Violent and aggressive behaviour towards the self (self-harm and suicide)**

Although this study found that patients suffering from dual diagnosis do not necessarily experience higher incidences of violent and aggressive behaviour, it did find that individuals with dual diagnosis are more likely to internalise their aggressive behaviour.

In this regard seven of the participants indicated that they had attempted suicide; one participant indicated that he had never attempted suicide, but had had thoughts of suicide, and two participants indicated that they had never attempted to hurt themselves in any way.

The following quotations reflect the research participants' experiences of violent and aggressive behaviour towards themselves:

P1: "Wel ek het gesorg dat ek alles doen sodat ek sterf. Dit was eendag in my huis gewees die eerste keer ek het 15g kalium gedrink ek het

myself met 100 eenhede insulien gespuit na ek vir vier dae nie geëet het nie, en ek het my femorale arterie gesny maar dis so klein maar ek weet presies waar dit is. En toe het ek in die stort gaan sit want ek wou nie hê my ouers moes op hierdie bebloede huis afkom nie.”

[I made sure I do everything so that I die. The first time, was one day at my home, I drank 15g of potassium and injected myself with a 100 units of insulin, did not eat for four days and cut my femoral artery, it is very small, but I know where it is. Then I got in the shower because I did not want my parents to find me in this blooded house.]

P9: “Yeah, I mean, as I said, I hurt myself to the point of bleeding, but I never tried to commit suicide. I thought about killing myself quite a lot when I was younger, but I’m too much of a wuss [too scared to follow through].”

P2: “And I was holding the nylon rope in my hands. And as I planned the whole thing, I do have a cat at home, and the cat is very lovable, you know, he’s like a lifeline to me, and then all of a sudden the cat’s face came up to me and then I asked myself: but listen here, this is unnecessary the cat still needs me”.

From the excerpts it is evident that depressive episodes and alcohol misuse is a well-known risk factor for suicide. In this regard a research study was conducted by Szerman et al. (2011:1) where they compared dual diagnosis patients with other groups of psychiatric patients to determine the different characteristics between them. Their study indicated that co-morbid substance misuse disorders were overrepresented in a sample of patients with mental disorders that have committed suicide. Furthermore, the most dangerous form of suicidal desire is caused by the simultaneous presence of two interpersonal constructs, the first of these constructs being a feeling of belonging and the second being a perceived burdensomeness (Van Orden, Witte, Cukrowicz, Braithwaite, Selby & Joiner, 2010:576). This research study concurs with Van Orden et al. (2010:576), as most of the participants who indicated that they had attempted suicide alluded to the fact that they had turbulent familial and social relationships, therefore not experiencing a sense of belonging. These individuals also thought of them as a burden on their families.

Trying to understand aggressive behaviour from a bio-psychosocial point of view, research has indicated that, when an individual is unable to deal effectively with anger on a psychological level, the negative emotion may turn to aggressive expression in the biological and social domain of functioning (Ghaemi, 2009:5., Szerman et al., 2011:1; Van Orden et al., 2010:576).

The next sub-theme will elaborate more on relationships of the dual diagnosed patient.

Sub-theme 2.3: Relationships structures of a dual diagnosed individual

Substance misuse and mental illness often result in serious consequences, not only for those living with the dual diagnosis but also for interpersonal relationships and family members (Tiet & Mausbach, 2007:513). It was established more than a decade ago that social interaction, or at least the perception thereof, influences treatment outcomes for dual diagnosis patients (Peirce et al., 2000:28). Peirce et al. (2000:28) hypothesised that constant positive social contact with individuals, especially family and friends, increases the perception of social support and belonging, decreasing depression and the need for self-medication or self-harm. In this regard the quality of social relationships predicts general health and mortality (Kendler et al., 2005:250). Therefore, it stands to reason that, if individuals are not receiving adequate support in their relationships, their treatment outcomes could be influenced negatively. Furthermore, as was pointed out by Van Orden et al. (2010:576) in the previous theme, that if individuals with a dual diagnosis do not experience a sense of belonging, or feel as though they are a burden on their families, this may be a risk factor for suicidal behaviour or self-harm.

The interviews revealed that dual diagnosis patients with depressive episodes and alcohol misuse tend to experience a higher instance of relationship breakdown. In this regard two sub-themes were isolated. Firstly, relationship structure and, secondly, support in relationships.

❖ Relationship structure

All of the participants had troublesome family structures, which the participants experienced as traumatic. Many of the participants indicated that they did not have strong relationship bonds with the people in their lives as they felt they are not accepted in their family structure.

