

2023

## Life Experiences of Facilitators Conducting Psychoeducational Groups

Gussi Leandre  
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# Walden University

College of Psychology and Community Services

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Gussi Leandre

has been found to be complete and satisfactory in all respects,  
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Walden University  
2023

Abstract

Life Experiences of Facilitators Conducting Psychoeducational Groups

by

Gussi Leandre

MA, Long Island University, 2012

BS, Hunter College, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

August 2023

## Abstract

Research suggested that mental health treatment for those dually diagnosed is complex because of the need to treat mental illness and substance use simultaneously; hence, an integrated model is needed to treat this population. Psychoeducational groups are part of the integrated treatment for this population because their objective is to support these individuals who are going through these illnesses. This qualitative phenomenology study was conducted to examine group facilitators' professional experiences when leading psychoeducational groups for dually diagnosed individuals. The population studied consisted of eight mental health group facilitators in New York City hospitals, group residential, and Alcoholics Anonymous/Narcotics Anonymous meetings. The job-demands resources model provided the framework for the study, which is an occupational stress model created to take the place of other well-being models that did not consider the productivity, motivation, and health of workers with high job demands and low resources. Data were collected via semi structured, face-to-face interviews, and NVivo was used to generate five themes: (a) open and welcoming group environment, (b) understanding and engaging with patients, (c) addictive behavior, (d) inpatients versus outpatient's treatment, and (e) retention issues and patient behaviors. The study's findings align with the body of literature on group facilitators' roles in better understanding dual-diagnosed people's behavior. They also provide additional insights, given that the study was based on the viewpoint of the facilitators. The implication for positive social changes is that the results encourage extra attention for patients with two diagnoses, which is a previously noted public health issue.

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## Dedication

I would like to express my appreciation and dedicate this dissertation to my father, Marcelin Leandre. He has always been my biggest cheerleader, encouraging me to pursue education and never stopped believing in my dreams. I also want to express my gratitude to my mother for teaching me the importance of self-discipline, which has been an invaluable asset on this journey. I would also like to thank my brother for his unwavering financial support and understanding, especially after the passing of both our parents. Lastly, I want to acknowledge my mentor and friend, Garry Maurice. It has been a challenging journey, but I am proud to have achieved my goal.

## Acknowledgments

I am incredibly thankful to everyone who has supported and encouraged me throughout my dissertation process. Drs. Michelle T. Ross and Leslie E. Barnes-Young were exceptional committee members, and I am grateful for their guidance and expertise. I owe a significant debt of gratitude to each of them for helping me to develop my writing and research skills. Additionally, I would like to express my gratitude to all those who participated in my study. Your willingness to share your experiences was a crucial factor in the completion of my dissertation. I appreciate your honesty, knowledge, and beautifully written accounts of your work with clients. To all who have aided me in various ways, whether mentioned or not, I am truly grateful.

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## Chapter 1: Introduction to the Study

The field of mental health includes not only mental health prevention, but treatment of individuals diagnosed with one or more psychological disorders. The term dual diagnosed, also commonly referred to as co-occurring disorders, describes the existence of two or more diagnoses that include at least one mental illness and a substance use disorder concomitantly (National Alliance on Mental Illness, 2019b; National Institute of Mental Health, 2019). Co-occurring mental health conditions and substance abuse affected 9.2 million U.S. adults in 2018, but only 7.4% received appropriate treatment because few programs specialize in treating dual diagnoses (National Alliance on Mental Illness, 2019a). The dual diagnosed population requires integrated intervention to recover appropriately; therefore, many mental health professionals must work together to provide the best-integrated treatment to these persons (Dixon et al., 2016; McCallum et al., 2015). This study captured the group facilitators' life experiences when performing their duties to understand the high turnover rate of group facilitators in psychoeducational groups and their perceptions of why they struggle to retain dual diagnosed individuals in psychoeducational groups despite their known effectiveness (Gitterman & Knight, 2016).

In this chapter the problem statement, study's purpose, and research questions will be articulated. Afterward, the conceptual framework for this study will be discussed. The chapter concludes with a summary of the nature of the study, including relevant definitions, assumptions, scope, limitations, and significance.

## **Background**

Group facilitators conduct psychoeducational groups as part of an integrated treatment for the dual diagnosed population (Furr, 2000; Srivastava & Panday, 2016). Psychoeducational groups aim to emotionally support and inform people who are going through any mental health problems (Furr, 2000; Srivastava & Panday, 2016). Psychoeducational groups provide effective treatment delivery to dual diagnosed individuals (Gitterman & Knight, 2016). Psychoeducational group facilitators are case managers with a bachelor's degree in any science field, social workers with a master's degree, psychologists with a doctorate, and credentialed alcoholism and substance abuse counselor trainees (CASAC-T) with 350 hours of training in counseling treatment for alcoholism and substance abuse. Beyond the educational requirements, group facilitators must develop skills in effective communication to deescalate conflicts and to demonstrate patience, compassion, respect, trustworthiness, caring, flexibility, and self-awareness.

Group facilitators hold many responsibilities: They are responsible for facilitating interactions among group members, including how the group makes decisions and how group members address emotions (Gitterman & Knight, 2016). Group facilitators can heal, nurture, develop, and educate, but they also have the power to destroy their members through poor facilitation (Hartford, 2006). A group facilitator's failure to encourage their clients' full participation can undermine the group's progress (Long et al., 2006).

Another responsibility of group facilitators is to regulate their own mental health to help their clients more effectively. Therefore, self-care should be encouraged and

implemented in every agency's training curriculum to teach them when to remove themselves from facilitating groups to take care of themselves. But research has indicated that organizations focus more on training facilitators to run the groups with outdated materials than updating their training manuals or paying for facilitators to participate in refresher courses or providing them with regular supervision (Kelly et al., 2017). When the necessary process of a group intervention is ignored due to a lack of resources and support, the psychoeducational group's effectiveness is impacted (Gitterman & Knight, 2016).

