

Adults living with stimulant abuse and bipolar disorder: Experiences of service users at treatment centres

by

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*'For I know the plans and thoughts that I have for you' says the Lord,
'plans for peace and wellbeing and not for disaster, to give you a
future and a hope. Jeremiah 29:11*

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ABSTRACT

Adults living with stimulant abuse and bipolar disorder: Experiences of service users at treatment centres

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The goal of the study was to explore how adults living with stimulant abuse and bipolar disorder experience treatment at treatment centres in the Gauteng Province. As the study was aimed at gaining an in-depth understanding of the lived experiences of service users in terms of treatment, a qualitative research approach was implemented. The research findings were aimed at adding knowledge to the field of social work, which could contribute to the development of treatment programmes and possible policy changes that could positively impact the recovery of individuals living with a dual-diagnosis, specifically the dual-diagnosis of bipolar disorder and stimulant abuse.

A phenomenological research design was used as it allowed the researcher to discover and report on the details pertaining to the participants' experiences in terms of the treatment they received. The phenomenological research design also enabled the researcher to describe the commonalities and discords expressed by participants in relation to the phenomenon. The sampling process for the research study took place in three phases. In the first phase, purposive sampling was implemented to select three substance abuse treatment centres in the Gauteng Province, and more specifically the Tshwane Metropolitan Municipality. The second phase of sampling was also purposive sampling, where inclusion criteria were supplied to a social worker at each treatment centre who identified possible participants. During the third phase of sampling, possible participants were approached and informed of the study and ultimately four (N=4) individuals volunteered to participate in the study. Data was collected through the use of semi-structured one-on-one interviews which were guided by an interview schedule. Data gathered during the literature review and interviews were analysed through the process of thematic analysis and aimed at answering the research question *"How do adults living with stimulant abuse and bipolar disorder experience services at treatment centres in the Gauteng Province?"*

The key findings indicate that admission to in-patient treatment programmes, for both stimulant abuse and psychiatric care, was prevalent among all participants, but re-occurring admissions to substance abuse treatment was more evident. Stimulants were primarily used as a means of coping with moods and emotions, as unstable mood patterns and emotions persisted regardless of the pharmacological treatment for bipolar disorder. The most helpful component of treatment which aided participants in managing their mood was counselling. When stimulants were not available and counselling was insufficient, other means of achieving psychological relieve were employed by participants, such as exercise, nicotine use, sweets and caffeine. The role of religion and spirituality in treatment is not clear, but all participants believe that religion and spirituality should be included in treatment. The need

for education in terms of bipolar disorder, addictive behaviours, lifestyle changes and coping mechanisms were mentioned by most participants. In addition to education provided by professionals, participants expressed a need for sharing experiences with individuals that have managed to recover from bipolar disorder and/or stimulant abuse. When treatment plans and goals are set participants believe that they and their family should be included, a factor relevant to in-patient and reintegration services. With regards to in-patient treatment programmes, the psychosocial-cultural environment created within the physical environment was also mentioned as a component that needs to be considered.

In order to deliver services that allow for the effective treatment and reintegration of individuals that abuse stimulants and are diagnosed with bipolar disorder the following recommendations are made: 1) Interventions, including prevention and early interventions, should be developed based on research findings focused on dual-diagnosis, to ensure that concurrent treatment and reintegration is achieved and sustained, thus promoting recovery, or the management, of both disorders. 2) Education in terms of stimulant addiction, cross-addiction, bipolar disorder, lifestyle changes, coping skills, as well as the interplay between these factors should be included in treatment programmes, however, education should be expanded to service providers and extended to family members too. 3) The role of religion and spirituality as part of dual-diagnosis treatment should be considered. 4) Treatment and support groups that focus on the specific dual-diagnosis of stimulant use and bipolar disorder, should be developed as part of in-patient treatment programmes, as well as supporting out-patient programmes, which could improve long-term recovery. 5) The physical and the psychosocial environments which are conducive to the recovery of dual-diagnosis patients should be established, as these environments could possibly be replicated, for example at home, and could ensure long-term recovery. 6) Service users and their families should be included in decisions regarding treatment planning and reintegration, as inclusion in this area of treatment could promote compliance to treatment. However, it should be stated that many of these recommendations are dependent on governing bodies, such as the Department of Social Development and the Department of Health, who are responsible for changing, developing and monitoring policies guiding treatment, which has a direct impact on the long-term recovery of individuals living with this dual-diagnosis.

Future research studies that can contribute to understanding this phenomenon can focus on 1) Repeating the study within other private and government based treatment centres across South Africa in order to determine whether treatment needs differ or whether it presents the same results. 2) Comparing studies from different centres and areas of South Africa in order to establish treatment needs of individuals diagnosed with a dual-diagnosis. 3) Research should be done to determine the actual prevalence of the dual-diagnosis of stimulant abuse and bipolar disorder in South Africa, focused on admissions in both substance abuse treatment centres and psychiatric treatment facilities. 4) Treatment programmes developed from research findings should be implemented, and research should be conducted on the effectiveness of treatment. 5) Research on different combinations of dual-diagnosis is necessary to determine how treatment needs differ, as this will ensure the development of appropriate treatment. Individuals working at treatment centres (for both substance abuse and psychiatric disorders) should be aware of the needs of dual-diagnosis patients, and be educated on this phenomenon. 6) It is recommended that research should be done with the staff of psychiatric treatment centres, as well as staff at substance abuse treatment centres, to determine their views and knowledge in terms of dual-diagnosis. 7) Research focussed on

the costs of not treating dual-diagnosis should be conducted. When the actual costs of non-treatment are established, government agencies and the private sector might be more prone to support treatment strategies. 8) Intervention strategies focused on families of dual-diagnosis patients should be implemented and the impact of these interventions on both patients and families should be researched. 9) More research in terms of this dual-diagnosis is necessary as this could allow for the development of effective treatment strategies that could lower relapse and readmission rates.

Keywords:

Adults
Substance abuse
Stimulant abuse
Bipolar disorder
Dual-diagnosis
Service users
Treatment centre
Gauteng Province
Tshwane Metropolitan Municipality

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CHAPTER 1

GENERAL INTRODUCTION

1.1 INTRODUCTION

The Minister of Social Development, Ms Bathabile Dlamini wrote the following statement in the National Drug Master Plan 2013-2017 (NDMP) (Department of Social Development [DSD], 2013:2):

The use of alcohol and illicit drugs impact negatively on the users, their families and communities. Alcohol and drugs damage the health of users and are linked to rises in non-communicable diseases including HIV and AIDS, cancer, heart disease and psychological disorders.

From this statement, it is evident that substance abuse is a phenomenon that does not just impact users on various levels of functioning but also the systems around them. Substance abuse or addiction can be defined as “[t]he misuse and abuse of legal or licit substances such as nicotine, alcohol, over-the-counter and prescription medication, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illegal or illicit substances” (DSD, 2013:19). The South African Community Epidemiology Network on Drug Use (SACENDU) (2016:11) reported that between July and December of 2015 a total of 3570 individuals were admitted to seventeen treatment centres in the Gauteng Province, of which 84% were first admissions and 20% reported stimulants as their drug of choice. The use of methcathinone (CAT), which is an amphetamine based synthetic stimulant, is increasing in all provinces but more so in the Gauteng Province where 9% of patients admitted to treatment under twenty years reported CAT to be their drug of choice (SACENDU, 2016:19). SACENDU (2015:3) identified the use of CAT among individuals under the age of 20 years in the Gauteng Province as a problem that should be monitored.

The use of substances has various effects on the physiological and psychological functioning of the body and poses certain challenges in terms of neuroscience (Gutkin & Ahmed, 2012:v). The National Alliance on Mental Illness (NAMI) stated that substances can trigger the onset of a psychiatric disorder or worsen an existing disorder (NAMI, 2013:1). A mental or psychiatric disorder is defined as “[a] psychological dysfunction within an individual that is associated with distress or impairment in functioning and a response to this which deviates from the person’s culture” (Austin, Bezuidenhout, Du Plessis, Jordaan, Lake, Nel, Pillay, Ure, Visser, Von Krosigk, Voster & Burke, 2009:4). In South Africa, psychiatric disorders are diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) which is compiled by the American Psychiatry Association (APA) (Olckers, 2013:1). Kupfer and Regier (APA, 2013a:xli) explain that the “... DSM is intended to serve as a practical, functional, and flexible guide for organising information that can aid in the accurate diagnosis and treatment of mental disorders”.

When a psychiatric disorder is coupled with a substance addiction it is referred to as a dual-diagnosis (Rethink, 2009:1), which the National Institute on Drug Abuse (NIDA) defines as “[t]he occurrence of two disorders or illnesses in the same person, either at the same time (co-occurring comorbid conditions) or with a time difference between the initial occurrence of

one and the initial occurrence of the other...” (NIDA, 2010:10). In terms of dual-diagnosis Tiet and Mausbach (2007:513) explain that 60% of individuals that seek treatment for drug abuse are diagnosed with psychiatric disorders, such as bipolar disorder, and 56% of individuals seeking treatment for bipolar disorder have a co-occurring substance abuse problem. SACENDU (2016:1) reported that 37% of the 9679 patients admitted to 78 treatment centres in South Africa during the second half of 2015 reported mental health problems upon admission. A study conducted by Fabricius, Langa and Wilson (2007:7) aimed at establishing the prevalence of dual-diagnosis among individuals in a treatment centre in Johannesburg and found that 57% of the 419 patients had a dual-diagnosis.

Swann (2010:278) provides that patients diagnosed with bipolar disorder are more inclined to use stimulants as they want to achieve the level of mania they experience during a manic episode of bipolar disorder. The presence of a dual-diagnosis complicates treatment in both disorders as individuals with a dual-diagnosis are less likely to comply with treatment and less likely to maintain sobriety in general (NAMI, 2013:1). Finding effective ways to treat these patients are made more difficult as there is a major lack of information on the co-occurrence of bipolar disorder and drug use, as well as the effects each, has on the other (Swann, 2010:276). Information is limited as studies focussing on the treatment of bipolar disorder usually exclude individuals with substance abuse problems, thus little is known regarding the treatment of these patients (Weiss, Griffin, Jaffee, Bender, Graff, Gallop & Fitzmaurice, 2009:212). Fabricius et al. (2007:3) assert that it is no surprise that there is no consensus with regards to treatment of this dual-diagnosis as there is no consensus on what causes it in the first place.

The researcher became aware of the challenges regarding the dual-diagnosis of stimulant use and bipolar disorder while working at a treatment centre in Pretoria. It was noted that these patients are more prone to relapse and that little information was available on effective forms of treatment, therefore the researcher focused on individuals that were in treatment for stimulant abuse and had a diagnosis of bipolar disorder. The study was conducted at three treatment centres in the Gauteng Province as the use of stimulants in this province was a cause of concern and often coincides with the diagnosis of mental health problems (SACENDU, 2016:14; Weiss et al., 2009:212). The key concepts used in this study are defined in the following section.

1.2 DEFINITION OF KEY CONCEPTS

The key concepts that are relevant to the particular study are:

Adults: “A child, whether male or female, becomes a major upon reaching the age of 18 years” (Children’s Act 38 of 2005, Section 17).

Stimulant abuse: *Substance abuse* is defined as “[t]he continued use of alcohol and/or other drugs in spite of adverse consequences in one or more areas of an individual’s life” (Fisher & Harrison, 2013:15). *Stimulant drugs* “...increase respiration, heart rate, motor activity, and alertness” (Fisher & Harrison, 2013:21). As there is no formal definition for stimulant abuse the researcher will define it as the continued use of substances classified as stimulants (cocaine, methamphetamines, khat and methcathinone), regardless of the negative consequences caused by continued use.

Bipolar disorder: “The bipolar I disorder criteria represents the modern understanding of the classic manic-depressive disorder ... Bipolar II disorder, requiring the lifetime experience of at least one episode of major depression and at least one hypomanic episode ... The diagnosis of cyclothymic disorder is given to adults who experience ... both hypomanic and depressive symptoms” (APA, 2013a:123). “A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with manic-like phenomena ... recognized in the diagnosis of substance/medication-induced bipolar and related disorder and bipolar and related disorder due to another medical condition” (APA, 2013a:123). “... [M]any individuals ... experience bipolar-like phenomena that do not meet the criteria for bipolar I, bipolar II, or cyclothymic disorder is reflected in the availability of the other specified bipolar and related disorder category” (APA, 2013a:123). In this study ‘bipolar disorder’ refers to all forms of the disorder.

Dual-diagnosis: “When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity [or dual-diagnosis] also implies interactions between the illnesses that affect the course and prognosis of both.” (NIDA, 2010:1).

Service users: “... a person who is abusing or [is] dependent on substances and who, following assessment, receives services in a treatment centre, halfway house or community-based service” (Prevention and Treatment for Substance Abuse Act 70 of 2008, Section 1).

Treatment centre: “Inpatient and residential treatment settings have the advantages of 24-hour supervision, the reduced likelihood of clients using AOD (alcohol and other drugs) while in treatment, highly structured days, and a total immersion in treatment, with removal from the everyday stressors and pressures that may interfere with treatment” (Fisher & Harrison, 2013:149).

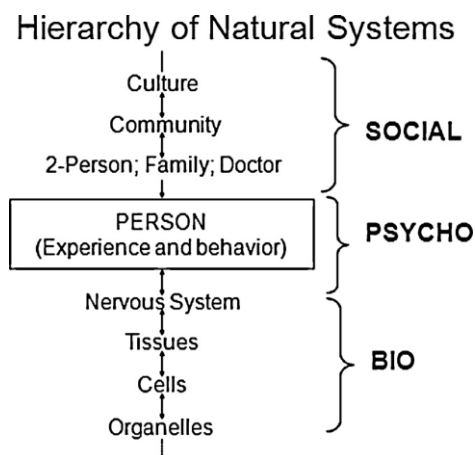
Gauteng: “South Africa has nine provinces ... the population [of Gauteng has] more than 12 million people ... the highest per-capita income level in the country... Johannesburg is the capital of the province ... Some 50 km north of Johannesburg lies South Africa’s administrative capital, Pretoria” (Republic of South Africa, 2015).

1.3 THEORETICAL FRAMEWORK

In 1977 George Engel introduced a new model to the medical field titled the biopsychosocial (BPS) perspective which was based on the systems theory (Adler, 2009:607). Engel’s focus was to add a patient’s psychological and social information to diagnostic and treatment procedures as it made medicine more scientific and humanistic (Smith, Fortin, Dwamena & Frankel, 2013:266). The perspective encourages practitioners to look at behaviour, genetics and culture when diagnosing and treating various illnesses and has since been adopted by other professions such as social work and psychology (Kaplan & Coogan, 2005:19).

The BPS perspective is based on the belief that all entities or systems, from the smallest to the largest, are connected and influence each other continuously through feedback loops (Smith et al., 2013:266). Kaplan and Coogan (2005:19) and Routledge (2005:39) explain that the perspective focuses on three components of an individual: (1) Bio, for biology, focus on the genetic, biochemical and physical factors of a person. (2) Psycho, for psychological,

focus on the developmental, psychological and psychopathological aspects of an individual. (3) Social, focused on family systems, diversity, culture, governments and social justice which are all incorporated in the individual's interpersonal relationships. However, in recent years some authors suggested that culture should be isolated as a fourth component. Hatala (2012:58) stated that "...health research and successful health promotion necessarily involves the dynamic interaction of biological, psychological, and social domains, while at the same time understanding the role of culture that informs and saturates all three". A factor which is especially true for South Africa where traditional health care forms part of many cultures and is often consulted before conventional health care systems (Global Health Action [GHA], 2014:4). Separating the different causes and effects stemming from these four components are difficult as they influence each other interchangeably (Routledge, 2005:39). An overview of the different components comprised of different parts that ultimately presents the BPS perspective as a whole is presented in Figure 1.1 below.



Source: Smith et al. (2013:266)

Figure 1.1: The Biopsychosocial Perspective

The goal of the BPS perspective is to integrate information gathered from the different components or spheres through open-ended questions aimed at understanding the individual's needs and experiences (Smith et al., 2013:266). In health care, this perspective has triggered resistance as it is time-consuming and is not seen as a scientific model (Adler, 2009:609). Kaplan and Coogan (2005:18), however, report that this perspective is appropriate and can be applied to understand and treat numerous phenomena, including psychiatric disorders and substance abuse. The BPS perspective was adopted as the theoretical framework guiding the study as it allowed a deeper understanding of the experiences and needs of the participants.

Both bipolar disorder and stimulant abuse share similar underlying physiological or biological factors such as impulsivity, stimulus orientation and susceptibility to external stressors (Swann, 2010:277). Due to the strong genetic predisposition linked to the development, course and expression of bipolar disorder, the main focus of treatment for any type of bipolar disorder has been mainly pharmacological; but this form of treatment has proven to be ineffective (Alloy, Abramson, Urosevic, Walshaw, Nusslock & Neeren, 2005:1044; Bordbar & Faridhosseini, 2012:323). Health care practitioners are therefore encouraged to look at other forms of supplementary treatment such as psycho-education and therapy with patients and their families (Bordbar & Faridhosseini, 2012:323). As the physiological factors cannot be

ignored, many patients receive medication to manage psychological and physiological symptoms during detoxification, enabling them to cope with psychological stressors while still developing skills to cope with these stressors more effectively (Fisher & Harrison, 2013:141).

Alloy et al. (2005:1047) mention that the external stressors that patients diagnosed with bipolar disorder often report as a cause for mood episodes include stressful life events, lack of social support, work stress and marital problems. The social well-being and mental health of individuals in South Africa are under additional pressure due to the political turmoil, and great prevalence of poverty and violence that is part of South Africa's present functioning and history, factors which are known to trigger the onset of substance abuse and bipolar disorder (Olckers, 2013:29). Substances are often used to cope with emotions caused by psychological factors such as self-image, which is influenced by social systems, such as family or friends (Rethink, 2009:5). Support from family and friends during treatment are thus very important and can lower the risk of mood episodes, whereas over involvement and criticism can contribute to relapse (Alloy et al., 2005:1052).

The researcher adopted the BPS perspective as a guide in this study to gain a comprehensive understanding of the experiences of adults in treatment. For example, an individual does not understand what bipolar disorder (biological) is and believes that medication is unnecessary (thoughts – psychological). They describe their family (social) as overbearing and too involved because they always want to know if s/he is taking his/her medication. When considering the communicated message it appears that the individual's social system is the main problem, as families that are too involved can cause harm. However, when the psychological aspect is taken into account it can be said that the family is acting out of concern and that the individual's negative perception of the medication influences his/her view of his/her social system. The lack of education on the biological level is thus the component influencing the individual's experience of treatment.

1.4 RATIONALE AND PROBLEM STATEMENT

NAMI (2013:1) states that “[d]ual diagnosis is a term used to describe people with mental illness who also have problems with drugs and/or alcohol. The relationship between the two is complex, and the treatment ... more complicated than the treatment of either condition alone”. Swann (2010:276) believes that drug abuse seems to be the rule rather than the exception when working with patients diagnosed with bipolar disorder, and when both are present a patient is at increased risk of suicide, violent outbursts and an unstable progression of the disorder. In addition to Swann's believe, Frye and Perugi (2010:31) state that individuals diagnosed with bipolar I and bipolar II disorder “...had the highest lifetime prevalence rate of alcohol abuse or dependence (46.2 and 39.2%, respectively) followed by schizophrenia (33.7%), panic disorder (28.7%), unipolar depression (16.5%) and the general population (13.8%)”.

It is evident that dual-diagnosis is a problem that is escalating and even though numerous studies indicate that bipolar disorder and substance abuse is a common dual-diagnosis there are few interventions focused on treating dual-diagnosis through therapy rather than pharmacotherapy (Weiss, Griffin, Kolodziej, Greenfield, Najavits, Daley, Doreau & Hennen, 2007:100). The use of medication as a sole intervention in the treatment of dual-diagnosis

has proven to be ineffective; therefore a need for alternative therapies is created. The increased need for alternative therapies is deemed critical as bipolar disorder is a high priority in terms of research due to the high prevalence, and personal and economic costs related to the disorder (Dell'Osso & Ketter, 2012:55).

Some interventions focused on this type of dual-diagnosis has been developed in the USA (Weiss et al., 2009:212), but after searching through multiple platforms, such as EBSCOhost and Google Scholar, the researcher could not identify any literature focussed on possible intervention strategies focused on this phenomenon in South Africa. In general, it seems that little attention is given to this phenomenon in South Africa. Even though the NDMP (DSD, 2013:3) makes reference to the relationship between substance abuse and psychiatric disorders there is no guidelines or plight for the development of treatment programmes for dual-diagnosis patients (Fabricius et al., 2007:4). SACENDU (2015:3) also acknowledges the high prevalence of the co-occurrence of substance abuse and mental health problems but has only added this as a topic that needs further research in their 2015 report. Nash, Robyn and O'Donoghue (2005:37) stress the importance of literature specific to the South African population, as historical and cultural factors of any society have an influence on every sphere of that society, especially physical and mental health.

One South African study conducted by Fabricius et al. (2007:5) in a private treatment centre in Johannesburg found that stimulants are often used by individuals diagnosed with mood disorders and no significant difference in the prevalence of gender in term of dual-diagnosis could be identified. The sample consisted of 419 patients, of which 239 had a dual-diagnosis (Fabricius et al., 2007:5). The respondents that were not diagnosed with a dual-diagnosis comprised of 71% male patients and 29% female patients, of the patients diagnosed with a dual-diagnosis 55% were male and 45% female (Fabricius et al., 2007:8). However, as this study was conducted at a private treatment centre it excluded individuals from lower socio-economic classes. Seeing that most South Africans come from lower income families, and individuals from lower income families are three times more likely to develop a dual-diagnosis, it can be assumed that the mentioned study did not represent the South African population as a whole (Routledge, 2005:32).

The researcher argues that if the experiences of individuals diagnosed with bipolar disorder and substance use disorder in South Africa can be understood more holistically, the type of treatment that ought to be developed to benefit this unique population and improve their chances of recovery could be determined. The present study will not only impact the individuals that have been diagnosed with stimulant abuse and bipolar disorder but could ultimately benefit their families and communities as well. The Gauteng Province was the research site for the present study as stimulant abuse is still high in this province (SACENDU, 2016:14). The **research question** that guided this study was: *“How do adults living with stimulant abuse and bipolar disorder experience services at treatment centres in the Gauteng Province?”*

1.5 GOAL AND OBJECTIVES

The **goal** of the study was to explore how adults living with stimulant abuse and bipolar disorder experienced treatment at treatment centres in the Gauteng Province.

The following **research objectives** were to be achieved:

- To conceptualise bipolar disorder and stimulant abuse as individual disorders and as a dual-diagnosis from an international, regional and national perspective.
- To explore the experiences of participants in terms of the treatment they receive for addiction to stimulant-type drugs.
- To explore the experiences of participants diagnosed with bipolar disorder and how the diagnosis contributes to stimulant abuse.
- To identify the challenges and perceived strengths participants experience in terms of their treatment due to the presence of both bipolar disorder and stimulant addiction.
- Based on the findings, to make recommendations for treatment at South African treatment centres that admit patients with a dual-diagnosis of stimulant use and bipolar disorder.

1.6 OVERVIEW OF RESEARCH METHODS

Throughout the research study, the researcher aimed to explore and comprehend how individuals that have been diagnosed with a stimulant drug addiction and bipolar disorder experienced treatment at treatment centres in the Gauteng Province. A qualitative research approach was used, as this approach allowed the researcher to explore several perceptions that exist regarding a specific phenomenon (Fouché & Delport, 2011:64). The perceptions and findings that were identified contributed towards understanding a phenomenon where limited knowledge exists and gave insight into problems faced in treatment practices. As a result, the study was applied research (Fouché & De Vos, 2011:94). The research study also had an exploratory purpose and was descriptive in nature as the study aimed to explore the experiences of participants, as well as describe these experiences in detail (Fouché & De Vos, 2011:94).

A phenomenological design was deemed most appropriate as it allowed the researcher to describe the commonalities in terms of the experiences shared by participants (Creswell, 2013:76). As the study aimed to explore the experiences of participants the data collection method used was a semi-structured one-on-one interview which was guided by an interview schedule (see Appendix A). The particular data collection method was beneficial as it allowed enough freedom to the researcher to explore the personal experiences of each participant (Greeff, 2011:351). All data collected was analysed through the process of thematic analysis. Clarke, Braun and Hayfield (2015:223) explain that this form of data analysis is used when a researcher aims to code data and identify themes rather than discovering facts that will be generalised.

Participants were selected from a population of adults that were admitted to three treatment centres in the Gauteng Province for stimulant drug abuse and who have been diagnosed with bipolar disorder. Participants were selected through a three-phase process: In **phase one** purposive sampling was used to select three treatment centres in the Gauteng province.

After permission was obtained from the treatment centres (see Appendices B, C & D) inclusion criteria were given to a social worker in each treatment centre which aided in the identification of possible participants, concluding **phase two** of the sampling process, which was also purposive sampling. The inclusion criteria used in the study were:

- Individuals who were older than 18 years.
- Individuals that had a stimulant drug addiction which includes cocaine, CAT, Khat or Meth.
- Individuals that were not in the detoxification phase of treatment.
- Individuals living with the dual-diagnosis of stimulant addiction and bipolar disorder which was confirmed by a medical practitioner or psychiatrist.
- Individuals could be either male or female.
- Individuals could be part of any religion and/or ethnic group.
- Individuals who were able to converse in Afrikaans or English.

In the **third phase** of the sampling process, all possible participants who met the inclusion criteria were approached and could volunteer to participate in the study and the researcher ultimately conducted interviews with a total of four participants.

Alasuutari, Bickman and Brannen (2008:96) urge researchers to adhere to ethical principles that will ensure that participants are not harmed in any way. Aspects such as ensuring confidentiality and obtaining written informed consent from all participants (see Appendix E) were some of the ethical components that were adhered to during the study. The research study also received ethics clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Appendix F). A more detailed discussion regarding ethical aspects of voluntary participation, avoidance of harm and debriefing, as well as the research methods, is contained in Chapter 3 of this report.

1.7 CONTENT OF MINI-DISSERTATION

The following content will be discussed in the remainder of the report:

Chapter 2: Literature Review

Based on an in-depth literature study the researcher will define both stimulant abuse and bipolar disorder and will report on the prevalence, causes, effects and treatment of each disorder separately. The prevalence, cause, effects and treatment of a stimulant abuse and bipolar disorder dual-diagnosis will then be discussed. Throughout the literature review, the researcher will report on international, regional and national findings and literature, where available.

Chapter 3: Research Methods and Empirical Findings

The third chapter will consist of two sections. In the first section, the researcher will give a detailed description of the research methods that were followed during the study and the ethical aspects related to the study, as well as an overview of the challenges and limitations of the study. In the second section, the researcher will present the empirical findings of the study and the interpretation thereof.

Chapter 4: Conclusions and Recommendations

In the final chapter, the researcher will reflect on the achievement of the goal and objectives of the study, followed by a discussion of the key findings and conclusions that could be drawn from the research findings. The chapter will be concluded with recommendations originating from the research findings.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In order to be diagnosed with a dual-diagnosis, at least one substance abuse disorder and one psychiatric disorder should co-occur; the diagnosis can however not be a combination of symptoms that can be attributed to one diagnosis (Fabricius et al., 2007:2). NIDA (2010) points out that it is difficult to distinguish between the symptoms of drug abuse and psychiatric disorders and it is thus necessary to make the correct diagnosis as this has a direct influence on the type of treatment offered to ensure long-term recovery.

The aim of this chapter is to conceptualise bipolar disorder and stimulant abuse as individual disorders and as a dual-diagnosis from an international, regional and national perspective. The researcher will discuss the categories, causes, prevalence, effects and treatment of both substance abuse, with specific reference to stimulants, and bipolar disorder separately before discussing the two disorders as a dual-diagnosis.

2.2 SUBSTANCE ABUSE

Several terms are used interchangeably to refer to patterns of addiction with regards to behaviours and drug use. Through the years various authors used an array of terms to discuss addiction, abuse, misuse and related terms. Rassool (2011:4) defines **addiction** as "...any behavioural activity, substance, object, or thing that has taken control of an individual's lifestyle that is causing harm to the individual and family". Rethink (2009:4) wrote that **substance use** simply refers to the actual taking of a substance and is usually seen as a risk but not as dangerous or even wrong. **Substance abuse** is described by the Prevention and Treatment of Substance Abuse Act 70 of 2008, Section 1, as "...the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances". **Substance dependence** can be psychological or physiological and develops when an individual has taken substances for a sustained period of time and find it difficult or impossible to function without the use of the substance unless the professional services are acquired (DSD, 2013:18). In the DSM 5 (APA, 2013a:483) **substance use disorder** is defined as "... a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems". The differences between these terms are not very distinctive and the variables used to determine when substance use converts to abuse and develops into dependence are not evident and presents differently in every individual.

As a means of 'controlling' licit and illicit substances countries divide all substances into schedules or categories based on the severity of consequences, overdose potential and addictiveness of each substance (Drug Enforcement Administration [DEA], 2015:8). The type of drug that an individual uses, therefore, has a direct influence on the migration from substance use to misuse to dependence. The different categories and types of drugs will be discussed in the following section.

2.2.1 Categories and Types of Substance Abuse

The DSD (2013:38) categorises substances in three broad categories: Hallucinogens, depressants and stimulants. The United Nations Office on Drugs and Crime [UNODC] (2016:1) however acknowledges that most drug users are polydrug users, meaning they use substances from different categories either sequentially or concurrently in an attempt to enhance the effects of the substances or in an attempt to manage the effects caused by substance use and withdrawal.

2.2.1.1 Hallucinogens/ Psychedelics

A category for substances that cause individuals to perceive ‘things that are not real’ and is known to prompt the onset of mental illness (Rethink, 2009:5). Substances in this category include drugs such as LSD (lysergic acid diethylamide) (a liquid on blotting paper), ecstasy (pills and powder) and mushrooms (eaten or brewed as tea) and are very popular in night club settings (Nutt, 2012:39).

2.2.1.2 Depressants

A group of substances that affects the central nervous system by slowing the system down (Rassool, 2011:70). As a result of use a calmer more controlled demeanour, which is often linked to suicide, self-harm and self-neglect, is produced (Rethink, 2009:5). Alcohol, benzodiazepines, ketamine, cannabis, opium, heroin and GHB (gamma hydroxybutyrate) are all categorised as depressants (DSD, 2013:38; Nutt, 2012:38). In recent years the use of depressants in conjunction with stimulants has increased and the use of opiates such as heroin in combination with an amphetamine, a combination known as ‘speedballing’, appears to be an emerging trend (UNODC, 2016:2).

2.2.1.3 Stimulants/ Psychostimulants

Where depressants slow the central nervous system down, stimulants have the opposite effect and would increase the activity of the system (Rassool, 2011:83). Effects include high levels of energy and mental functioning with a loss of appetite, followed by a phase of extreme fatigue, paranoia, anxiety and depression known as a “crash”. Its initial use leads to an improved self-esteem and sense of exhilaration, but when used regularly stimulants cause homicidal and suicidal tendencies, as well as aggression, fear and hostility (DEA, 2015:45). The use of stimulant drugs is prevalent among individuals diagnosed with psychiatric disorders and in some cases the diagnosis of bipolar disorder can be overlooked as stimulants counter depressive mood cycles (Swann, 2010:278). It is due to the high prevalence of stimulant use among patients diagnosed with bipolar disorder that the present study focuses on stimulant substances specifically.

The regulation of stimulants is complex as there are various *licit forms* which are often abused by individuals for their euphoric effect. Rassool (2011:83) considers caffeine and nicotine to be the most abused licit forms of stimulants. The DEA (2015:44) explains that individuals also commonly abuse diet aids (Fastin® or Dindrex®), medication with amphetamines as active ingredients (Dexedrine® and Adderall®) or medications prescribed for the treatment of attention-deficit hyperactivity disorder (ADHD) which contains

methylphenidate (Ritalin® and Concerta®). In terms of *illicit stimulants* the DEA (2015) identified the following types of stimulants:

Khat (cathine/cathinone): A plant that can be chewed, dried to make tea or sprinkled over food as a spice. Effects include manic behaviour such as delusions of grandeur, paranoia, hyperactivity and hallucinations (DEA, 2015:49).