The following quotations reflect some of the participants' experiences:

P8: *"It has never been good. It became not good after my mother's passing. Because he [the father] was abusive to my mother. And he was not okay, so my mother was looking after us and looking after him, but at the same time he was beating her."*

P7: *"Not physically, but emotionally, yeah. There was attempted family murder, which was also--A big thing. My father tried to shoot us, but he still stayed in the house with us."*

P4: *"....and since then, they had these, I don't know what they call it today, those days it was a hat party. Everybody comes to visit, they put a hat in the middle of the floor and everybody put their keys in there, and it's all women, because it's a lot of lesbians. And then they'd pick up the keys and then whoever's key you got, that's the person you go home with. But, there were also men involved, so my main problem was the men. I ended up with the men....There's a lot of things that happened. It's not only that --. Sometimes, you got locked up for about three to four days in a room. They tied me down to a bed. If they wanted to do what they needed to do, you were tied down. Because you were kicking and screaming and trying to get away from them."*

Traumatic events experienced in the family home on a social level may have triggered the development of depressive episodes on a psychological level (Dogar,2007:13). Furthermore, the quotes show that the family structures in these instances are not conducive to the teaching of coping mechanisms on a psychosocial level. Therefore, most of these individuals started using alcohol as a coping mechanism in an attempt to self-actualise (Grobler & Schenck, 2009:2), which in turn contributed to the escalation of the depressive disorder. Further contributing to relationship breakdown on a social level is relationship support.

❖ Relationship support

Relationship support came to the researcher's attention when most of the participants indicated that they did not feel their family members and friends understood what they were going through, therefore they felt detached and alienated from their families. Research conducted with Mexican youths supports these findings and is of the opinion that alcohol misuse and depressive episodes are very common when individuals feel that they are not supported in the social domain, as social support from family and friends can lessen the

association between stress, depression and negative treatment outcomes (Raffaelli, Andrade, Wiley, Edwards, Sanchez-Armass & Aradillas-Garcia, 2012:283).

Family involvement in the lives of people with co-occurring depressive episodes and alcohol misuse is associated with an improved outcome, suggesting that familial support is clinically beneficial (Mueser, Glynn, Cather, Xie, Zarate, Smith, Clark, Gottlieb, Wolfe & Feldman, 2012:1).

The following quotations reflect the participants' views regarding social support in their relationships:

P7: "My mother definitely doesn't understand [what I am going through], because she's only making it about herself. [She] doesn't know I'm here now, that's my choice. Because I don't want to go through her 'poor me' again. My father also doesn't know I'm here. He wasn't allowed to visit when I was at the clinic the first time. So he sat in the parking lot, which probably pissed him off, but so what? He's also not talking to me really, because--. He knows he wronged me in some way, but he will never say sorry. Neither my brother, nor sister know I'm here now, only my sister came to visit when I was in another clinic a previous time, and it was also more pity than empathy."

P8: "There's no support structure. There's no one who's supporting me. I'm doing this alone, that is why the drinking part. I ended up being only happy when I was drunk. I become happy when I'm drunk. Like, otherwise, just sadness. Can you imagine being sad and angry every day of your life? No."

On a social domain a support structure plays an important role, however in many instances family and friends may not understand the interaction between mental illness and substance misuse. As a result relatives may enable negative behavioural patterns or be unsupportive; believing the patient is in control of the behaviour and therefore is able to simply change negative behaviour patterns (Meuser & Fox, 2002:254). The dual diagnosis individual experiences this as a rejection in the social domain and often starts pushing family members away (Horsfall et al., 2009:25). The next theme will focus on the social domain of functioning with regard to economic and financial needs.

THEME 3: SOCIAL NEEDS: ECONOMIC/FINANCIAL DOMAIN NEEDS

Financial difficulties may influence treatment and treatment outcomes for dual diagnosis patients. From a bio-psychosocial point of view external social factors influence and attribute to psychological and internal social problems (Alvarez et al., 2012:175). Therefore, Theme 3 will deal with the economic domain of dual diagnosis. The data analysis revealed two sub-themes regarding financial aspects in dual diagnosis: work related issues that may lead to financial problems and financial management

Sub-theme 3.1: Work-related issues that may lead to financial problems

The bio-psychosocial approach depicts how biological, psychological, and social influences interact to the underpinning of dual diagnosis (Zunker, 2008:96). Seeing that these three dimensions have interplay on one another, stressful events will trigger responses on all three dimensions (Zunker, 2008:96). This was very clearly reflected in the research findings, when eight of the research participants indicated that they had experienced work related difficulties; however, not all of them have led to financial difficulties. The research found that reoccurring hospitalisation and high treatment cost can be a contributing factor to financial difficulty. This was not a common reason for financial difficulty in the research sample, as all of the participants had medical insurance. The following quotations reflect some of the work-related difficulties the research participants have experienced.

P1: "Ek het geweet toe ek nou die keer 'gerelaps' het ek kan nie werk toe gaan nie, ek het weer eens gejok en gesê ek het griep en diarree en ek word nie beter nie en ek sal my dokter gaan sien."

["Yes, the depression and I knew the last time I relapsed that I could not go to work, so I lied once again I said I had the flu and diarrhea and I am not getting better I am going to see a doctor"]

P8: "Oh. Yeah, now, I was suspended for three months without pay because of absenteeism, absconding—."

P9: "Yes, intoxicated at work. I've been there a couple of times."