Group facilitators may also experience specific challenges in retaining dual diagnosed patients in psychoeducational groups because of the diversity of mental health settings in which such groups are run (hospitals, residential homes, Alcoholics Anonymous, Narcotics Anonymous, and rehabilitation centers). Running such groups may be challenging for the group facilitators because they have to maintain a safe environment, ensure a supportive environment, and strengthen exploration and leadership for their servicing populations (Dixon et al, 2016; Mental Health America, 2016). Beyond their responsibilities, group facilitators must also remind dual diagnosed individuals of the importance of taking their medications as prescribed and attending their psychiatric appointments as scheduled to avoid any decompensation and conflicts. Decompensation happens when recidivists (those who consistently return to psychoeducational groups to repeat therapy) are refusing medications or other community treatments, which makes the individual's behavior so disturbing to the point hospitalization becomes necessary (Herz & Melville, 1980; Turkat & Buzzell, 1983).

Further, many group facilitators are trained to provide integrated treatment to dual diagnosed patients in their psychoeducational groups.

When the relationship between the group facilitators and dual diagnosed individuals is fractured, it causes a turnover rate issue, affecting care continuity, destabilizing agencies, and diminishes services' quality (Glisson & James, 2002; Knudsen et al., 2003; Mor Barak et al., 2001). In publicly-funded mental health settings, turnover rates range from 30%-60% annually (Ben-Dror, 1994; Mor Barak et al., 2001; Paris & Hoge, 2010). Several factors—organizational expectations, disorganization, and lack of administrative support contribute to the turnover rate for mental health workers, including group facilitators, within an organization. The study captured the group facilitators' life experiences when performing their duties in order to understand the high turnover rate of group facilitators in psychoeducational groups and thus their perceptions of why group facilitators struggle to retain dual diagnosed individuals in psychoeducational groups despite their known effectiveness (Gitterman & Knight, 2016).

### **Problem Statement**

The problem explored by the current study is that group facilitators encounter many challenges conducting psychoeducational groups in hospitals, rehabilitation centers, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and residential homes. A plethora of research has been completed on the life experiences of participants in psychoeducational groups. Specifically, researchers have explored dual diagnosed individuals and the efficacy of psychoeducational groups in their treatment (Hale & Cows, 2015; McCallum et al., 2015) or the challenges facing mental health professionals



generally (Dixon et al., 2016; Dreison et al., 2016; Hale & Cows, 2015; Lee et al., 2019; Sturzu et al., 2019; Tzeletopoulou et al., 2018). But research has recommended further avenues for exploration, such as group facilitators' training and selection processes (Hale & Cows, 2015), strategies used by facilitators based on knowledge and training specific to the group therapy method and target population (Dixon et al., 2016), and the workplace environment to identify circumstances that positively or negatively influence the psychological needs of mental health providers (Lee et al., 2019). This study was conducted to address these recommendations through exploring the lived professional experiences of psychoeducational group facilitators who work with dual diagnosed individuals.

### **Purpose of the Study**

The purpose of the current qualitative, phenomenological study was to describe the lived professional experiences of group facilitators who conduct psychoeducational groups with the dual diagnosed. Group facilitators are essential in the recovery of dual diagnosed patients. Therefore, it was vital to investigate their experiences when performing their work to determine what is working for them and how their work experiences can be improved to encourage clients' retention. Having competent psychoeducational group facilitators for dual diagnosed individuals is significant to the recovery and retention in treatment. A high turnover rate among group facilitators affects care continuity, destabilizes agencies, and diminishes services' quality (Glisson & James, 2002; Knudsen et al., 2003; Mor Barak et al., 2001). Therefore, group facilitators may require a better work environment with adequate supervision to manage stress and

prevent turnover.

### **Research Questions**

RQ 1: How do psychoeducational group facilitators experience working with dual diagnosed individuals?

RQ 2: To what extent does the group setting of the clients affect group facilitators' experiences when dealing with dual diagnosed individuals?

RQ 3: How do psychoeducational group facilitators perceive the needs of dual diagnosed individuals in terms of their retention in psychoeducational groups?

### **Conceptual Framework**

The theoretical framework guiding this study is the revised job-demands resources (JD-R) model (Nachreiner & Schaufeli, 2001). The JD-R model is an occupational stress model designed to replace the other well-being models that did not take into consideration the health impairment, motivation, and the productivity of the employees with high job demands with low resources (Schaufeli & Taris, 2014). According to the original theory, every job consists of two broad categories of job demands and job resources, which contribute to specific outcomes in the workplace environment (Demerouti et al., 2001). The revised form defines job demands as physical, social, and organizational aspects of a work environment that lead to physiological and psychological harm (Demerouti et al., 2001; Schaufeli, 2017). But job resources provide assistance in work tasks and reduce the impact of demands (Demerouti et al., 2001; Schaufeli, 2017). The revised theory further addressed the negative outcomes of stress and burnout and the positive effect of work engagement and motivation as mediators to

the relationships between job demands and resources and resulting physical conditions and psychological well-being (Schaufeli & Bakker, 2004).

The revised JD-R theory provided a conceptual framework of the present research on the lived experiences of psychoeducational group facilitators by establishing a framework to consider both positive and negative factors in the work environment that impact the target population. The revised JD-R theory allows for a flexible variety of demands and resources to frame the skills of the study participants (Schaufeli & Bakker, 2004; Schaufeli & Taris, 2014). Application of this model may allow the psychoeducational group facilitators to perform their job tasks better by balancing their requirements and the resources available to achieve their goals.