Methamphetamine (Meth): A type of drug that bears a resemblance to small fragments of glass or blue-white rocks which can be snorted, swallowed, smoked or injected. Prolonged use of meth can cause strong hallucinations, delusions, paranoia, confusion and aggression (DEA, 2015:50-51).

Cocaine: A white powder that produces a strong euphoric effect when snorted injected or smoked, either pure or mixed with other illicit substances. Tolerance for cocaine builds up rapidly and users have to increase drug intake to achieve the same effect (DEA, 2015:47-48). Cocaine can also be prepared in a smokable crystal form which is referred to as 'crack', which is deemed to be more addictive and more harmful than cocaine powder (Nutt, 2012:38).

Methcathinone (CAT): A stimulant drug that was used as an antidepressant in the former Soviet Union in the early 1900's (De Bie, Gladstone, Strafella, Ko & Lang, 2007:888) and which regained popularity in Europe and USA in 2011 as "bath salts" (Bonano, Glennon, Felice, Banks & Negus, 2013:200). CAT is highly addictive (De Bie et al., 2007:888) and difficult to regulate as instructions on obtaining ingredients and manufacturing CAT is readily available on the internet (De Bie et al., 2007:886).

The DEA (2015:44) asserts that individuals mostly binge on stimulants, which means a large amount of drugs is administered in a short amount of time, generally in social settings, until a user crashes and discontinues use for a number of days. Dependence develops as binges become more frequent and higher doses of drugs are administered in an effort to experience the initial euphoric effect, a process known as tolerance (DEA, 2015:44). Rassool (2011:8) holds that when amphetamines are abused tolerance and psychological dependence builds up rapidly but physical dependence is very limited. The pursuit of the euphoric effects caused by stimulants has been identified as one cause for stimulant abuse, but there are numerous other causes associated with drug abuse other than pure physiological effects.

2.2.2 Causes of Substance Abuse

The United Nations Office on Drugs and Crime (UNODC) (2015:18) wrote that:

There is no single cause of drug use and addiction. Drug use should be seen as an unhealthy behaviour linked to the developmental process. Although most drug use starts in adolescence... it is important to note that what occurs during adolescence very much depends on what happened earlier on in an individual's development, during childhood and early adolescence.

Nutt (2012:65) believes that in essence there are only two reasons that motivate individuals to use substances; firstly, to relieve suffering and secondly, to experience pleasure. Within these two reasons, a multitude of causes for addiction can be identified. Rassool (2011:36) indicates that the reasons for initial use of stimulants is voluntary and can be motivated by

physiological pleasure, availability of drugs, enhanced work performance, peer influence, boredom or weight loss to name a few. The continuation of any addiction seems to be less voluntary and "... includes a combination of factors such as dependence, chaotic use, fear of withdrawal symptoms, social exclusion, mental health problems and other psychosocial and environmental conditions" (Rassool, 2011:36). Within these reasons of use, the presence of risk factors can also be identified. Nutt (2012:134) believes that risk factors predispose an individual to the development of a substance addiction and is subject to genes, background and environment and can be subdivided into four areas of functioning known as biological, psychological, social and cultural functions, which influence each other in a continual circular manner.

2.2.2.1 Biological causes

Biological theories on the causes of addiction refer to factors such as genetics or neurochemicals, or a combination thereof, which inhibits an individual's ability to control consumption of substances and consequently abstinence is regarded as the only way of averting addiction (Rassool, 2011:29). Wallace (2012:169) describes the brain as 'a sea of chemicals' and upon the entry of a substance to the brain it changes the chemistry of the brain and results in changed behaviour, affects, cognitive abilities and physical functioning. The chemicals, called neurotransmitters, which are influenced by substances are involved in brain functions which encourage individuals to repeat behaviours that 1) is necessary for survival, 2) reduce suffering, 3) trigger pleasurable experiences and 4) prompt powerful memories (Nutt, 2012:136). Everyday activities, such as spending time with family or practising hobbies, releases endorphins and dopamine which influence learning systems within the brain; in turn, these learning systems encourage individuals to repeat the activities that foster the release of these chemicals (Nutt, 2012:69; Rose & Walters, 2012:13). Dopamine is identified as the most important chemical involved in learning and survival, thus the body and brain crave anything that releases dopamine, which floods the brain when stimulants are used and thus tricks the brain into thinking drugs are necessary for survival (Rose & Walters, 2012:13). When these physiological responses are combined with factors such as impulsivity (not considering long-term effects), compulsion (a lack of control over behaviour), hyperactivity and anti-social behaviours, the susceptibility to drug addiction is undeniable (Nutt, 2012:136; Rassool, 2011:33).

In contrast to other findings Rose and Walters (2012:13) and Routledge (2005:26) believes that there are many studies that focus on the role that genetics play in the development of an addiction but most studies confirm that genetics mostly influence how individuals experience substance abuse physiologically, thus the genetic components related to addiction does not mean substance use is inevitable but rather remains a choice. In relation to this belief Nutt (2012:65) asserts that the strongest biological factor that leads to the development of an addiction is the physiological response the body has to substances.

In some cases individuals start using substances for medicinal purposes, which then escalate to an addiction, even to licit drugs; for example, the prescription of legal opioids to relieve emotional trauma or pain can develop into an addiction and some individuals might revert to using illegal forms of these substances when prescriptions are no longer available (Nutt, 2012:65; Rassool, 2011:32). It is evident that the mere pleasurable sensation induced by psychoactive substances positively reinforces future use and is reinforced even further by

the fear of pending withdrawal symptoms (Rassool, 2011:32). Even though the biological response of the body towards substances is undeniable most individuals continue drug use due to the psychological and social causes of drug use. Gutkin and Ahmed (2012:v) suggest that if one wants to understand the course of addiction, it is necessary to look at the link between the psychological and physiological functioning of an individual.

2.2.2.2 Psychological causes

Routledge (2005:27) expressed that developmental, cognitive, personality, familial and learning factors all play a role in the psychological causes of substance abuse, but it is important to note that distinguishing between the psychological and social causes of substance abuse can seem impossible. Rose and Walters (2012:10) refer to theories of negative and positive reinforcement to explain why individuals start and continue to revert to substances from a psychological perspective. *Negative reinforcement* is rooted in the belief that an 'unpleasant state' is removed by either suppressing negative emotions (e.g. anxiety) or by relieving physical withdrawal symptoms (Rose & Walters, 2012:10). *Positive reinforcement* is seen to 'add' positive effects, both physical and/or emotional, and thus drug use continues (Rose & Walters, 2012:12). Positive reinforcement is especially considered with regards to causes of stimulant substance abuse (Rassool, 2011:32) but both positive and negative reinforcement encompass various factors such as social and psychological environment stressors.

Nutt (2012:69) and Routledge (2005:27) explains that drugs interact with the chemical learning systems of the body in the same way as enjoyable activities do and can produce the most intense and pleasurable experiences. If these experiences aid an individual in "escaping" environmental stressors, such as conflict at home, substance use will continue (Routledge, 2005:27). The UNODC (2015:23) report that children who grow up in turbulent homes are at greater risk for substance use as it is more likely that they have not learned effective problem solving and coping skills and thus revert to substances as an escape or means of coping. Fisher and Harrison (2013:57) acknowledge that it is not just adolescents that turn to substances to cope with their home environment but adults that experience high levels of stress in their homes are also more likely to use substances, for example, women in abusive relationships. The UNODC (2015:13) supports this by explaining that women who grew up in homes where conflict was high and interpersonal relationships were poor experienced a high burden of responsibility growing up and started using substances while still living at home. Higher levels of anxiety and depression, in general, were also found to be strong indicators for the development of a drug addiction (Nutt, 2012:147). Families also act as models for children to learn behaviour, thus children raised in families where addiction is present are more likely to become addicted to substances due to family modelling (McCrary, Ladd & Hallgren, 2012:231).

In addition to psychological stressors caused by social systems, there are numerous psychiatric disorders that are often associated with the initiation of substance use. Chung, Ross, Wakhlu and Adinoff (2012:287) and Fisher and Harrison (2013:57) note that the presence of an undetected mental health problem can contribute to the development of substance abuse, for example, when gamma-aminobutyric acid (GABA) receptors are low an individual will feel a constant state of anxiety and the use of substances would alter these receptors and allow the individual to feel 'normal'. Rassool (2011:165) indicates that

“[i]ndividuals with eating disorders are up to five times likelier to abuse alcohol or illicit drugs and those who abuse alcohol or illicit drugs are up to 11 times likelier to have eating disorders”. Other psychiatric disorders such as bipolar disorder are also believed to precede the onset of substance abuse and are seen as a great risk factor for the development of substance abuse and alcoholism (Merikangas & Peters, 2010:56). It is interesting to note that when other psychiatric disorders such as ADHD is detected and Ritalin® is prescribed, children are more likely to follow the prescription instructions, but children that use Ritalin® recreationally tend to use much higher doses of the drug (Nutt, 2012:67). Nutt (2012:67) ascribes this to the fact that when licit substances are moved to an illicit category they tend to be abused more due to the level of risk involved.

It should be noted that the effects of drugs do not seem to “cure” the initial cause of abuse, but rather aggravate the initial stressor; for example, when an individual uses drugs to manage psychological symptoms the drugs can cause more severe psychological symptoms to develop (Fabricius et al., 2007:2). In addition to the above-mentioned biological and psychological stressors, social and cultural factors in an individual’s surrounding environment can also influence the psychological well-being of an individual and will be discussed in the following section.

2.2.2.3 Social and cultural causes

Rassool (2011:35) states that “[a]lcohol and drug misuse thrive in areas of social exclusion and multiple deprivation with high unemployment, low quality housing and a lack of social and community services”. In essence, social and cultural causes of substance use can be subdivided into personal dimensions, which include financial and physical stressors, and social dimensions, which include family, peers and the surrounding community (Fisher & Harrison, 2013:56). The relationships between these systems are however complex and cannot be compartmentalised.

Individuals that grew up in poverty are three times more likely to abuse substances than those who grew up in wealthy families (Routledge, 2005:32). According to Rotgers (2012:134), marginalised groups also experience more stress due to their position in society and are more prone to addiction in general. Routledge (2005:32) and the UNODC (2015:22) explains that adolescents that grew up in families that faced difficulties such as unemployment, substance abuse, trauma and/or health problems were less likely to use drugs if their family received any form of intervention focused on these stressors, as opposed to those that did not access services, who are seven times more likely to abuse drugs. Families also play a major role in the maintenance of substance abuse (Routledge, 2005:29). Some theorist, however, warns that substance use can play a role in the survival and functioning of a family system and when the substance abuse problem is addressed the balance of the system can be disturbed and lead to more trauma and dysfunction in an attempt to restore the balance within the system (Routledge, 2005:30).

When children grow up in a supportive home environment they are less likely to buckle under peer pressure (McCrary et al., 2012:232). On the other hand, peer pressure is identified as a major contributor to the onset of drug use during adolescence, regardless of sociocultural status but a supportive family structure is seen as a protective factor in this regard (Routledge, 2005:32). Peer influence plays an important role, especially during

adolescents, as drugs are mostly consumed in groups and aids social interaction as it promotes talkativeness and lessens anxiety, refusing to use with a group can also cause anxiety and could encourage use (Nutt, 2012:66). The influence of peers had a great impact on the progression of substance abuse as the younger an individual is when he or she starts using alcohol and/or nicotine the more likely they will be to use drugs as well (UNODC, 2015:28). Jung (2010:448) and Routledge (2005:33) explain that there is one factor that plays a superior role to peers during adolescence and has a stronger influence on initial drug use - media. A statement by Rassool (2011:35) supports this statement as he writes that “[c]uriosity, subset of youth culture and music, social acceptability, peer pressure, and the media ...” are all known to influence drug use among youth. When considering the social factors influencing adults’ substance abuse, Nutt (2012:187) found that work environments laden with high levels of competition and long work hours are commonly associated with stimulant drug abuse.

When looking at culture it is necessary to take into account that some drugs, such as khat, are used as part of cultural traditions, for example, men from cultures such as Somalis, Ethiopians and Yemenis will gather in chewing houses (mafreshi) to conduct social or formal meetings while using substances (Nutt, 2012:127). In other cultures and religions alcohol and some psychoactive substances are introduced to children as a rite of passage, for example, some Jewish rituals commend the use of wine, while other religions prohibit the use of substances completely, for example, alcohol use amongst Islam (Nutt, 2012:63; Rassool, 2011:16). As people started migrating between different countries these cultural practices continued and substances were introduced to other countries and cultures across the world (Nutt, 2012:127).

In terms of South African culture, there are no traditions or rituals mentioned in literature which include the taking of drugs, but rather the ‘culture’ of political turmoil and violence in the country is believed to affect the onset of substance use among all racial groups (Olckers, 2013:29). Some substances are however more prevalent in, but not limited to, certain cultures and geographical areas, for example, meth use which is more prominent among the coloured cultural grouping in the Western Cape Province of South Africa (SACENDU, 2016:8). The prevalence of substance use on global and local levels will be discussed in more detail in the following section.

2.2.3 Prevalence of Substance Abuse

When the prevalence of any phenomenon is known it is easier to determine how important intervention efforts are in addressing the specific need or problem. The prevalence of substance abuse on an international, African and South African level will be discussed in the subsequent section, as this will give an indication of how serious the substance abuse problem in South Africa is in relation to other parts of the world.

2.2.3.1 International prevalence

The UNODC (2016:1) estimated that in the year 2014 approximately 247 million people between the ages of 15 and 64 years were abusing illicit substances globally, of which 29 million individuals were described as problem drug users that could be diagnosed with substance use disorder, of this population cannabis was the most popular drug among users

(183 million), followed by amphetamines (33 million users). Of this entire population, almost half of the individuals that accessed treatment in 2014 were first-time treatment seekers of which the majority was in treatment for cannabis and stimulant (amphetamine) type substances (UNODC, 2016:xiii).

An average of 12 million people globally injects drugs and 14% reported a positive HIV status (UNODC, 2016:ix). When gender differences are considered men were found to be three times more likely to use cocaine, amphetamines or cannabis, and women were more likely to misuse prescription drugs (UNODC, 2016:13).

2.2.3.2 Prevalence in Africa

It is difficult to establish the prevalence of drug use in Africa as voluminous countries do not have sufficient and reliable data collection initiatives and many do not participate in international studies, for example, in 2011 Nigeria was the only country in African that submitted reports to the United Nations Office on Drugs and Crime (UNODC) (West African Commission on Drugs [WACD], 2014:40). Regardless of the limited data available on the prevalence of drug use in Africa it is evident that substance abuse is increasing in the African continent. It was found that, compared to the global average, cocaine and methamphetamine use is increasing in West and Central Africa as seizures and manufacturing of specific methamphetamine has been increasing (WACD, 2014:40). The global average for cannabis use is estimated at 3.9%, but in Africa, it has been found to be closer to 7.5% (WACD, 2014:40).

In Western and Central Europe an average of 1 in 5 substance abusers are accessing treatment but in Africa this number changes to 1 in 18; figures that only include problem drug users and excluded individuals that are in need of initial intervention focused on preventing drug use from escalating to addiction (UNODC, 2015:30). Unfortunately, due to the lack of data on African drug abuse trends, it is not possible to determine actual drug trends, apart from a general increase in drug use globally and a noted increase in methamphetamine manufacturing and seizure (WACD, 2014:40).

2.2.3.3 Prevalence in South Africa

Most individuals start using substances between the ages of 14-15 years, which fall in the adolescent life phase (Routledge, 2005:10). SACENDU (2016:5) has however reported that children between the ages of five and nine years have been admitted to treatment programmes in South Africa. Unfortunately, there are no regular surveys focused on illicit substance use in South Africa and thus data regarding substance abuse patterns are very limited and tend to focus on specific types of drugs or certain sub-groups of drug users (Pasche & Myers, 2012:339).

Pasche and Myers (2012:338) explain that:

Prior to 1994 and the first democratic elections, alcohol, cannabis and methaqualone were the primary substances of misuse in South Africa. With South Africa's transition to democracy and subsequent reopening of borders, there has been an influx of and a growing burden of harm associated with illicit drug use.

Based on the findings of various research studies, Pasche and Myers (2012:339) concludes that in terms of illicit drug use in South Africa, cannabis (dagga) is the most abused drug (2%) followed by cocaine and sedatives (0.3% respectively), amphetamines (0.2%) and opiates, hallucinogens and inhalants (0.1% each); findings which differ in comparison to those found among adolescent and is therefore not seen as an accurate representation. Among adolescents, as with adults, cannabis is also the most abused drug (13%), followed by inhalants (12%), prescription drugs (12%), methaqualone (Mandrax) (7%), cocaine and other club drugs (7%) and heroin (6%) (Pasche & Myers, 2012:339). In the period of July to December of 2015 SACENDU (2016) gathered the following information from 17 treatment centres in Gauteng:

- 45% of the 3570 individuals admitted to treatment were between 15 and 24 years of age.
- 27% of the individuals were referred to treatment by the judicial system, social services or schools.

The percentage of individuals under the age of 20 years using stimulants as a primary or secondary drug of choice is presented in Table 2.1 below:

Table 2.1: Primary and Secondary Drugs of Choice (stimulants)

Drug	Primary drug of choice (%)	Secondary drug of choice (%)
Cocaine	1	2
CAT	6	14
Meth	2	7

Source: SACENDU (2016)

It should be noted that the data collected and presented by SACENDU does not include statistics from psychiatric institutions which could indicate a large gap in data. A study conducted by Davis, Tomita, Baumgartner, Mtshemla, Nene, King, Susser and Burns (2016:1,3) with 87 patients admitted to a regional psychiatric hospital in the KwaZulu-Natal Province reported the following findings:

- 56.3% had grade 12 or higher qualifications.
- 59.8% reside in urban environments.
- 4.6% used cocaine.
- 12.6% used other stimulant substances.
- 32.2% was diagnosed with bipolar disorder.

The findings presented above indicate that a large group of individuals using substances are in psychiatric treatment centres and supports the suspicion of gaps in data with regards to the accuracy of data predicting the substance abuse prevalence in South Africa. The DSD (2013:2) states that the effects of drug abuse are not limited to the individual using them, but reaches to systems surrounding the individual, systems which will be discussed in more detail in the following section.

2.2.4 Effects of Substance Abuse

It is no secret that continuous substance use holds serious consequences on various levels of an individual's functioning (Wallace, 2012:168). "The consequences of drug and alcohol addiction do not only affect the individual user but also their families, communities and the entire society and economy" (Rassool, 2011:13). The effects of substances abuse can be divided into three categories which influence each other interchangeably and are often difficult to separate:

2.2.4.1 Effects on individual

Drug abuse impacts the physical, emotional, psychological and cognitive functioning of users which negatively impacts and holds occupational and social problems for the individual (Fisher & Harrison, 2013:171). The UNODC (2016:69) explains that school dropout rates, poor development, risky sexual behaviour and violence are all increased when drug abuse is present. Additional health consequences caused by substance use is another concern as the UNODC (2015:36) found that individuals that were addicted to or are currently addicted to substances have twice as much health expenses as the general population and these financial expenses usually fall on the family or state. Health expenses are inevitable as individuals that use stimulants are known for chaotic use patterns which are more detrimental to health and are associated with mental health problems, HIV and chronic illnesses such as liver damage (Rassool, 2011:39).

Rethink (2009:5) warns that the abuse of stimulants can cause major health problems related to hypertension and cardiac health. In addition to this Baumann, Ayestas, Partilla, Sink, Shulgin, Daley, Brandt, Rothman, Ruoho and Cozzi (2012:1192) report that in addition to cardiac health concerns, there is also an increase of neurological health problems in individuals that use stimulant type substances. Additional physical effects associated with stimulants abuse include nausea, insomnia, paranoia and anxiety, but some individuals are admitted to hospitals with more severe symptoms such as irregular heartbeat, excessive sweating, severe headaches and pressure on the chest (Nutt, 2012:118). In addition to these symptoms, Rassool (2011:225) report that myocardial infarction, arrhythmias, cardiomyopathy, acute myocardial ischemia and sudden death are all associated with the use of stimulants. Individuals that are poly drug users not only faces increased health problems, as mentioned above, but they experience poorer treatment outcomes as well (UNODC, 2016:2). In terms of gender it has been found that women start using drugs at a later age, but their progression of substance abuse, for example using multiple drugs and becoming physically dependent on drugs, advances faster than men, thus worsening disease outcomes in an already vulnerable group (UNODC 2015:14).

Nutt (2012:64) holds that even though drug abuse destroys health, relationships and the ability to function at a normal level, humans are programmed to seek out and repeat pleasurable behaviours, such as those caused by drug use, regardless of negative effects. The effects that substance abuse has on relationships will be discussed in the following section.

2.2.4.2 Effects on relationships

Relational problems often occur in families where there are addiction and children often times experience learning difficulties, anxiety, their own addiction or display delinquent behaviour when they perceive their family as emotionally unsafe (Wallace, 2012:171). SACENDU (2016:18) found that twenty-three percent of families of individuals admitted to treatment centres in the Gauteng Province during the second half of 2015 were financially responsible for treatment costs, possibly causing or worsen financial and relational problems within families further. Individuals using substances also tend to withdraw from their families, contributing to turmoil and the negative emotional state of the family (Fisher & Harrison, 2013:219). Wallace (2012:170) believes that marital problems are also common in families where drug addiction exist and due to substance use these individuals are less likely to develop effective tools to rebuild relationships and often times use more substances to avoid discomfort. Family-related violence towards children and women specifically is very high in families where there is substance abuse (UNODC, 2016:67).

Statistics South Africa (2014:8) reported that in 2014 an estimated 5.51 million people in South Africa were living with HIV in South Africa. Between 19 - 56% of the individuals that attended HIV clinics presented with a co-occurring psychiatric disorder such as substance abuse, depression or anxiety (Breuer, Stoloff, Myer, Seedat, Stein & Joska, 2014:1133). Individuals that abuse stimulants are not only three times more likely that heroin users to contract HIV, TB and Hepatitis through sexual behaviour and needle sharing, they are also very likely to infect others (UNODC, 2016:16). In addition to this, sexually transmitted diseases among individuals that abuse stimulants are a major concern as risky sexual behaviour; general risk-taking behaviour and aggression are much higher among these individuals (Nutt, 2012:186). Breuer et al. (2014:1134) also noted that the outcomes of these diseases, when paired with a psychiatric disorder, are not as positive as with patients that only have one disease such as HIV.

As stimulant use increase sexual behaviour these health outcomes are not limited to the individual or their family but have a great socio-economic impact as well, as the spread of these diseases are inevitable (Nutt, 2012:186). The high prevalence of diseases such as HIV and other psychiatric disorders make it difficult to detect a dual-diagnosis early in the course of the disease as the South African primary health care system is already flooded and resources and available measurement tools are limited (Breuer et al., 2014:1134). Poor progression of and higher levels of illness has a great impact on the socio-economic system of any country, a factor that will be discussed in the following section.

2.2.4.3 Socio-economic effects

On a global level drug use is ranked as one of the top 20 risk factors for poor health, and in developed countries drug use is ranked in the top 10 risk factors (UNODC, 2015:35). The impact of addiction on the economy of any society is undisputed (Rassool, 2011:17). In South Africa specifically, the effects of substances cost the country around R104.8 billion per year in social and economic resources (DSD, 2013:37). In the USA the costs related to the treatment of methamphetamine alone were \$23 billion (est R 322 billion) and Brensilver, Heinzerling and Shoptaw (2013:45) explains that this includes costs related to crime, environmental damage, lost productivity, infectious diseases, family disruptions, cognitive

dysfunction and premature death. The use of substances places an immense burden on healthcare and social systems within South Africa and worsens disease outcomes for specifically HIV, AIDS and TB (DSD, 2013:37; Routledge, 2005:11). SACENDU (2016:1) and UNODC (2016:5) reported that substances such as CAT were amongst those substances that individuals injected more regularly and are a cause of concern with regards to the spread of diseases such as HIV and TB. In the Gauteng Province, the state-funded an estimated 40% of the substance abuse treatment programmes in the second half of 2015 alone (SACENDU, 2016:18). Some authors go as far as describing addiction as a plague in a society that leads to the waste of immeasurable individual lives and financial resources (Gutkin & Ahmed, 2012:v). The UNODC (2015:36) points out that the earlier drug abuse is detected and treatment initiated the lower the risk becomes for poor health, disability and comorbidity, thus reducing the cost of treatment and eliminating many other risk factors, not only for individuals but for governments as well. The treatment of substance abuse remains a controversial issue as there is no set standard or a proven programme that is followed by all service providers and treatment outcomes of different substance abuse programmes are vastly different (Fisher & Harrison, 2013:137). The treatment programmes and plans most commonly associated with substance abuse treatment will be discussed in the following section.

2.2.5 Substance Abuse Treatment

The UNODC (2016:xxiii) states that “[p]revention, early intervention treatment, care, recovery, rehabilitation and social integration measures ... based on scientific evidence, reduce drug use and thus its impact on public health ...”. Rassool (2011:5) believes that one of the concerns regarding treatment interventions is that the training that health and social care professionals receive in terms of addiction is insufficient and practitioners are not urged to expand their knowledge and expertise in the field of addiction. Rassool (2011:4) and the UNODC (2016:73) indicates that the stigma that professionals involved in substance abuse treatment services project toward service users are also a concern as it discourages individuals to access treatment and leads to lower levels of recovery. There is no one discipline that is responsible for addiction and it should, therefore, be addressed on various levels by different professions (Rassool, 2011:6).

In terms of treatment in South Africa, Pasche and Myers (2012:339) recognised that firstly, the demand for treatment is much higher than can be supplied, secondly that affordable treatment that is state-sponsored is not available in all South African provinces, and finally, private treatment centres is not affordable for the majority of substance users. Low access rates in terms of treatment on a global level are ascribed to these factors identified by Pasche and Meyers (2012:339). In addition to these factors, the UNODC (2015:35) ascribes low access rates to the fact that substance abuse treatment programmes are not part of general health care delivery, thus complicating the process of gaining access to services.

Traditionally substance abuse treatment involves the confrontation of individuals in denial and educating individuals about their addiction as a disease (Marinchak & Morgan, 2012:141). Even though there are many theories guiding treatment the most well-known is the 12-step approach which is described as an informal bio-psycho-social-spiritual model towards addiction that focuses on “...the origins, maintenance, and modification of addictive behaviours...” displayed by anyone with any addiction (Wallace, 2012:167). Rassool

(2011:278) indicates that effective treatment interventions include and consider the following aspects:

- Services should be available and accessible.
- Treatment should change according to the needs of an individual.
- The period of time spent in treatment should be adjusted and adequate for every individual.
- Both counselling and behavioural therapies should be included.
- Psychiatric disorders and substance abuse should be diagnosed and treated concurrently.
- Involuntary treatment should not be deemed ineffective.
- Detoxification should not be seen as part of treatment but rather as the first step in treatment.
- The diagnosis and treatment of infectious diseases should be part of treatment.
- There should be a focus on risk reduction focused on all spheres of functioning.

The UNODC (2015:34) found that the most effective treatment has been proven to be ongoing treatment, not only focused on various social and psychological aspects of an individual's life but is rather integrated into the individual's community. The different levels at which treatment intervention should take place are:

2.2.5.1 Treatment on a biological level

Rassool (2011:94) warns that a "...stimulant user may become extremely agitated and violent, displaying erratic and unpredictable behaviour. The patients may also experience panic attacks, delirium, irritability, confusion, tactile, auditory and visual hallucinations". The safety of the user and those around them can only be ensured once these behaviours are addressed, and should take place before further treatment can commence (Rassool, 2011:94). After it was established that there are biological components involved in addiction, medications were developed to counter the changes in brain chemistry brought on by substance abuse (Chung et al., 2012:281). The prescription of medication to individuals that are addicted to stimulants are favoured as stimulants triggers high levels of dopamine which cause the brain to recruit an 'anti-reward process' which can be managed by pharmacotherapy (Brensilver et al., 2013:450). It is common that individuals that are addicted to stimulants are prescribed anti-depressants when they halt drug use as this manages major depressive episodes associated with the discontinuation of stimulant use (Rassool, 2011:95). Gutkin and Ahmed (2012:v) explain that if one wants to understand the course of addiction, it is necessary to look at the relationship between the psychological and physiological functioning of an individual. Sometimes a psychiatric diagnosis such as bipolar disorder can be overlooked due to the physiological effects of drugs (Swann, 2010:278). Even though social workers are not equipped to diagnose and prescribe medications, they can play an important role in ensuring that psycho-education takes place and treatment options are discussed with the family of the stimulant user (Rassool, 2011:94). However, the continuation of stimulant use is ascribed to psychological dependence rather than physiological dependence it is necessary to focus on the psychological treatment of substance addiction as well (Rassool, 2011:8).

2.2.5.2 Treatment on a psychological level

Due to the lack of strong evidence proving the effectiveness of pharmacotherapy for stimulant drug treatments, psychosocial interventions became the most common form of treatment (Rassool, 2011:95). Treatment focused on the psychological dependence of addiction is not limited to substances but include addictive behaviours such as sex, gambling, food, physical activities and relationships (Rassool, 2011:8). Whether an individual is taking drugs to manage psychological symptoms or as a means of promoting social interaction, it is necessary to help them develop skills and behaviours that will enable them to achieve the same desired effect through more conductive means (Nutt, 2012:69).

Marinchak and Morgan (2012:141) identified that employment, health, financial, intrapersonal, interpersonal and legal aspects should be considered as areas where intervention might be necessary. It is however suggested that information should also be gathered from other individuals that function within these spheres of a patient's life to allow the full picture to develop and permit effective intervention (Marinchak & Morgan, 2012:141). Fisher and Harrison (2013:151) point out that one of the most important aspects to contemplate when providing treatment is ensuring that enough time is allowed for treatment, which should be at least three months, to address psychological aspects of addiction effectively. Among stimulant users, cognitive behavioural therapy, counselling, social support and abstinence-based psychosocial treatments have been found to be the most effective means of treatment (Rassool, 2011:96). Decisional balance worksheets are often used to enable the individual in treatment and the therapist insight into the way the individual perceive their life and addiction, and to explore the possible changes that can be made and the costs of these changes (Rotgers, 2012:114). The costs related to change should, however, outweigh the cost of use before change can take place and social and cultural aspects can be great motivators for change.

2.2.5.3 Treatment on a social and cultural level

Family systems, diversity, culture, governments and social justice are all factors that need to be considered when focussing on the socio-cultural level of an individual's functioning (Kaplan & Coogan, 2005:19; Routledge, 2005:39). The UNODC (2016:74) writes that:

Programmes are more effective when they recognize that drug use can be the result of multiple causes, and when they incorporate not only drug-specific components, but also skills that help individuals to deal effectively with the challenges of each phase of life, such as relationship skills for adolescents or parenting skills for parents.

The above statement not only advocates for a focus on social aspects involved in treatment but also for social skills that are indispensable with regards to coping with the demands of specific life phases, a factor often neglected during treatment. Therapy focused on the needs associated with specific life phases are supported by authors such as Marinchak and Morgan (2012:238) who explain that therapy conducted with individuals that are married was more effective when behavioural couple therapy was used as opposed to individual behaviour therapy. The recovery rate for individuals that abuse substances are also much higher when family members are actively involved in the treatment process (Marinchak & Morgan, 2012:238).

The involvement of family members holds certain challenges in terms of treatment, as drug use behaviour is mostly enabled by friends and/or family members in an attempt to help and support the substance abuser (Rotgers, 2012:234). Rotgers (2012:233) acknowledges that it is common for family members, and especially wives, to either withdraw from the substance user or increase conflict in an effort to motivate or force them to stop, but this has been proven to have the opposite effect. In the United Kingdom alone there are an estimated 1.5 million adults who are affected by the drug use of a relative, indicating the need for services that supports these family members as families are mostly responsible for caring for substance users (Rassool, 2011:262). It is, however, important to remember that the family functions within a larger community and culture and these factors need to be explored and respected when providing treatment (McCrary et al., 2012:246).