Although not all of these incidences have resulted in dismissal, most of the participants were on a final warning and found their work environment to be very stressful. This consequently feeds the negative cycle as this may cause the stress to worsen the depression, the depression worsens the alcohol misuse, and the alcohol misuse leads to trouble at work.

Zunker (2008:105) and Katona et al. (2008:22) are of the opinion that a person with depressive episodes and alcohol misuse has difficulty in processing information, as well as having negative self-appraisal, all of which leads to disruptions in job performance and career development. Complicating financial matters even more is that individuals with a dual diagnosis experience difficulties with financial management.

Sub-theme 3.2: Financial management

Money management is part of an individual's daily independent functioning and therefore it can be viewed as an essential component of psychiatric disorders (Elbogen et al., 2011:224). Because individuals who suffer from depressive episodes and alcohol misuse experience many functional impairment in the pre-frontal cortex of the brain, which is responsible for functions such as planning and task execution; they may find money management to be a challenge (Beaumont et al., 2011:169). Elbogen et al. (2011:224) are of the opinion that financial management is a common unmet need reported by individuals with psychiatric illnesses, such as dual diagnosis. Also individuals who misuse substances, such as alcohol, is more likely to spend large amounts of money to support their alcohol habit contributing to more financial difficulties (Peltzer et al., 2007:18).

The research findings of this study support these statements as most of the participants indicated that they have suffered financial difficulties because of their dual diagnosis. Some of the participants were in a fortunate position to be financially secure however; they too indicated that, although this might not have affected their livelihood, they had been reckless in this regard. The following quotations reflect the research participants' opinions regarding financial management:

P5: "Yeah, at some point I actually pulled a budget together with all my credit card slips and how much the Thirsty Badger is costing me and sheesh! I've got shares in the damn place!"

P9: "Yes, I've spent a lot of money. Every cent you get, you use on alcohol, so there's not much money for anything else, because that's all you think of. That's your main thing, as long as you have the alcohol, nothing else really matters."

P7: "There was always enough money for alcohol [laughs]. It was essential. It's like having milk in the house, there must be alcohol!"

Furthermore, from the psychosocial domain the mismanagement of finances could also spill into the family environment, as the whole family will be affected by the financial strain. This may lead to more problems in their personal relationships (Elbogen et al., 2011:224; Zunker, 2008:105).

3.4 SUMMARY

In this chapter the researcher presented qualitative research findings as well as analysed and interpreted the bio-psychosocial needs of dual diagnosis patients with depressive episodes and alcohol misuse. These findings have suggested that dual diagnosis patients have specific bio-psychosocial needs that need to be met in a dual diagnosis programme. The needs were divided into three broad domains: biological needs that included physical well-being and addictive habits, psychological needs that included coping mechanisms, violent and aggressive behaviour and relationships, and social needs including economic financial needs.

The biological needs that were exposed in this study is that most of the individuals suffered from some form of chronic illness, which can contribute to more negative effect with regard to depressive episodes. Furthermore, the researcher found that there was an indication that individuals with dual diagnosis may develop cardiovascular difficulties because of their dual diagnosis. On the domain of addictive habits the researcher found that patients with dual diagnosis will most likely present with other addictive tendencies.

With regard to general coping mechanisms this study has found that individuals with dual diagnosis do not possess the needed coping mechanisms to deal with traumatic events. The research also exposed that traumatic incidences are a predecessor of dual diagnosis. Further exploration was done on very specific coping mechanisms, which included conflict management skills, communication skills, and problem solving skills. The research determined that patients with dual diagnosis do not have adequate conflict management skills and try to avoid conflict as far as possible, usually just making the conflict worse. The research also identified that, in terms of communication skills as a coping mechanism, individuals with dual diagnosis believe that they can communicate effectively with regard to every day settings, but not when it comes to communicating their own needs. This was also reflected in terms of problem solving; dual diagnosis patients are of the opinion that they are able to solve small problems, however, cannot solve their own emotional problems.

On the domain of violent and aggressive behaviour the research indicated that individual with a dual diagnosis of depressive episodes and alcohol misuse tend to become agitated more easily, but this behaviour does not necessarily turn violent. However, this research study revealed that most of these aggressive behaviours are turned inwards and individuals with dual diagnosis are more at risk of self-harm and suicidal behaviours.

With regard to relationships this research study indicated that individuals with dual diagnosis most likely come from an unstable family environment. Furthermore, these individuals feel that their family members do not understand what they are going through. Therefore, family breakdown is one of the aspects present in dual diagnosis patients suffering from depressive episodes and alcohol misuse.

Lastly, in the domain of economic and financial needs the research found that individuals with dual diagnosis are more likely to suffer problems at work due to their dual diagnosis. These individuals also show signs of ineffective financial management contributing to financial difficulties for the dual diagnosis patient.

Chapter 4 will summarise the research study and will provide conclusions and recommendations.