### **Nature of the Study**

The study was qualitative as the purpose was to understand the experiences of psychoeducational group facilitators treating dual diagnosed individuals. The phenomenological research design was appropriate, because the study involved common phenomena experienced by a similar group of people and aims to understand participants' experiences (Moustakas, 1994). The research questions were answered by recruiting a sample of eight–12 psychoeducational group facilitators who have worked with dual diagnosed individuals for at least one year for saturation purposes. The participants required to be case managers, qualified mental health professionals such as therapists, credentialed alcoholism and substance abuse counselors, social workers, mental health counselors, or psychologists with at least one year of experience facilitating groups. Data were collected through individual, in-depth, semi structured interviews. The meetings

was audio-recorded for transcription later and analyzed through interpretive phenomenological analysis (IPA; Smith & Osborn, 2004). This research helped evaluate the challenges that group facilitators encounter day by day during their work hours.

### **Definitions**

*Dual diagnosed:* As psychoeducational groups can be helpful to a wide range of illnesses, I focused on dual diagnosed individuals, which refers to individuals who are affected by both mental illnesses and who are abusing legal or illegal substances for any purpose (McCallum et al., 2015; Shipley et al., 2016).

*Facilitators:* The facilitators' job is to support everyone to do their best thinking. To do this, the facilitator encourages full participation, promotes mutual understanding, and cultivates shared responsibility. By supporting everyone to do their best review, a facilitator enables group members to search for inclusive solutions and build sustainable agreements (Sam et al., 1996).

*Psychoeducation:* Psychoeducation is defined as systematic, structured, educational information on illness and how to treat it. It includes integrating emotional aspects to enable patients and family members to cope with the disease (Pitschel-Walz et al., 2009).

### **Assumptions**

The following assumptions were made for this study. I assumed that all participants would be sincere when responding to the questions they were asked and when sharing their experiences facilitating psychoeducational groups to provide better ways to identify the core issues that prevents retention of the clients in the

psychoeducational groups. Another assumption was that the participants would remain focused and committed throughout the entire interview process to provide enough information about that topic for the study, which allowed for enough data to be collected.

### **Scope and Delimitations**

Delimitations are the researcher's responsibility to control in any research (Simon, 2011). The process of delimitation in a study should be made with caution because while it is essential, it can also limit the scope of a survey. To better assess the population being studied, the study's scope was narrowed to the experiences of psychoeducational group facilitators currently working in hospitals, residential homes, and rehabilitation centers who have at least 1 year of experience working with dual diagnosed individuals. The psychoeducational group facilitators were not selected from specific sections of the city, state, or treatment facility where I work.

### **Limitations**

Mental health research has not adequately acknowledged psychoeducational group facilitators' lived experiences working in treatment facilities with the dual diagnosed population. This study was limited to the psychoeducational groups' facilitators for dual diagnosed patients conducting groups in hospitals, residential homes, and rehabilitation centers in the United States with more than 1 year of work experience. Qualitative research is concerned with the deepening of understanding a given problem where the researcher can be both the subject and the object of the research (Andre et al., 2017). However, qualitative research also has some limitations: the scope of the study in time is a longer range, the researcher's point of view is internal, and the theoretical

framework and hypotheses are less structured (Andre et al., 2017).

### **Significance**

This study fills the research gap by exploring the psychoeducational group facilitators' lived experiences in different treatment settings influencing psychoeducational groups' effectiveness (see Gitterman & Knight, 2016). This study's findings may provide mental health policymakers with the needed information to justify giving group facilitators better training. These policies might ensure that group facilitators are better equipped and prevent clinical burnout. Mental health providers have a significant responsibility when working with dual diagnosed individuals. If appropriately used, psychoeducational groups can provide dual diagnosed individuals with new ways to cope with life situations and explore their feelings to find the roots of their issues (Gitterman & Knight, 2016). But treatment often fails due to a variety of issues experienced by the group facilitators, such as being overwhelmed, stressed out, and clinically burned out (Shiple et al., 2016). The study results may provide a more in-depth understanding of how psychoeducational group facilitators can benefit from better resources on guiding and supporting this population as part of their demanding tasks without feeling overwhelmed and clinically burnout. The findings would also prepare mental health professionals with more insight into how psychoeducational groups can be applied with a higher chance of success, reducing the stress of taking clients' relapse personally and a sense of despair within the groups' facilitators.

The research aimed to bring positive social change to the psychoeducational group facilitators working with dual diagnosed individuals in the mental health field.

Further, the results may offer a different understanding to the group facilitators about the struggle of the dual diagnosed and their challenges as psychoeducational group facilitators and contribute to better training for the group facilitators to prevent stress burnouts. Mental health providers could benefit from this study by using more empirically supported ways to help group facilitators prevent clinical burnout and manage them effectively when present.

### **Summary**

Co-occurring mental health conditions and substance abuse affected 9.2 million U.S. adults in 2018; only 7.4% received appropriate treatment because few programs specialize in treating dual diagnoses (National Alliance on Mental Illness, 2020). Many of these individuals do not receive integrated treatment because not many group facilitators use integrated treatment in their psychoeducational group programs. This issue is due lack of training for the facilitators. As a result, group facilitators experience many relapses with their patients, which can lead to stress and burnout.

Chapter 2 focuses on the literature search strategy, which was the structure of key terms used for the search. The conceptual framework, which was the map of the study. The background of dual diagnosis is where dual diagnosis is defined as well as the appropriate treatment to help this population. The chapter also covers the struggles experienced by group facilitators when conducting psychoeducational groups for the population in question.

## Chapter 2: Literature Review

Effective psychoeducational group facilitation requires adequate training to apply the constructs of psychoeducational group therapy, knowledge specific to the target population of participants, and a level of self-development that supports insights into others and the confidence to direct the group (Brown, 2019). Within the context of group therapies that consist of dual diagnosed individuals, the depth of knowledge needed by the group facilitator encompasses a detailed understanding of multiple psychiatric illnesses, a range of substance use disorders, and a clinical awareness regarding the potential influence that each diagnosed disorder may have on the other (Green et al., 2015; Subodh et al., 2018). The complexities involved in addressing two multifaceted disorders in individuals that often present with diverse symptoms and significant differences in illness severity contribute to the challenges faced by health care practitioners who facilitate group therapies in this population (Dixon et al., 2016; Green et al., 2015; Subodh et al., 2018). Moreover, each participant brings a unique clinical presentation to the group based on their dual diagnoses and the severity of their illnesses, further contributing to the challenges faced by the group facilitator (Green et al., 2015; Subodh et al., 2018). Barriers to effective group facilitation also include limited resources, time constraints, and oversight by third-party providers that limit therapy time and devalue the role of the facilitators (Dixon et al., 2016).