Rassool (2011:96) mentions that interpersonal relationships and social systems are impacted by substance users as individuals that use stimulants are more likely to inject drugs, to practice unsafe sex (as they have lowered sex inhibition) and they are more likely to experience premature labour, factors that impact interpersonal and community relationships and other aspects negatively. Rassool (2011:96) therefore advocates for harm reduction strategies to be set in place as a critical aspect of treatment and recognise the role that policy and government play in terms of guidelines and monitoring treatment programmes.

The UNODC (2015:34) explains that most substance abuse interventions are seen as ineffective as individuals mostly receive acute care rather than chronic care, contributing to high relapse rates. It should be noted that even though it is expensive to provide substance abuse services, the UNODC (2015:34) found that drug treatment programmes cost less in comparison to the costs related to incarceration or no treatment; as no treatment leads to health and social costs that often fall on family and/or governments. Some governments aim to eradicate drugs completely, while others attempt to discourage substance use by making legal drugs such as alcohol and tobacco more expensive through sin tax (Jung, 2010:450; Nutt, 2012:69).

As technology and other aspects of society are being developed at an immense rate government agencies need to be proactive in their attempts of addressing the substance abuse problem. One such area of concern that should receive more attention globally is the use of the Internet, in particular, the “dark net”, as a platform used in drug trade which is increasing at an alarming rate (UNODC, 2016:24). Users that use the dark net to purchase drugs are more prone to be poly-drug users, and use higher quantities of drugs due to the “safety” associated with the darknet as contact with dealers and law enforcement is minimal (UNODC, 2016:25).

The African Regional Office of the World Health Organization (2015) suggest that the following aspects should be considered to allow for the development of effective substance abuse treatment programmes in Africa: 1) The support of government and acquiring resources is necessary. 2) The development of policies that protect human rights and ensure effective service delivery should be developed. 3) Research and information systems should be put in place to guide programme and policies development, and 4) training and developing human resources, especially in areas of prevention and early intervention services are essential. In South Africa the DSD (2013:45) identified the following factors that

they believe should be addressed in terms of substance abuse treatment in South Africa (in order of priority):

- Better parenting or the development and application of parenting skills and competencies that will enable community members to deal with substance abuse;
- Recreation or providing facilities and opportunities for especially the youth so as to occupy the time and resources that might otherwise be devoted to substance abuse;
- Tavern closure or a plea, related to the availability of alcohol and drugs, to remove this source of dependence-forming substances;
- Law enforcement or the application of policies, laws, protocols and practices designed to reduce the threat of substance abuse;
- Spiritual care or the provision of facilities and opportunities for spiritual or religious observance;
- Availability or reducing the availability of dependence-forming substances such as alcohol and cannabis;
- Knowledge or knowledge of the process of identifying and dealing with the problems of prevention, treatment, aftercare and reintegration with the community of those affected by substance abuse;
- Rehabilitation or provision of access to and application of detoxification, rehabilitation, aftercare and reintegration with society for those suffering from substance abuse/dependence;
- Influence or the ability to persuade community members to become involved in the process of dealing with substance abuse;
- Healthy mind or the ability to resist the temptation to abuse substances, coupled with the concept of bipolar problems;
- Employment or lack thereof; and
- Poverty or the lack of adequate means of support.

Source: DSD (2013:45)

The above abstract indicates that the DSD acknowledges that substance abuse treatment should focus on the social and cultural aspects surrounding substance users, but one factor that is not mentioned by the African Regional Office of the World Health Organization or the DSD is harm reduction as a part of treatment. The DSD (2013:4) rather describes harm reduction as a strategy to eradicate substance use, together with the reduction of drug supply and demand. Harm reduction is defined as “[t]he development of policies and programmes that focus directly on reducing the social, economic and health-related harm resulting from the use of alcohol and other drugs (DSD, 2013:18). Rassool (2011:236) stresses that because many individuals are not ready to abstain from substance use governments should adopt a humanistic approach such as harm reduction to limit the harms associated with drug abuse for individuals and governments. Many individuals, however, use substances as a way of managing symptoms of psychiatric disorders. It was estimated that among those individuals that have been diagnosed with bipolar disorder, around 40% use substances to self-medicate (Camacho, Ng & Frye, 2010:190). Due to this high prevalence, bipolar disorder will be discussed in the following section.

2.3 BIPOLAR DISORDER

Bipolar was identified as a disorder in 1851 in France by Jean-Pierre Farlet, who described patients that presented with cycles of depression and mania in varying intervals, which was called *folie circulaire* (Grobler, 2012:20). In the DSM-IV-TR bipolar disorder was categorised as a mood disorder, but in the DSM-5 bipolar and related disorders became a separate category and was no longer classified as a mood disorder (APA, 2013b:4). The DSM-5 (APA, 2013a:810) expresses that the focus of bipolar disorder falls on changes in mood as well as changes in energy and activity involvement and is therefore not deemed a pure mood disorder. In terms of a bipolar diagnosis, moods are clustered into two groups, manic and depressive symptoms.

Manic symptoms include euphoria, increased energy, increased drive to achieve goals and an increase in irritability, the need for sleep decreases, distractibility and self-confidence are heightened, and there is an increased involvement in activities despite damaging consequences (APA, 2013a:124; Bender & Alloy, 2011:393). Hypomanic episodes usually last four consecutive days, whereas manic episodes last a week and are seen as more severe than hypomanic episodes (APA, 2013a:124; Kusumakar, Bond & Yatham, 2009:3). Miklowitz (2010:28) explains that manic episodes usually follow four stages:

- **Prodromal period (Stage1):** During the first manic episode family members do not notice that anything is wrong. Individuals are described as being wired, irritated or focused on too many things at once. The energy and zest for life presented by the individual is often enjoyed by families but in subsequent manic episodes, the first stage often causes anxiety as the family knows what will follow in later stages.
- **Active or acute period (Stage 2):** Individuals tend to sleep very little, make foolish decisions; they are grandiose and become motorically hyperactive.
- **Active or acute period (Stage 3):** Hallucinations, delusions, rapid talking and irritability start and family members realise they are facing a problem. Hospitalisation is usually discussed at this point but is generally met with resistance by the individual as he or she is unaware of their behaviour. Arrest is very common at this stage as many individuals tend to run away from home. However, many patients never enter this stage of mania and are more likely to remain in Stage 1 of hypomania.
- **Recovery stage:** In this stage, manic symptoms decelerate back to Stage 2 and Stage 1, but regress to a depressive episode, sometimes without having a period of healthy mood. The consequences of the manic behaviour need to be addressed during this phase and can cause stress, as the losses associated with the manic episodes become reality for the individual and their family, for example, arrest and excessive spending.

Depressive symptoms include a decrease in energy levels, an increase in feelings of hopelessness and/or worthlessness, low self-confidence, weight loss, sleep difficulty, an inability to concentrate and psychomotor retardation (Bender & Alloy, 2011:393; APA, 2013a:125). Stages of depressive episodes are far less clear-cut as the progression between mild, moderate and acute depression can be very gradual (Miklowitz, 2010:30). Families caring for relatives diagnosed with bipolar disorder indicated that even though it is less challenging to manage a family member that is experiencing a depressive episode in

comparison to a manic episode, it remains stressful and confusing to them as main caretakers (Miklowitz, 2010:30).

The DSM-5 (APA, 2013a:123) distinguishes between several types of bipolar and bipolar-related disorders which are diagnosed based on the severity of the manic and depressive symptoms and the period of time these symptoms remain present or active. The types of bipolar and bipolar-related disorders will be discussed in the following section.

2.3.1 Types of Bipolar Disorder

The different combinations and time intervals of manic and depressive symptoms are divided into seven subtypes of bipolar disorder:

2.3.1.1 Bipolar I

When three or more manic symptoms are present for a period of one week an individual can be diagnosed with Bipolar I disorder. The manic episode can be preceded or followed by a hypomanic or major depressive episode; which is the presence of five or more depressive symptoms that last two weeks (APA, 2013a:123-126). The average age of onset for bipolar I disorder is 18.2 years and affects men and women equally (Colin, 2013:164). Syndromic recovery is very high in this type of bipolar disorder, but full functional recovery was observed to be very low and was less likely to occur the younger an individual is at the age of onset (Goodwin & Lieberman, 2010:13).

2.3.1.2 Bipolar II

When an individual meets the criteria for a hypomanic episode (three or more manic symptoms over a period of four days) which was followed or preceded by a major depressive episode they can be diagnosed with Bipolar II disorder. There should, however, be no evidence of a manic episode according to the APA (2013a:134). The age of onset of this type of bipolar disorder is estimated at 20.3 years and is less common in men (Colin, 2013:164). Goodwin and Lieberman (2010:14) indicate that bipolar II disorder clusters within families and suicide rates within this group is also found to be higher than when compared to bipolar I disorder.

2.3.1.3 Cyclothymic

When hypomanic and depressive symptoms are present over a period of two years and symptoms are never absent for more than two months, but is not severe enough to be diagnosed as hypomanic or major depressive episodes, a cyclothymic diagnosis can be made (APA, 2013a:139). Alcohol use, substance abuse, extra-marital affairs and promiscuity is estimated to be presented by 40% around of individuals diagnosed with this type of bipolar disorder (Goodwin & Lieberman, 2010:14).

2.3.1.4 Substance/Medication-Induced Bipolar and Related Disorder

An individual can be diagnosed with this type of bipolar disorder when the individual's functioning is impaired due to the presence of manic symptoms, with or without the presence

of depressive symptoms, and these symptoms “... developed during or soon after substance intoxication or withdrawal or after exposure to a medication [and the] involved substance or medication is capable of producing...” the presented manic symptom which cannot be ascribed to another bipolar related disorder (APA, 2013a:142). Some antidepressant medication and stimulant type substances are especially prone to initiate this type of bipolar disorder, however, due to a lack of research the prevalence cannot be established, and it is believed the prevalence of this type of bipolar disorder will change as new substance abuse trends emerge (APA, 2013a:144).

2.3.1.5 Bipolar and Related Disorder due to another Medical Condition

The APA (2013a:146) defines this type of bipolar disorder as the “... presence of a prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy predominating in the clinical picture that is attributable to another medical condition”. The most common medical disorders associated with this type of bipolar disorder are traumatic brain injury, stroke, multiple sclerosis and Cushing’s disease (APA, 2013a:146).

2.3.1.6 Other Specified Bipolar and Related Disorder

The diagnosis of other specified bipolar and related disorder can be made when symptoms of bipolar disorder are present and another type of bipolar disorder cannot be diagnosed, as well as the fact that a clinician is able and willing to provide a specific reason why another diagnosis cannot be made (APA, 2013a:148). According to the APA (2013a:148) the following reasons can be provided: 1) Short-duration hypomanic episodes (2-3 days) and major depressive episodes, 2) Hypomanic episodes with insufficient symptoms and major depressive episodes, 3) Hypomanic episode without prior major depressive episode or 4) Short-duration cyclothymia (less than 24 months).

2.3.1.7 Unspecified Bipolar and Related Disorder

When a clinician chooses not to disclose the reason why an individual does not meet the criteria for another type of bipolar disorder the type of bipolar can be diagnosed (APA, 2013a:149). This type of bipolar is mostly diagnosed in emergency situations where more information is needed before an accurate diagnosis can be made (APA, 2013a:149).

The causes, prevalence and effects of bipolar disorder will be discussed in the following sections.

2.3.2 Causes of Bipolar Disorder

The cause of bipolar disorder can be linked to biological, psychological and social risk factors that contribute to the onset, development and course of the disorder (Alloy et al., 2005:1068).

2.3.2.1 Biological causes

“Bipolar disorder is unquestionably a disorder of genetic and biological origin, and it cannot be treated with psychotherapy alone” (Miklowitz, 2010:41). Various studies confirm the part that genetics play in the onset of bipolar disorder, especially in the case of bipolar II disorder (Kusumakar et al., 2009:4). Miklowitz (2010:37) report that children born from a parent diagnosed with bipolar disorder are four times as likely to develop a mood disorder, and 72% of children born from mothers diagnosed with bipolar disorder will develop a psychiatric illness during their lifetime.

Neurotransmitters such as serotonin, dopamine, neurohormone, norepinephrine and gamma-aminobutyric acid are all believed to be linked to the diagnosis of bipolar disorder, and thus pharmacotherapy focused on these neurotransmitters is seen as an important factor in the treatment of bipolar disorder (Miklowitz, 2010:41). Frye and Perugi (2010:33) warns that the use of nicotine seem to make bipolar disorder more active and inhibits the effectiveness of treatment as individuals who use nicotine show a higher prevalence of suicide attempts, mixed episodes, substance and alcohol abuse, more severe mood symptoms and reduced response rates to medication. In terms of biology, gender does not seem to play a role in the prevalence of bipolar disorder, but rather plays a role in the type of bipolar disorder diagnosed; however, women over represent the population in psychological treatment facilities (Merikangas & Peters, 2010:55).

In terms of the onset of bipolar disorder, the use of illicit substances and alcohol is known to trigger the onset of psychiatric disorders such as bipolar disorder (Couwenbergh, Van den Brink, Zwart, Vreugdenhil, Van Wijngaarden-Cremers & Van der Gaag, 2006:319; NIDA, 2010:3). Bender and Alloy (2011:385) assert that between 40-76% of individuals diagnosed with bipolar disorder are able to link the first onset of their disorder to a stressful life event indicating that even though a biological predisposition is present, the onset is usually caused by psychological factors.

2.3.2.2 Psychological causes

When investigating and defining the causes of any disorder it is always necessary to consider the risk factors associated with the disorder. In terms of bipolar disorder Merikangas and Peters (2010:56) and Rassool (2011:167) identified the following risk factors:

- Low socio-economic standing.
- Higher income countries.
- Lower levels of education.
- Individuals that are separated, divorced or widowed as oppose to married or single individuals.
- The presence of other psychiatric illnesses.

- The presence of an eating disorder.
- A diagnosis of ADHD, oppositional defiance disorder (ODD) or anxiety disorder during childhood.
- A diagnosis of anxiety disorder or sleep disorders during adulthood.
- Substance abuse.
- The presence of physical disorders (for example cardiovascular disease, reoccurring migraine, diabetes, asthma, arthritis, regular back and neck pain, and allergies).

Muzina, Kemp, Yatham and Calabrese (2009:22), Miklowitz (2010:37) and Merikangas and Peters (2010:56) explain that many individuals diagnosed with bipolar disorder report the same experiences during childhood and adolescence, giving way to the identification of the following childhood risk factors with regards to the diagnosis of bipolar disorder was:

- Children that are described as aggressive and moody from a young age.
- Children who are very concerned about their parent's emotional state.
- Children who struggle to display empathy towards others.
- Children diagnosed with ADHD, ODD or anxiety disorder during childhood.
- Children who present with subsyndromal signs of mania (burst of rage, self-cutting, impulsive suicide attempts, and substance abuse) which is often misdiagnosed as ADHD, depression or ODD.
- A family history of bipolar disorder.

It was found that children born of parents diagnosed with bipolar disorder often become their parent's caretakers and have a very low level of functioning during adulthood, but if these children develop meaningful friendships with other individuals outside of their family better treatment outcomes are reported (Miklowitz, 2010:37). However, protective friendships are not a norm as persons diagnosed with bipolar disorder, in general, have fewer interpersonal relationships, have lower cognitive abilities and are found to be less autonomous (Vázquez, Kapczynski, Magalhaes, Córdoba, Jaramillo, Rosa, Sanchez de Carmona & Tohen, 2011:325). Individuals diagnosed with bipolar disorder are also described as very sensitive and have high expectations of themselves, thus they have high levels of energy and motivation when they have to perform a task but relapse is therefore quite high when they feel out of control and expect to fail (Bender & Alloy, 2011:393). When psychological stressors are not identified and treated, mood relapse is inevitable. It is estimated that 90% of individuals with bipolar disorder will relapse, with either manic or depressive symptoms, and will experience an average of three mood episodes and five hospitalisations within a ten year period (Miklowitz, 2010:23). Manic episodes are however less prevalent than depressive episodes and depressive episodes are more challenging to treat effectively (Miklowitz, 2010:23).

In addition to these factors, Vázquez et al. (2011:326) found that individuals diagnosed with bipolar disorder are concerned that they might be stigmatised and tend to withdraw from situations where stigma is possible, this, in turn, reinforces possible stigma from other individuals toward them. Stigma can also be produced by culture and cultural and social cause are difficult to separate from psychological causes, as they contribute to psychological stress which precipitates mood relapse. Other social and cultural factors contributing to the onset of bipolar disorder will be discussed in the following section.

2.3.2.3 Social and cultural causes

The social well-being and mental health of individuals in South Africa are put under more pressure due to the political turmoil, poverty and violence that is part of South African history and present functioning (Olckers, 2013:29). Seedat Williams, Herman, Moomal, Williams, Jackson, Myer and Stein (2009:346) state that “South Africa has a legacy of racially inequitable, fragmented and inadequately resourced mental health care services, characterised by provincial variability” and these factors contribute to the onset of disorders such as bipolar disorder. Allott (in Archambeault, 2009:27) explain that mental health care concepts and treatment become more complex when an individual is part of a multi-cultural society as psychiatry is a component of Western medicine and was developed around research based on the Western culture.

Families of patients diagnosed with bipolar disorder have been found to be less affectionate or more domineering, with the presence of maltreatment and abuse reported in some cases (Alloy et al., 2005:1052-1064; Swann, 2010:277). Mood relapse is also found to be significantly higher in individuals that return to families where aspects such as conflict, criticism and emotional overinvolvement are present (Miklowitz, 2010:5). It is however very important to understand that family environments does not cause bipolar disorder but rather triggers an already existing problem and families should therefore never be blamed for the initial onset of bipolar disorder but should rather be guided to prevent future relapses (Miklowitz, 2010:51).

Individuals diagnosed with bipolar disorder become more sensitive to psychosocial-cultural triggers over time and the amount of stress needed to trigger a mood episode becomes less with every consecutive episode, thus the earlier a comprehensive diagnosis can be made and effective treatment can commence the greater the chance for recovery becomes (Bender & Alloy, 2011:395).

The prevalence of bipolar disorder from an international, regional and national level will be discussed next.

2.3.3 Prevalence of Bipolar Disorder

Miklowitz (2010:31) believes it is challenging to diagnose bipolar disorder as it is very difficult to establish where bipolar disorder starts and where other disorders, such as substance abuse or ADHD, end. Due to the difficulties related to the diagnosis bipolar disorder, the prevalence of bipolar disorder is not well known but rather estimated by organisations focused on treating bipolar disorder.

“Bipolar disorder (BD) affects an estimated 2-4% of the U.S. population and is the sixth leading cause of disability among physical and psychological disorders worldwide” (Bender & Alloy, 2011:384). According to Ng, Cahill, Malhi and Berk (2009:81), it is estimated that up to 5% of the world population will have a lifetime prevalence of bipolar disorder. Grobler (2012:6) acknowledges that there is a major lack in terms of studies on bipolar disorder in Africa and more specifically South Africa which makes it difficult to report on the prevalence and effects of this disorder in detail (Grobler, 2012:6). Establishing the prevalence of bipolar disorder is complicated further as most individuals that experience mental health problems consult general practitioners first and access to more specialised mental health care seems

to be reserved for patients with the worst symptoms which complicate the collection of accurate statistics (Seedat et al., 2009:349). In South Africa there is a very unique and very broad primary health care system as Seedat et al. (2009:350) remind us that individuals in South Africa may also consult traditional practitioners or complementary and alternative treatment (CAM), complicating the process of attaining accurate data in South Africa further.

When looking at general mental health in South Africa, Herman, Stein, Seedat, Heeringa, Moomal and Williams (2009) found that compared to other countries South Africa has the ninth highest rate of anxiety disorder and tenth highest rate of mood disorders globally. “Compared with Nigerians, twice as many South Africans had lifetime anxiety disorders, 4 times as many had lifetime mood disorders, and almost 6 times as many had substance use disorders” (Herman et al., 2009). The South African Depression and Anxiety Group (SADAG) reports that an estimated 1% of the South African population has bipolar disorder, the year and source of their information is however not clear. After consulting various online platforms such as Google Scholar, EBSCOhost and Sage the researcher could not find literature reflecting on the prevalence of bipolar disorder in South Africa as a whole.

One South African study conducted by Grobler (2012:167) with 103 psychiatric patients with a history of manic episodes in three hospitals in the Limpopo Province found that 1) twenty-seven percent have attempted suicide, 2) a quarter of them had a tertiary education, 3) a third of them have a criminal history, 4) half of them have a history of violent behaviour and 5) two-thirds consulted a traditional and faith practitioner before seeking medical attention. Grobler (2012:164) however found that the course and presentation of black individuals diagnosed with bipolar disorder differ from that of white individuals with a similar diagnosis, a finding confirmed by a study done in London which found that a mainly manic presentation of bipolar disorder was more than double in the black population than the white population. The studies mentioned were however conducted with patients diagnosed with bipolar disorder who presented with manic symptoms and do not represent all patients diagnosed with bipolar disorder (Grobler, 2012:82).

Determining the prevalence of bipolar disorder is important as the more prevalent a disorder is, the broader the effects will reach. The effects of bipolar disorder on individual, interpersonal and community level will be discussed in the following section.

2.3.4 Effects of Bipolar Disorder

Bordbar and Faridhosseini (2012:323) state that a diagnosis of bipolar disorder has devastating effects on the individuals, their family and society and is identified as a debilitating disorder. Bipolar disorder is described as a ‘relapsing and remitting illness’ that affects all patients regardless of their adherence to medication or their social environment (Miklowitz, 2010:5). The effects of bipolar disorder will be discussed in terms of the individual, relational and socio-economic consequences it entails.

2.3.4.1 Effects on individuals

Miklowitz (2010:26) report that in a study done with 253 individuals diagnosed with bipolar I or II disorder, more than half of these individuals were not able to return to work or they worked in a very sheltered environment. After a year only 24% of these individuals were able

to resume the level of functioning they possessed prior to the initial episode. Torres and Malhi (2010:71) report that cognitive impairments are evident when individuals are experiencing a manic or depressive episode. During depressive episodes, attention, verbal learning, verbal memory, verbal fluency, cognitive flexibility, problem-solving and psychomotor speeds are impaired (Torres & Malhi, 2010:71). During manic episodes, decision making, judgement, cognitive flexibility, inhibitory control, verbal fluency, verbal memory and recognition, verbal learning and attention is inhibited (Torres & Malhi, 2010:71).

Financial problems, poor general health, homelessness, incarceration, suicide, dysfunctional relationships, readmission to hospitals and treatment centres, employment and school problems, and social isolation are all consequences of bipolar disorder (Archambeault, 2009:108; Bender & Alloy, 2011:384; Muzina et al., 2009:25). Risky sexual behaviour, impulsiveness, poor business decisions and reckless driving is also common behaviour displayed by individuals diagnosed with bipolar disorder and each effect hold their own set of consequences for individuals and their families (Miklowitz, 2010:24). In addition to the above-mentioned effects, Ng et al. (2009:85) add that the younger an individual is when their bipolar disorder symptoms first present, the more inclined the individual will be to develop destructive behaviour patterns such as substance abuse, and the worse treatment outcomes are. Stimulants specifically are used as individuals attempt to achieve the level of hypomania they experience during manic episodes of bipolar disorder (Swann, 2010:277; Weiss et al., 2007:100). The severity of the effects of bipolar disorder is believed to differ based on the type of bipolar disorder an individual is diagnosed with; for example, bipolar II disorder is generally associated with a younger age of onset and higher rates of suicide attempts, both indicating poorer treatment outcomes (Kusumakar et al., 2009:5).

In addition to the actual effects of bipolar disorder, the pharmacological treatment used to treat bipolar disorder also holds certain concerns as the miscarriage rate for women using bipolar disorder medication is estimated at 30%, and children born from mother using medication for the treatment of bipolar disorder are found to present with developmental and cognitive defects (Grobler, 2012:170). In light of this finding it can be stated that the chronic emotional and behavioural effects that bipolar disorder has on individuals diagnosed is not only debilitating to the individual diagnosed but has devastating effects on everyone in relation to them (Dell'Osso & Ketter, 2013:55; Miklowitz, 2010:5). The effects that bipolar disorder has on relationships will be discussed next.

2.3.4.2 Effects on relationships

If bipolar disorder remains undiagnosed the course and severity of the disorder escalate as poor mood control cause chaos in homes, which in turn breeds a more unstable mood in patients (Alloy et al., 2005:1046). Rehospitalisation and incarceration which is described as effects experienced by the individuals diagnosed will essentially impact the family functioning and finances as well (Bender & Alloy, 2011:384). The following statement by Miklowitz (2010:26) presents what family members can experience when another family member is diagnosed with bipolar disorder:

Episodes can be quite traumatic for a patient's relatives, because it is difficult for them to make sense of what has happened to their ill relative or to the family unit. It is easy to understand how the kind of stress and burden they experience can make them angry or resentful of the patient.

Family members often express that they do not mind supporting a family member through mood episodes but they become frustrated and despondent when their advice is rejected and the family member's mood does not improve (Miklowitz, 2010:31). In light of this Archambeault (2009:116) believes that families and caretakers of individuals with mental health needs should be included in service delivery strategies as they can experience a great sense of loss, which can present in the following ways:

- Complicated bereavement can occur as a family feel they have lost someone, even though they are still physically present in an altered state. A factor which is especially true when personality characteristics change.
- When family members experience anger towards the individuals with psychological health needs it can cause feelings of guilt and conflict as they know anger is not "right".
- Isolation, shame and insularity are also common as mental health problems still carry strong stigma towards families and individuals experiencing mental health problems.

Green, Hayes, Dickinson, Whittaker and Gilheany (in Archambeault, 2009:118) implies that many families that access mental health services tend to ignore mental health problems and does not understand what the service user experiences; friends, on the other hand, seem to disappear over time but never reject the service user or their disorder explicitly. Individuals diagnosed with bipolar disorder were found to have fewer friends and often have poor social skills which become more severe as symptoms of bipolar disorder emerge which complicates relationships even further (Alloy et al., 2005:1052).

Archambeault (2009:121) warns that service providers should not expect social networks and family members to manage the psychological stressors and symptoms of an individual, but should remain a source of support to both patient and family. Miklowitz (2010:5), however, acknowledges that continued support from service providers is challenging as periods of hospitalisation has become shorter over the years, and many patients are discharged while their symptoms are still active, placing a greater burden on family members. The changes in terms of the length of hospitalisation can be ascribed to the socio-economic effects of mental health and will be discussed next.

2.3.4.3 Socio-economic effects

Bordbar and Faridhosseini (2012:323) state that it costs the USA an estimated 45 billion dollars (R630 billion) and the UK 2055 million pounds (R33 million) per year to treat patients diagnosed with bipolar disorder. The GHA (2014:4-5) reports that similar data from South Africa is rather outdated but it is estimated that the country devoted 2.7% of the 2005 health budget to mental health care in general, and in 2001 the cost of bipolar disorder treatment for individuals with private health care was around R8000 per annum.

The socio-economic effects of bipolar disorder are not limited to the costs of treating the actual disorder as costs related to incarceration, unemployment, readmission to treatment centres and hospitals, as well as homelessness associated with bipolar disorder should be included in the calculation (Bender & Alloy, 2011:384). South Africa also needs to consider additional socio-economic costs as the GHA (2014:3) reports that almost 6% of individuals attending HIV clinics in South Africa can be diagnosed with bipolar disorder.

The following statement by the GHA (2014:8) indicates why South Africa should give more attention to the development and implementation of treatment programmes focuses on multiple categories of diseases, including mental health: “South Africa faces a growing burden of mental, neurological, and substance use disorders, which are often co-morbid with HIV and other chronic diseases. A considerable mental health treatment gap exists, with significant care shortage in rural areas”.

The treatment of bipolar disorder will be discussed in the following section.

2.3.5 Treatment of Bipolar Disorder

Archambeault (2009:108) made the following statement regarding the treatment of bipolar disorder:

Treating persistent mental health needs involves a range of approaches, but quite commonly this involves prescribing psychotropic medication, medication that is meant to have an effect on the symptom being described...to treat an acute manic episode, to prevent a recurrence of mania and to treat periods of depressed mood.

The above statement explains the role of medication as part of treatment but does not refer to other aspects that should be involved in treatment. Miklowitz (2009:577) believes that the biopsychosocial approach in terms of the treatment of bipolar disorder is most appropriate, as it is important to focus on psychosocial aspects, for example, stress, as well. Numerous authors support Miklowitz’s view and express that treatment which focuses on one level of functioning has not proven to be effective and therefore treatment should focus on the following three areas (Bordbar & Faridhosseini, 2012:323):

2.3.5.1 Treatment on biological level

To ensure effective treatment an accurate diagnosis, made within the least amount of time possible, is necessary. Salloum, Pani and Cooke (2010:355) hold that there is an estimated 10-year period that elapses between the initial consultation, the actual diagnosis and the start of treatment for bipolar disorder. Long periods of time elapsing between the presentation of symptoms and treatment is a concern as disease outcomes become worse as time progress (Salloum et al., 2010:355). Miklowitz (2010:32) urges practitioners to get an in-depth behavioural history from family members and significant others to ensure that the correct diagnosis is made.

After diagnosis, the first priority of treatment is to ensure that the individual diagnosed with bipolar disorder is in a safe environment and that a pharmacological treatment plan is started, however, the final treatment plan should always focus on restoring the full psychosocial function of the individual and should not be limited to medication (Kusumakar et al., 2009:5). Mood stabilisers, anti-depressants and anti-psychotic medications are those most commonly prescribed to individuals diagnosed with bipolar disorder but medication regimes typically change depending on the stage of bipolar disorder (Dell’Osso & Ketter, 2013: 55; Salloum et al., 2010:360). Non-adherence with regards to medication is estimated at 70% within the first 9 months of treatment as individuals feel they do not need medication, or they develop an aversion to side-effects or stigma related to taking psychiatric medications (Miklowitz, 2010:45). Non-adherence is very problematic as it can trigger mood

relapse and patients tend not to respond as effectively to medication when it is re-introduced after a period of non-adherence (Miklowitz, 2010:46). To limit non-adherence, it is important to involve the patient in selecting medications as adherence to all the aspects of treatment is enhanced when patients feel involved in treatment planning and are comfortable with the prescribed medication, along with its side-effects (Miklowitz, 2009:577). It is also suggested that family members of individuals diagnosed with bipolar disorder should be educated on the biological components of the disorder, as this will enable them to understand that the individual is not merely being uncooperative, and that medication plays an important role in treatment (Miklowitz, 2010:31). The inclusion of family in treatment can not only improve adherence to treatment but patients that received individual and family therapy in addition to pharmacological treatment reported higher levels of life satisfaction and improved quality of life (Miklowitz, 2010:27). In addition to this statement, it was found that when pharmacological treatment is used without any other form of intervention, treatment outcomes are poorer, thus supporting Bordbar and Faridhosseini's (2012:323) believes that the psychological and socio-cultural components should be included in the treatment of bipolar disorder.

2.3.5.2 Treatment on psychological level

Miklowitz (2009:577) indicates that emotional, behavioural and cognitive therapies need to be initiated with individuals diagnosed with bipolar disorder as they; firstly, need to adjust to their lives without manic symptoms or the precipitation thereof, and secondly, need to develop effective ways of coping with new challenges on a practical and emotional level. The importance of psychological intervention in the form of therapy is significant as the therapeutic relationship can mean the difference between adherence and non-adherence to treatment (Scott & Tacchi, 2010:276).