CHAPTER 4:

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter concludes the research report, with an outline of the empirical findings with regard to the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse. This chapter will provide an overview for the research findings, as well as indicate how the goal and objectives of the study were achieved. Thereafter, the research question will be answered followed by the key findings, conclusions and providing recommendations. In terms of recommendations, this chapter will provide an overview of the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse with regard to the multidisciplinary team. Lastly, this chapter will offer recommendations for future research.

4.2 GOAL AND OBJECTIVES OF THE RESEARCH STUDY

The **goal** of the study was to determine the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse.

This goal was achieved through the objectives that are outlined below, and the description of their respective accomplishments.

The **objectives** of the study were as follows:

- **Objective 1:** To conceptualise dual diagnosis and the various elements of treatment within the context of a developing world

This objective was achieved in Chapter 2 (see paragraph 2.2) with a detailed literature review, describing global, national and local trends in dual diagnosis research and treatment. In this regard, the literature provided a breakdown of depressive episodes and alcohol misuse as separate entities, as well as how they function as part of a dual diagnosis. The literature chapter focused on identifying and exploring the various elements that need to be addressed in dual diagnosis therapies. These elements were broken down and explored in three main themes, namely biological, psychological and social needs.

- **Objective 2:** To explore and describe the bio-psychosocial treatment needs of patients, diagnosed with depressive episodes and alcohol misuse, from the patient's perspective

This objective was comprehensively addressed throughout Chapter 3 with the three main themes and subsequent sub-themes. The three main themes identified were:

- 1) The **biological needs** of dual diagnosis patients with the sub-themes of a) physical health issues and b) health habits;
- 2) The **psychological needs** of dual diagnosis patients with the sub-themes of a) general coping mechanisms, b) violent and aggressive behaviour and c) relationship structures;
- 3) The **social needs** of a dual diagnosis patient with the sub-themes of a) work-related issues and b) financial management.

Furthermore, Chapter 3 focused on the dual diagnosed patient's perception of dual diagnosis in different spheres of functioning. Therefore, following the data analysis process, the researcher was able to explore and describe the bio-psychosocial treatment needs of dual diagnosed patients with depressive episodes and alcohol misuse. Thereafter, a range of conclusions are reached (These conclusions are presented in this chapter, Chapter 4, see paragraph 4.3.2).

- **Objective 3:** Based on the outcomes of the study, to make recommendations for a multidisciplinary team approach to the treatment of patients diagnosed with depressive episodes and alcohol misuse in South African treatment centres

Chapter 4 (see paragraph 4.3.2) provides recommendations for a multidisciplinary team approach to the treatment of patients diagnosed with depressive episodes and alcohol misuse in South African treatment centres. Subsequently, the recommendations for further social work research are also presented in Chapter 4 (see paragraph 4.3.2).

The study aimed to answer the **research question**, namely:

- ❖ What are the bio-psychosocial treatment needs of dual diagnosis patients, specifically for patients with depressive episodes and alcohol misuse?

The research question was answered through the identification and exploration of the following bio-psychosocial treatment needs:

- The biological treatment needs included the improvement of general well-being and health habits, as well as the management of other addictive habits, of a dual diagnosis patient with depressive episodes and alcohol misuse are related to an inactive lifestyle, poor diet and the presence of co-occurring chronic illnesses.
- The psychological treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse include the development and utilisation of more effective coping mechanisms with regard to conflict management, communication, and problem solving skills. Furthermore, the management of violent and aggressive behaviours and the development and sustaining of healthy relationships.
- The needs of dual diagnosis patients expressed on a social level include economic/ financial domain needs with regard to the management of work related issues due to their dual diagnosis, as well as needs regarding financial mismanagement.

4.3 KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The key findings, conclusions and recommendations that are listed below are the results of the literature review and individual interviews with patients with co-occurring depressive episodes and alcohol misuse.

4.3.1 Literature review

Before an empirical study could be undertaken, the researcher had to conduct an in-depth literature review to guide the research study; the key findings of the literature review are as follows:

(i) Key findings: literature review

- There is an inability among academia and practitioners to reach a consensus regarding the conceptualisation of dual diagnosis as an illness.
- The prevalence of co-occurring psychiatric illnesses and substance abuse is approximately 50% and is on the increase with an estimated 2.7 million adults (18 years and older) worldwide suffering from co-occurring depressive episodes and alcohol misuse.

- The phenomenon of dual diagnosis may manifest itself in several different ways: 1) Alcohol misuse and depressive episodes may co-occur by coincidence, 2) Alcohol misuse may cause depressive episodes or increase the severity of symptoms, 3) Individuals with depressive episodes may misuse alcohol to relieve a specific set of symptoms, such as apathy, irritation and insomnia (Rethink, 2009:3) or 4) Depressive episodes and alcohol misuse are caused by an unknown external factor, for example, poverty, abuse or trauma.
- Dual diagnosis of depressive episodes and alcohol misuse manifests itself in different ways, as well as on different spheres of functioning. Each sphere affecting the others, for example experiencing a depressive episode on a biological or cellular level, leads to the need for self-actualisation on a psychological level, spilling over into ineffective coping behaviour such as alcohol misuse on a social level.
- Social workers play a pivotal role in the mental health sector; however co-existing problems and complex needs associated with mental health issues and problematic substance use may contribute to difficulties in service delivery. Factors that contribute to problematic service delivery are ineffective training for social workers in both mental illness and substance abuse, as well as not being provided with the needed support and research, as dual diagnosis treatment is still very fragmented in South Africa.