The workplace environment experienced by mental health professionals, including group facilitators, has further raised concerns regarding the extent of job responsibilities, levels of stressors in the workplace setting, and the recognition of



challenges associated with emotional labor that contributed to clinical burnout in this population (Dreison et al., 2016; Lee et al., 2019; Tzeletopoulou et al., 2018). Within the past few years, researchers have recognized and explored symptoms of depression, burnout, and aggressive behaviors among mental health professionals, noting the importance of the appropriate supervisory support, self-efficacy development, and staff cohesion for individuals serving in mental health settings (Dreison et al., 2016; Lee et al., 2019; Sturzu et al., 2019; Tzeletopoulou et al., 2018). Although job stressors and clinical burnout have been recognized among mental health professionals, little progress has been made in protecting this population from adverse outcomes (Dreison et al., 2016).

Though substantial research informs the efficacy of psychoeducational group therapy in dual diagnosed patients, research is lacking in understanding the lived experiences of group facilitators as these health care professionals face challenges presented; not only by the complexities of this difficult-to-treat population but furthered by the difficulties of work situations, job stressors, and, in many cases, clinical burnout (Dixon et al., 2016; Dreison et al., 2016; Hale & Cowls, 2015; Lee et al., 2019; Sturzu et al., 2019; Tzeletopoulou et al., 2018). Accordingly, several researchers identified areas for future research: group facilitators' training and practices as well as environmental factors affecting retention of group facilitators and problems of burnout (Dixon et al., 2016; Dreison et al., 2016; Hale & Cowls, 2015; Lee et al., 2019; Tzeletopoulou et al., 2018). This study advances knowledge and awareness of the experiences of group therapy facilitators who work with the diverse and complex population of dual diagnosed patients.

The remainder of this chapter is organized to discuss the conceptual framework chosen to guide the study, followed by a description of the search strategy employed in obtaining the literature included in this review. The literature review follows and is organized by sections and subsections that include a discussion of the group facilitator that encompasses responsibilities, training, and complexities of group participants, the group facilitator and treatment barriers, the group facilitator and workplace demands, the group facilitator and workplace resources, and the group facilitator and burnout. The chapter concludes with a summary and a transition to Chapter 3.

### **Literature Search Strategy**

The literature used in this review was obtained using online databases and search engines including Google Scholar, PsycINFO, PSYCHarticles, ERIC, DeepDyve, ProQuest, Research Gate, Science Direct, Google Books, Google, PubMed, and government-supported websites such as the National Institute of Health. Search limitations included available options per search site such as peer-reviewed journals, dates of publications focusing on works since 2015, author name searches when needed, access to related and previously cited articles, and the use of full-text or pdf availability for published documents. Literature consisted of information from peer-reviewed journals and relevant books, websites, and dissertations. Search terms included the use of entries in single terms or Boolean search manners: *dual diagnosed*, *dual diagnosed patients*, *dual diagnosed*, *facilitators*, *facilitators experiences*, *psychoeducational groups*, *group leader*, *group facilitator*, *psychoeducation*, *psychoeducational setting*, *burnout*, *stress*, *wellbeing*, *mental health worker*, *social worker*, *counselor*, *psychologist*, *therapist*, *setting*

*characteristics, setting importance, characteristics, treatment, trust, healthcare providers, health providers, health practitioners, healthcare professionals, mental, challenges, defined, co-occurring, co-occurring disorders, dual psychopathology, substance use disorder, mental health, mental illness, psychiatric comorbidity, job demands, job resources, job demands resource, and revised job demands resource.* Much of the research literature used was published between 2015 and forward, with a total representation of the literature in that timeframe included in this review to be 81 of the total 110 works cited, or 74%.

### **Conceptual Framework**

The conceptual framework chosen to guide the current study is the revised job demands-job resources (JD-R) model of burnout, developed initially by Demerouti et al. (2001). The revised theory was created by Schaufeli and Bakker (2004). According to the original idea, every job consists of two broad categories of job demands and job resources, and each class contributes to specific outcomes in the workplace environment (Demerouti et al., 2001). The original model defined job demands as physical, social, and organizational aspects of the work environment, leading to physiological and psychological harm (Demerouti et al., 2001; Schaufeli, 2017). In circumstances of high or increasing demands, and when times of rest and recuperation fail to allow the individual to sufficiently recover, sustained physical and psychological detriment persist, which leads to eventual physical and mental exhaustion and burnout (Demerouti et al., 2001). Job resources include the same work aspects of physical, social, and organizational factors, yet are viewed positively as providing practical assistance in work tasks, reducing

the impact of opposing demands, and stimulating personal growth and career development (Demerouti et al., 2001; Schaufeli, 2017).

As researchers applied the theory over the years and across multiple study populations, the theory evolved to the revised form that more clearly frames workplace experiences as those that involved high demands that contributed to stress, strain, and health impairments and, conversely, high levels of resources, both personal and job-oriented, that created work engagement, increased levels of motivation, and work productivity (Schaufeli & Taris, 2014). A primary difference in the original and revised JD-R theory includes the balanced positive outcomes of work engagement and well-being considered the offsets to the adverse effects of stress and burnout (Schaufeli & Bakker, 2004). The revised theory suggests that stress and burnout contribute to stress-related physical health conditions, such as cardiovascular disease, gastrointestinal disorders, and psychological conditions that may include psychosomatic complaints and a declining sense of well-being (Schaufeli & Taris, 2014). In contrast, the positive impacts of resources create work engagement described as a fulfilling state of mind associated with the workplace, increased vigor framed as higher energy and mental resilience related to work tasks, dedication to job duties, enthusiasm toward job responsibilities, and absorption in the work environment described as focus and positive involvement in work-related activities (Schaufeli & Taris, 2014).