Scott and Tacchi (2010:276) recommend that discussions take place which focuses on 1) the fears related to the side-effects of medications, 2) the longing to experience the highs associated with mania, 3) criticism from significant others, 4) the presence of substance abuse, and 5) their beliefs regarding the disorder. Bordbar and Faridhosseini (2012:324) suggest that patients should have knowledge on bipolar disorder; knowing what triggers mood episodes, the importance of treatment, various methods of treatment, how to take control of mood swings and other symptoms, knowledge of the importance of lifestyle choices and side effects of medication. The use of mood charts is often associated with treatment interventions for bipolar disorder as it gives individuals an opportunity to reflect on possible triggers for moods, patterns of mood changes, sleep patterns and adherence to medication (Miklowitz, 2010:142). Miklowitz (2010:27) warns that some individuals can 'over-identify' with their diagnosis of bipolar disorder and will not aim to achieve the level of functioning which they are capable of but will rather accept a disabled role.

Social and cultural aspects of treatment should also be addressed as many individuals find it difficult to talk to someone about their mental health difficulties and this can be made worse when one's community and family reacts in a way that does not seem accepting or tolerating (Archambeault, 2009:107).

2.3.5.3 Treatment on social and cultural level

Psychiatry was developed as part of western medicine, thus the influence of culture, for example, African culture, did not play a significant role when mental health care (diagnosis and treatment) was defined and developed, due to these origins, many feel that social injustice is a major concern with regards to mental health care services (Allott in Archambeault, 2009:27). Treatment is often avoided by patients and their families because they fear the stigma related to their own or family member's diagnosis, especially in societies where other cultural and religious opinions regarding psychiatric disorders are present (Archambeault, 2009:117). The withdrawal from families poses additional concerns as Yatham et al. (2009:2) warn that symptoms associated with bipolar disorder are very common in other disorders and thus families should be included from assessment to ensure that the correct diagnosis is made, more so when manic symptoms are present.

The nature and origin of mental health care created a need for psycho-education with patients and their families as this has a direct impact on relapse rates, especially in families where criticism, hostility and over-involvement are common (Miklowitz, 2009:577). Families and significant others should thus be educated on bipolar disorder to enable them to understand and recognise warning signs and to inform them of how they can support their relative (Miklowitz (2010:26). Muzina et al. (2009:117) believe that when families are involved in treatment they will not only gain knowledge but they will be able to determine and report whether treatment is effective or not. The role that families play in the treatment of bipolar disorder is also important in identifying possible risks factors associated with the onset of future mood episodes; for example the use of substances, non-adherence to medication, or severe family conflict (Miklowitz, 2010:26). Families should also be included in setting realistic treatment goals in terms of resuming psychosocial responsibilities, to ensure that the family or the individual diagnosed do not assume too much or too little responsibility in an unreasonable amount of time (Miklowitz, 2010:27). The risk of not including family members means they will not understand bipolar disorder and become less supportive and often times disregard the seriousness of the disorder, leading to more instances of non-adherence among patients (Scott & Tacchi, 2010:277).

Weiss et al. (2007:100) acknowledge that the majority of studies conducted with patients diagnosed with bipolar disorder have shown that many of these patients have a substance addiction as well. When an individual abuses substances and is diagnosed along with a psychiatric disorder, it is referred to as a dual-diagnosis (Rassool in Couwenbergh et al., 2006:319). Fisher and Harrison (2013:158) estimated that around 50-75% of individuals with a substance addiction can be successfully diagnosed with a psychiatric disorder and due to the growing prevalence of dual-diagnosis this has become a topic of interest in past years. In the following section, dual-diagnosis will be expanded on.

2.4 DUAL-DIAGNOSIS

The interest in dual-diagnosis has grown over the last decade due to two reasons: firstly, because long-term psychiatric treatment is being discouraged and faster reintegration is promoted, and secondly, because the prevalence of substance use, in general, has increased (Rassool, Villar-Luis & Braga, 2007:141). Many types of dual-diagnosis exist, but dual-diagnosis in this section refers to the co-occurrence of stimulant abuse and bipolar

disorder. An overview of dual-diagnosis and discussions on the causes, effects and possible treatment of the dual-diagnosis will be discussed in this section.

2.4.1 An Overview of Dual-Diagnosis

Due to the high number of individuals in South Africa diagnosed with a psychiatric disorder endorsing the use of illicit substances Davis et al. (2016:5) express a proactive need for "...inquiry about substance use amongst both inpatients and outpatients of psychiatric services...". The DSM-5 acknowledges that there are no studies available on the epidemiology of substance-induced bipolar disorders and they expressed the need for research with regards to this phenomenon (APA, 2013a:144). The first large-scale study focused on determining the prevalence of mental health disorders in South Africa was only conducted in 2009 by Herman et al. (2009:1) but some authors and organisations have drawn certain conclusion and estimates regarding the co-occurrence of bipolar disorder, other psychiatric disorders and substance abuse within South African and global populations:

- SACENDU (2016:1) reports that in South Africa 37% of the individuals admitted to treatment centres across all provinces of South Africa in the last six months of 2015 reported mental health conditions upon admission.
- McCrady et al. (2012:236) estimate that between 19-34% of individuals with mood disorders has a comorbid substance abuse disorder.
- Miklowitz (2010:300) and Muzina et al. (2009:24) state that substance abuse disorder is more likely to co-occur with bipolar disorder than with major depression and they estimate that 48-61% of individuals diagnosed with bipolar disorder have a substance addiction.
- Rethink (2009:1) estimates that individuals diagnosed with bipolar disorder are 4.1% more likely to misuse substances during depressive episodes, and 14.5% more likely to misuse substances during manic episodes.
- Couwenbergh et al. (2006:319), NAMI (2013:1) and Weiss et al. (2009:212) estimated that between 59-88% of patients receiving treatment for bipolar disorder have a substance use disorder, and the co-occurrence of these disorders increases the risk for suicide, lowers medication adherence and slows down recovery from mood episodes.
- Miklowitz (2010:300) reports that adolescents receiving treatment for bipolar disorder are five times more likely to abuse substances than adolescents that are not diagnosed with bipolar disorder.

Swann (2010:279) and Tiet and Mausbach (2007:526) indicate that the most common types of drugs used by individuals diagnosed with bipolar disorder is cocaine, cannabis and hypnotic-sedative drugs; which was also found to increase impulsivity in patients, however, impulsivity was not detected when individuals used depressants such as heroine. Authors acknowledge that there is a general lack of information on dual-diagnosis and the treatment thereof, specifically the co-occurrence of bipolar disorder and drug use (Swann, 2010:276; Tiet & Mausbach, 2007:514). It should also be mentioned that the limited data available on dual-diagnosis mainly focus on all substances and all psychiatric conditions making it difficult to determine the treatment needs of individuals diagnosed with other types of dual-diagnosis. Specific information is needed as treatment that focuses on all psychiatric

disorders combined with a substance use disorder will not be as effective, as different psychological conditions which present with different symptoms, altered course of disease and unique challenges when combined with different types of substances (Weiss, 2004:311).

Fabricius et al. (2007:14) explain that much more studies focused on dual-diagnosis are needed, with specific reference to treatment thereof, as education on this phenomenon, substantiated with evidence, needs to take place more urgently and on a larger scale. Due to the lack of information, especially regarding bipolar disorder, it makes it difficult to persuade individuals that they need intervention, more so in South Africa where research on mental health care, in general, is lacking (Bordbar & Faridhosseini, 2012:330; Fabricius et al., 2007:14). One study conducted by Lachman, Nessen, Hawkridge and Emsley (2012) with 139 adolescents in a psychiatric hospital in the Western Cape Province of South Africa, found that methamphetamine was associated with high numbers of psychotic and mood disorders. It should be stated that the authors explain that their study is the first to report on South African statistics of dual-diagnosis among adolescents, and they conducted the study in an effort to provide data that will encourage the development of effective intervention strategies (Lachman et al., 2012).

Interventions are necessary to limit the effects that a dual-diagnosis has on various spheres of an individual's life. In order to develop interventions, it is, however, necessary to determine the causes and effects of this dual-diagnosis.

2.4.2 Causes of Stimulant Abuse and Bipolar Disorder Dual-Diagnosis

Based on findings from a number of studies Fabricius et al. (2007:2) identified the following five explanations to describe the cause of a dual-diagnosis:

- Some believe that a psychiatric disorder precedes substance use, and the use of substances is a means that enable individuals to control or change the symptoms of the psychiatric disorder.
- Substances are believed to simply trigger psychological conditions which individuals are predisposed to, thus implying that substance use causes psychiatric disorders.
- The same genetic brain structures are found in individuals diagnosed with attention deficit hyperactivity disorder (ADHD) and those who abuse substances, thus a conclusion was drawn that these individuals are simply genetically vulnerable to both disorders.
- Psychiatric symptoms are exacerbated when an individual use substances and experience withdrawal, thus more substances are used in an attempt to control the aggravated psychiatric symptoms.
- Even though the number of reported cases of both disorders increases concurrently, some researchers believe there is no relationship between substance use and psychiatric disorders as there is too little evidence attesting the relationship.

When considering these explanations it is evident that identifying the causes of dual-diagnosis is complex, as it is the combination of the causes and effects of both disorders respectively, that leads to the development of the dual-diagnosis. For example, individuals diagnosed with bipolar disorder are seen as less sociable (Vázquez et al., 2011:325), and Nutt (2012:66) explains that as drugs are used in social settings and acts as a social

lubricant, stimulants can bring about change in the substance users social life; thus the social setting that causes anxiety within an individual diagnosed with bipolar disorder can become a positive environment that produces less anxiety when substances are used.

The effects that the dual-diagnosis of stimulant abuse and bipolar disorder entail will be discussed in the following section.

2.4.3 Effects of Stimulant Abuse and Bipolar Disorder Dual-Diagnosis

Rassool (2011:226) made the following statement to explain the relationship between substances and psychiatric disorders:

The withdrawal from alcohol or drugs can mimic or give the appearance of some psychiatric disorders; psychiatric symptoms may be covered up or masked by alcohol or drug use; untreated alcohol and drug dependence can contribute to a reoccurrence of psychiatric symptoms; and untreated psychiatric disorders can contribute to an alcohol or drug lapse or relapse.

The above statement not only indicates how complex the relationship between the two disorders are but also point out how important it is to address both of these disorders effectively. NIDA (2010:1) explains that it is important to diagnose and treat the factors related to dual-diagnosis as soon as possible to ensure the recovery of the individual. The use of stimulant drugs can complicate the diagnosis of psychiatric conditions as the effects of stimulant drugs can be confused for psychiatric symptoms and be diagnosed as hypomania, schizophrenia or acute psychosis (Rassool, 2011:220). Frye and Perugi (2010:31) refer to various studies that found that of all the individuals admitted to dual-diagnosis treatment centres for a dual-diagnosis of bipolar disorder and substance abuse; only 33% met the criteria for bipolar disorder, thus treatment could be inappropriate and ineffective.

Lower rates and shorter periods of recovery, higher relapse rates, more visits to emergency hospital care and hospitalisation, higher rates of suicidal behaviours and thoughts, frequent displays of impulsivity and violence, greater occupational impairment, higher rates of non-adherence to treatment, mixed mood states instead of manic or depressive cycles, higher levels of anxiety disorders, diminished quality of life and extensive utilisation of services are some of the common effects experienced by individuals that have a dual-diagnosis of bipolar disorder and drug abuse (Goldberg, 2009:232; Rassool, 2011:226). Couwenbergh et al. (2006:325) report similar effects and trends among adolescents with a dual-diagnosis who have been admitted to drug treatment programmes. Lachman et al. (2012) report that 61% of the 139 South African adolescents admitted to a psychiatric hospital in the Western Cape Province with a dual-diagnosis were not enrolled in or attending school; a factor that has been found to negatively impact mental health outcomes, compliance to treatment and risk-taking behaviour.

Lachman et al. (2012) and Salloum et al. (2010:354) acknowledge the need for early detection of dual-diagnosis because as time pass symptoms become so intertwined that it becomes very difficult to determine where one disorder ends and the other begin. Early detection and intervention is, therefore, necessary and is known to significantly improve treatment outcomes (Lachman et al. 2012; Salloum et al., 2010:354). However, it should be mentioned that individuals presenting with psychotic symptoms are generally not accepted

into substance abuse treatment programmes until their symptoms have been treated, thus compromising the recovery of these individuals (Lachman et al., 2012). Miklowitz (2010:300) believes that it is more difficult to treat substance abuse than it is to treat depression or suicidal tendencies, but the treatment of substance abuse is very important as stimulant drugs can trigger manic episodes or cause more severe depressive cycles, worsening the course of bipolar disorder.

The process of treatment of individuals with a dual-diagnosis is complicated as some stimulants cause patients to become physiologically resistant to bipolar medications, and the two disorders trigger relapses in one another, making recovery in both less achievable or sustainable (Swann, 2010:276). The treatment of the dual-diagnosis is very individualised as some individuals might need to be admitted to hospitals or other health care facilities for a period of time, while others might only need to consult with a psychiatrist once every few weeks (Archambeault, 2009:104).

The treatment of the dual-diagnosis is however where the challenge comes in as there is no information that focuses on treatment options (Swann, 2010:276), as will be discussed in the following section.

2.4.4 Treatment of Dual-Diagnosis

Treatment for an acute disorder is usually easily achieved and successful, but when multiple chronic disorders such as bipolar disorder and substance abuse need to be treated simultaneously the focus shifts to maintaining long-term stability (Salloum et al., 2010:354). Rassool (2011:227) believes that time, ample resources and experience in terms of dual-diagnosis are components that are necessary when assessing and treating dual-diagnosis patients, however, the greatest challenge with regard to dual-diagnosis treatment at this point is the fact that there are a lack of specificity and knowledge with regards to how specific disorders influence one another. Fabricius et al. (2007:2) assert that it is no surprise that there is a lack of focus on developing treatment as there is no consensus as to the causes of this dual-diagnosis in the first place.

Whether drugs caused bipolar disorder, whether undiagnosed bipolar disorder caused drug use, or whether the same genes cause both disorders are but a few of the unanswered questions associated with dual-diagnosis (Fabricius et al., 2007:2; Rethink, 2009:2). There is, however, a consensus that psychological and substance abuse treatment should be combined and that the severity of both disorders should determine the time that treatment should continue (Fabricius et al., 2007:4; Rassool, 2011:218).

In terms of gender, NIDA (2010:9) indicated that women tend to go to psychiatric institutions for treatment, and men usually go to rehabilitation programmes to receive treatment, making it difficult to determine the actual prevalence and needs of these individuals.

Archambeault (2009:20) wrote the following:

A holistic approach to identifying, understanding and responding to mental health distress would involve a bio-psychosocial framework, one that acknowledges and considers the interconnected impact of biological, medical and genetic influences along with the psychological, emotional, social and spiritual aspects of an individual.

The biological, psychological, social and cultural aspect of treatment will be discussed under separate headings in the following section.

2.4.4.1 Treatment on a biological level

The use of medication for the treatment of psychiatric disorders is a common practice and the effects of these medications are well researched. In terms of alcohol and opioid addiction medications such as Antabuse and Methadone are well known and are being prescribed quite regularly (Marinchak & Morgan, 2012:153). In recent years some studies have been conducted to determine the effects of some psychiatric medications in the treatment of substance abuse, but other than alleviating physical symptoms of detoxification, these medications have not proven to be effective (Carroll & Kiluk, 2012:340). Patients that have a co-occurring stimulant addiction and psychiatric disorder can benefit from medication, as the same chemicals associated with the onset of psychiatric disorder are associated with addiction, however, medications should be complimentary to other interventions (Carroll & Kiluk, 2012:340).

Kuehn (2010:2022) explains that individuals diagnosed with bipolar disorder and use drugs experience more rapid mood cycling and even if patients are still in active addiction they should be motivated to continue pharmacological treatment as it will inhibit some of the effects of mood cycling. Miklowitz (2010:302) urges service providers to explain to patients and family members the biological effects that the combination of drug use and bipolar disorder have on one another. Highlighting the biological effects will seem less judgemental and will create a feeling of concern around the individual's health, even though time and possible mood relapses might be necessary before the individual will fully comprehend the truth in terms of the biological interactions (Miklowitz, 2010:303).

In addition to conversations about illicit substance use, service providers will also need to address the impact that the use of licit substances might have on treatment interventions. Frye and Perugi (2010:33) explain that the nicotine quit rate among individuals diagnosed with substance abuse and bipolar disorder is much lower than in the general population, placing individuals diagnosed with a dual-diagnosis in the lowest quit rate category. The effects of nicotine use bring along a whole new list of health effects, compromising the health of individuals even further.

In an attempt to explain the relationship between stimulant use and bipolar disorder Camacho et al. (2010:190) provide the following example of a patient who was diagnosed with bipolar disorder during late adolescence and started using methamphetamine because she found that the drug would stop the onset of the depressive cycles of bipolar disorder and would keep her in a more manic mood. As her addiction progressed the depressive symptoms that set in when she started withdrawing became worse and her family sought treatment as her suicidal behaviour became more severe. Several medication trials were unsuccessful but as family support improved she was able to abstain from methamphetamine and her mood became more stable. Camacho et al. (2010:190) explain that literature consistently indicates that integrated approaches to treatment are important in dual-diagnosis, validating treatment focused on the psychological and socio-cultural components of an individual's life.

2.4.4.2 Treatment on a psychological level

When mental health treatment plans are considered, Archambeault (2009:82) express the importance of taking into account the mental health needs of an individual, considering the type of diagnosis, the severity, duration, and type symptoms reported, as well as all the possible treatment options. When looking at the mindset of individuals diagnosed with the dual-diagnosis of bipolar disorder and stimulant abuse, patients usually do not see the need for treatment or the need to change their behaviour when intervention starts, therefore practitioners are urged to be patient and continue intervention with individuals and their families even if progress is slow (Miklowitz, 2010:300). Practitioners should be creative and look to therapies and techniques used in the treatment of both disorders to gain inspiration. For example, the use of mood charts in the treatment of bipolar disorder (Miklowitz, 2010:142), and the use of decisional balance worksheets for drug abuse treatment (Rotgers, 2012:114) indicate that individuals diagnosed with a dual-diagnosis can benefit from activities encouraging them to reflect on thinking patterns, and the role that psychological and social stressors play.

It is recommended that social workers in mental health care settings focus on various levels of treatment, such as 1) establishing a setting where an individual can express and acknowledge their experiences and their perceptions of themselves, 2) enabling individuals to understand and respond to their social environment, and 3) guiding individuals to understand and value of their social context, which includes policies and legal aspects that influence their social milieu (Archambeault, 2009:118).

The treatment of dual-diagnosis is, however, not the responsibility of one field or profession but requires a multi-dimensional approach that can address the complex needs of individuals living with a dual-diagnosis (Rassool, 2011:228). Salloum et al. (2010:354) call on practitioners to move from providing acute care focused on symptom management to a new 'culture' of treatment where the focus falls on the active prevention of reoccurring relapses.

Some practitioners refer patients to NA or AA groups before other forms of therapy are initiated, as the use of substances counters the positive effects of therapy (Miklowitz, 2010:300). Substance abuse programmes are also not inclined to admit individuals that present with active psychiatric symptoms (Lachman et al., 2012). Salloum et al. (2010:355) voice a concern regarding these occurrences and report that it is still very noticeable that psychiatric institutions deliver inadequate substance abuse treatment services, and substance abuse treatment centres have inadequate mental health services available, thus many individuals with a dual-diagnosis receive inadequate treatment as a result thereof.

The inclusion of parents, partners and caretakers in the assessment, treatment planning, intervention and maintenance phases of treatment is very important and needs to be managed by one lead service that coordinates all treatment interventions (Rassool, 2011:228). The family of dual-diagnosis patients should also be included in discussions regarding the reasons for substance use and other stressors as this can allow the identification of possible family system problems (Miklowitz, 2010:303). The social and culture aspects that need to be considered and addressed in treatment will be discussed in the following section.

2.4.4.3 Treatment from a social and cultural level

There are no proven effective treatments for dual-diagnosis, but persons working with substance abuse and mental health disorders are in agreement that these disorders need to be treated simultaneously, as suicide attempts and psychotic episodes are less prevalent when treated concurrently (Rethink, 2009:5). Salloum et al. (2010:354) found that both disorders should be addressed by one practitioner or multiple practitioners that meet regularly, over an extended period of time to ensure that the multitude of needs of these individuals can be addressed. The most successful approaches with regards to the treatment of dual-diagnosis thus far have the following characteristics (Miklowitz, 2010:301; Rethink, 2009:6):

- Participation in a group that focuses on both substance abuse and bipolar disorder.
- Establishing social support and involving friends and family during all phases of treatment.
- Educating all persons involved in various aspects related to the diagnosis and treatment (combination of medication and therapy) of both disorders.
- Teaching family and patients coping skills and social skills.
- Managing sources of conflict within families.
- Maintaining a strong focus on relapse prevention.

When individuals are referred to groups that focus on each disorder separately, individuals can start justifying behaviour by using opposing treatment goals discussed in groups; for example some AA or NA groups believe all substances are 'bad' and many individuals diagnosed with bipolar disorder use this as a justification to discontinue taking medication for their bipolar disorder (Miklowitz, 2010:301). Due to the challenges of sending patients to appropriate treatment groups, Weiss et al. (2007:101) developed a treatment group which "...employs a cognitive behavioural relapse prevention model that integrates treatment by focussing on similarities between recovery and relapse processes in bipolar disorder and substance use...". The groups developed by Weiss et al. (2007:101) are known as integrated group therapy and is based on the believe that the same thought patterns underlie both disorders and should, therefore, receive attention simultaneously.

In South Africa the lack of accessible and affordable substance abuse services is undeniable; however, substance abuse centres that treat co-occurring mental health problems are even less accessible, regardless of the high rates of dual-diagnosis reported by many authors and entities (Pasche & Myers, 2012:340). Lachman et al. (2012) report that even substance abuse programmes offered by the DSD do not focus on co-occurring disorders and readmissions of adolescents to psychiatric institutions who need to access substance abuse services are alarming. However, the concerns regarding the accessibility and availability of appropriate treatment services are shared globally, as the UNODC (2016:66) found that especially women struggle to access programmes that are appropriate, as many programmes neglect psychological and social aspects, for example, additional financial costs associated with child care and transport.

The divide between substance abuse treatment and psychological treatment in South Africa can be ascribed to South African policies that place substance abuse in the scope of the social welfare sector and mental health in the scope of the health care sector (Pasche &

Myers, 2012:340). The effect of these policy decisions contributes to the fact that to this day professionals in both sectors are ill equipped to detect the secondary illness. Pasche and Myers (2012:340) believe that the first step in addressing the dual-diagnosis treatment gap in South Africa is to determine the prevalence of dual-diagnosis and to establish the treatment needs of this population, subsequently, this information can guide programme development. In addition to treatment gaps the GHA (2014:9) identified the following four gaps in knowledge that should be used to inform policy development in South Africa:

- To adequately inform spending decisions the economical and epidemiological burdens of psychological and substance disorders need to be understood.
- The costs, effectiveness and use of traditional therapies for psychological and substance abuse should be researched to develop interventions that cross biomedical and traditional lines.
- The integration of mental health services into the primary health care system should be strategised, designed and tested.
- Data on the cost-effectiveness of integrated care interventions should be researched to advocate for resources.

Even though it seems that many professionals are aware of the existence of dual-diagnosis the main focus in South Africa appears to be falling on policy changes that guide the development of effective interventions and social workers can play an important role in advocating for and developing these services.

2.5 SUMMARY

It is evident from this literature review that substance use and bipolar disorder are both debilitating disorders that have dire effects on individuals, families and society as a whole. When two disorders, such as stimulant abuse and bipolar disorder, come together and develop a dual-diagnosis the effects are merely exacerbated. However, it is evident that there is not enough research on the exact effects, causes and treatment options focused on this dual-diagnosis, a factor that needs to be addressed, urgently. From a biological perspective, both of these disorders can be treated through pharmacotherapy and detoxification. The psychological components indicate that psychological stress during childhood, adolescence or early adulthood are main contributors to psychological stress and the development of more conducive coping mechanisms will enable individuals to address these factors. In terms of social and cultural aspects, the researcher believes more research is needed to explore and establish what the exact treatment needs of these individuals are. Family involvement, psycho-education and appropriate reintegration strategies and programmes seem to be aspects that need more attention in the treatment of both disorders separately and as dual-diagnosis. The noted division between the social services and health care services in terms of the treatment of substance abuse and mental health disorders indicate that a holistic approach facilitated by a multidisciplinary team will be the most effective and responsible approach with regards to the treatment of this dual-diagnosis.

In the next chapter, Chapter 3, the focus will be on the research methods and empirical findings of the study.

CHAPTER 3

RESEARCH METHODS AND EMPIRICAL FINDINGS

3.1 INTRODUCTION

The goal of the study was to explore how adults living with stimulant abuse and bipolar disorder experience treatment at treatment centres in the Gauteng Province. To enhance the understanding of these experiences, a comprehensive literature review in Chapter 2 offered an overview of the prevalence, causes, effects and treatment of both disorders respectively and as dual-diagnosis. In Chapter 3 the researcher presents the research findings which will be substantiated with literature and be interpreted from the theoretical framework.

In this chapter the focus will be on the following research objectives: To explore the experiences of participants in terms of the treatment they receive for addiction to stimulant-type drugs; to explore the experiences of participants diagnosed with bipolar disorder and how the diagnosis contributes to stimulant abuse; and to identify the challenges and perceived strengths participants experience in terms of their treatment due to the presence of both bipolar disorder and stimulant addiction.

The chapter will be divided into two sections. In the first section, the research methods and ethical considerations that guided the study will be discussed. Subsequently, the second section will present the biographical information of the participants, as well as the empirical findings of the study. The empirical findings will be divided and discussed under themes and sub-themes.

SECTION 1: RESEARCH METHODS AND ETHICAL CONSIDERATIONS

The research approach, type of research, research design, study population and sampling, data collection and analysis, trustworthiness, pilot study and ethical considerations that guided the study, as well as the challenges and limitations of the study, will be discussed in this section.

3.2 RESEARCH APPROACH

The researcher made use of the qualitative research approach during the study. A qualitative research approach assisted the researcher in understanding social phenomena, by discovering the experiences and the perceived challenges and strengths associated with the dual-diagnosis as experienced by participants (Isaacs, 2014:318). Leedy, Ormrod, Neuman and Salkind (2010:52) state that when different perceptions regarding the same phenomenon exist the qualitative research approach aims to expose the nature of the different perspectives regarding the phenomenon. The qualitative approach rather than a quantitative approach was used as the multiple perceptions and individual needs of participants, as well as the meaning they attribute to their experiences of treatment could be explored in depth (Lietz & Zayas, 2010:190; Nieuwenhuis, 2007a:50).

Challenges associated with qualitative studies is evaluating whether the findings are accurate and to ensure that the researcher's own perceptions do not guide the study (Alasuutari et al., 2008:51; Lietz & Zayas, 2010:191). Regardless of these challenges, the researcher believes a qualitative approach was necessary as there is little known about the phenomenon and the inductive nature of the qualitative approach did not limit information to controllable variables as a quantitative approach would have (Lietz & Zayas, 2010:190).

The study followed an exploratory purpose as the researcher explored the experiences of adults living with stimulant abuse and bipolar disorder with regards to the treatment they received at treatment centres in the Gauteng Province. Qualitative approaches in research are customarily rooted in exploratory research as it allows the researcher to gain insight into the experiences of participants (Fouché & De Vos, 2011:96). In addition to this, the study was descriptive in nature, as it was a concentrated analysis of the phenomenon itself and deeper meanings assigned to it, thus leading to a very detailed description of the experiences shared by participants (Fouché & De Vos, 2011:96).

3.3 TYPES OF RESEARCH

The research study was applied research as the focus of the study fell on aiding practitioners in solving problems faced in practice (Fouché & De Vos, 2011:95). Kumar (2011:10) explains that applied research is used when knowledge gained from research can be applied in different ways to develop policies or elaborate on the understanding of a phenomenon. The problem the researcher focused on was the treatment experiences of adults with a dual-diagnosis, "...which is a term used to describe people with mental illness who also have problems with drugs..." (NAMI, 2013:1). The knowledge gained from the research study gives insight into possible treatment to address the needs of dual-diagnosis patients. Applied research was most effective as it allowed the researcher to add knowledge to an area of practice where very limited information is available as opposed to basic research that would have strengthened existing theories (Fabricius et al., 2007:14; Fouché & De Vos, 2011:95).

3.4 RESEARCH DESIGN

The research design was phenomenological as the researcher aimed to describe the commonalities in the way adults living with a dual-diagnosis experience treatment (Creswell, 2013:76). Wertz (2011:124) asserts that this design aims to "...faithfully conceptualize the processes and structures of mental life, how situations are meaningfully lived through as they are experienced...and investigate *what* is experienced and *how* it is experienced". As the researcher aimed to establish how participants experienced and perceived the treatment they were receiving, as well determine which of these experiences were shared by other participants, this design was deemed most appropriate (Delpont, Fouché & Schurink, 2011:305; Gray, 2014:30).

The current phenomenological study is also rooted in a social constructionist paradigm which is focused on emphasising multiple realities of participants and is subjective rather than objective in nature (Rubin & Babbie, 2016:17). As reality can only be shaped by the experience of actually living through the phenomenon being study, this paradigm was most

appropriate in allowing the researcher to accurately report on the experiences of the participants (Fouché & Schurink, 2011:310).

3.5 RESEARCH POPULATION AND SAMPLING

Rubin and Babbie (2016:372) explain that a research population is a group of individuals that a researcher wants to gain a general understanding about. Sampling methods are used to select a portion of the population that will be used for a research study (Kumar, 2011:193; Nieuwenhuis, 2007b:79). The research population comprised of adults that used stimulants and was diagnosed with bipolar disorder and have been admitted to treatment centres in the Tshwane Metropolitan area of the Gauteng Province. It should be noted that all patients at these treatment centres who were diagnosed with bipolar disorder were included in the study, irrespective of the subtype of the bipolar diagnosis.

During **Phase 1** of the sampling process, the researcher selected a purposive sample focusing on three treatment centres, located in different areas of the metropolitan area in the Gauteng Province, which provided different types of programmes over varying lengths of time. The three treatment centres were selected as they were easily accessible to the researcher and spread across the largest metropolitan municipality in the Gauteng Province, namely Tshwane.

The sampling process consisted of another two phases:

Phase 2 of the sampling process was purposive sampling, as participants were selected because they posed certain attributes which made them "... the holders of the data needed for study" (Nieuwenhuis, 2007b:79). Purposive sampling was most appropriate as it allowed the researcher to identify participants that have certain characteristics and matched the set requirements which allowed the researcher to attain rich data (Strydom & Delpont, 2011:392). Inclusion criteria were given to a social worker at each treatment centre who identified possible participants in the centre. The inclusion criteria set some parameters to determine the population of the study which allowed for a sample that was able to share data related to the phenomenon being studied (Strydom & Delpont, 2011:392). The following inclusion criteria were used for the study:

- Participants had to be 18 years or older.
- Participants had to be addicted to a stimulant drug (CAT, cocaine, Khat or Meth).
- Participants had to have completed the detoxification phase of treatment.
- Participants had to be individuals living with the dual-diagnosis of stimulant addiction and bipolar disorder which was confirmed by a medical practitioner or psychiatrist.
- Participants could be either male or female.
- Participants could be part of any religion and/or ethnic group.
- Participants had to be able to converse in Afrikaans or English.

After possible participants were identified by the social worker the **third phase** of the sampling process was initiated. The social worker in each treatment centre explained the aim and process of the research study to possible participants and participants could then volunteer to participate, a method known as volunteer sampling (Strydom & Delpont, 2011:394). A list of names of the individuals willing to participate in the study was sent to the

researcher by the social worker as individuals in treatment did not have access to modes of communication. The researcher then conducted interviews at the respective treatment centres where participants that have given voluntary informed consent were admitted, at a time determined by the management of the treatment centre. Interviews/data collection was conducted with all individuals that were willing to participate in the study.