(ii) Conclusions: Literature review

Based on the literature review, the researcher reached the following conclusions:

- The inability among academia and practitioners to reach a consensus regarding the conceptualisation of dual diagnosis consequently has a negative impact on the development of treatment programmes for patients suffering from dual diagnosis.
- Psychiatric illnesses, such as depressive episodes, are on the increase. This, combined with the low prevalence of seeking treatment, pushes individuals to self-medicate and make use of substances, such as alcohol.
- Because dual diagnosis may manifest itself in several different ways, many individuals with a dual diagnosis of depressive episodes and alcohol misuse find themselves caught between different branches of mental health care and substance abuse rehabilitation.

- Dual diagnosis patients experience treatment needs on all levels of functioning, including biological and psychological. Each level has an impact on the other.
- Social workers find themselves unable to provide adequate treatment for dual diagnosis patients due to 1) the increase of client loads with complex needs; 2) substance abuse and psychiatric disorders still being treated linearly or consecutively; as well as 3) the private, public sector defied with regards to resources for treatment.

(iii) Recommendations: Literature review

Based on conclusions from the literature review, the researcher recommends the following:

- Intensifying efforts in research, as well as practice, to develop a workable definition and conceptualising of dual diagnosis.
- More education, preventative therapies and treatment is needed with regard to psychiatric illnesses like depressive episodes to prevent the use of alcohol as a way to self-medicate.
- In order to remedy parallel or sequential treatment approaches, institutions should consider investing in the development of integrated treatment programmes for dual diagnosis patients.
- In order to effectively treat dual diagnosis, it is recommended that dual diagnosis treatment takes place on all the different levels of functioning, including biological, psychosocial and social spheres. Therefore, more research is required on the development of dual diagnosis treatment in order to address all these aspects effectively.
- It is recommended that more clear policies be developed in terms of the role of the social worker when working with patients with a dual diagnosis. The development of a unified integrated treatment approach that can be implemented in both the private and public sector.
- Therefore, providing more training for social workers working in the field of mental health and dual diagnosis is also recommended.

4.3.2 Empirical study

The literature review guided the researcher to conduct an empirical study regarding the bio-psychosocial treatment needs of patients with a dual diagnosis of depressive episodes and alcohol misuse. The key findings are as follows:

(i) Key findings: Empirical study

- Through the research study it was noted that, in order to treat patients with a dual diagnosis of depressive episodes and alcohol misuse effectively, there has to be good clinical communication between all members of the multidisciplinary team.
- The demographic profile indicated that the research participants varied in age, gender and race. It was also found that the socio-economic status varied between individuals.
- It was identified that patients with a dual diagnosis of depressive episodes and alcohol misuse do not exercise or follow an active lifestyle and have a lowered perception of adequate physical activity levels. These individuals tend to follow a poor diet and are at a greater risk for the development of other chronic illnesses, including hypertension and cardiovascular illnesses.
- Dual diagnosis patients suffering from depressive episodes and alcohol misuse are more likely to smoke and use other addictive agents apart from alcohol.
- The interviews revealed that patients with a dual diagnosis of depressive episodes and alcohol misuse tend to have suffered a traumatic event prior to the onset of the depressive symptoms that lead to alcohol misuse.
- Individuals with a dual diagnosis of depressive episodes and alcohol misuse tend to have poorly developed coping mechanisms to deal with traumatic events. They also have limited resources for gaining an improved sense of well-being.
- The research reflected that individuals with a dual diagnosis are unable to effectively express their emotions or deal with conflict situations. More specifically, these individuals find it difficult to manage conflict situations in their personal lives, but not necessarily in their work environment.
- Regarding communication, this research identified that patients with a dual diagnosis of depressive episodes and alcohol misuse find it difficult to communicate their needs and emotions to others. Furthermore, they would only communicate their needs and feelings if they are under the influence of alcohol.

- Individuals with a dual diagnosis do experience a higher incidence of aggression and frustration, but will not necessarily aggress or become violent towards others. These individuals are more likely to internalise their frustration and aggress towards themselves by means of self-harm and suicidal behaviour.
- The data analysis revealed that dual diagnosis patients with depressive episodes and alcohol misuse tend to experience a higher instance of relationship breakdown in terms of relationship structure and relationship support.
- Dual diagnosis patients are more likely to experience work-related issues due to their depressive episodes and alcohol misuse, which in turn may lead to disciplinary actions at work that has a financial impact on the patient. It was also found that individuals with a dual diagnosis tend to mismanage personal funds, which ultimately contribute to financial difficulties.