Aligned with the aims of the current study, researchers like Dreison et al. (2016) have used the JD-R model to examine stress and burnout among mental health care workers. They found that 21%–67% of individuals experience burnout in this population

of workers. Adverse outcomes experienced by the mental health sector include cardiovascular disease, back pain, anxiety, depression, poor sleep, and impaired concentration. Further, the stress experienced by mental health workers contributes to unfavorable client outcomes. Study findings indicated that the three job resources of autonomy support, self-efficacy, and staff cohesion created negative associations with depersonalization and emotional exhaustion outcomes and positive associations with individual accomplishment (Dreison et al., 2016).

Similar to other stress models, such as the job demands control model by Karasek (1979) and the 1996 effort-reward imbalance model by Schaufeli and Taris (2014), the revised JD-R model (Demerouti et al., 2001; Schaufeli & Bakker, 2004; Schaufeli & Taris, 2014) supports that the balance between work positives, meaning resources, negative activity, meaning demands, resulting in influencing individual health and well-being. Applying the revised JD-R theory provides the opportunity to incorporate various needs and help determine the influences of both on the target population versus narrowed types of demands or resources that may not be relevant to the study population (Schaufeli & Taris, 2014). Regarding the current study, the revised JD-R theory supports the exploration of the lived experiences of psychoeducational group facilitators by establishing a framework to consider both positive and negative factors in the work environment that are perceived to impact and influence the target population. The broad scope of the model allows for a flexible variety of demands and resources to frame the affairs of the study participants (Schaufeli & Bakker, 2004; Schaufeli & Taris, 2014).

### **Literature Review Related to Key Concepts and Variables**

Psychoeducational group therapy contributes to patients' learning and awareness about both mental illness and substance use disorder (Hale & Cowls, 2015). Such groups have a general format that assists the facilitator in creating the content and flow of the group while encouraging participants to interact with group members and the facilitator to establish a sense of value, belonging, and inner meaning of the experiences and knowledge shared (Bledin et al., 2016; Gitterman & Knight, 2016). Still, the diverse symptoms and clinical presentations central to the illnesses of the dual diagnosed group members challenge group facilitators to provide a format that promotes recovery and disease state management in a manner relevant to all participants (Gitterman & Knight, 2016; Hale & Cowls, 2015). Research literature discussed in this review provides evidence of the challenges faced by psychoeducational group facilitators in understanding and meeting the needs of participants with attention to outcomes associated with facilitator strategies and across treatment settings.

### **Complexities of the Dual Diagnosed**

Results have shown characteristics of dual diagnosed patients, including the increased likelihood that patients were male, had a concurrent personality disorder diagnosis, accomplished lower levels of education, and experienced problems with employment (Ponte et al., 2017). The most frequent co-occurring mental illnesses includes mood, anxiety, and psychotic disorders. The diverse societal problems associated with dual diagnosed individuals include issues of unemployment (Fong, 2017), increased medical and mental health spending (Pantalon et al., 2014), ongoing or relapsed

drug use, legal problems, and poverty conditions, including homelessness (McCallum et al., 2015; Piacentini & Pataki, 2016). Dual diagnosed patients require awareness by treatment providers regarding appropriate psychological interventions per patient because they often struggle with cognitive difficulties, psychosocial challenges, disabilities, medical comorbidities, and increased chances of suicide (Kiosses et al., 2017).

The nature of multiple or comorbid psychiatric diagnoses place even more responsibility on treatment providers to discern appropriate interventions, including providers who facilitate group therapies (Green et al., 2015; Klimkiewicz et al., 2015). Moreover, poor physical health reported by individuals with dual diagnoses contributes to poor adherence to treatment and lack of participation in group therapy (De Hert et al., 2015; Kerner, 2015; McCallum et al., 2015; Walker & Druss, 2017). Engaging dual diagnosed patients in treatment is multifaceted and requires steps to optimize recovery-oriented attitudes and skills required to provide practical therapy experiences (Dixon et al., 2016). The complex needs of dual diagnosed patients require knowledgeable health care professionals to ensure that integrated treatment approaches meet the needs of the patients (Ponte et al., 201&). The education provided through psychoeducational group therapy relies on the insight and knowledge of the group facilitator in recognizing and addressing the needs of the dual diagnosed group participants (Dixon et al., 2016; Gitterman & Knight, 2016; Ponte et al., 2017). Dual diagnosed individuals require diverse treatment methods, including integrated, multidisciplinary approaches tailored to mental health illnesses and substance use disorders (McCallum et al., 2015). As such, treatment providers have faced challenges in meeting the needs of this unique population

of patients that encompass the design and implementation of appropriate integrated or paralleled care, including primary and follow-up modalities, focused on both illnesses in tandem. Although psychoeducational group therapy is influential, research has shown that dual diagnosed individuals sought treatment only 21.6% of the time, controlling for ethnicity and outpatient treatment (Fong, 2017).

### **Therapy Considerations**

The complexities of dual diagnosis has contributed to using therapy models to address specific patient manifestations in this population: cognitive-behavioral therapy (CBT), modified therapeutic community programs, multidisciplinary team approaches, integrated dual disorder treatment, and psychoeducational group therapy (Priester et al., 2016). The CBT approach has resulted in positive outcomes in dual diagnosed patients with posttraumatic stress disorder accompanied by substance use disorders (Priester et al., 2016). Modified therapeutic committee interventions have led to an overall improvement in a population of dual diagnosed patients, including outpatients, offenders, and the homeless, with significant positive outcomes regarding substance use recovery, improvement in the mental illness disorder, increased employment, reduced rates of crime, and improved housing (Priester et al., 2016). Well-coordinated multidisciplinary team approaches conducted separately or in tandem with integrated care have resulted in many dual diagnosed patients (Green et al., 2015; Priester et al., 2016).