Ultimately the study included four participants and although this small sample size fits within the scope of phenomenological research the researcher attempted to attain a larger sample by including more treatment centres in the study. Yet, a larger sample was not available as treatment centres were not willing to participate, a factor that could be credited to fear that the services they provide would have been scrutinised, not understanding that the focus was on the experiences of the service users. Even though the researcher hoped to include a larger research sample, which finally included four participants, Creswell (2013:78) and Gray (2014:30) explain that sample sizes for phenomenological studies are often as small as three participants.

3.6 DATA COLLECTION

The researcher believes that a semi-structured one-on-one interview guided by an interview schedule allowed the researcher to gather detailed data that enabled her to understand the phenomenon. “An interview is a two-way conversation in which the interviewer asks the participant questions to collect data and to learn about the ideas, beliefs, views, opinions and behaviours of the participant” (Nieuwenhuis, 2007b:87). According to Isaacs (2014:320), a semi-structured interview is guided by set questions but the interview can follow any direction which the researcher deems interesting and applicable to the study.

Through semi-structured interviews, the researcher collected rich data seeing that there was enough flexibility to explore the participants’ personal experiences and to clarify what was being shared (Isaacs, 2014:321; Nieuwenhuis, 2007b:87). The use of open-ended questions such as “*How do you experience the treatment you are receiving for stimulant abuse?*” or “*How does the fact that you have both stimulant drug abuse and bipolar disorder influence your recovery?*” were structured adequately to give guidance to focus a participant but allowed enough freedom for the participant to explain the context that shaped his/her answers (Isaacs, 2014:320). The researcher thus made use of an interview schedule (see Appendix A) that focused the interviews. The interview questions were informed by the biopsychosocial perspective, the literature review and the experience the researcher has gained while working as social worker in the field of addiction.

Due to the nature of the data collection method, a large amount of in-depth information was obtained in a short period of time which was an advantage to the researcher (Greeff, 2011:360). Participants could, however, choose not to cooperate or could have given inaccurate information which is some of the disadvantages associated with this form of data collection (Greeff, 2011:360). It was necessary for the researcher to be attentive and explore possible lines of emerging data and to guide participants to stay on track (Nieuwenhuis, 2007b:87). Factors of class, gender and race were also kept in mind to ensure that the participants and researcher were comfortable and data was not influenced negatively (Isaacs, 2014:320).

Greeff (2011:359) and Nieuwenhuis (2007b:89) explain that audio-recording an interview is much more effective than taking notes during an interview, thus the researcher, with the permission of participants, made use of an audio recorder during all of the interviews. All interviews were then transcribed verbatim and formed the basis from which data analysis followed (Isaacs, 2014:321).

3.7 DATA ANALYSIS

Nieuwenhuis (2007b:81) states that data gathering and data analysis in qualitative research are not seen as two separate processes, but is rather seen as a cyclical and ongoing process. Schurink, Fouché and De Vos (2011:397) describe data analysis as a process where the vast amount of data gathered is ordered and structured to give the essence of what was found. Thematic analysis was used for data analysis in this study as the goal of the thematic analysis is not to find universal facts but rather allowed the researcher to develop themes and code data from a unique standpoint (Clarke et al., 2015:223). Even though thematic analysis is not commonly associated with a phenomenological research design, Clarke and Braun (2013:120) explain that in recent years this form of analysis has received recognition along methodologies such as interpretative phenomenological analysis (IPA). Thematic analysis is also not confined to fixed theoretical frameworks and is seen as a basic method which is appropriate for novice researchers and can be utilised with any size of the sample (Clarke & Braun, 2013:120). The researcher was guided by the following phases of thematic analysis:

Phase 1: Familiarisation with data

The researcher familiarised herself with the data by spending time curiously and critically listening to and reading the data after transcripts were completed (Clarke et al., 2015:231). Schurink et al. (2011:409) suggest that a researcher should get a sense of the data as a whole to simplify the process of coding data. The researcher read through the transcripts multiple times and listened to all the audio recordings to become familiar with all the data gathered (Clarke & Braun, 2013:121). The researcher referred back to the research question, theoretical framework, and goal and objectives of the study during this time to remain focused (Isaacs, 2014:321). The researcher assigned a colour to each participant and highlighted all the data that was relevant to the research study before coding was attempted.

Phase 2: Coding

Ultimately the purpose of coding is to minimise the load of raw data into smaller chunks (Schurink et al., 2011:410). Coding is described as the foundation of the research themes and by skipping this process a researcher would struggle to follow phases and would not be able to identify less obvious themes (Clarke et al., 2015:234). Isaacs (2014:321) explains that the coding of data can seem confusing and overwhelming, but as the researcher becomes familiar with the data, codes will 'announce themselves' and some categories might merge or be sub-divided. Clarke et al. (2015:236) hold that there is no fixed process for coding, but they suggest that a researcher should rather code too much to ensure that important data is not skipped over. The researcher started with one transcript and coded data in the margin, as codes were identified the researcher created a master list where

each code was described briefly (Nieuwenhuis, 2007c:105). The researcher read through all the transcripts three times to ensure all applicable data was identified and only added new codes when data did not fit an existing code. All codes were then written, as headings, on portions of cardboard, with short data statements supporting the code listed beneath. Statements extracted from transcripts could be traced back to the transcript of origin through colour coding and page referencing.

Phase 3: Searching for themes

In this phase of data analysis, the researcher identified themes that would enable her to answer the research question (Clarke et al., 2015:236). Themes were developed when the researcher “promoted” certain codes that then became a theme, or a number of codes were clustered together to form a new theme (Clarke et al., 2015:236). The researcher moved the cardboard portions around to discover the best way of combining codes to construct themes and sub-themes that represented the data best (Clarke & Braun, 2013:121).

Phase 4: Reviewing themes

During this phase of data analysis, the researcher went back and forth between the themes and data to determine if all the relevant data has been included and to establish whether the identified themes answer the research question best (Clarke et al., 2015:238). The researcher also re-read the transcripts to ensure all relevant data was identified and included before finalising the themes (Nieuwenhuis, 2007c:110). During this phase, the researcher also discussed the possible themes and sub-themes with her research supervisor to ensure that the themes had a logical flow and answered the research question.

Phase 5: Defining and naming themes

The researcher wrote a short description of each theme which allowed her to capture the essence of each theme, along with its boundaries and scope (Clarke et al., 2015:247; Nieuwenhuis, 2007c:109). The researcher complied with the suggestion of Clarke and Braun (2013:121) that the names of theme should be punchy, concise and catchy while still representing the theme and sub-themes as a whole.

Phase 6: Writing up

Clarke et al. (2015:242) explain that writing the thematic analysis start as soon as the analysis process starts and there are no rules or requirements for this phase. Even though there are no rules or requirement, Isaacs (2014:321) believes that the presentation of data should form a neat package of all the data obtained.

The research findings of this study are presented in themes and sub-themes which are supported by data excerpts from various participants (Clarke et al., 2015:242; Kumar, 2011:278). The researcher also linked the research findings with existing literature to demonstrate how the data validates existing knowledge and to indicate where new understanding was brought (Nieuwenhuis, 2007c:111; Schurink et al., 2011:410).

3.8 TRUSTWORTHINESS IN QUALITATIVE RESEARCH

Trustworthiness is achieved when the researcher is able to substantiate that the methods used to collect, analyse and present data accurately represent the experiences and needs of the participants included in the study (Lietz & Zayas, 2010:191). Auditability, credibility, confirmability and transferability are four components that need to be addressed to ensure the trustworthiness of a qualitative research study (Lietz & Zayas, 2010:191; Morrow, 2005:251; Nieuwenhuis, 2007b:80).

Lietz and Zayas (2010:195) define **auditability** as “...the degree to which research procedures are documented allowing someone outside the project to follow and critique the research process”. Research supervision, field notes, transcripts and journals kept by the researcher on all decisions made and steps taken during the research study are all tools used to promote auditability (Lietz, Langer & Furman, 2006:450). The trustworthiness of data is improved as these tools can be reviewed for bias and reflectivity by individuals that are not involved in the study (Lietz et al., 2006:450; Rubin & Babbie, 2016:634). In order to comply with the principle of auditability, the researcher made use of transcripts, kept a journal of all decisions and steps taken during the research process and consulted with her research supervisor throughout the study.

The **credibility** of a study depends on how accurate the researcher presents the participants experiences by being aware of possible research bias and the influence that the study methods might have on the information given by participants (Lietz & Zayas, 2010:192). The credibility of the study was promoted through the following means:

- 1) The researcher reviewed all themes and sub-themes with her research supervisor (Nieuwenhuis, 2007c:109).
- 2) After themes and sub-themes were identified the researcher met with one of the participants who had the opportunity to review and comment on the themes and sub-themes identified by the researcher, a process known as member or stakeholder checking (Nieuwenhuis, 2007c:114). The member checking process was an encouraging experience for the participant as he was able to identify with all of the themes and sub-themes that were shared. The participant however elaborated on some of the fears that he had in terms of reintegration and suggested that a follow-up study be done on the reintegration of individuals living with a dual-diagnosis.
- 3) Isaacs (2014:319) holds that the trustworthiness of a study can be compromised if a researcher is familiar to the participants, however, as the researcher is not employed by any of the treatment centres the trustworthiness of the study cannot be called into question.

Confirmability is achieved when other researchers or practitioners can confirm the findings of a study, thus limiting subjectivity on the researcher’s part (Lietz & Zayas, 2010:197; Morrow, 2005:252). The researcher believes that confirmability was achieved as the research findings were compared to existing literature and other research findings that supported the findings of the particular study.

Transferability focuses on how applicable the research study is and whether the research findings will contribute to future research, theories or practice (Lietz & Zayas, 2010:195). Transferability can be achieved when a reader can apply the research findings to a similar situation in practice (Morrow, 2005:252). The researcher improved the transferability of the research findings by reporting on the research methods that were used, allowing the possible replication of the study in similar research settings.

3.9 PILOT STUDY

Clarke et al. (2015:228) and Neuman (2011:312) indicate that the purpose of a pilot study in a qualitative research approach is to test the nature of the interview questions and to determine if the responses gained from the questions are sufficient. Pilot studies are conducted with a smaller group than the actual study group, with individuals that possess the same characteristics as the actual participants (Strydom & Delpont, 2011:394).

The researcher conducted a pilot test through two semi-structured one-on-one interviews, guided by the interview schedule, with two participants. The two participants were admitted to the treatment centres included in the study, and the same sampling criteria used to identify participants in the main study were provided to treatment centres to identify individuals for the pilot study. The participants that formed part of the pilot study were not included in the main study.

3.10 ETHICAL CONSIDERATIONS

Strydom (2011:113) explains that “[t]he fact that human beings are the objects of study in the social sciences brings unique ethical problems to the fore which would never be relevant in the pure, clinical laboratory setting of the natural sciences”. Ethics basically refers to the values and principles that guide the research study, which ensure that the research participants do not suffer any harm (Alasuutari et al., 2008:96). The researcher took the following ethical aspects into consideration during the study:

- **Avoidance of harm:** Neuman (2011:146) indicates that harm can be done on a physical, psychological and/or emotional level and measures should be taken to avoid this. Emotional harm is more difficult to identify and thus great care was taken to inform participant beforehand of the effects the study might have on their emotional well-being. When emotional harm was detected during an interview the researcher referred the participant to their designated case manager in the treatment centre.
- **Voluntary participation:** All participants participated on a voluntary basis and could terminate their participation without any negative consequences at any point (Alasuutari et al., 2008:99). The researcher ensured that all participants were aware that they could discontinue participation at any time.
- **Informed consent:** All participants have to be notified of what is expected of them and what potential harm exist (Alasuutari et al., 2008:99). Rubin and Babbie (2016:635) suggest the use of informed consent which is a form that contains accurate information on the focus and consequences of the study which human subjects sign. The researcher compiled a letter of informed consent (see Appendix E)

which contained all the information and ethical considerations related to the study. The researcher also explained that all recordings and personal information will be kept confidential and will be stored in the safe of the Department of Social Work and Criminology at the University of Pretoria for a period of 15 years.

- **Violation of anonymity and confidentiality:** Rubin and Babbie (2016:363) explain that confidentiality refers to the fact that the researcher is able to identify the participant but will not do so publically, whereas anonymity refers to a scenario where a researcher cannot link the identity of a participant to their response. The identity and location of participants will be kept anonymous/ confidential and participants were not in any way forced to disclose information which they did not want to disclose. The researcher made use of pseudonyms in the research study to ensure the anonymity of participants, confidentiality can however not be ensured as the researcher knows the identity of the participants.
- **Debriefing of participants:** Debriefing sessions provide an opportunity for participants to ask questions that they might have and to work through their experience of the research study (Strydom, 2011:122). The researcher debriefed participants after the interview by reflecting on their experience and by answering any questions they had after the interview. After debriefing, only one participant required further counselling and he was referred to the counsellor at the treatment centre.
- **Action and competence of researcher:** Strydom (2011:123) states that researchers should have the necessary skills and supervision expected from them to comply with the ethical standards of their profession and institution. The researcher consulted with a supervisor on a regular basis and ensured that all ethical guidelines were followed throughout the research study. The researcher also completed a research methodology course before the commencement of this study.
- **Publication of findings:** The research findings are presented in this research report and comply with the standards set by the University of Pretoria. The researcher also ensured that plagiarism and misconduct were avoided and data was not misrepresented or manipulated for the study (Strydom, 2011:126). In addition to this, the research findings may be published in an accredited journal or be presented at a conference.

Before the empirical study was implemented, each of the three treatment centres provided written permission for the study to be conducted with clients admitted for treatment at their centre (see Appendices B, C & D). Thereafter the researcher secured ethical approval from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Appendix F).

3.11 CHALLENGES AND LIMITATIONS OF THE STUDY

The following challenges and limitations regarding the study should be noted:

- Transferability of data is limited as the research study was qualitative in nature.
- Transferability of data is limited as the participants were all from one racial group.
- The research study was conducted in private treatment centres, thus data cannot necessarily be generalised to public treatment centres.

- The research study was only conducted with individuals in alcohol and drug treatment centres, whose experiences can differ from individuals admitted to psychiatric treatment centres.
- The research study focused on a dual-diagnosis of stimulant abuse and bipolar disorder and recommendations can therefore differ for other combinations of dual-diagnosis.
- As the study progressed and a limited amount of participants were available, treatment centres from the Ekurhuleni Municipality were included in an attempt to attain a larger research sample. Many of the treatment centres were however not willing to allow the researcher to conduct research within their centres. A factor that could be attributed to the fact that they feared that the services they provide would have been scrutinised, not understanding that the focus was on the experiences of the service users.

In the first section, the researcher discussed all the aspects related to the research process and methods that guided the study. The following section will present the research findings and offer an interpretation of the findings.

SECTION 2: RESEARCH FINDINGS AND DATA INTERPRETATION

In this section, the researcher will give an overview of the biographical information of the participants, followed by the research findings and the interpretation thereof.

3.12 BIOGRAPHIC PROFILE OF PARTICIPANTS

The researcher collected the biographical information of participants during interviews by means of the interview schedule. The biographical information contains the ages, level of education, marital status and other biographical facts of participants which are included in this report to give an overview of some of the characteristics and backgrounds of the population being studied (Nieuwenhuis, 2007c:103). The biographical information of participants is presented in Table 3.1, where after the information of the four participants will be compared to one another and interpreted from the literature.

Table 3.1: Biographical Information of Participants

Gender	Race	Religion	Home language	Highest qualification	Marital status	Number of children	Primary drug of choice	Secondary drug of choice	Amount and frequency of use	Other psychiatric disorders diagnosed *
Male	White	Christian	English	Honours degree	Separated	0	Meth	CAT	1.3g in 1.5 hours	ADHD, anxiety disorder & body dimorphic disorder
Male	White	Not sure	Afrikaans	Grade 12	Single	0	Dagga & CAT	Any except heroin	Whatever is available daily	ADHD
Male	White	None	English	Grade 12	Engaged	0	Meth	CAT	2-3 grams a day	ADHD, anxiety disorder & ODD
Female	White	Christian	Afrikaans	Grade 12	Single	1	Heroin & CAT	None	3-20 grams a day	Eating disorder

*Other psychiatric disorders diagnosed were mentioned during the interviews by chance. As this aspect was not the focus of the study some disorders might not have been mentioned.

As indicated in Table 3.1, all of the participants completed high school, while only one participant achieved a tertiary degree, and a second failed to complete his university degree. In a study conducted with 139 adolescents in a psychiatric hospital in the Western Cape Province of South Africa, Lachman et al. (2012) found that 61% of adolescents diagnosed with a dual-diagnosis dropped out of school, which does not seem to be the case in this study. The finding can, however, be attributed to the fact that other protective factors, such as supportive relationships and a good socio-economic status, were present in the lives of participants and thus these participants completed school, as described from the BPS perspective (Vázquez et al., 2011:325; Routledge, 2005:32).

All of the participants have been admitted to previous drug treatment programmes and three of the participants mentioned admission to psychiatric treatment centres as well. Lachman et al. (2012) reported re-admission rates (to psychiatric treatment) of 41% among South African youth and attributes these high rates to a lack of focus on dual-diagnosis in treatment. The concerns related to repeated re-admission to treatment programmes is shared by Archambeault (2009:108) and Bender and Alloy (2011:384), who explain that re-admission not only increases the financial burden on the individual, their family and society but moreover affects health, treatment and occupational outcomes negatively.

Merikangas and Peters (2010:55) state that bipolar disorder affects men and women equally, but women over represent the population in psychiatric treatment centres. In addition to this NIDA (2010:9), in the USA, reports that in terms of dual-diagnosis men seem to access rehabilitation treatment programmes and women are more inclined to access psychiatric treatment. Fabricius et al. (2007:8) ascribe these differences to the fact that women who have children avoid substance abuse treatment as they fear intervention from social services, and in general, the stigma regarding substance abuse among females is greater. In terms of bipolar disorder women, as opposed to men, experience more severe and more regular depressive cycles and it can thus be assumed that due to depressive symptoms they are more likely to seek help in terms of mental health rather than substance abuse (Taylor, Steiner & Soares, 2009:154). The above findings seem to be supported by the study sample as only one of the four participants was female.

Half of the participants reported that they use stimulants in conjunction with depressants, a practice that has become a trend in recent years according to the UNODC (2016:2). Another finding supported through literature is a report by Grobler (2012:170) who explained that children born from women using medication for bipolar disorder often present with developmental and cognitive defects, as was confirmed by a female participant who has been taking medication for bipolar disorder for several years and disclosed that her child has sensory and other problems.

Other disorders mentioned by participants include ADHD, ODD, eating disorders, anxiety disorders and body dysmorphic disorder. The APA (2013a:247) reports that substance use disorders are often comorbid with body dysmorphic disorder, thus confirming this factor. The presence of eating disorders can be supported by findings by Martin, Woo, Timmins, Collins, Islam, Newton and Goldstein (2016:89) who conducted a study in Canada with a total of 131 adolescents, of which 82 were diagnosed with bipolar disorder and 49 acted as a control group. In the study, it was found that 73% of the individuals diagnosed with bipolar disorder, as opposed to 39% in the control group, resorted to binge eating due to stress (Martin et al.,

2016:91). Martin et al. (2016:93) reviewed other studies focused on the incidence of eating disorders among individuals diagnosed with bipolar disorder and found that 1) eating disorders is more prevalent among individuals diagnosed with bipolar disorder than individuals not diagnosed with bipolar disorder, and 2) that among individuals diagnosed with bipolar disorder, those that have a co-occurring eating disorder have an earlier age of onset of bipolar disorder, and have more ascetic moods. The presence of ODD and ADHD is also identified as some of the most common comorbid disorders with bipolar disorder and are seen as risk factors in the development of both bipolar disorder and substance abuse (Berwaerts, Kurcher & Kusumakar, 2009:189; Merikangas & Peters, 2010:56). The APA (2013a:132) indicates that anxiety disorders, ADHD, conduct disorders and substance abuse are the most common comorbid disorders for individuals diagnosed with bipolar I disorder. Individuals diagnosed with bipolar II disorder are also prone to present with comorbid disorders such as anxiety disorders, substance abuse and eating disorders, although comorbid disorders are not as common as with bipolar I disorder (APA, 2013a:139).

Table 3.2 contains the current ages of the participants, as well as the age they started abusing stimulant drugs and the age at which they were diagnosed with bipolar disorder.

Table 3.2: Current Age, Age of Stimulant Abuse Initiation and Age of Bipolar Disorder Diagnosis (in years)

	Current age	Age when stimulant abuse started	Age when bipolar disorder was diagnosed
PAR01	37	16	28
PAR02	21	19	21
PAR03	24	16	19
PAR04	28	14	25

The average age of onset for Bipolar I and II disorder was determined as 18.2 and 20.3 years, respectively (Colin, 2013:164). Routledge (2005:10) reports that individuals usually start abusing substances between the ages of 14-15 years. Even though the ages of onset are different from that reported in literature it should be taken into account that some participants started misusing other substances at a younger age and all of the participants were diagnosed with other disorders, such as ADHD, before they were diagnosed with bipolar disorder.

Many of the participants were diagnosed with ADHD as children, identified by Miklowitz (2010:37) as a childhood risk factor for bipolar disorder. In Table 3.3 the other risk factors mentioned by Miklowitz (2010:37) will be stated as well as the number of participants that revealed the particular risk factor during data collection:

Table 3.3: Number of Participants Mentioning Childhood Risk Factors

Risk factors identified by Miklowitz (2010:37):	Number of participants that mentioned the risk factor:
Aggressive and moody behaviour as child	4
Concern for parents emotional state	1
Struggling to display empathy	0
Signs of mania (suicide, cutting, ADHD, ODD, depression)	4
Family history of bipolar disorder	3

The reasons for initial substance use mentioned by participants were mostly due to curiosity, availability, peer influence and a means of coping with emotions, reasons that are in line with causes of substance abuse forwarded by authors, such as Fisher and Harrison (2013:56). Motives for the continuation of use are however mostly fixated on creating states of mania in an attempt to cope with feelings of depression or to avoid withdrawal symptoms (Rassool, 2011:36).

The following section will present the qualitative data of the study and will be interpreted from literature and the theoretical framework underpinning the study.

3.13 QUALITATIVE DATA AND INTERPRETATION

The qualitative data will be presented in the form of themes and sub-themes, represented by short, punchy phrases as encouraged by Clarke and Braun (2013:121). The researcher will include verbatim quotations from participants to substantiate and describe every theme and sub-theme. Literature will also be included and linked to the experiences shared by participants, regardless of whether it is contradictory or supportive in nature. The researcher will also interpret the data from the biopsychosocial (BPS) perspective as the theoretical framework guiding the study. An overview of the themes and sub-themes are presented in Figure 3.1 below and will be followed by the first theme.

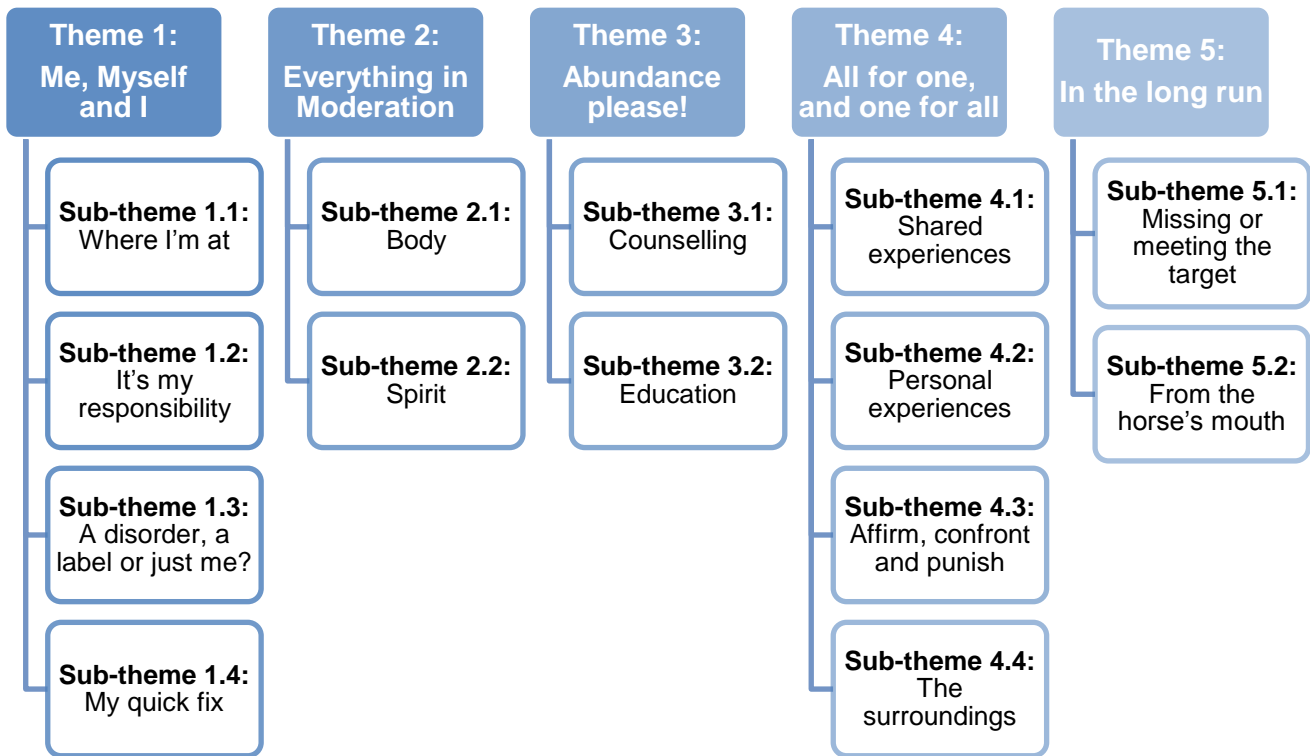


Figure 3.1: Overview of Themes and Sub-Themes of Study

Theme 1: Me, Myself and I

The first theme gives an overview of how participants experienced themselves in relation to the treatment they receive. The four sub-themes underpinning this theme focus on various aspects that shaped these experiences of the participants and comprise of aspects such as emotions, relationships, responsibilities, the opinions of others as well as the coping mechanisms participants revert to while in treatment.

The experiences shared by participants give a broad indication of how these individuals view themselves in relation to the biological, psychological and social aspects that shape their lives. In terms of substance abuse treatment Fisher and Harrison (2013:49) explain that it is important to consider the aspects shaping an individual's life as this cultivates the multivariate nature of the BPS perspective, allowing practitioners to understand the causes of substance abuse, therefore enabling them to implement the most effective treatment strategy. In terms of bipolar disorder, Alloy et al. (2005:1068) urge service providers to reflect on the influence that biological, psychological and social aspects of an individual's life have on the onset, course and treatment of the disorder.

The first theme will reflect on the emotions of the individuals regarding the treatment experience.

Sub-theme 1.1: Where I am at

The aim of this sub-theme is to describe the state of mind and the emotions that participants expressed at the time of data collection. It would appear that even during treatment participants still experienced the same course of emotions as they experienced before treatment. The experiences shared by participants also gave the impression that they felt a loss of control over their emotions as they could not manipulate their moods with substances at any given time.

PAR01: *“Right now I’m not in control of how I feel. And you know, in, some days I just feel like, some days I’m like ‘Ah man I love this place and the people, I’m gonna be with these guys for six months and I’m gonna learn so much and I’m gonna’ you know. And then some days I’m like ‘(sigh) another day’, you know. It’s very inconsistent and it’s very frustrating...”*

PAR02: *“Uhm my mood in, in the space of one day goes like this tsh-tsh-tsh-tsh-tsh (making zigzag with hand), up-and-down, up-and-down, up-and-down. You can’t ask me how did I feel today. Because you’d have to ask me that like every hour “How are you feeling?”, and then I can like tell you ok I’m feeling like this. And every hour it changes you know, kind of thing. But it’s mostly down, like (pause) when I can’t pick myself back up kind of down, you know.”*

PAR04: *“...soos vandag is ‘n af dag, vandag is regtig ‘n af dag, maar gister was weer ‘n heeltemal ander dag, jy weet, net nou kan weer heeltemal ‘n ander emosie wees.” / [“...like today is an off day, today is really an off day, but yesterday was a completely different day, you know, the next moment can be a completely different emotion again.”]*

Even though all of the participants were receiving pharmacological treatment it was still apparent that they experienced an unstable mood, suggesting that pure pharmacological treatment was not sufficient. A statement given by Carroll and Kiluk (2012:340) support this point as they explain that even though pharmacological treatment for dual-diagnosis patients is helpful, it should always be complementary to other methods of treatment. Fisher and Harrison (2013:151) endorse this point when they state that the role of medication in the treatment of substance addiction is mainly to manage withdrawal symptoms and should take place as part of a comprehensive treatment programme.

The following statements indicate that in the case of some of the participants these fluctuating emotions have been present for extended periods of time and it would seem that individuals either became accustomed to these emotions or felt overwhelmed by them.

PAR01: *“You know I’ve always felt the same way. The way I feel now is the same way I felt then, just this insecure, unsafe, like, like, you know like you, you know like small things can set me off, the smallest things can make me so happy and then, but also the other way like make me so down. The drugs helped me to control my moods. Because I knew that if I used this I would feel this and that’s all I needed to do, you know.”*

PAR02: *“Throughout my life, I have felt the way that I’m feeling now. Even before the drugs. Which is sad, thinking about death, lonely, no way out, and then, it’s like I’m so sad all the time, that little bit of time that I’m happy, I’m like super happy and jumping around the house whistling, and making noise and irritating people.”*

PAR04: *“So om dan van die dwelms af te kom en tien jaar se emosies kom weer terug en al die trauma wat daar gebeur het, en dan moet jy dit nog hanteer bo-op*

'bipolar' waar dit net 'skyrocket' en 'out of control' is. Dit is soos 'n water ballon wat bars en al die water skiet net uit en jy probeer net alles weer terug druk en jy kan nie.' / ["So to come off the drugs then and ten year's emotions come back again and all the trauma that happened there, and then you have to handle it on top of bipolar where everything skyrockets and is out of control. It's like a water balloon that bursts and all the water shoots out and you try to push everything back in again but you can't."]

The emotions described by the participants fit the descriptions of bipolar disorder, as both manic and depressive symptoms were mentioned, but as this study is aimed at determining the relationship between bipolar disorder and stimulant abuse the following section reflects on how the emotional state experienced by participants influenced their longing for substances:

PAR01: *"And I think that to some degree there is a dependency on like taking something or another to keep yourself together. Whether it's crystal meth or whether it's um psychiatric medication. You know like it's always like taking one or the other."*

PAR02: *"I need to put something in my system to not commit suicide, you know?"*

PAR03: *"A lot of the times I'm down and it makes me wish that I could get back to drugs to get like that quick fix to get happy and high again..."*

PAR04: *"Uhm ek dink die grootste ding is soos, baie kere raak ek depressief en ek wil net weghardloop en ek wil gaan gebruik." / ["Uhm I think the biggest thing is like, lots of times I become depressed and I want to just run away and I want to go use."]*

The above statements support Rassool's (2011:36) belief that over time substance abuse seems to become less voluntary and rather becomes a way of coping with emotions, and in the context of the above statements it appears as if stimulants were mostly used or considered as a means of coping with emotions of depression. With regards to the treatment of bipolar disorder Miklowitz (2010:23), Swann (2010:277) and Weiss et al. (2007:100) explain that manic episodes are less prevalent than depressive episodes and depressive episodes are more challenging to treat effectively, thus explaining why many of these individuals consider reverting to substances to achieve more manic emotions.

Mood fluctuations and the need to take stimulants in an attempt to control mood can be better understood in light of the BPS perspective. In terms of dual-diagnosis, this sub-theme touches on the interaction between the biological and psychological spheres of an individual's life. Bender and Alloy (2011:385) assert that psychological stressors and chemical stimulation (including stimulant drugs) affect gene expression and over time the reactivity profile of an individual changes and cause long-term susceptibility to stress, therefore less stress is needed to trigger mood relapse which sets forth a cycle of stimulant use and mood relapse. As the participants' susceptibility to stress appeared to have been higher it could explain why they felt easily overwhelmed by emotions and considered stimulants as a means of coping with psychological stressors (Rose & Walters, 2012:10). The reasons leading to the initial use of substances thus seem to impact the biological and psychological spheres of functioning, which offset a continuous cycle of deterioration in both disorders.