(ii) Conclusions: Empirical study

Based on the empirical study, the following conclusions were reached:

- Ineffective clinical communication leads to fragmented service delivery regarding dual diagnosis treatment. Therefore, ineffective clinical communication contributes to the linear development of psychiatric and substance misuse programmes.
- There is no clear demographic profile that can be determined in terms of race, gender, age or socio-economic status of a dual diagnosis patient with depressive episodes and alcohol misuse. However, it should be noted that the sample of this study was not representative, therefore these conclusions should be interpreted cautiously.
- Unsatisfactory health habits, combined with a dual diagnosis of depressive episodes and alcohol misuse, have profound effects on the quality of life and physiological well-being of an individual. This may leave them vulnerable to the development of other chronic illnesses. Therefore, it can be concluded that the biological treatment needs of a dual diagnosis patient is related to an inactive lifestyle, poor diet and the presence of co-occurring chronic illnesses.
- Individuals suffering from dual diagnosis tend to have other addictive habits apart from alcohol misuse. Therefore, another treatment need with regard to biological needs is the management and treatment of all other dependencies.
- The experience of a traumatic event may be a trigger for the onset of a dual diagnosis of depressive episodes and alcohol misuse.

- Due to poorly developed repertoires of coping mechanisms, individuals with dual diagnosis are unable to deal with everyday stressors, leading to deterioration of emotional well-being. Therefore, one of the psychological treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse includes the development and utilisation of more effective coping mechanisms with regard to conflict management, communication skills and problem solving skills.
- A dual diagnosis patient's inability to deal with conflict has less to do with the skill itself, but more to do with the inability to apply the skill in emotionally charged situations, such as in personal relationships.
- Due to the inability of dual diagnosis patients to communicate their emotions and needs effectively, dual diagnosis patients tend not to communicate with others, leading to relationship breakdown, as well as problems in their work environment.
- Although individuals with dual diagnosis present with more instances of aggression, aggressive and violent behaviour towards others seems to be linked to the intensity of alcohol intake. Therefore, these individuals tend to aggress towards themselves by means of self-harm and suicidal behaviour.
- Due to dual diagnosis patients' troublesome family and relationship structures, these individuals do not tend to have the needed support systems in dealing with a dual diagnosis, which consequently leads to less effective treatment outcomes.
- The needs of dual diagnosis patients, expressed on a social level, include the economic/financial domain, which pertains to work-related issues and financial mismanagement. In other words, dual diagnosis patients may experience severe financial difficulties on a social level due to their dual diagnosis.

(iii) Recommendations: Empirical study

Based on the conclusions of the empirical study, the following is recommended:

- It is recommended that every effort is made to promote effective and efficient clinical communication between all members of the multidisciplinary team in order to prevent fragmented treatment. Recommendations for the multidisciplinary team with regard to the biological treatment needs of dual diagnosis patients, include:
 - **Psychiatrist:** Treatment of depression episodes, as well as the pharmacological treatment of alcohol misuse symptoms and other co-occurring chronic illnesses.

- **Social worker:** Providing psycho-education services for both the family and the patient regarding dual diagnosis, as well as education regarding the co-occurring chronic illnesses and its ramifications.
- **General practitioner:** Should an institution have a general practitioner along with a psychiatrist, it should ideally be the responsibility of the general practitioner to diagnose and manage other chronic illnesses, such as hypertension and cardiovascular disease through pharmacological treatment protocols.
- **Nursing staff:** It should be the responsibility of the nursing staff to administer medication, as well as evaluate and assist in the treatment of chronic and acute medical conditions. In this regard it is recommended that good clinical communication is in place so that the nurse is able to communicate to the rest of the multidisciplinary team how the patient is reacting to the medication, as well as give feedback regarding the patient's overall health condition.
- Recommendations for the multidisciplinary team with regard to the improvement of health habits, such as healthy eating and exercise of the dual diagnosis patients:
 - **Dietician:** The development of an effective eating plan to promote healthy eating habits of dual diagnosis patients.
 - **Biokineticist:** Evaluating the patient's capabilities and needs with regard to physical activities. Developing effective exercise plans that can be utilised on an individual level, as well as in a group setting.
 - **Social worker:** Educating patients, as well as family members, on the importance of healthy life habits such as diet and exercise and motivating adherence to the recommendations of other professionals, such as the dietician and biokineticist.
 - **General practitioner:** Managing illnesses and medical complications that may have stemmed from unhealthy habits, such as hypertension, cardiovascular illnesses, and diabetes.
- Recommendations for the multidisciplinary team concerning the management of 'all' dependencies of dual diagnosis patients:
 - **Psychiatrist:** It is recommended that, on a pharmacological level, patients receive assistance in order to manage dependency symptoms. The psychiatrist may assist by prescribing anti-booze to the patient, as well as painkillers and sleeping tablets to help ease the withdrawal symptoms.
 - **Psychologist:** It is recommended that the psychologist provides individual psychotherapy to the patient. Individual therapy will help the patient explore

some of his or her dependency triggers, as well as possible causes that may have led to alcohol misuse.