The integrated treatment model remains the recognized standard of care for the treatment of co-occurring disorders (Priester et al., 2016). Components recommended in integrated care include employing a bio-psychosocial approach, incorporating



motivational aspects, providing for unlimited time parameters for patient access to care, encompassing both substance abuse therapy and specified mental illness treatment concomitantly, and encouraging evidence-based practices and a multidisciplinary team approach across treatment settings in effectively treating dual diagnosed patients (Priester et al., 2016). Facilitators of psychoeducational group therapy who employ the integrated model require adequate training, sufficient knowledge of both disorders, and the capacity to both engage and educate the patients and the group on each condition concurrently, realizing that, while the dual diagnoses of other group participants likely differed, each participant required the same attention to education and engagement (Lawrence, 2017).

### **Psychoeducation Group Therapy**

Psychoeducational groups provide an opportunity for participants to become better informed about their diagnoses, address concerns, issues, or problems, develop self-understanding and interpersonal relationships, and develop problem-solving skills to aid in recovery and treatment adherence (Brown, 2019). While participant education is the general focus of psychoeducational groups, various group-oriented goals provide facilitators with formats specific to the intent of the facilitator and the needs of the participants, further shown to be cost-effective and helpful therapies across multiple patient populations with diverse needs (Brown, 2018; Delgadillo et al., 2016; Depp et al., 2015; Ebener & Smedema, 2016; Hesse & Thylstrup, 2016; Hirvikoski et al., 2017). Psychoeducational groups have proven successful for individuals of all ages and demographic differences (Macpherson et al., 2016), for a variety of illnesses (Casañas et al., 2015; Ebener & Smedema, 2016; Michalak et al., 2016), throughout the continuum of

care (Sin et al., 2017), and across state lines and global borders (McGovern et al., 2014; Shipley et al., 2016; Van Wamel et al., 2015).

Recognizing that education and subsequent learning are the end goals, psychoeducational group leaders work to provide a balance of affective and cognitive material following the premise that teaching illness-oriented information and new skills lead to learning and implementation in ways that contribute toward preventing relapse and maintaining wellness (Anderson et al., 2001; Brown, 2019; Hale & Cowls, 2015). For example, psychoeducation groups can guide skills training and development, personal development, clinical understanding, support issues, transitional matters, populations such as family therapy, or, aligned with the current research, focus on specific disease states, including the dual diagnosed (Brown, 2018). According to Gitterman and Knight (2016), four benefits observed across psychoeducational group therapies included a) participant development of self-insight and individual circumstances, b) developed feelings of empowerment and coping capacities, and c) peer-support that contributed to optimism and positive motivation reassurance that reduced feelings of isolation and low self-esteem.

With a focus on substance use issues, Chilton et al. (2018) examined the effectiveness of psychoeducational therapy groups in dual diagnosed patients meeting criteria for the study, including those required a diagnosis with a severe mental illness with a comorbid substance use disorder. The participants were assessed at baseline and endpoint for psychological wellbeing, psychiatric symptomology, and substance abuse patterns (Chilton et al., 2018). Of the initial 80 participants enrolled, 29 dropped out after

the first assessment, with 51 participants completing the program. Study findings indicated a decline in the use of alcohol, cocaine, cannabis, amphetamine, other illicit benzodiazepines, as well as methadone, yet did not indicate a reduction in the use of heroin. Other findings showed overall improvements in both psychological wellbeing and disease state symptomatology. The researchers concluded by encouraging mental healthcare providers to focus on using integrated approaches that included psychoeducational therapy aimed to reduce harm from ongoing substance use and non-compliant treatment behavior through education. The Chilton et al. (2018) study findings indicated positive treatment outcomes for dual diagnosed individuals through psychoeducational group therapy as aligned with the observations by Gitterman and Knight (2016).

In a study of healthcare professionals' perceptions, Roncero et al. (2016) surveyed 250 professionals with experience managing patients with a dual diagnosis. The researchers put forth a survey designed to determine professional opinions regarding treatment adherence and the consequences of non-compliance with treatment considering dual diagnosed patients. Seven variables used in the study included therapeutic alliance, medication compliance, psychoeducational therapy, early treatment intervention, medication tolerability, disease awareness, and family support. The study findings showed that most healthcare professionals viewed the therapeutic alliance as the most critical variable in positive outcomes for dual diagnosed patients with medication compliance, the second most important. The patient's disease awareness was the third most important variable, with psychoeducational therapy positioned as fourth. Other

findings included that 96% of participants shared the view that patients lacked insight and awareness of their mental illness, and 87% viewed a similar lack of patient awareness regarding their substance use disorder. Overall, the healthcare professionals surveyed indicated that 73.5% recognized the significance of psychoeducational therapy, with this form of treatment identified as the most critical nonpharmacological intervention (Roncero et al., 2016).

In another study of the significance of psychoeducational therapy, Kallestad et al. (2016) conducted an adequate trial to determine the long-term effects of either individual or group psychoeducation on hospitalizations. While the population studied included patients diagnosed with bipolar disorder, the researchers recognized the significant comorbidity of substance use disorders in this population, with an estimated 60% incidence of patients diagnosed with both diseases. Study participants included 85 bipolar disorder patients randomized to either individual or group psychoeducational therapy. Patient assessments occurred at baseline and throughout the main phase of the study consisting of measuring the time to first hospital admission over 27 months. Study findings indicated that participants in the psychoeducational group therapy arm had longer survival times during the initial 27-month period than the individual therapy arm. Ten patients, or 23%, were hospitalized versus 15 patients or 35% in the individual therapy arm. However, patients in the group therapy arm with co-occurring substance use experienced the shortest time to hospitalization, including comparisons to similar patients in the individual therapy arm. The researchers concluded that substance use significantly predicted hospitalizations in patients with comorbid bipolar disorder and concluded that

participating in psychoeducational group therapy resulted in more extended hospitalization overall than individual therapy (Kallestad et al., 2016). The results by Kallestad et al. (2016), evidenced by the researcher's conclusions, further aligned with the observations by Gitterman and Knight (2016).