As seen in the above statements, most of the participants experienced times when they considered abandoning recovery and reverting back to drug use. Reasons for not leaving

treatment varied but were mostly rooted in the sense of responsibility that participants felt, as discussed in the following sub-theme.

Sub-theme 1.2: It's my responsibility

The reintegration of dual-diagnosis patients into society poses a challenge for families as external role players, including government and medical aid policies, are discouraging long-term treatment and as a result, many patients are discharged prematurely (Rassool et al., 2007:141). Miklowitz (2010:27) suggests that different role players should be involved when treatment and reintegration goals are set for patients, to ensure that too little or too much responsibility is placed on patients, as this can prompt mood relapse. In the following statements it can be perceived that participants experienced a sense of responsibility for the psychological and behavioural aspects of their lives, although it appeared to produce personal affliction:

PAR01: *"I feel, you know, I feel very sad that I am 37 and um I'm back in treatment...and um (silence) it's hard for me to just accept what a mess I made again, you know. Although it's my responsibility like it's just something like I have to deal with you know."*

PAR02: *"...because I believe like my impulsivity and all of these things are like, I don't want to blame it, it's me (swear word). You know like I have to like take responsibility for my behaviour, but (pause) I just wanna be heard, man."*

Miklowitz (2010:27) clarifies that all the psychosocial responsibilities which are relevant to an individual should be taken into account when setting reintegration and treatment goals, however, the amount of time allowed to achieve these goals should be reasonable. Individuals should, therefore, start taking responsibility for a wide variety of aspects and some of these aspects are indicated in the following scenarios described by participants:

PAR03: *"...even the relationship with my parents as well I haven't been able to speak to them or see them... I know it's based on consequences for my actions and getting extras, but uh, I still don't think that uh that's right or necessarily."*

PAR02: *"I've done a lot of things wrong... so um I have, I won't be able to see my parents or have any contact with them for quite some time Uhm because of this. So I can't blame that on the centre."*

PAR01: *"Uhm I think that for my relationship with my parents a long-term programme is the only option I have. So my not being here isn't actually an option..."*

In the first two statements, it is evident that the participants could not have contact with their parents due to behavioural problems. PAR03 did not seem to take full responsibility for his behaviour, whereas PAR02 acknowledged that he could not blame the treatment centre for not seeing his parents. PAR01, on the other hand, saw the completion of his treatment programme as a way of restoring the relationship between himself and his parents and thus took responsibility for restoring this relationship by remaining in treatment. Taking responsibility appeared to be an individual process and could be rooted in different motives, and even though participants thought about their responsibilities it does not seem to be a deliberate or guided process. Miklowitz's (2010:27) recommends that 'taking responsibility' should be a topic of interest during treatment and reintegration, for the reason that, when individuals take on too much responsibility or they take responsibility for the wrong things at

the wrong time it can be detrimental to their recovery. The following statements support Miklowitz's recommendation:

PAR02: *"Uhm, so when I'm in a tranquil environment like, maybe like for instance this place. Where there's no stress, you know, it's save, it's, um there's no ability to relapse, um, then it seems all cool and calm on the surface you know. But (pause) what I don't tell anyone, that like, like um, (pause) I'm ducking. Do you know the term?"*

Researcher: *"No what's ducking?"*

PAR02: *"You know like a duck on the surface of a pond it looks so peaceful and happy, but underneath (paddle with hands), the feet is like going a hundred miles an hour."*

Researcher: *"OK."*

PAR02: *"So inside I'm super sad, I'm destroying myself, I'm depressed, I'm thinking about suicide, but on the outside I'm putting up this face and trying to work the programme, and trying to advance in the programme, you know..."*

With regards to the above statements, it appears as if the participant took responsibility for the completion of his treatment programme, but did not take responsibility for his psychological well-being while completing the programme. Ultimately this could place his recovery from addiction and management of bipolar disorder in jeopardy. When considering the BPS perspective, Engel (1981:102), the founder of this perspective, urge practitioners to ensure that service users take responsibility for their treatment and cooperate with the treatment plan, which includes disclosure of underlying disparities that cause stress. In addition to this Griffiths (2005:192) believes that many definitions of specifically addiction place too little responsibility on the individual dependent on substances. It can thus be said that responsibility is an effect of psychological processes within a person, motivated and influenced by social systems, such as families and counsellors, either intentionally or unintentionally. However, it is interesting to note that participants expressed responsibility in terms of their substance abuse, but not in terms of bipolar disorder. Possible reasons for this observation will be formulated in the subsequent sub-theme.

Sub-theme 1.3: A disorder, a label or just me?

Practitioners involved in the treatment of any dual-diagnosis are urged to make an accurate diagnosis as treatment goals and ultimately treatment outcomes will depend on the diagnosis made (NIDA, 2010). Rassool (2011:220) warns that stimulant drugs mimic symptoms of hypomania which makes an accurate diagnosis of bipolar disorder challenging. The complex relationship is not just evident to practitioners, but to participants as well.

PAR01: *"However I do believe that too many people are diagnosed with bipolar that don't have bipolar because they're diagnosed too soon after they come into recovery. So I think the stimulant, that's what I was saying to you about the false positive about bipolar, you know the stimulants make you like you know, you come off that stuff you become, you're like up and down and if you see a psychiatrist in that state and then it's just like bipolar. I mean ask anybody to answer that questionnaire that they give you and everybody will turn out bipolar, you know."*

PAR03: *"...like a lot of um psychiatrist just label um a lot of drug addicts as bipolar so that's why I'd like to learn more about it, and you can maybe differentiate between the two."*

It is evident that these participants perceived bipolar disorder as a label often associated with individuals using substances. PAR03 mentioned that learning about bipolar disorder

would have allowed a deeper understanding of the differences in the two disorders; a view shared by most participants who believed that knowledge about bipolar disorder would have allowed them to understand themselves better. The following statements indicate that participants did not only have a need for knowledge in terms of bipolar disorder in an attempt to understand themselves better, but the majority of participants appeared to have been uncertain about their diagnosis in general.

PAR02: *“Ja’ because (deep breath) I need to understand what’s going on, you know. Uhm I know I’m not officially diagnosed but (pause), I still feel the way I do so regardless of what, whether or not I’m diagnosed I need to, I, I’m here because I want help. You know, and I’m not getting that.”*

PAR03: *“Well because I have been clean so long like I, I can see that like I do have bad bipolar but um during my drug use that’s like actually when I don’t see it at all. Uhm because I’m not sure if it’s coming down from the drugs or just being on the drugs, or if it’s because of skipping one day of medication or like if it’s my bipolar just acting up. ‘Ja’. And I’d like to know exactly what bipolar is all about, and all the details of bipolar, um all the characteristics, um personality flaws, all of that. ‘Ja’.”*

PAR04: *“Nee ek sal graag wou weet, ek sou graag wou weet soos wat is my ‘diagnosis actually’, en dan leer oor ‘bipolar’.” / [“No I would really like to know, I would really like to know like what my diagnosis actually is, and then to learn about bipolar.”]*

When looking at NIDA’s (2010) call on practitioner to make an accurate diagnosis to ensure that appropriate treatment commence, it can be assumed that if treatment is deemed correct by practitioners it does not matter whether the individual diagnosed understand or agree with their diagnosis, because the precise treatment, according to the practitioner, will still be provided. On the other hand, Miklowitz (2009:577) explains that educating individuals diagnosed with bipolar disorder as well as their family members, on various factors of the disorder, is crucial as this has a direct impact on relapse rates. Education holds a prominent place in substance abuse treatment as well, as authors such as Rassool (2011:94) indicate that families and patients should be educated on various treatment options in terms of substance abuse treatment to ensure that the most appropriate type of treatment is initiated. In light of the above statements, it is evident that treatment is not a set regimen provided by a practitioner, but it is rather a learning process where all parties involved make informed decisions, based on knowledge, throughout the treatment process, to ensure holistic recovery. It can, however, be assumed that if participants felt confused and uninformed regarding their own disorder it is likely that their families also felt confused and uninformed regarding factors related to their relatives’ diagnosis of bipolar disorder.

When this sub-theme is assessed in light of the BPS perspective it is evident that biological, psychological and social factors influenced the cause and solution underlying these experiences. The biological presence and manifestation of both bipolar disorder and stimulant abuse influenced the psychological functioning of participants (Swann, 2010:277; Rethink, 2009:5), however, participants expressed a need to know if and how, and to what extent bipolar disorder influenced their psychological functioning. When psychological stressors are not addressed effectively certain behaviours are triggered in an attempt to manage symptoms of confusion and anxiety (Griffiths, 2005:192). The statement made by PAR02 clearly indicates that when a social system (service provider) empowers a service user with knowledge with regards to their psychological experiences, it is seen as ‘help’.

Individuals, in this case PAR02, are generally motivated to approach a service provider in an attempt to find solutions for problems if the individual is certain that the service provider can offer such solutions (Engel, 1981:102). If participants were to mention their confusion or disbelief in terms of their diagnosis to other social systems, for example, family members, they could have been alarmed and turmoil in the family system could have emerged, reinforcing the decision to seek help (Miklowitz, 2010:28). However, it appears as if mere intervention from a social system (service provider) did not solve the psychological turmoil experienced by participants, as most of them believed that an additional external factor – in this case, education- could have enabled them to cope with psychological stressors more effectively.

When knowledge about self or about dual-diagnosis was limited and treatment felt insufficient individuals seemed to revert to other ways of managing their emotions and past experiences in an attempt to achieve balance or relief. The following section will explain some of the ways in which participants attempted to manage these factors.

Sub-theme 1.4: My quick fix

In sub-theme 1.1 it was presented that when participants experienced emotions of depression or they felt out of control they craved stimulants, which generally acts as a quick fix. In this sub-theme, the researcher will give an account of the other quick fixes participants used in an attempt to manage their emotions while in treatment.

PAR02: *“(Silence) I need something to be happy, all the time. Whether it is drugs, or watching a movie, or, something needs to be there to make me happy...”*

PAR01: *“Uhm psychologically this is tough hey. Like in the other rehabs, you can call your parents, you can, you know, you can get like tuck (tuckshop) every single day kind of thing, you eat chocolate every day so you can like feed some kind of like a, like a need or a lack or whatever, you can fill yourself with, with, with nonsense.”*

PAR02: *“If I’m extremely, extremely depressed and I can’t do anything, I struggle to sweep the floor. Like then I’m, then I’m like at my lowest. Go into the bathroom. Slit. Come out then I’m happy. Healed.”*

Researcher: *“Ok en met hierdie program wat is vir jou regtig die positiewe punte van die program? Soos jou ‘highlights’ die goed waarsonder jy glad nie sal kan lewe nie?” / [“ok and with this program what for you are the positive points of this programme? Like the highlights, the things you can’t live without?”]*

PAR04: *“Hmmm sonder die fisiese goed?” / [“Hmmm without the physical things?”]*

Researcher: *“Wel alles.” / [“Well everything.”]*

PAR04: *“Ok. Die koffie, die sigarette...” / [“Ok. The coffee, the cigarettes...”]*

PAR02: *“...we have three, a, a, a lady that comes in and does exercise, that like physical training with us three times a week. Uhm, and it works, it helps, it’s awesome, but I’d like some more.”*

PAR01: *“...I just wanted to go and lie down and just escape the world, you know.”*

Fisher and Harrison (2013:290) and Rassool (2011:8) state that food, sweets, exercise, caffeine, sex, gambling, nicotine and relationships are all seen as psychologically addictive. Addictive behaviours or substances are often times used by individuals receiving treatment for substance abuse in an attempt to relief psychological stress and is referred to as cross-

addictions (Fisher & Harrison, 2013:40). Martin et al. (2016:93) explain that emotional eating is very common among adolescents and young adults diagnosed with bipolar disorder, validating the participant's expressed need for food. Self-mutilation was another factor mentioned by participants and is a behaviour which is more prevalent among individuals using substances and bipolar disorder respectively (Evren & Evren, 2005:19; Joyce, Light, Rowe, Cloninger & Kennedy, 2010:252). Some of the elements mentioned by participants can also be used to find stability in other areas of life as presented by PAR03:

PAR03: "...tell me how I can handle my situation of missing them instead of resorting to cutting myself and then only getting attention. 'Ja' because I, whenever I try to mention it, it gets blown off and only when I resorted to drastic measures have they paid any attention to it, to any of my problems."

It appears that this participant did not use self-mutilation to relieve psychological stress, but rather used it as a means of ensuring support from social systems, which the participant expected would support him in resolving psychological stressors. There are numerous cross-addictive behaviours that individuals in recovery can use, but these behaviours only suppress psychological discomforts, and some behaviours have their own adverse effects. The importance of effectively addressing cross-addictions is highlighted by authors such as Frye and Perugi (2010:33) who found that for example, nicotine use, a common cross-addiction, not only causes bipolar disorder to be more active but also inhibits the effectiveness of treatment.

When interpreting cross-addictions from the BPS perspective it can be seen that due to stressors experienced on a psychological and social level, participants found comfort through the utilisation of physical or biological elements. Griffiths (2005:192) believes that the only reason why individuals use any type of substance, including food and nicotine, is because some sort of reward is experienced. Services users generally approach service providers with a need which they believe the service provider can address, but when stressors are still present after treatment has been acquired; other means of reward or comfort are used to address the presented need. Engel (1981:102) explains that it is the practitioner's responsibility to search through all spheres of the service user's life and develop a hypothesis that will address the presented needs. It can be assumed that participants experienced that some of their psychological needs were not met in treatment, and thus they reverted to other means of addressing their needs.

At this point it should be mentioned that when some of these cross-addictions are practised in moderation it can be very effective in the treatment of both bipolar disorder and substances abuse, these factors will be presented in the following theme.

Theme 2: Everything in moderation

As mentioned in the previous theme there are various behaviours or products that individuals adopt or use in an attempt to achieve a sense of stability. Most of these behaviours and products can benefit the recovery and overall health of individuals when practised in moderation. Hatala (2012:58) points out that when one aims to improve the health of any individuals, as considered from the BPS perspective, it is imperative to consider the relationship between the biological, psychological, social and cultural aspects influencing the general well-being of that individual. The first sub-theme will focus on

physical health, thus address the biological component of treatment, followed by a sub-theme focused on spiritual health.

Sub-theme 2.1: Body

When considering the physical health of individuals diagnosed with bipolar disorder and who abuses stimulants, there are many authors that express concern for these individuals' physical health. Health problems encompass neurological, cardiovascular and other minor health problems associated with stimulant use and are well researched and reported (Baumann et al., 2012:1192; Nutt, 2012:11; Rassool, 2011:225). The physical health of individuals using substances receives a great deal of attention as the UNODC (2015:36) estimates that the health expenses of substance users are double that of non-using members in society. In addition, Bender and Alloy (2011:384) and Muzina et al. (2009:250) report poor general health and health outcomes among individuals diagnosed with bipolar disorder as well. In agreement with these findings, participants also shared concerns regarding their personal health, not only in terms of the effects that drugs had on their health but also the anticipated effects that bipolar medication might have on their health.

PAR01: *"...and you know I get very like down on the fact that my body isn't functioning the way that it use to..."*

PAR04: *"Uhm ek sukkel maar dit is 'obviously' nog van die uhm heroine en goed soos dit waar ek nou fisiese probleme het en ek raak maklik siek. Maar soos met Suster, sy is baie 'nice' en sy help."/ ["Uhm I struggle but it is obviously still because of the heroine and things like that where I now have physical problems and become sick easily. But like with Sister, she is very nice and she helps."]*

PAR03: *"...I would love to stop taking my medication, like for example there are medications that I am taking, such as (name of medication), which cause severe liver damage and now I have to worry like whether I should choose to live with bipolar without tablets and try, maybe get myself in trouble or uhm live a life with tablets and maybe suffer from uhm chronic diseases. 'Ja'. So 'ja' it's difficult."*

Participants also shared their views on aspects of physical health that forms part of their treatment which they find beneficial or lacking:

PAR04: *"Uhm 'obviously' is daar soos medikasie as ek in pyn is, maar daar's ook 'fitness', ons eet gereeld, uhm jy weet en al daai goed help. Veral omdat ek nou gesond eet uhm en die oefening. Dit help. En jy sit nie net die heel dag rond nie, jy bly besig. So dit help."/ ["Uhm obviously there is like medication when I have pain, but there's fitness as well, we eat often, uhm you know and all those things help. Especially because I eat healthy now uhm and the exercise. It helps. And you don't sit around the whole day, you stay busy. And that helps."]*

PAR02: *"...for example, there is gymming equipment and uhm punching bags, and that's a great release for me of energy you know I, I, that's how I handle emotion basically. Because emotion handles me..."*

PAR03: *"... exercise is good especially when you are having a difficult time, just go exercise and take some frustration out, release some dopamine, you know would be good."*

PAR02: *"...and to learn coping and a healthy lifestyle outside..."*

Miklowitz (2010:41) and Nutt (2012:136) explain that neurotransmitters such as serotonin, dopamine, neurohormone, norepinephrine and gamma-amino butyric acid can be linked to both bipolar disorder and stimulant abuse and thus pharmacotherapy is seen as an important factor in the treatment of both disorders. Physical exercise is also known to impact neurotransmitters and can explain why participants view exercise as a positive factor and regard it as an important part of treatment. Zastrow (2012:359) reports that he always encourages service users to exercise as physiological changes, such as lowered blood pressure and heart rate can be brought on by exercise, it also supplies individuals with enough physical strength to manage stressful situations more effectively and is known to relieve tension. In addition to exercise, a balanced diet, sleep and appropriate medical care also need to be taken into account when emotional well-being is addressed (Zastrow, 2012:359). In terms of bipolar disorder, Bordbar and Faridhosseini (2012:324) and Scott and Tacchi (2010:276) explain that knowledge regarding the importance of lifestyle choices and side effects of medication should be discussed and worked through as part of treatment, which supports PAR02's need for knowledge regarding a healthy lifestyle. The researcher, however, should point out that in the vast amount of resources that was consulted during the study; very view pertinently highlighted the importance of health and lifestyle choices as a part of treatment, especially in terms of substance abuse treatment.

When reviewing the experiences of the participants and the literature findings in terms of the BPS perspective the following conclusions can be made:

- 1) On a biological level substance use caused physical health problems in PAR01 and PAR04, who experienced physical stress due to substance abuse, while PAR03 was concerned about possible future health consequences associated with medication. The effects and anticipated effects mentioned by participants caused psychological discomfort and can cause possible non-adherence to treatment for PAR03. Non-adherence (bio) and psychological discomfort can lead to relapse, as described in sub-theme 1.1, but this can be offset when appropriate psychological intervention is initiated (Scott & Tacchi, 2010:276).
- 2) Physical aspects, such as exercise (bio) appeared to have helped participants cope with emotions (psycho), which is supported by Zastrow (2012:359) who believes that exercise provided physical and emotional strength necessary to cope with various stressors.
- 3) Instead of being forced to be healthy and exercise by an external role player (socio), participants seem to be motivated to live healthy due to the psychological benefits they experienced due to exercise (bio). PAR02 also expressed a need to learn additional coping skills and healthy lifestyle choices which he could apply when he was no longer in treatment. It can be concluded that the physical (bio) need for exercise of participants were based on the psychological benefits it held rather than the influence of external role players (social).

The conclusions drawn above can be supported as stated by Kaplan and Coogan (2005:19) who acknowledge that physical components related to any presenting problem should always be explored, acknowledged and included in a treatment plan.

The following sub-theme will focus on the spiritual aspect of treatment.

Sub-theme2.2: Spirit

Religion is generally a very sensitive subject to discuss; nonetheless, as all three treatment centres are Christian-based it was a point of interest that produced diverse experiences and views. Okunroumu, Allen-Wilson, Davey and Davey (2016:46) describe religion as an organised system which contains certain symbols, rituals, practices and beliefs that aid in the development and improvement of closeness to a god or Higher Power. In this study, only one participant was positive about the inclusion of religion in treatment programmes and another converted to Christianity while in treatment, but still had many questions regarding his faith. The other two participants were not religious; yet, one participant felt religion is necessary, where the other felt religion should be replaced with spirituality in treatment programmes. Spirituality is described as a personal quest in an attempt to understand life, the meaning of life and the relationship with the transcended and sacred, with no focus on one specific god or being (Okunroumu et al., 2016:46).

The following statements give light to some of the concerns regarding religion as part of treatment programmes:

PAR01: *“But that treatment didn’t work because they were so concentrated on praying the gay out of me you know, and I wasn’t yet into psychiatric meds at that stage.”*

PAR02: *“I’m really struggling with this. I’m struggling to like, cause I, I feel the need and I know there is a Greater Power and all of these things but spirituality; they do a good job here. They, they, that’s like 90% of the stuff. That’s why there is lacking in the other things.”*

PAR03: *“...but I believe that you can make your own choices of, uhm what, of what, what goes where, ‘ja’ how to live your life, because that’s basically what a religion is, it’s a book on how to live your life, uhm because I think if we didn’t have that the world would be chaos. ‘Ja’.”*

In these statements, it is evident that some participants believed that religion received too much attention and thus other aspects of treatment lacked. Others saw religion as a mere guideline or a set of rules used to control people’s behaviour. Even though these experiences of religion as part of treatment seemed very negative, the following statements indicate that to some extent the participants experienced a need for this component as part of treatment:

PAR01: *“More time for written work uhm and uhm I think more, more in depth like teaching of the gospel.”*

PAR02: *“...there’s one problem. Is that if you are not religious or you, you don’t want to follow this practice. Then you’re doomed and the centre will do nothing for you. Because even the homework is based on like Christianity and the gospel. And I don’t deny the gospel (pause) but ‘ja’, that, that, that’s the way that I’m gonna get better. It’s the gospel.”*

PAR04: *“Ek was al in baie ‘rehab’s’ en baie van hulle het soortvan gekonsentreer op die geloof, maar nog nooit regtig verduidelik jy weet of regtig moeite daarin gesit nie... dit was nog altyd ‘n deel van my ‘recovery’ en in my lewe wat ek mis, so.” / [“I’ve been in many rehabs and many of them sort of focussed on religion, but never really explained you know, or really put effort into it... it was always a part of my recovery and my life that I missed. So.”]*

The positive effects of religion were expressed by one participant and a need for more education in terms of religion was conveyed by another, however, PAR02 seemed to experience affliction in terms of the inclusion of religion in treatment, but also gave the impression that religion can ensure recovery.

Fisher and Harrison (2013:184) explain that religion is much more prevalent in the treatment of addiction than in the treatment of any other mental health problem, and it plays an immense part in programmes such as AA and NA. In-depth research focused on the positive role that religion plays in the recovery of individuals with any mental illness is however limited, but Laudet, Morgen and White (2006:39) report that religion has been found to facilitate the mental health recovery process.

When considering the influence of religion from a BPS perspective, religion is compartmentalised in one sphere, namely the socio-cultural sphere. Authors such as Laudet et al. (2006:37), however, acknowledge that the inclusion of religion in general life not only leads to better health and a higher quality of life but acts as an aid in managing life stresses on multiple levels as well, indicating that there are both biological and psychological effects associated with religion. Religion and involvement in religious groups and activities were also found to be a protective or supportive role in terms of the initial use of substances and relapse rates after treatment, thus religion acts on a social level as well (Laudet et al., 2006:39). Engel (1981:103) holds that if treatment plans neglect to address all of the aspects of the presenting problem and rather singles out one aspect that needs treatment, it not only disregard other areas in need of intervention but can cause harm to these neglected areas. A statement by Kaplan and Coogan (2005:20) supports this view, as they express that religion, culture, race and sexual orientation is very important factors to consider when developing treatment plans. However, Okunroumu et al. (2016:51) point out that religion is greatly impacted by components such as race, as some racial groupings are more prone to consult churches with regard to mental health problems, before consulting mental health services.

Even though the experiences of participants in terms of religion are diverse, the following theme reflects on aspects where a general consensus was reached and includes areas of treatment where participant experience a great lack of focus.

Theme 3: Abundance Please!

A theme calling for abundance following a theme calling for moderation could seem inconsistent. Yet, all participants indicated the need for more attention to be given to counselling and 'mental health' during treatment.

Sub-theme 3.1: Counselling

Counselling or therapy is one aspect that all participants focused on and is an aspect that had a great influence on their experiences of treatment. In the following statements, it can be seen that their need for counselling was rooted in the fact that they did not feel capable of working through emotions independently.

PAR01: “So I’m very like, people dependant I need to speak about what’s going on with me ... but, you know it’s like I don’t know how to process the hurt that I have inflicted on myself.”

PAR03: “I struggle to uhm handle my own like emotions and things that I’m not in control of and they don’t teach you how to control that in the beginning.”

PAR01: “... it just feels like a very uhm, I feel like I live from one counselling session to the next. So basically I live from Thursday to Thursday, to Thursday, to Thursday, because the time in between is all just I don’t know what.”

PAR02: “‘Ja’, ‘ja’, entirely. I can sit in counselling and openly discuss whatever I need to discuss but I feel the need for a lot more counselling time than I actually get. You know because it’s like I go to counselling and then I’m cool and then you know like I can handle it but then, I, I, I wait until the next week for counselling that like, uh I wait for counselling every week basically.”

The views of these participants are supported by Archambeault (2009:118) who states that the need for an environment where individuals can share their perceptions and experiences about themselves is very important and is a focal point in effective mental health treatment programmes. In terms of substance abuse treatment, this need expressed by participants is also supported by Fisher and Harrison (2013:151) who explain that the most effective treatment programmes include counselling, which can take place individually, in groups, or a combination thereof.

When considering the importance of this experience in terms of treatment it is necessary to reflect on sub-theme 1.1, where participants shared that they craved stimulants when they experienced emotional stress, thus acknowledging the importance of counselling. In relation to this, it is necessary to reflect on Rassool’s (2011:8) belief that with time stimulant drugs become a psychological addiction rather than a physical addiction and thus counselling is strongly recommended in the treatment of stimulant addiction. When reflecting on the preceding statements it is evident that the relationship between bipolar disorder and stimulant drug use is complex and the provision of counselling is a point of interest in the treatment of both disorders.

The following statements indicate that participants were satisfied with counselling, but they experience a need for more counselling to be included in treatment:

PAR01: “You know if there’s more counselling than once a week and if there was group therapy and you know like less workstations.”

PAR02: “You know at least twice a week I want someone to speak to me about my (swear word). So that I can work through it and understand why is the way that I’m feeling, the way that I’m feeling. And why as soon as I walk out of that gate I will pick up a joint, because I feel the way that I feel.”

It is interesting to note that one participant’s treatment programme included more counselling, which was seen as a great benefit, thus supporting the need for more counselling mentioned by PAR01 and PAR02.

PAR04: “Dis baie goed. Soos ek kry ‘counselling’ twee keer ‘n week. Uhm by my ‘case manager’ en dan by iemand anderste van buite af, wat regtig baie, baie help. Die, soos daar’s altyd iemand om mee te praat as jy sukkel. Uhm jy weet hulle sê nie net vir jou ‘deal’ met dit op jou eie nie. Daar soos, daar’s mense.” / [“It’s very good.

Like I get counselling twice a week. Uhm with my case manager and then with someone else from outside. Which really helps a lot, a lot. The, like there's always someone to talk too when you struggle. Uhm you know they don't just tell you to deal with it on your own. So there, they're people.”]

Participants view counselling, which is an intervention focused on the psychosocial level of the participants' functioning, as an aspect of treatment that is the main contributor to their ability to cope on a psychological level. It is interesting to note that this need for counselling is expressed even though all of the participants are receiving medication for bipolar disorder, indicating that treatment focused on the biological level alone is not sufficient. A statement by Kaplan and Coogan (2005:22) supports this finding as they explain that any approach focused on only one aspect of the biopsychosocial needs of an individual is less effective, therefore they encourage service providers to consider all possible social and cultural factors that can influence any area of recovery negatively.

PAR03 indicated that there was a lack of education in terms of managing emotional stress experienced in treatment, highlighting another aspect of treatment mentioned by all participants which will be discussed in the following theme.

Sub-theme 3.2: Education

In this section the researcher will explain a component that all of the participants are longing for - education. The following statements express the participants' experiences in terms of education related to substance abuse:

PAR02: *“Ja’ knowledge of your addiction, and, and, and, and, and to learn coping and a healthy lifestyle outside. You know. Like what they do here is very good, it’s like they, they, they make you do a relapse prevention plan, uhm and all of this but I need to know more. Because I’ve missed out on so much of it, uhm (pause) it, there just needs to be more. I need more stimulation. But that’s just me.”*

PAR02: *“I’d like personally to have a lot more in depth knowledge about my addiction and like uhm the previous centre that I went to we were learning about behaviour styles, assertiveness and all of this uhm, and, and, and how drugs affect that behaviour and whatever...”*

PAR03: *“The drug use and the bipolar. Maybe, because I know they might be similar but I don’t think there, I mean I think there are differences between the two and I would like to differentiate between the two and get to know myself better as well.”*

The participants' expressed a need for education is validated by Marinchak and Morgan (2012:141) who highlight the importance of educating individuals on addiction as a disease. Programmes that focus on drug-specific components, that focus on multiple causes of drug use and that teach coping skills which can replace substance use are found to be most effective (UNODC, 2016:74). The UNODC (2016:74) also suggests that treatment should focus on teaching skills related to different life phases, however, it appears that the participants are more focused on dealing with current emotions rather than learning coping skills guided by or dependent on life phases. The statement made by PAR03 focused on knowledge based on both disorders which the participant believed would have enabled him to distinguish between the two disorders. Numerous authors, such as Lachman et al. (2012) and Salloum et al. (2010:354), acknowledge that symptoms of bipolar disorder and substance abuse become so intertwined that it is difficult to distinguish between the two

disorders, thus supporting the participant's experience. The participants' needs in terms of education focused on bipolar disorder were expressed in the following statements:

PAR02: *"I don't think it is really treated here or even looked at. Uhm we, we get sent to the psychiatrist but uhm... that's basically just to get me on pills it's not actually to help me manage or uh even make me uhm weary of my bipolar disorder. Like I, I haven't gained any knowledge of my bipolar disorder since I've been here, or in any of my other uhm things I've been diagnosed with."*

PAR04: *"...ek's nog nie heeltemal seker nie want ek's nie heeltemal seker wat bipolar heeltemal is nie, of uhm, hoe dit my rerig 'effect' nie. Ek weet nie of ek behandeling daarvoor kry nie." / ["...I'm not sure yet because I'm not completely sure what bipolar is completely, or uhm, how it really affects me. I don't know if I am receiving treatment for it."]*

Researcher: *"Kry jy soos medikasie?" / ["Do you get medication?"]*

PAR04: *"ja, ja ek kry medikasie, ek is al lank op medikasie, van veertien a..." / ["Yes, yes I get medication; I have been on medication for long, since fourteen..."]*

In support of these statements, Bordbar and Faridhosseini (2012:324) explain that patients should have knowledge on bipolar; knowing what triggers mood episodes and the importance of treatment. In addition to this, Miklowitz (2009:577) suggests that emotional, behavioural and cognitive therapies should be followed with individuals diagnosed with bipolar disorder to ensure their adjustment to a life without manic symptoms or the precipitation thereof, and to foster the development of constructive coping skills.