- **Social worker:** It is recommended that social workers working with dual diagnosis provide education regarding addiction, as well as develop and implement psycho-educational and support groups for these individuals. In the absence of a psychologist, the social worker could provide the counselling as previously recommended for the psychologist.
- **Nursing staff:** It is recommended that nursing staff members compile a medical history regarding substance abuse behaviours. This includes monitoring the patient in the ward to manage withdrawal symptoms.
- Recommendations for the multidisciplinary team with regard to trauma as a trigger for dual diagnosis:
 - **Psychologist:** Exploring the trauma by means of trauma counselling in order to develop a better understanding of why the trauma had such a profound impact on the patient.
 - **Social worker:** Teaching the patient coping mechanism to deal with trauma experiences, as well as how to prevent re-traumatisation if the patient is still being exposed to the traumatic environment.
 - **General practitioner:** Treating physical wounds caused by the trauma.
- Recommendations for the multidisciplinary team with regard to the psychological needs and coping mechanisms of the dual diagnosis patient:
 - **Psychiatrist and psychologist:** Providing individual therapy and trauma counselling, assisting the patient in coming to terms with traumatic experiences, as well as exploring biological, psychological and social domains that may have an impact on the patient's well-being.
 - **Social worker:** Providing psycho-education and support, as well as assisting patients in developing more socially acceptable coping mechanisms with regard to conflict management, communication and problem solving skills.
- With regard to managing conflict in emotionally charged personal relationships, the recommendations for the multidisciplinary team are as follows:
 - **Psychiatrist:** Managing unstable emotions due to depressive episodes with mood stabilising medication.
 - **Social worker:** By means of group work, teaching the patient practical skills to manage conflict in an emotionally charged situation.

- **Psychologist:** Providing individual therapy to assist the patient in exploring his emotions and evaluating the reason for these emotions.
- **Nursing staff:** Creating a safe environment in the ward for patients to be able to express their emotions in a non-condemning manner.
- Recommendations for the multidisciplinary team with regard to communication patterns of dual diagnosis patients with depressive episodes and alcohol misuse:
 - **Social worker:** Through group work and family counselling, educating the patient and family members on how to recognise and communicate their needs and emotions to one another.
 - **Psychologist and Psychiatrist:** Assisting patients in identifying needs and emotions they may not be aware of by means of individual therapy.
- Recommendations for the multidisciplinary team with regard to psychological needs pertaining to violent and aggressive behaviour:
 - **Psychiatrist:** Pharmacological intervention is recommended to treat aggressive symptoms and suicidal ideation that arise due to depressive episodes, as well as assistance with withdrawal symptoms that may cause aggressive behaviour.
 - **Social worker:** The development and implementation of anger management programmes to be dealt with in groups that could assist patients in dealing with built up aggression and negative emotions towards the self.
 - **Nursing staff:** It is recommended that good clinical communication is in place so that nursing staff can be made aware if a patient presents with violent tendencies. These communication patterns are also of importance when it is necessary for the nursing staff to inform other members of the multidisciplinary team about aggressive and violent behaviour.
- Recommendations for the multidisciplinary team with regard to psychological needs pertaining to relationships:
 - **Psychiatrist, Psychologist and Social Worker:** It is recommended that family counselling be provided, as well as psycho-education and support groups for family members of dual diagnosis patients.
 - **Nursing staff:** It is recommended that all ward staff receive training with regard to skills to appropriately refer to other members of the multiprofessional team when patients disclose relationship problems to the nursing staff.
- Recommendations for the multidisciplinary team with regard to economic or financial domain needs include:

- **Social Worker:** Providing psycho-education with regard to basic financial management. In addition, linking patients with outside sources that can assist them with their financial management, such as a debt counsellor. It is also recommended that the social worker liaise with the patient's work/employer to ensure a suitable work environment for the patient, in other words, creating an enabling work environment for the patient. This will most likely include liaising with the company's Employee Assistance Programme (EAP) practitioners, if there are any available. It is further recommended that the patient be equipped with tools to reintegrate into the workplace, such as time management skills.

4.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations can be made with regard to future research:

- To repeat the study at other private as well as government institutions to determine whether the same results are reflected in both the private and public sectors.
- To conduct the study at institutions outside Gauteng Province in order to establish the treatment needs of dual diagnosis patients on a representative scale.
- It is recommended that the study be repeated with participants using different dual diagnosis components, for example anxiety and misuse of over the counter medications.
- It is recommended that more research is done on the development of programmes that can be utilised in treatment facilities to address the need for skills development.
- It is recommended that more research is done on the impact of dual diagnosis on the family structure.
- To investigate some of the social causes of a dual diagnosis of depressive episodes and alcohol misuse.
- More research be done regarding how family structure influences dual diagnosis.
- From an EAP perspective it is recommended that more research be done on how to assist employees with depressive episodes and alcohol misuse in the workplace.

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APPENDIX A

Ethical Clearance



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

3 March 2014

Dear Prof Lombard

Project: The bio-psychosocial treatment needs of dual diagnosis patients: depressive episodes and alcohol misuse
Researcher: Y Lindeque
Supervisor: Dr LS Geyer
Department: Social Work and Criminology
Reference number: 28346786

I am pleased to be able to inform you that the above application was **approved** by the **Research Ethics Committee** on 27 February 2014. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.