Similarly, Lawrence (2017) conducted a systematic review of studies involving patients with comorbid substance use and bipolar disorders to determine effective treatment strategies, including the role of psychoeducational group therapy. Lawrence recommended integrated care approaches after stabilization that incorporated medication management strategies. Integrated systems recommended included psychoeducational therapy to advance knowledge and awareness of patients regarding the details of their diagnoses and address treatment compliance in tandem to stabilize the bipolar disorder symptom presentation (Lawrence, 2017).

Hale and Cowls (2015) posited that group therapy promoted mutual support, hope, and universality in mental health settings, as psychoeducational groups brought people with similar mental health states together. Psychoeducational therapy facilitated active learning while individuals shared personal concerns and strategies for overcoming their problems relevant to other group participants (Hale & Cowls, 2015). The researchers added that combining educational experiences with interactive therapy strategies resulted in greater efficacy than merely receiving information (Hale & Cowls, 2015).

Psychoeducational group therapy significantly contributes to positive outcomes for participants. Yet, challenges persist regarding the complexities involved with dual

diagnosed patients, their lack of participation in such treatments (Dixon et al., 2016), and the effectiveness of the therapy based on the guidance provided by the group facilitator (Gitterman & Knight, 2016). While group facilitators consist of healthcare professionals with various educational backgrounds, training, and qualifications, they share the responsibility to facilitate the interactions between group participants, oversee group decisions, and guide participants in addressing emotions as they learn about their diagnoses and take steps toward both mental illness treatment and stability and substance use recovery (Gitterman & Knight, 2016). When facilitators ignored the recommended psychoeducational group therapy intervention processes, the relevance and validity of the effectiveness of the psychoeducational group became questionable (Gitterman & Knight, 2016).

The identified effectiveness of psychoeducational group therapy in many patient populations and treatment settings informs the need for further research (Dixon et al., 2016; Gitterman & Knight, 2016; Hale & Cowls, 2015). The complexities of the dual diagnosed population and the low rates of psychoeducation group therapy participation warrant exploring interventions that might improve participation toward goals of education and learning regarding all disorders diagnosed, reductions in relapses and hospitalizations, and the promotion of disease state stability and treatment compliance (Holzinger et al., 2017). A deeper understanding of how psychoeducational group facilitators and different treatment settings influence the attendance and participation of dual diagnosed patients in such therapy warrants further research.

## **Psychoeducational Group Therapy Across Settings**

The progression of care across treatment settings for the dual diagnosed places added difficulties on treatment providers, including group facilitators, as efforts that established trust and group participation in one environment may abruptly shift the patient out of the comfort of one setting and into the unfamiliar surroundings of another, further contributing to treatment barriers within the context of continuity of care (McCallum et al., 2015; Priester et al., 2016). Moreover, as compared to patients with single mental health morbidities, dual diagnosed patients add to the challenges of healthcare professionals in addressing higher rates of relapse, ongoing and worsening functional impairment, poor outcomes across all diagnosed conditions, added burdens on healthcare systems associated with readmissions and service usages, higher risks of dropping out of treatment, and greater risk of falling through gaps in treatment transitions intended to maintain the continuity of care (McCallum et al., 2015). Compared to patients with only mental illness, dual diagnosed individuals also have lower educational statuses and worse employment situations (Ponte et al., 2017).

In a comprehensive and systematic review of the literature that included 18 quantitative studies, McCallum et al. (2015) described treatment settings that offered programs for dual diagnosed patients, including therapy interventions such as psychoeducational group therapy, considered by researchers as components of the care continuum for this population of patients. Identified treatment settings included emergency room services, medical hospital inpatient admissions, inpatient psychiatric hospital admissions consisting of crisis stabilization programs and both extended- and

short-term inpatient programs, hospital-supported intensive and less-intensive outpatient mental health and substance abuse programs, residential mental health and substance abuse programs, private and community-supported intensive and less-intensive outpatient mental health and substance abuse treatment, and care oversight provided through primary care providers. According to McCallum et al., healthcare professionals generally held two perspectives of successful continuity of care for dual diagnosed patients. One perspective included a one-dimensional view referring to a dual diagnosed patient transitioning from one treatment program. The second overarching perspective encompassed the duration of treatment and all changes in that patient's treatment (McCallum et al., 2015).

McCallum et al. (2015) further observed the lack of consistent definitions and applications of continuity of care services accompanied by indirect treatment guidelines. For example, treatment guidelines emphasized the importance of continued care yet failed to offer clear definitions or practical methods for accomplishing such, thereby burdening service providers to establish systems that eased transitions and ensured that patients did not fall into gaps between services. The researchers found six core types of treatment that encompassed continuity across service types. The six types included continuity through patient-provider relationships, transfers, intensity and regularity of care, continuity in response to patient needs, and successful patient transition or linkage. The researchers noted the overall improved changes through the integrated care model and further called for further research into treatment modalities for dual diagnosed patients (McCallum et al., 2015).



Consistent with the findings of McCallum et al. (2015), Belling et al. (2011) employed a qualitative survey design using in-depth, semi-structured interviews with 113 health and social care professionals to explore facilitators and barriers that influenced continuity of care. While community mental health teams (CMHTs) contributed to integrated service delivery, they also contributed to organizational challenges. Belling et al. recognized that integrated care strategies aided in reducing patient and provider distress and confusion by improving treatment retention rates, reducing service fragmentation, and encouraging interdisciplinary communication regarding care coordination and decision making. Study findings showed that decision making, team leadership, and experiences of teamwork support positively influenced cross-boundary and team continuity with negative influences consisting of specific leadership styles, certain models of decision making, generic working, blurred role boundaries, and lack of training (Belling et al., 2011).