When considering literature focused on education it can sound very daunting and as if it involves hard work. Another concept often associated with education is homework; a concept usually seen in a very negative light. However, participants appeared to have a very positive experience with regard to homework as part of treatment, and found it very beneficial, as expressed in the following statements:

PAR01: *"...and they give you counselling homework and you've got to like do, write that stuff, and I enjoy getting into that stuff you know, and I want to add my utmost..."*

PAR04: *"iets wat regtig vir my soos 'n verandering gemaak het is die huiswerk wat ons hierso kry... dit het heeltemal my perspektief oor alles verander. Uhm op 'n Christelike, emosie, emosionele, jy weet op al daai vlakke het dit, het dit vir my iets verander. En dis iets wat in al die 17 rehabs waar ek al was het ek nog nooit so iets tee gekom nie. En ek dink as ek dit nie hierso gehad het nie dan sou hierdie rehab net soos al die ander gewees het vir my." / ["Something that really for me like, made a difference for me was the homework that we get here... it completely changed my perspective over everything. Uhm on a Christian, emotion, emotional, you know, on all those levels it, it changed something for me. And it's something that in all the 17 rehabs that I've been in something that I've never come across. And I think that if I didn't have that here then this rehab would have been like all the others for me."]*

The positive experiences regarding homework can be attributed to the fact that participants appeared to have gained knowledge about themselves, and their dual-diagnosis through homework. The effectiveness of homework tools is supported by authors such as Miklowitz (2010:142) and Rotgers (2012:114) who indicate that tools help individuals reflect on personal psychological and social stressors, as well as thinking patterns, therefore fostering recovery.

Psycho-education contributes to the psychological level of an individual's functioning and it is provided by a counsellor or social worker which forms part of the social level of functioning (Rassool, 2011:94). Psycho-education as part of treatment might seem redundant and simple, but it can mean the difference between recovery and relapse. Bordbar and Faridhosseini (2012:323) urge health care practitioners to appreciate supplementary services, such as psycho-education, when treating patients and their families. Miklowitz (2009:577) indicates that psycho-education has a direct impact on relapse rates of individuals diagnosed with bipolar disorder as well.

When interpreted from a BPS perspective it can be stated that psycho-education is mainly focused on the psychological level of functioning. When psycho-education is not provided individuals can be ignorant to the effects of physical behaviour, for example, non-adherence to medication, which can lead to mood relapse. Mood relapses are known to trigger relapse in substance abuse according to Rassool (2011:226), all of which negatively impacts the biological, psychological and socio-cultural systems of functioning. Goldberg (2009:232) holds that once substances are used by an individual diagnosed with bipolar disorder, treatment outcomes for both substance use and bipolar disorder decrease, thus indicating that psycho-education impacts much more components within the biopsychosocial functioning of an individual than is assumed at first.

Counselling and education are both 'individualised' experiences and it can appear as if recovery only takes place on an individual level but the following theme explains how treatment for both bipolar disorder and substance abuse is equally dependent on individualised treatment, as well as shared experiences.

Theme 4: All for one, and one for all

The phrase 'all for one, and one for all' can be used to describe the interchangeable relationships that exist between individual units and groups in two ways. Firstly, this phrase can be used to encourage unity and solidarity as it states that a group can and will support an individual within the group if the individual supports the group. Secondly, it indicates that when there is a group of individuals working towards one goal and the goal is reached, it will benefit all the members on an individual level as well. The four sub-themes underlying this theme will explain how recovery is experienced by an individual as a single unit and as part of a group, as well as how the context surrounding these aspects influences the participants' individual experiences of treatment.

Sub-theme 4.1: Shared experiences

Group therapy is a common practice in the treatment of both psychiatric disorders and substance abuse and creates a platform where individual experiences can be shared to achieve the individual and common goal of recovery (Laudet et al., 2006:40). Miklowitz (2010:300) explains that mental health practitioners would often refer patients to NA or AA groups before addressing psychiatric disorders, however, Rethink (2009:6) and Miklowitz (2010:300) suggest that individuals should attend groups that focus on their specific dual-diagnosis, where both disorders are addressed simultaneously.

NA and AA groups were developed to provide an environment where individuals can share experiences that would allow attendees to gain hope and to stay aware of how far they have come (Laudet et al., 2006:40). The following statements indicate how participants believed other people influenced their individual road to recovery:

PAR01: *“And I do like uhm feel that in the group therapy uhm you’re able to be so much more honest, like so honest...but sometimes it’s just in group therapy sessions; that are so deep, it’s just like you process so much there and you just connect with the other people and you connect with their problems and you’re like ‘oh my goodness I can relate to that’ like you know. It’s not just you; or it’s not just me, or, whereas here it feels like very isolated.”*

PAR03: *“I think we should have, we should invite people from the outside to join our groups or we should travel to the outside groups, which are already set out there and hear stories from different people. So they can also share their experiences uhm with us and their strengths and ‘ja’, what got them through it.”*

PAR04: *“Ek dink, die mense wat hier is, en veral die ouens wat hier werk wat al lank skoon is, en om te sien hoe hulle lewe en hoe hulle lewens reg gekom het. Dit wys net daar is hoop.” / [“I think, the people that are here, and especially the guys that work here that have been clean for long, and to see how they live and how their lives are coming right. It shows that there is hope.”]*

It is evident from the statements above that other individuals in a way validates and normalises the participants’ experiences of recovery, which is of the functions that treatment group play (Toseland & Rivas, 2009:16). Additional benefits of group work mentioned by Toseland and Rivas (2009:17) include the selection of role models, establishing hope and learning from others, which are aspects mentioned by participants as well.

When considering this sub-theme from the BPS perspective it can be stated that when participants share their experiences with other individuals in treatment, as well as with individuals that have completed treatment (socio) it not only provides hope for recovery, but they gain knowledge from these experiences as well (psycho). Support groups are also known to help individuals develop supporting relationships (socio) which further motivates individuals to maintain their recovery on a physical level (bio) (Fisher & Harrison, 2013:180). It is, however, important to add that everyone will not derive the same benefits from groups, therefore treatment should include different interventions and the needs of individuals should be taken into account and guide treatment (Toseland & Rivas, 2009:18; Fisher & Harrison, 2013:151). The consideration of the individual needs of participants is encompassed in the next sub-theme.

Sub-theme 4.2: Personal experiences

Although participants derive benefits from shared experiences, they still expressed a need to be treated as individuals, without having their experiences generalised, as indicated by the following statements:

PAR03: *“Yes ok what I, what I mean is that I want it to be more personal and help, it help, they must help guide you through that certain situation and not just generalise uhm your recovery or, uhm, or what you’re doing wrong because they tend to generalise it and put it in a group instead of helping you through specific problems, like for example I am struggling with not seeing my family and they would generalise*

it and say; ok but you're on extras like everyone else gets extras that can't see their family, instead of helping me through my specific problem."

PAR02: *"Ja' heard exactly (pointing to cuts on arms) that is what this was all about. They were like "ok we get your message now", you know kind of thing. And for me, it wasn't even like that. I don't know I just knew that after I do this then I feel better. You know and for them, it was like a communication thing, they were like "awe, no we understand the way you feel, if you have issues" and I was like ok well that's one way of looking at it. I was just doing it because it makes me feel better. Point."*

The above statements indicate a need for individualisation of treatment, not only with regards to the emotional challenges that participants face but with regards to the treatment of substance abuse, as well. The need for individualisation in term of substance abuse treatment is addressed by authors such as Rassool (2011:278) and Fisher and Harrison (2013:151) who point out that effective treatment programmes are those that change according to the needs of individuals. Kaplan and Coogan (2005:19) indicate that psychological and developmental processes such self-efficacy and self-image, which are unique to each individual, should be respected, as such components are affected when an individual is forced to adapt to a debilitating disorder such as a dual-diagnosis.

The idea that individuals should receive treatment based on their individual needs, determined by the biological, psychological, social and cultural aspects contributing to the cause and solution of their disorders is the very essence of the BPS perspective (Hatala, 2012:51; Engel, 1981:103). Fisher and Harrison (2013:49) suggest that service providers should adapt to the multivariate nature of substance abuse and assess all the needs of an individual and draw up multiple hypotheses, as this will not force the service user to fit into fixed criteria or a set programme. In terms of bipolar disorder, Merikangas and Peters (2010:56) explain there are many factors that can contribute to mood relapses and thus specific skills and process need to be developed and set in place to enable an individual to cope with any stressors on all levels of functioning.

In the next sub-theme, the focus shifts to how participants experience the relationship between the staff members providing treatment and themselves as individuals receiving treatment.

Sub-theme 4.3: Affirmation, confrontation and not punishment

Shared experiences mainly focus on the interactions between individuals in recovery, but there is another relationship that greatly influences the treatment experience of individuals, and that is the therapeutic or helping relationship. When the therapeutic relationships, was considered it was clear that aspects of affirmation, confrontation and punishment had a great impact on how the relationship was experienced.

PAR01: *"You know I'm very like people dependant I need to speak about what's going on with me I need to speak and I need to get affirmation and I need to get, and I seek that stuff..."*

PAR04: *"So ek dink hulle kan bietjie meer 'encouraging' wees, nie in die kantoor self waar die 'therapy' gebeur nie maar aan die buite kant waar ons werk en ons daaglikse dinge doen." / ["So I think they can be a bit more encouraging, not in the office itself where therapy happens but on the outside where we work and we do things daily."]*

In terms of confirmation, affirmation and encouragement Fisher and Harrison (2013:151) mention the use of incentives to motivate for and reward changes in behaviour or the refinement of skills, thus supporting the experience of participants. The opposite of confirmation can be identified as confrontation, and seeing as participants long for confirmation it is naturally assumed that confrontation will not be a need. The following statements, however, indicate that participants expressed a need for confrontation as part of treatment, an aspect which is actually included in traditional substance abuse treatment (Marinchak & Morgan, 2012:141).

PAR03: *“Uhm, I like the counselling, I just think there should be more of that. Uhm also (clears throat) the, uhm, what we call uhm confrontation group, where we call people out on their bad behaviour, their addictive behaviour.”*

PAR01: *“Well there are two counsellors, one on either side of the group uhm then there’s the, the, the you know patients who all sit around in a circle and they will call you on your stuff, the counsellors, but it’s the counsellors who are calling you on your stuff. You know.”*

Researcher: *“Not the other people?”*

PAR01: *“And other people also get the opportunity to do it, uhm but it’s not like, it’s not done in a way to humiliate you or to, you know, it’s done in a way to constructively and therapeutically like get you to see the nature of your ways. And you know I’m not aware of the gravity of my situation at the moment. I’m in so much denial that I can’t actually even like tell you like what a mess my life is in, do you know what I mean. Uhm and uhm and that concern me.”*

Toseland and Rivas (2009:16) consider groups to be a great tool in terms of discussing problems and concerns, and to receive feedback on behaviours and thoughts, which is often rooted in the skill of confrontation. Fisher and Harrison (2013:163) however warn that when this skill is used inappropriately it can influence the long-term recovery of individuals negatively. Due to the possible negative effects of confrontation, it is an aspect which is approached very cautiously in therapeutic relationships, but the participants of this study hold that confrontation is not only positive but also necessary during treatment. Toseland and Rivas (2009:116) shed light on positive aspects of confrontation and explain that it can be a very effective tool in enabling members to become aware of certain thoughts and behaviours where change is needed, especially when individuals are resistant and lack motivation. The next statements show that even though confrontation is seen as a positive experience, punishment appears to have the opposite effect:

PAR02: *“It’s like uhm. I just want to be heard. I just want to be understood. The way I feel. You know. Not just shunned for my behaviour...”*

PAR03: *“Yes that as well, but also help me with my cutting, helping me realise what my problem is, why I do it, help me through it, maybe uhm, I don’t know like, counselling in some way to get over it... instead of getting punished for it without understanding why.”*

PAR01: *“But other than that it’s like this is a need to know based treatment centre. And uhm I’m a little scared to ask why because I’m scared I’m going to get into trouble.”*

The fear of getting into trouble influenced participants negatively and made them reluctant, to be honest, and to ask questions. Rassool (2011:4) and the UNODC (2016:73) express concern with regards to this factors as they found that substance abusers are reluctant to access available service due to the behaviour and attitudes of the staff providing treatment.

In terms of bipolar disorder, the fear of stigma from friends, family and the community is an additional aspect discouraging individuals to access treatment (Miklowitz, 2010:45; Okunroumu et al., 2016:46).

When reviewing confirmation, confrontation and punishment from of the BPS perspective it can be stated that these three factors are mainly portrayed or displayed by social systems, for example, family, community and service providers; and cause discomfort or motivation on a psychological level. As mentioned in the section on confrontation it is prominent that the use of this skill does indeed produce motivation (psycho) for behavioural change (bio) which is received well by participants. Even though confrontation motivates change, participants experience a need for confirmation as an additional means of motivation. In support of this finding Bender and Alloy (2011:193) explain that the biological functioning of individuals diagnosed with bipolar disorder are found to be physically different and thus they are much more sensitive to the experiences of punishment, failure and rewards (psycho). Service providers and family members (socio) should be made aware of these factors and treatment should be altered to avoid relapse in mood (psycho) and substance use (bio).

As stimulants are seen to be more psychologically addictive rather than physically addictive, it gives insight into why participants experience a need in terms of the psychological aspects of treatment (Rassool, 2011:8). The next sub-theme explains how the physical environment in which treatment takes place influences the participants' treatment experiences.

Sub-theme 4.4: The surroundings

The environment in which treatment takes place appears to make a difference to some participants, while others believe it makes no difference to their recovery. The following statements present the different views of participants regarding treatment environment:

PAR04: *“Die feit dat die omgewing baie rustig is, in ‘n ‘sense’, dit help baie. Want as daar te veel goed om my aangaan en daar’s te veel ‘chaos’ of stres dan ‘freak’ ek gewoonlik uit. Dan of ‘escalate’ my emosies of ek ‘withdraw’ en ek klim in my gat in.” / [“The fact that the environment is very relaxed, in a sense, that helps a lot. Because if there are too many things that go on around me and there’s too much chaos or stress then I usually freak out. Then either my emotions escalate or I withdraw and I climb in my hole.”]*

PAR02: *“Pressure makes me crack. And stress makes me crack I, it’s (pause) you know like my head just starts spinning and it’s ‘oef’. I don’t like it. Uhm, so when I’m in a tranquil environment like, maybe like for instance this place. Where there’s no stress, you know, it’s safe, it’s, uhm there’s no ability to relapse.”*

PAR01: *“No, external environment doesn’t really matter. Where you go you take yourself with you. You know and that is a 100% true. So you know like there’s nothing that’s uhm, there’s no place I can go to, to hide from myself basically.”*

The statements above give the impression that the actual physical environment in which treatment takes place does not matter as much as the psychosocial environment created within a treatment centre. The psychosocial culture created in the treatment environment was deemed positive or negative based on the emotions it triggered within participants. For example, PAR04 experienced stress when the environment felt chaotic, and PAR02 experienced chaotic thinking and emotions which was relaxed by a tranquil stress-free

environment. The following statements describe how participants experienced the environment in which they received treatment:

PAR01: *“Uhhh (sigh) ‘jaaa’ I do but I just find everyone here so disorganised you know. One week it’s this, one week it’s that, I don’t know how I don’t know what’s going on. I never know what’s happening, you know.”*

PAR04: *“Nee, daar, op die oomblik, kyk ek is nou al sewe maande in rehab, uhm, vyf maande hier, so die struktuur is, die roetine is fine maar om dit vir vyf maande aaneenlopend te doen, dieselfde goed raak bietjie erg vir my. En ek weet hulle sê ‘n mens het dit nodig want dit is hoe dit in die buite wêreld gaan wees, maar hierso is dit verskriklik ‘predictable’, dis. Jy weet wanneer jy gaan rook, jy weet wanneer jy gaan koffie drink, jy weet, so, Uh, ja dit frustrer my baie.” / [“No, there, at this moment, look I’ve been in rehab for seven months now, uhm, five months here, so the structure is, the routine is fine but to do this for five months continuously, the same things become a bit bad for me. And I know they say a person needs that because that is how it’s going to be in the outside world but here it’s very predictable, it’s. You know when you’re going to smoke, you know when you’re going to drink coffee, you know, so. Uh, so yes it frustrates me a lot.”]*

PAR02: *“Like I said, ‘ja’, ‘ja’, stress and pressure like, but that’s the problem cause it’s everywhere.”*

Researcher: *“Ok and for your bipolar?”*

PAR02: *“Same thing.”*

Researcher: *“Ok same thing, just stress and pressure?”*

PAR02: *“‘Ja’ stress, pressure and like emotional, emotional like uhm, (pause) instability.”*

Researcher: *“Ok and what causes emotional instability for you?”*

PAR02: *“Conflict. There’s a lot of things, but among them conflict. Conflict with people because uhm (pause) ‘ja’ mainly conflict with people.”*

From the above statements, it is evident that most of the participants described the psychosocial environment they experienced and not the actual physical environment. Environments that conjured feelings of relaxation and tranquillity appeared too dependent on structure and order, rather than a strict and predictable routine. In support of these experiences, Bender and Alloy (2011:393) express that individuals diagnosed with bipolar disorder could easily relapse due to their emotional environment, especially when they feel out of control or feel that chances of failure are great. As additional support to the experience of participants, authors found that the negative experiences linked to stressful and chaotic environments cause unstable mood in individuals diagnosed with bipolar disorder and triggers relapse in both substance use and bipolar disorder (Alloy et al., 2005:1046; Laudet et al., 2006:35).

When this component is reviewed in relation to the BPS perspective it is evident that the physical environment (bio) in which participants function does not influence the experiences of participants as much as the psychosocial aspects of the environment. Conflict with others (social) and unforeseen changes in programme structure (socio-cultural) triggers emotions of frustration and anxiety (psychological), triggering cravings for substances (bio) that individuals believe can stabilise moods (psycho).

Stress, as expressed by PAR02, is one component that Laudet et al. (2006:34) and Miklowitz (2009:577) believe should be addressed as a completely separate component and cannot be excluded from treatment plans. Bender and Alloy (2011:392) support the importance of addressing stress, as the relationship between a young age of onset of bipolar

disorder and stress is prominent. In addition to a younger age of onset, a neurodevelopmental implication which affects decision-making and the regulation of emotions was also linked to stress (Bender & Alloy, 2011:392). It can be said that the behaviours of others (socio-cultural) can cause psychological factors such as stress, conflict and depression, which impacts certain biological processes, making it more challenging to cope with psychological factors, which could, in turn, motivate the use of substances as a way of managing emotions related to psychological stressors (sub-theme 1.1).

The factors discussed in this theme focused on aspects influencing the experiences of participants while in treatment, the following theme will describe the factors influencing the long-term recovery of participants.

Theme 5: In the long run

Recovery is not limited to a particular programme or to the time that individuals are admitted to a treatment centre, but is rather a lifelong process (Fisher & Harrison, 2013:151). The UNODC (2015:34) reports that the most effective substance abuse treatment has been proven to be ongoing treatment that is not only focused on various social and psychological aspects of an individual's life but is integrated into the individual's community as well. To ensure the long-term recovery of any individual, Laudet et al. (2006:49) suggest that treatment should be reviewed and changed in accordance to 1) how accessible resources are and 2) how the needs of the individual in recovery change. In the first sub-theme, the researcher will discuss some of the factors that participants' experienced as detrimental to their long-term recovery, and in the second sub-theme suggested programme changes will be discussed.

Sub-theme 5.1: Missing or meeting the target

As discussed in sub-theme 4.2 treatment programmes should be changed according to the needs of the individual in treatment (Rassool, 2011:278). The goals that individuals want to achieve and the goals set by the individual's family and treatment providers need to be aligned as far possible to ensure treatment success. Fisher and Harrison (2013:151) explain that treatment programmes that take the individual needs of service users into account are found to be more successful; however, this is not limited to the time spent as an inpatient but needs to focus on their needs and goals in terms of individuals' re-integration as well. The following statements shed light on how participants experience opposing goals in terms of treatment and long-term recovery:

PAR01: *"...I don't know, sometimes I question whether I'm in the right place. You know uhm because my focus is now so much on finding God that I'm actually forgetting whether or not I do want to stop using drugs, like you know it's like, kind of like that happens."*

PAR02: *"...I believe I might even be in the wrong place because I believe that (pause) if my bipolar is sorted then the need for drugs will be gone... So uhm, I may be wrong but I think that (scratching head vigorously) the dru, the drug addiction is definitely an aspect but for me, what's more important is my bipolar."*

PAR01: *"And I said to her specifically like I don't, I only take weight neutral medication I won't take anything that will make me pick up weight because I've got very bad body dimorphic disorder... And I said to her if I gain weight I'm going to, I'll*

re, it's a trigger for me you know; when I used meth I was so lean it was the most beautiful feeling."

PAR03: *"...but uh 'ja' they have more addressed the issue of the substance abuse than the bipolar. No matter if, even if I come to them with my emotional problems they rather just address religion and substance abuse."*

The above statements indicate that participants believed that their goals and the goals of treatment providers were different with regards to different areas of treatment. Factors such as religion, treatment focused on the wrong disorder and dissatisfaction with medication were the main factors associated with opposing treatment goals. It can be seen that these experiences caused participants to question whether they were in the right place and whether the correct disorder was being addressed. The experiences mentioned by participants are acknowledged by authors such as Miklowitz (2010:577), who urge practitioners to involve individuals in the process of choosing medication, as this could promote adherence, not only in terms of medication but to treatment in general. The effects of medication are limited, and adherence to psychosocial aspects of treatment, for example, skills development and family therapy, is also important and can promote life satisfaction, quality of life and long-term recovery (Miklowitz, 2010:27). Fisher and Harrison (2013:151) explain that the same is true in terms of substance abuse treatment confirming the importance of shared treatment goals.

Some participants believed that if they received adequate treatment for bipolar disorder, the treatment of substance use would have been easier or even unnecessary for some. Authors such as Rassool (2011:278) and Camacho et al. (2010:190) state that effective treatment programmes need to treat psychiatric disorders and substance abuse concurrently to ensure effective rehabilitation in both disorders. The suggestion that both disorders should be treated simultaneously supports the experiences of participants, as a lack of focus on their bipolar disorder is a great concern. Miklowitz (2010:301) explains that one of the main reasons why individuals should attend dual-diagnosis groups focussing on specifically bipolar disorder and stimulant addiction is to ensure that there are no opposing goals. For example, if a NA group discourage the use of any medication and a bipolar disorder support group is not aware of behaviours indicating substance abuse, relapse in both disorders can be overlooked, supporting the needs of participants further. Even though all of the participants in the study received medication for bipolar disorder at the time of data collection, they all declared that they experienced a lack of focus on treatment of bipolar disorder, mostly in terms of knowledge regarding the disorder, and with regards to learning skills to cope with emotions.

When viewed from a BPS perspective it can be said that the issue of goal setting was influenced by factors contained in all spheres of functioning, and whether these effects were addressed effectively or not, would trigger either positive or negative effect in all of the other spheres. For example, goal setting takes place on a psychological level and is then shared with service providers and family members within the social level. When goals are achieved or failed it has a great impact on the mood of the individual (psycho) (Bender & Alloy, 2011:193). The moods triggered by either the achievement or failure of achievement of the set goals can trigger a need for stimulants or not (bio) (see sub-theme 1.1). Even though the failure to achieve goals can be ascribed to numerous factors, setting unrealistic goals and a

lack of support from social systems the most prominent reasons for failure according to Miklowitz (2010:27).

In the following sub-theme, some of the recommendations made by participants in terms of improving their treatment experience will be discussed.

Sub-theme 5.2: From the horse's mouth

In this sub-theme, three categories will be addressed. In the first two categories, the challenges and perceived strengths that participants experienced in terms of their treatment, due to the presence of both bipolar disorder and stimulant addiction will be discussed. The third category will focus on aspects that participants believe would have improved their treatment experience.

- The good

The perceived strengths associated with the presence of both bipolar disorder and stimulant use, and the influence this had on the participants' treatment experiences were described as follows:

PAR01: *"...I think maybe a person with bipolar that has no drug abuse history maybe it's more difficult for them because I mean I do think that the cases of people who are just bipolar, and especially with bipolar hypomania uhm you know they, they struggle a lot more than I do because I was actually creating states of mania, because I wanted to be in that space, you know."*

PAR04: *"(Stilte) Ek dink met die regte behandeling, want kyk ons almal sukkel maar met emosies as jy van die dwelms af kom, en ons, ek weet ek het, baie mense gebruik dwelms om emosies te 'suppress'. So met 'bipolar' behandeling leer jy dalk meer hoe om emosies te hanteer; waar 'n ander persoon wat dit nie kry nie kan dalk nog sukkel met basiese emosies waar ons meer 'tools' kry om die emosies te hanteer." / ["(Silence) I think with the correct treatment because look we all struggle with emotions when you go off the drugs, and we, I know I did, many people use drugs to suppress emotions. So with the bipolar treatment, you maybe learn more how to handle emotions; where a person that didn't get it can maybe still struggle with basic emotions where we get more tools to deal with the emotions."]*

PAR02: *"Any benefits? (laughing) What are you asking me to like look for a needle in a haystack here? Uhm (silence) the only thing that I can come up with is to help other people that are in the same space as me, with bipolar and an addiction."*

The participants shared thought-provoking perspectives in terms of the perceived strengths due to their dual-diagnosis with regard to the treatment they received for stimulant use. PAR01 believed that because he created his own manic episodes through the use of substances his experience of treatment was much easier than it would have been for someone that has hypomanic symptoms due to bipolar disorder alone. In support of this finding Miklowitz (2010:30) explains that family members of persons diagnosed with bipolar disorder find it very difficult to manage manic behaviours, and when these behaviours cannot be 'solved' by simply halting substance use these challenges are prolonged. PAR04 did not believe that the actual dual-diagnosis made her treatment experience more positive, but she rather believed that because both bipolar disorder and stimulant use were present, she received more skills in terms of coping with emotions, as opposed to other patients that only received coping skills focused on one disorder. The UNODC (2015:23) and Rethink (2009:6) support this view and deems the acquiring of coping skills as a positive factor in terms of the

treatment of both bipolar disorder and substance use, as individual and dually diagnosed disorders. PAR02 did not see the presence of a dual-diagnosis as a benefit while he was in treatment, but rather saw treatment as a process that would enable him to support others that have the same dual-diagnosis. Even though the participant was not confident that this is possible, programmes such as NA, AA and similar support groups are based on the principle of giving back knowledge (Laudet et al., 2006:40). The principle of shared experience is a means of giving hope in the ‘treatment’ of various disorders such as bipolar disorder is also acknowledged by Toseland and Rivas (2009:16). Even though participants identified strengths in terms of their treatment due to their dual-diagnosis, these strengths were based on the anticipation of effective or successful treatment outcomes and not on their current reality.

When this factor is interpreted from the BPS perspective, it can be concluded that the presence of the dual-diagnosis on a biological level did not seem to influence the treatment experience of the participants negatively, as they found meaning for their dual-diagnosis in other psychological and social factors, such as the development of coping skills (psycho) and the possibility of sharing their knowledge with others (social). Rose and Walters (2012:15) explain that in terms of treatment, factors contained in the social dimension of an individual’s life can often aid as motivation for change. Individuals also experience treatment more positively when social factors are seen in a positive light, for example when family members are included in therapy and relationships are repaired individuals are motivated to sustain their recovery (Marinchak & Morgan, 2012:237). In terms of substance abuse the inclusion of and participation in social structures such as support groups, play an important role in recovery and influences the physical and psychological recovery of individuals, as they find meaning in these social structures (Laudet et al., 2006:40).

The following section indicates the challenges that participants experienced in terms of treatment due to the presence of the dual-diagnosis:

- The bad

The statement below indicates that the participant experienced treatment to be more challenging due to the presence of the dual-diagnosis; a finding which is supported by numerous authors (Salloum et al., 2010:354).

PAR03: *“I think it is more difficult, uhm I think with bipolar I’m more dependent on drugs, uhm like, cause I’ve been uh treated a few times for my drug abuse and I have relapsed a few times. Uh ‘ja’ I definitely think it’s harder with bipolar than without bipolar to overcome drugs.”*

The experience of continued relapse due to ineffective treatment is supported by Rassool (2011:226) who opines that when bipolar disorder or stimulant abuse is treated separately, the reoccurrence of mood episodes, or the use of stimulants, can trigger relapse in both disorders, thus leading to readmission. Swann (2010:276) and Tiet and Mausbach (2007:514) acknowledge that there is a general lack of information on stimulant abuse, bipolar disorder dual-diagnosis, which poses a challenge to the researcher to link literature to the experiences shared by the participant in this regard.

- The change

In this category, some of the needs experienced by participants in terms of the treatment they received for their dual-diagnosis will be discussed. The experienced needs will be discussed as possible changes recommendations in treatment programmes and each suggested change will be discussed individually.

PAR03: *“I think they should have more groups which we focus on uhm defeating the, the, the drug dependency and also whatever illnesses go along with that and not only just mainly focus on religion.”*

Researcher: *“Ok, and illnesses, what illnesses?”*

PAR03: *“Uh, like psychiatric illnesses.”*

The above statement reflects on the participant’s need for a dual-diagnosis group, which is a need that is supported by authors such as Fisher and Harrison (2013:151), Fabricius et al. (2007:4) and Rassool (2011:218), who report that when both disorders are treated simultaneously the chances for recovery in both are much higher. In support of this view Swann (2010:282) considers that instead of focusing on substance abuse in general, treatment should focus on stimulant abuse in the context of bipolar disorder to ensure the efficacy of treatment.

In the following statement, a participant explains how treatment programmes should include the involvement and education of family members with regards to the treatment of their dual-diagnosis, a point supported by authors who explain that families play a major role in the maintenance of substance abuse (Routledge, 2005:29). Marinchak and Morgan (2012:238) also validate the importance of this point as they believe that the recovery rate for individuals that abuse substances are much higher when family members are actively involved in the treatment process. In terms of bipolar disorder, family involvement is just as important and Archangeault (2009:116) explains that it is not just to the benefit of the participant but it will benefit the other family members as well.

PAR03: *“Oh, I think they should uh maybe be coached on how to handle a person when they are having a, like a, an episode, like when there is an up or down episode where, and also, uhm that’s the bipolar side. And then with the when it comes to the, with the, with the drug abuse I think uhm our close, the people that are close to us, uhm should also get taught on uhm how to handle cravings, uhm, how to handle uhm us as, as addicts, (clears throat) when, because we are manipulative as well and they should be able to see past that. And uh, also have uhm more uhm control over us uhm until we have proved ourselves worthy.”*

Positive reinforcement is often used to encourage change, and in this statement, it is evident that it is a need for this participant:

PAR04: *“In die program? Ek dink ek sou meer ‘rewards’ in plek gestel het, uhm, dis baie gefokus op die ‘consequences’ maar baie min op die ‘rewards’ en as daar ‘rewards’ is, is ons nie regtig veel bewus daarvan af nie.” / [“In the programme? I think I would have put more rewards in place, uhm, it’s very focused on the consequences but very little on the rewards and if there are rewards, we are not very aware of it.”]*

The role of motivation in terms of the treatment of both substance abuse and mental health problems reported in literature seem to be encompassed in a method known as motivational interviewing. According to Fisher and Harrison (2013:124) the main focus of motivational interviewing is focused on enabling service users to find motivation within themselves

through pointing out discrepancies in their goals and behaviours, as this will be the driving force for long-term recovery, which is more sustainable than material motivations such as money, for example.

When considering the BPS perspective in terms of the changes suggested by participants the following conclusions can be drawn:

- 1) The need for dual-diagnosis groups is supported by Miklowitz (2009:577) and Bordbar and Faridhosseini (2012:324) who explain that knowledge on both disorders can give an individual the opportunity to acquire skills that will enable them to cope with emotions (psycho) and to identify triggers associated with relapse, and thus the impact on social factors such as family and the health care system is lowered (UNODC, 2015:36). Lower relapse rates will also have a positive effect on biological components as fewer relapses ensure better health outcomes and general functioning (UNODC, 2015:36; APA, 2013a:125).
- 2) When factors within the social sphere of functioning are incorporated in the psychological sphere, as is the case of family involvement in treatment, chances for recovery is found to be higher (Miklowitz, 2009:577, Routledge, 2005:32).
- 3) Rewards impact the psychological function of an individual and acts as a motivating factor. Bender and Alloy (2011:193) however found that rewards are experienced differently by individuals diagnosed with bipolar disorder as they are more sensitive to this aspect due to biological differences.

The findings contained in this chapter will be summarised in the following section.