Sincerely

Prof Karen Harris
Acting Chair: Postgraduate Committee &
Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail:Karen.harris@up.ac.za

Research Ethics Committee Members: Dr L Blokland; Prof Prof M-H Coetzee; Dr JEH Grobler; Prof KL Harris (Acting Chair); Ms H Kopper; Dr C Panabianco-Waensens; Dr Charles Puttergill; Prof GM Spaas; Dr Y Spies; Prof E Tjalling; Dr P Wood

APPENDIX B

Permission Letter



22 November 2013


Attention: University of Pretoria
To whom it may concern

RE: YOLANDA LINDEQUE (8905250144088)

Vista Clinic hereby gives Ms Yolanda Lindeque permission to conduct research on the topic "The bio-psychosocial treatment needs of dual diagnosis patients: depressive episodes and alcohol misuse".

Please feel free to contact Dr Jemie Bezuidenhout at Tel [012] 644 9020, should you have any enquiries relating to the aforementioned.

Kind regards



Dr Jemie Bezuidenhout
Director Medical Services

Vista Trust t/a Vista Clinic | Reg No: TMP 789 | Vat No: 4790103461 | BHF Practice Number: 0550005500087
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APPENDIX C



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Researcher: Yolanda Lindeque
Tel. Numbers: Cell: 082 349 7753
Office: 012 664 0222

Participant's name: _____

INFORMED CONSENT

1. **Title of the study:** The bio-psychosocial treatment needs of dual diagnosis patients: Depressive episodes and alcohol misuse.
2. **Purpose of the study:** The goal of the study is to determine the bio-psychosocial treatment needs of dual diagnosis patients with depressive episodes and alcohol misuse.
3. **Procedures:** I willingly responded to an invitation to form part of this study. I expect to be interviewed one-on-one by the researcher where after the information gathered will be transcribed, documented and analysed. I am aware that the interview will take approximately one hour.
4. **Risks and procedures:** There are no physical risks in participating in the study, although I may experience emotional distress when talking about my life and living with dual diagnosis and sharing my perceptions and experiences with the researcher. I am aware that further counselling, if I wish to do so, will be provided by Ervin Lass, a clinical psychologist at Vista Clinic.
5. **Benefits:** I understand that there are no known direct benefits for me participating in this research study. The results of the study will, however, assist the researcher to gain better understanding regarding the bio-psychosocial treatment needs of dual diagnosis patients.
6. **Participant's rights:** I acknowledge that participation is voluntary and that I may withdraw from participating in the study at any time without negative consequences.

7. **Confidentiality:** In order to record accurately what is said during the interview, the researcher will make use of an audio recorder. The recording will be listened to only by the researcher (Yolanda Lindeque). I understand that the data obtained will be kept confidential unless I ask that it be released. The data obtained from me will be destroyed if I decide to withdraw from this study. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.
8. **Right of access to researcher:** If I have any questions or concerns, I can call Yolanda Lindeque on 082 349 7753 from Mondays to Fridays during working hours (08:00-16:00). I will be able to contact the researcher by means of email or phone should I seek clarification on any issue or if doubts should arise, whether it is before or after the study.

I understand my rights as a research participant and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done.

I am aware that, in accordance with University of Pretoria policy, the data will be archived for a period of 15 years in the Department of Social Work and Criminology.

Signed at.....on this.....day of.....201.....

.....
Signature of Participant

.....
Signature of Researcher

APPENDIX D

Interview Schedule

Semi-structured interview:

The bio-psycho-social treatment needs of dual diagnosis patients:

Depressive episodes and alcohol misuse

In order for me to determine the bio-psycho-social needs of someone living with dual diagnosis (specifically depressive episodes and alcohol misuse), I will ask you questions about the following components:

- Financial difficulties
- Violent and aggressive behaviour
- Relationships
- Coping mechanisms, and
- Physical health.

Please feel free to answer all questions according to your experience and point of view.

BIOGRAPHICAL INFORMATION

- Gender
- Age
- Province of origin
- Home language/Mother tongue
- Highest qualification

- Occupation
 - Racial grouping
 - Religion (if any)
 - Marital status
 - Number of children (if any)
 - How many alcoholic drinks consumed per day
 - Time/date of diagnosis with depressive episodes
1. Describe your life as a person living with dual diagnosis?
 - 1.1 Explore different themes:
 - Financial difficulties
 - Violent and aggressive behaviour
 - Relationships
 - Coping mechanisms
 - Physical health
 - Other needs
 2. How can treatment centres/ psychiatric clinics offer treatment to you to cope better with alcohol misuse and depressive episodes?
 - Information classes and group therapy
 - Individual therapy
 - Activities
 - Medication
 3. I have asked you some questions regarding dual diagnosis and your experiences, is there anything you would like to add or discuss further?

Thank you for your time and patience.