3.14 SUMMARY

In the first section of this chapter, the researcher explained the research methods that guided the study, followed by a second section which gave an overview of the biographical information of the participants that was included in the study, as well as the qualitative findings of this study. The empirical findings described the experiences of these participants with regards to the treatment they received as individual's diagnosed with bipolar disorder and who abuse stimulant substances. The experiences shared by the participants focused on areas of biological, psychological, social and cultural functioning and was presented under five main themes and related sub-themes.

On a biological level, participants described a very positive treatment experience. Exercise, healthy lifestyle and medication were components which shaped positive treatment experienced shared by participants. Some indicated a lack of knowledge in terms of healthy lifestyle choices and others expressed a need for more physical exercise, but in general, the biological sphere of functioning was not a main point of focus. Other factors that came to light in the biological sphere were the use of sweets, nicotine and caffeine which participants had an affinity for during treatment, as this appeared to enable participants to cope with psychological stressors. The physical environment in which treatment took place did not seem to influence the experiences of participants, even though routine and organised structure contributed to a sociocultural environment which caused less stress.

The negative experiences expressed by participants with regards to treatment were predominantly rooted in the psychological experiences participants had to face while in treatment. In general, the participants experienced mood fluctuations which caused distress and triggered thoughts associated with substance use, especially so when symptoms of depression were experienced. The reasons participants attributed to mood fluctuations were rooted in three factors; 1) participants felt incapable of dealing with past experiences and emotions, 2) participants felt that they were not receiving enough guidance in terms of developing coping skills that enabled them to deal with emotions, and 3) participants did not have enough knowledge regarding bipolar disorder or substance abuse and therefore they felt as if they did not know themselves. In addition to the lack of self-knowledge, participants also seemed uncertain of their bipolar diagnosis and saw bipolar disorder as a label often times places on individuals abusing substances. The need for education expressed by participants is however not limited to participants but should be extended to other social systems. Other socio-cultural aspects that influenced the treatment experiences of participants included religion and the behaviours and attitudes of staff members toward participants.

The participants felt that treatment programmes should consider their individual needs and experiences rather than having generalised rules and explanations which are simply repeated with every service user. Most participants enjoyed sharing their experiences with other individuals that were in treatment with them and expressed a need to establish contact with individuals that have recovered as this can give them insight and hope for recovery. Positive aspects of having both disorders were rooted in effective treatment outcomes as participants believed that effective treatment will enable them to cope with emotions more effectively, and will allow them to help others experiencing the same challenges. Affirmation and confrontation from others also contributed to positive experiences for participants, but punishment and fear for the reactions of staff members did not bode well with most participants and discouraged their participation in treatment. The inclusion and role of religion were, however, one aspect where consensus was not reached among participants.

In the next chapter, Chapter 4, the focus will be on the key findings of the study, conclusions and concomitant recommendations.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The researcher presented the empirical findings of the qualitative study in the preceding chapter and will conclude the mini-dissertation with this chapter. The results of the study with regard to how adults living with a stimulant addiction and bipolar disorder experience treatment at treatment centres will be outlined and an overview of the research findings and the achievement of the research goal and objectives will be discussed. The research question will be answered, through the presentation of the key findings, conclusions and recommendations of the study. The recommendations will provide guidelines for social work services to provide appropriate interventions that will address the needs of adults living with the dual-diagnosis, and will also forward recommendations for future research.

4.2 RESEARCH GOAL AND OBJECTIVES

The **goal** of the study was to explore how adults living with stimulant abuse and bipolar disorder experienced treatment at treatment centres in the Gauteng Province.

The following **research objectives** enabled the researcher to achieve the research goal:

- **Objective 1:** To conceptualise bipolar disorder and stimulant abuse as individual disorders and as a dual-diagnosis from an international, regional and national perspective.

The first objective was achieved in Chapter 2, where the causes, effects, prevalence and treatment of stimulant abuse (see Chapter 2, paragraph 2.2) and bipolar disorder (see Chapter 2, paragraph 2.3) as individual disorders were discussed. A discussion of the causes, effects, prevalence and treatment of these disorders as a dual-diagnosis followed in paragraph 2.4 of Chapter 2. The biological, psychological and social aspects influencing each of the disorders were discussed, as the study was guided by the BPS perspective. Literature on the causes, effects and prevalence of these disorders in terms of the international, regional and national contexts were provided throughout Chapter 2. Factors unique to South Africa, for example, the political history of South Africa that impacts the mental health of individuals, although limited, was provided throughout the literature review (see Chapter 2).

- **Objective 2:** To explore the experiences of participants in terms of the treatment they receive for addiction to stimulant-type drugs

During data analysis, following data collection, the researcher was able to describe how participants experienced the treatment they received for stimulant abuse throughout paragraph 3.13 (see Chapter 3). The research findings were divided into themes and sub-

themes and were linked to existing literature to provide a comprehensive understanding of the participants' experiences, followed by an interpretation from the BPS. Components that influenced how participants experienced treatment in terms of stimulant abuse included 1) taking responsibility for treatment (see Chapter 3, subtheme 1.2), managing cravings (see Chapter 3, sub-theme 1.4), the role of physical and spiritual health (see Chapter 3, theme 2), education (see Chapter 3, sub-theme 3.2), individualisation of treatment (see Chapter 3, sub-theme 4.2 and 5.1), exposure to the experiences of other individuals (see Chapter 3, sub-theme 4.1), and the role that confirmation, confrontation and punishment play in recovery (see Chapter 3, sub-theme 4.3).

The researcher supplied reasons to explain how the second objective was reached in the preceding paragraph; however, it should be expounded that objective 2 and 3 were achieved in combination with one another. The participants' experiences in terms of treatment of these disorders were intertwined since many of the needs and positive aspects of treatment of one disorder tend to strengthen or create a deficit in the treatment of the other. For example, the inclusion of religion in substance abuse treatment is popular, but when religious discussions or classes are prioritised, time focused on counselling or psycho-education is insufficient, thus mental health treatment is neglected. The third objective will be discussed in the succeeding section.

- **Objective 3:** To explore the experiences of participants diagnosed with bipolar disorder and how the diagnosis contributes to stimulant abuse.

As mentioned in the previous paragraph, the experiences of participants were discussed comprehensively in paragraph 3.13 of Chapter 3, although findings are intertwined with those of the second objective, the following section reports those aspects focussed on objective 3 specifically.

Even though many participants question the accuracy of their bipolar diagnosis (see Chapter 3, sub-theme 1.3), the influence that symptoms of bipolar disorder have on stimulant abuse patterns is evident (see Chapter 3, sub-theme 1.1). In an attempt to manage emotions and limit cravings for stimulants participants turn to aspects such as exercise, caffeine, sugar and smoking (see Chapter 3, sub-theme 1.4). In terms of treatment, participants expressed a need for knowledge regarding bipolar disorder (see Chapter 3, sub-theme 1.3 and 3.2), the role that lifestyle choices play in treatment (see Chapter 3, sub-theme 2.1). A need for individualised treatment (see Chapter 3, sub-theme 4.2 and 5.1), an environment that is conducive to recovery (see Chapter 3, sub-theme 4.4) and most importantly, more counselling (see Chapter 3, sub-theme 3.1) was also expressed. All of these needs allowed participants to cope with emotions associated with bipolar disorder, minimising the need for stimulants.

- **Objective 4:** To identify the challenges and perceived strengths participants experience in terms of their treatment due to the presence of both bipolar disorder and stimulant addiction.

The perceived challenges and strengths in terms of the treatment experiences of participants varied and were discussed extensively in Chapter 3 (see sub-theme 5.2), ultimately, allowing the researcher to achieve this objective. Perceived strengths seemed to dominate this theme but experiences were based on external factors and the anticipation of successful treatment and not on actual treatment outcomes. For example, one participant believed that recovery is easier for individuals that create mood fluctuations with external factors such as stimulants, in comparison to individuals whose mood fluctuates without the presence of external variables such as substances. Another participant expressed that due to the presence of both disorders, they received more knowledge and thus they were better equipped with coping skills, which improved their chances of recovery.

- **Objective 5:** Based on the findings, to make recommendations for treatment at South African treatment centres that admit patients with a dual-diagnosis of stimulant use and bipolar disorder.

Based on the research findings presented in Chapter 3 and the key findings offered in Chapter 4 (see paragraph 4.3), the researcher was able to make recommendations in terms of the treatment of dual-diagnosis in South Africa, thus reaching this objective (see Chapter 4, paragraph 4.5). Recommendations are focused on three aspects influencing treatment of dual-diagnosis: 1) Recommendations in terms of programme changes for treatment centres in terms of dual-diagnosis; 2) recommended changes in terms of policy development and modifications which are informed by research focused on the treatment of dual-diagnosis and 3) recommendations in terms of future research (see Chapter 4, paragraph 4.6).

The achievement of the goal and objectives ultimately allowed the researcher to answer the following research question:

“How do adults living with stimulant abuse and bipolar disorder experience services at treatment centres in the Gauteng Province?”

The research question was answered during the research process and the findings were presented in Chapter 3. The findings of the study and in essence the answer to the research question can be found in the key findings of the study, which will be presented in the following section.

4.3 KEY FINDINGS

The key findings are drawn from the literature review and empirical findings, and will be divided into two sections:

4.3.1 Key Findings from Literature Review

The key findings contained in literature related to stimulant abuse, bipolar disorder and these disorders as a dual-diagnosis can be summarised as follows:

- In terms of *prevalence*, there are an estimated 29 million problem drug users in the world, of which 33 million use amphetamines, the second most abused type of substance succeeding cannabis (UNODC, 2016:1). It is estimated that between 48-61% of individuals diagnosed with bipolar disorder abuse substances (Muzina et al., 2009:24). However, the data available on the prevalence of stimulant abuse and bipolar disorder in South Africa is very limited.
- Both bipolar disorder and stimulant substances have similar *causes* in terms of the biological, psychological and social functioning of individuals. Risk factors contributing to the development of both disorders include the role of neurotransmitters, home environments characterised by conflict, lower levels of education, poverty, impulsivity, compulsion, hyperactivity as well as anti-social behaviours.
- Numerous similarities in terms of the biological, psychological and social *effects* of substance abuse and bipolar disorder exist. **Biologically** it is reported that the same neurotransmitters are involved in the course and progression of both stimulant abuse and bipolar disorder. The **psychological** health of individuals living with either bipolar disorder or stimulant addiction is known to be poor in relation to individuals with no diagnosis or addiction. The financial and emotional strain placed on families and governments as **social** systems surrounding individuals diagnosed with bipolar disorder or abusing stimulants are also severe.
- With regards to the *treatment* of a dual-diagnosis, it is necessary to identify and address the biological, psychological and social factors of both stimulant abuse and bipolar disorder simultaneously. Pharmaceuticals are mostly used to treat the **biological** components of bipolar disorder and to alleviate withdrawal symptoms in terms of addiction treatment. From a **psychological** perspective, the mental dependence on stimulant substances is more prevalent than the physiological dependence on the substance. In terms of bipolar disorder, individuals need to become comfortable with the idea of living without the presence or anticipation of manic episodes. In terms of treatment on a **social** level, it was found that when social systems, such as family members, are included in the treatment of both stimulant abuse and bipolar disorder the treatment outcomes are more favourable.
- The need for treatment programmes that focus on more specific combinations of substances and co-occurring psychiatric disorders are mentioned by numerous authors. Different types of substances have different effects on different types of psychiatric symptoms. The combinations of psychiatric condition and types of substances can also influence treatment outcomes, for example, the use of stimulants can influence the effectiveness of bipolar medication as resistance develops toward medication on a biological level.

- Resources allocated to substance abuse treatment as well as the mental health care system in South Africa are very limited. Services rendered are also mostly focused on either mental health or substance abuse, and never on the treatment of dual-diagnosis.
- Service delivery and training in terms of substance abuse and mental health care in South Africa are separated, as substance abuse treatment is the responsibility of the Department of Social Development and psychiatric treatment that of the Department of Health, but departments and service and treatment providers need to work together and broaden their scope of knowledge and practice if effective treatment is to be achieved.

The following section will report on the key findings drawn from the empirical findings of the study.

4.3.2 Key Findings from Empirical Study

The key findings in terms of how adults living with a stimulant addiction and bipolar disorder experience treatment at treatment centres in the Gauteng province can be summarised as follows:

- All of the participants have been admitted to multiple substance abuse treatment centres, some up to 17 times, and most of the participants mentioned that they have been admitted to a psychiatric in-patient programme at least once.
- The need for stimulants seems to be rooted in the facts that participants desire an instantaneously elevated mood at times. The need for an elevated mood is mostly triggered when feelings of depression and emotional turmoil are experienced. It is evident that this need is still experienced by individuals that have been in treatment for several months, regardless of pharmacological intervention.
- The most prominent factor influencing the experiences of participants was counselling. Most participants enjoyed counselling and found it beneficial, but a need for more counselling was evident. Participants believed that counselling would enable them to cope with psychological stressors which influenced their mood, regardless of their compliance to pharmacological treatment.
- During the course of the study, it was evident that participants attached value to the inclusion of lifestyle factors as part of treatment programmes. Whether unhealthy lifestyle options such as sweets and cigarettes were available or healthy lifestyle factors such as exercise was included in treatment programmes, they appear to bring a sense of relieving to participants.
- Some lifestyle habits appeared to become cross-addictions, as participants appeared to overindulge in aspects of exercise and caffeine while admitted to their treatment programme.
- The role of religion is prominent, even though some participants are not religious; they are of the opinion that both religion and spirituality have a place in treatment programmes. However, literature focused on the role of religion in terms of treatment, especially mental health treatment, is limited, but the literature focused on the BPS perspective supports that if services users express a need for the inclusion of religion, it should be respected by service providers.

- Education in terms of behaviour styles, coping mechanisms, lifestyle choices, bipolar disorder and substance abuse was another need that was expressed by most participants.
- Inclusion in treatment discussion, goals, plans, discussions and processes was mentioned by most participants; however, this includes the inclusion of family members as well and extends to recovery after the in-patient programme.
- Exposure to other individuals that have recovered from addiction and incorporation of more group therapy as part of the treatment was a need expressed by most participants. Contact with and the inclusion of individuals that have experienced the same challenges faced by participants; play an important function in the motivation and encouragement of participants. Support and treatment groups can also play an important role in terms of confrontation and affirmation, which is another need expressed by participants.
- The type of environment that participants found most conducive did not depend on the physical environment, but rather on the psychosocial-cultural environment created within the physical environment. For example, rules, structure and limited conflict were described as an environment conducive to recovery. Although predictability caused frustration for some participants.

Constructed from the key findings contained in the literature review and the empirical findings certain conclusions can be drawn, which will be presented in the following section.

4.4 CONCLUSIONS

Based on the key findings presented in the previous sections, the following conclusions with regards to this study can be made:

4.4.1 Conclusions Based on the Literature Review

- Due to the lack of epidemiological data on the prevalence of both bipolar disorder and stimulant abuse in South Africa, the prevalence of this specific dual-diagnosis is not known and thus the true impact of this dual-diagnosis cannot be determined and individuals cannot be treated effectively.
- As many of the risk factors associated with the onset and development of bipolar disorder and stimulant abuse are similar, it can be assumed that individuals are very likely to develop this type of dual-diagnosis when either one of these disorders is present.
- As the effects associated with both stimulant abuse and bipolar disorder are similar, it can be concluded that when an individual is dually diagnosed all of the effects are exacerbated, which leads to poor treatment outcomes and has dire effects on surrounding family and society.
- Treatment outcomes for both disorders are more favourable when it is focused on the biological, psychological and social aspects on an individual's life, thus both stimulant abuse and bipolar disorder should be treated concurrently. However, it can be concluded that if one of these spheres are neglected in the treatment of either one of the disorders the likelihood of relapse is heightened.

- It can be determined that the unique interplay of factors contributing to the development and progression of any type of dual-diagnosis will determine the type of treatment that will be most appropriate. When treatment is generalised to all forms of substances and all forms of psychiatric illness, important factors can be missed. It is also very difficult to provide proper psycho-education on all substances and psychiatric disorders, thus important information can be missed, jeopardising recovery.
- When individuals receive treatment from a facility focused on either substance abuse or psychiatric disorders, it is inevitable that important aspects of treatment will be missed. Psychiatric treatment centres might not be aware of the presence of an addiction, and substance abuse treatment facilities will not necessarily identify the bipolar disorder.
- It can be concluded that the divide between psychiatric services provided and guided by the Department of Health, and the provision of substance abuse treatment provided and guided by the Department of Social Development has caused a breach where individuals with a dual-diagnosis fall through on a continual basis. It is thus necessary for these two departments to form a working relationship that ensures that appropriate services are established to breach this gap in treatment.

4.4.2 Conclusions Based on the Empirical Findings

The following conclusions were drawn from the key findings made in terms of the empirical findings of the study:

- Due to multiple re-admissions to substance abuse treatment centres and to psychiatric treatment programmes, it can be concluded that individuals diagnosed with a dual-diagnosis are prone to relapse and subsequent readmissions, which have an impact on financial, occupational and familial aspects of life.
- It can be concluded that as participants feel unequipped to deal with their emotions and past experiences they consider using stimulants as a way of medicating themselves to achieve an instant state of mania in an attempt to avoid negative moods.
- Counselling is one aspect of treatment that influences the experiences of participants the most as it enables participants to cope with psychological stressors, thus it can be concluded that if sufficient counselling is provided it could have a direct influence on the relapse and subsequent readmission rates of dual-diagnosis patients.
- As the effects of pharmaceutical treatment and still cause mood fluctuations which in turn foster a need for stimulants, but the inclusion of lifestyle factors, such as exercise, aids psychological stress relief, it can be concluded that the inclusion of health lifestyle factors and education is essential for long-term recovery.
- Both unhealthy and healthy lifestyle factors are available during treatment, however, the researcher believes that participation in exercise was initially forced and participants became aware of the benefits only once they started participating in exercise. The use of unhealthy lifestyle factors seems to be more appealing to participants as results are more rapid and more accessible.
- As mentioned in the previous conclusion, healthy and unhealthy lifestyle factors should be addressed in treatment programmes, nonetheless, as behaviour such as

exercise and eating habits can become a new type of addiction and merely suppress emotions that could trigger relapse, these factors should be implemented with care.

- Although there is no consensus with regards to the role that religion plays in treatment, all of the participants acknowledge that there is a place for religion and for others a place for spirituality, in treatment programmes.
- Based on the research findings it can be concluded that knowledge in terms of dual-diagnosis allow individuals to understand themselves better and enables them to manage their diagnosis and aspects related to their diagnosis more effectively.
- Many authors, as discussed in the research findings, calls of service providers to include service users and their families in various aspects of treatment. As participants and their families need to take ownership of recovery and need to implement treatment plans set by services providers they are in the best position to explain when and why treatment plans and goals are not feasible.
- It can be concluded that individuals that have been diagnosed with stimulant abuse and bipolar disorder feel overwhelmed by emotions and experiences, and shared experiences act as a source of encouragement. In addition to sharing their experiences, they also find comfort in knowing other individuals have the same experiences and that recovery is attainable. Aspects of affirmation and confrontation focused on behaviours displayed by members also promote recovery.
- When considering the type of environment that participants describe as conducive to recovery it is mostly rooted in the psychosocial environment created in a treatment programme. When reviewing literature most authors, especially with regards to mental health, also refer to the psychosocial environment of treatment, which influences the psychological state of individuals in the treatment centre.

Based on the conclusions drawn from the literature review and empirical findings the researcher will make certain recommendations which will be discussed in the following section.

4.5 RECOMMENDATIONS

Grounded in the key findings and recommendations presented in the previous sections the researcher offers the following recommendations:

4.5.1 Recommendations for South African Treatment Centres that Admit Patients with a Dual-Diagnosis of Stimulant Use and Bipolar Disorder

- It is recommended that individuals that have been diagnosed with a dual-diagnosis should be treated in a facility that has a transparent multi-disciplinary approach. The inclusion of multiple disciplines and open communication between professionals and services users will ensure that all aspects related to the biological, psychological and social treatment needs of both disorders are addressed before reintegration is initiated.
- Many participants feel overwhelmed with emotions and past experiences and tend to resort to coping skills that are detrimental. It is thus recommended that individuals diagnosed with a dual-diagnosis should be encouraged to develop and practice more conducive coping skills while in treatment. Treatment programmes should ensure

that coping skills be taught to individuals as soon as they are admitted to a programme, and ensure opportunities where coping skills can be modelled and refined. For example, exercise should be seen as part of treatment, and groups should contain role play.

- It is recommended that treatment programmes should include positive lifestyle factors, such as exercise and healthy eating habits, as part of treatment. Individuals, family members and service providers should also be educated on the effects of lifestyle choices, both positive and negative, and on the impact of lifestyle choices on long-term recovery.
- Education focused on the risks related to cross-addictions, especially those viewed as positive, for example, exercise, and should be provided to patients, family members and practitioners. Education could allow those involved in the recovery process to understand that cross-addictions can suppress but not treat the psychological and biological causes of dual-diagnosis, and merely postpone relapse.
- Many substance abuse programmes, for example, AA and NA, were initially rooted in religion, which was substituted with spirituality over the years, therefore religion and spirituality is more likely to be included in substance abuse treatment. The role of religion and spirituality in terms of mental health treatment should, however, be evaluated, and services providers should be educated on the role that religion plays in terms of treatment of a dual-diagnosis.
- Psycho-education in terms of stimulant drugs, bipolar disorder, and dual-diagnosis needs to be provided to ensure that individuals understand why treatments focused on both disorders are important. Individuals should also understand that relapse in one disorder will have an impact on the other. Psycho-education should, however, be expanded to families and communities, to address possible stigma, and to allow for more reassuring support structures for these individuals.
- It is recommended that group therapy should not only be included in treatment programmes but should be developed as part of reintegration programmes as well. Groups focused on the specific dual-diagnosis can play a role in the following aspects:
 - It can ensure that members continue with healthy lifestyle changes.
 - Discussions regarding medications and side effects can be included to encourage compliance.
 - Members can be encouraged to attend counselling sessions and if risk factors are identified, intervention can take place before relapse is too severe.
 - Groups can act as a new social support system as loss of friends in terms of stimulant abuse can have devastating effects.
 - Group members can also evaluate the actions of other members and confront regressive actions, and affirm actions promoting recovery.
- Service users, family members and service providers should be aware of the factors that influence the treatment environment both positively and negatively. When all role players are aware of these factors the environment in which a service user functions can be controlled, thus creating a sense of stability regardless of where they need to function. For example, if an individual knows what type of environment they find conducive, they can find employment which fosters that type of environment, thus promoting recovery.

- Treatment programmes and policies guiding practitioners should promote the inclusion of service users and their families when treatment plans and recovery goals are set, as this promotes recovery. However, this will only promote recovery if psycho-education is sufficient.
- Prevention and early intervention strategies should be developed and implemented when individuals present with or are exposed to, risk factors associated with either of the disorders. All such strategies should be informed by research and should be adapted to fit groups and individuals.
- Policies need to be put in place to guarantee that individuals with a dual-diagnosis receive adequate services to ensure lower relapse rates. The importance of such policies can be guided by research establishing the costs associated with the ineffective treatment of dual-diagnosis patients. Policies should provide clear guidelines on aspects such as extensive psycho-education for staff, patients, and families, the inclusion of social systems in treatment, sufficient counselling, life-skills training, and to allow for sufficient treatment time.
- It is recommended that the Department of Health and the Department of Social Development determine how policies and services need to be changed and improved to ensure that individuals with a dual-diagnosis receive appropriate treatment based on research.
- Social workers and other professionals should also be encouraged, and maybe even required, to attend training sessions where they are educated on the same aspects that service users and their families need to be educated on. As this will ensure that social workers and other professionals are able to identify when service users need to be transferred so substance abuse treatment services; these professionals will also be better equipped to support individuals that need to be reintegrated as well.

4.5.2 Recommendations for Future Research

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

- To repeat the study within other private and government based treatment centres across South Africa in order to determine whether treatment needs differ or whether it presents the same results.
- To compare studies from different centres and areas of South Africa in order to establish treatment needs of individuals diagnosed with a dual-diagnosis.
- Research should be done to determine the actual prevalence of the dual-diagnosis of stimulant abuse and bipolar disorder, focused on admissions in both substance abuse treatment centres and psychiatric treatment facilities.
- Treatment programmes developed from research findings should be implemented, and research should be conducted on the effectiveness of treatment.
- Research on different combinations of dual-diagnosis is necessary to determine how treatment needs differ, as this will ensure the development of appropriate treatment. Individuals working at treatment centres (for both substance abuse and psychiatric conditions) should be aware of the needs of dual-diagnosis patients, and be educated on this phenomenon.

- It is recommended that research should be done with the staff of psychiatric treatment centres, as well as staff at substance abuse treatment facilities, to determine their views and knowledge in terms of dual-diagnosis.
- Research focussed on the costs of not treating dual-diagnosis should be conducted. When the actual costs of non-treatment are established government agencies and the private sector might be more prone to support treatment strategies.
- Intervention strategies focused on families of dual-diagnosis patients should be implemented and the impact of these interventions on both patients and families should be researched.
- More research in terms of this dual-diagnosis is necessary as this could allow for the development of effective treatment strategies that will lower relapse and readmission rates.

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APPENDIX A: INTERVIEW SCHEDULE

Interview schedule:

Adults living with stimulant abuse and bipolar disorder: Experiences of service users at treatment centres

To allow me to understand how an individual that is in treatment for stimulant drug abuse and who is diagnosed with bipolar disorder experiences treatment I will ask you questions that focus on the following aspects:

- Biographical information
- General details about your drug abuse history
- General details regarding your bipolar diagnosis
- Your experience of the relationship (if any) between bipolar and stimulant drug abuse
- Your experience of treatment in the treatment centre.

There is no correct answer so please answer all the questions as you perceive them.

1. Biographical information

- 1.1 Age
- 1.2 Gender
- 1.3 Race
- 1.4 Religion (if applicable)
- 1.5 Home language
- 1.6 Home province
- 1.7 Highest qualification
- 1.8 Occupation
- 1.9 Marital status
- 1.10 Number of children
- 1.11 Primary drug of choice
- 1.12 Secondary drug of choice
- 1.13 Amount of drugs used per use
- 1.14 Frequency of use
- 1.15 Date/age that stimulant addiction was confirmed
- 1.16 Date/age that bipolar diagnosis was made
- 1.17 Professional who made the diagnosis of bipolar

2. Information regarding stimulant abuse

- 2.1 How do you experience the treatment you are receiving for your drug addiction?
Explore different aspects like:
 - i. Physical
 - ii. Psychological
 - iii. Emotional
 - iv. Relationships
 - v. Spiritual/religious
 - vi. Other areas affected by drug abuse
- 2.2 How has/does your stimulant abuse influence your bipolar diagnosis? (Explore the same aspects as in question 2.1).

3. Information regarding bipolar diagnosis

3.1. How has/does your bipolar diagnosis influence your stimulant abuse? Explore the different areas of your life:

- i. Physically
- ii. Psychologically
- iii. Emotionally
- iv. Spiritually/ religiously
- v. Your relationships with others
- vi. Any other area

3.2. How does the treatment you are receiving impact your bipolar diagnosis?

a. Explore questions like:

- i. Are you receiving treatment (both pharmacological and psychological/psychiatric)?
- ii. Do you receive different treatment at the centre?
- iii. Does it influence your programme?

4. The relationship between stimulant drugs and bipolar diagnosis

4.1. Which of these two factors (bipolar or stimulant abuse) presented first?

4.2. How did the diagnosis of the first influence the development of the second?

4.3. How does the fact that you have both a stimulant drug addiction and bipolar disorder influence the recovery process?

a. Explore questions like:

- i. What are their benefits of having both disorders?
- ii. What are the challenges of having both disorders?
- iii. Does having both disorders influence certain aspects of your programme negatively/positively?

b. Also, explore how it influence your recovery in the following areas:

- i. Physically
- ii. Psychologically
- iii. Emotionally
- iv. Spiritually/ religiously
- v. Your relationships with others
- vi. Any other area

5. Your treatment experience

5.1. What aspects of the treatment you are receiving are helpful?

5.2. What aspects of the treatment you are receiving would you like to change, or would you like to make recommendations for treatment at treatment centres?

Thank you for taking the time to contribute to this study.

APPENDIX B: PERMISSION FROM TREATMENT CENTRE

FORM REMOVED TO PROTECT IDENTITY OF TREATMENT CENTRE

APPENDIX C: PERMISSION FROM TREATMENT CENTRE

FORM REMOVED TO PROTECT IDENTITY OF TREATMENT CENTRE

APPENDIX D: PERMISSION FROM TREATMENT CENTRE

FORM REMOVED TO PROTECT IDENTITY OF TREATMENT CENTRE



APPENDIX E: INFORMED CONSENT



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities

Department of Social Work & Criminology

Researcher: Mrs K.M van Zyl

Contact number: (+1) 832 998 2049

E-mail address: vanzyikarina@yahoo.co.uk

Participant's identification details: _____

INFORMED CONSENT

1. **Title of research study:** Adults living with stimulant drug abuse and bipolar disorder: Experiences of service users at treatment centres.
2. **Goal of study:** The goal of the study is to explore and describe how adults living with stimulant abuse and bipolar disorder experience treatment at treatment centres in the Gauteng Province.
3. **Procedures:** I, the participant, understand that I will be interviewed in a one-on-one interview with the research where I will be asked questions about my experience while in treatment for stimulant drug abuse and being diagnosed with bipolar disorder. The interview will take approximately one hour. The interview is voluntary and will take place at the treatment centre and will be audio recorded by the researcher for accurate data capturing.
4. **Risks and discomforts:** I will not be subjected to any physical harm and the researcher will minimise any emotional discomfort. If I do experience any emotional discomfort I know that I can contact my case manager at the treatment centre for counselling.
5. **Benefits:** There is no benefit, financial or material, for participating in the mentioned study. I do however know that my study will help the researcher gain and share knowledge of my dual-diagnosis which can be used to develop more effective treatment plans for my dual-diagnosis in future.
6. **Participant's rights:** I understand that I can withdraw from the study at any time with immediate effect and my withdrawal will not hold any negative consequences.

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Fakulteit Geesteswetenskappe
Lefapha la Bomotho



- 7. **Confidentiality:** In order to record what is being said accurately the interview will be audio recorded by the researcher. This recording will only be used for the purpose of research and everything I say will be kept confidential. If I withdraw from the study the data will be destroyed. The results of this study may be included in professional publications or conferences, but my identity will not be disclosed, unless required by law.
- 8. **Queries:** If more information about the research study and findings is desired please make contact with the researcher at the contact details provided on the first page.

With my signature I indicate that I understand the information explained to me in this document as explained by the researcher and that I am participating on a voluntary basis. I also understand that the research data collected will be archived for a period of 15 years at the Department of Social Work and Criminology at the University of Pretoria. I understand that the data could be used in future for follow-up research.

I _____ (name and surname of participant) hereby provide my consent to participate in this study.

I _____ (name and surname of case manager of participant) hereby provide my consent that _____ (name and surname of participant) may be a participant in this study.

This document was signed at _____ on the _____ day of _____ 2016.

Signature of participant: _____

Signature of case manager: _____

Signature of researcher: _____



APPENDIX F: ETHICAL CLEARANCE



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

27 May 2016

Dear Prof Lombard

Project: Adults living with stimulant abuse and bipolar disorder:
experiences of service users at treatment centres
Researcher: K van Zyl
Supervisor: Dr LS Geyer
Department: Social Work and Criminology
Reference number: 10487507 (GW20160523HS)

Thank you for the well-written application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 26 May 2016. 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

PP.

Prof Maxi Schoeman
Deputy Dean: Postgraduate Studies and Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Dr L Blokland; Dr R Fasselt; Ms KT Govinder; Dr E Johnson; Dr C Panebianco; Dr C Puttergill; Dr D Reyburn; Prof GM Spies; Prof E Taljard; Ms B Tsebe; Dr E van der Klashorst; Mr V Sithole