Belling et al. (2011) further noted that face-to-face communications involving general practitioners and case managers and the voluntary sector positively influenced information continuity. Negative influences included high caseloads, inadequate staffing, and administrative duties controlling time spent with patients. Belling et al. observed that extensive challenges existed in accessing the positive outcomes of integrated CMHTs regarding the continuity of care for individuals diagnosed with severe mental illnesses. The researchers recognized the need for better treatment for dual diagnosed individuals applicable to treatment modalities such as psychoeducational group therapies. Belling et al. concluded by suggesting that CMHTs invest in training and education for leadership,

role development, workforce retention, and skill improvement for mental health teams to meet the complex needs of dual diagnosed individuals.

Similar to the research by Belling et al. (2011) and McCallum et al. (2015), Dixon et al. (2016) investigated the continuity of care for dual diagnosed individuals. Dixon et al. posited that individuals diagnosed with severe mental illnesses often struggled to engage in continued treatment evidenced by significant dropout rates, further noting that poor engagement and dropout contributed to unwanted repercussions such as worsening clinical outcomes across all diagnoses, symptom relapse, and rehospitalizations. Variables that influenced the level of treatment engagement observed by Dixon et al. included accessibility of care, therapeutic alliance, and developed trust in the suitability of treatment by the patient. The researchers used the framework of recovery-oriented care, focusing on empowerment, autonomy, and respect of the patient, to view techniques and tools for treatment engagement, concluding that person-centered care for mental health treatment contributed toward promising engagement outcomes (Dixon et al., 2016).

It is often the case that dual diagnosed individuals participate in treatment initially and then gradually attend less frequently. Humensky et al. (2017) found that, after initial hospitalization, 84% of discharged patients attended their initial follow-up appointment. A higher chance of attendance occurred with proper case management, medical comorbidities, homeless patients or those living in a shelter, and inpatient dual diagnosed treatment. A lower chance of treatment attendance occurred in non-Latino black patients. Humensky et al. added that patient population, hospital characteristics, and the

availability of local outpatient services influenced overall continuity of care and further noted that variables determined to affect the success rate of treatment warranted further study (Humensky et al., 2017).

### **Strategies Toward Effective Psychoeducational Therapy**

According to Anderson et al. (2001), the first step toward effective psychoeducational group facilitation involved actions by the facilitator to challenge their beliefs and expectations. Developing positive perspectives that anticipated the desired group outcomes, leadership actions, and behaviors that showed respect for the group members and shared expectations for active survival versus passive victimization contributed to successful outcomes (Anderson et al., 2001). Still, many healthcare professionals charged with treating dual diagnosed patients, including group facilitation, lacked knowledge regarding practical approaches for addressing the needs of patients both short-term and across treatment settings (Bonnie, 2017).

In a U.S. study of 256 treatment programs across 11 states, only 9% of mental health programs and 18% of addiction treatment services met the criteria for efficacy in treating dual diagnosed patients (Bonnie, 2017). Researchers suggested a comprehensive treatment approach that integrated innovative and well-validated treatment methods to address dual diagnosed individuals' multi-dimensional and complex clinical presentations, including psychoeducational group therapy (Gardiner et al., 2017).

Moreover, in a literature review regarding content development for training healthcare professionals, 13 content areas were determined as critical focal areas for education included psychoeducation (Bonnie, 2017). While psychoeducational groups

involved a format and generally have structured limitations, participation of dual diagnosed individuals in psychoeducation group therapy established a critical need for facilitator knowledge and awareness of the complexities of the diagnoses to accomplish the intent of the group allowing for flexibility as warranted (Bonnie, 2017; Brown, 2019; Gitterman & Knight, 2016; Hale & Cowls, 2015).

Gitterman and Knight (2016) suggested that the popularity of psychoeducational group therapy resulted from the success of the groups and the relative ease of implementation. The researchers encouraged social workers who lead psychoeducational groups to select topics for discussion appropriate for the group participants, further noting that much of the published literature focused on the content of such groups versus the process and interactions within the group. Consistent with the group focal conflict theory (Whitman & Stock, 1958), as Champe and Rubel (2012) presented, Gitterman and Knight (2016) argued that if facilitators adhered too rigidly to the curriculum content, participants' ability to understand and internalize the information was compromised. The researchers advocated for an approach to psychoeducational groups that emphasized the flexible presentation of the curriculum, further noting that encouraging collaborative learning involving patient interactions with each other and the group leader contributed to positive effects, including an increase in group participation. Psychoeducational groups, when appropriately applied, provided dual diagnosed individuals with new ways to cope with life situations and explore their feelings to uncover the roots of their issues (Gitterman & Knight, 2016). Despite the great purpose of psychoeducational groups to educate participants about their illnesses and cope with them, treatment sometimes results

in adverse outcomes. Treatment often failed due to a suspected lack of trained professionals, inaccessible treatments, and fragmented services such as groups for mental illness separated from substance abuse groups (Shiple et al., 2016).

Beneficial psychoeducational group leader traits require knowledge, self-development, training, and an appreciation for the possibilities and benefits of psychoeducational therapy specific to the population of the group participants (Brown, 2018). Brown (2018) described an effective group leader as possessing the capacity to identify, understand, and respond appropriately to any issues that developed within the group and to provide strategies to overcome those issues while recognizing that dual diagnosed individuals faced significant challenges and need interventions that promoted their self-determination, autonomy, and adaptive functioning. Similarly, Dixon et al. (2016) suggested that group facilitators optimize recovery-oriented attitudes and skills to lead psychoeducational groups that included dual diagnosed participants effectively. Schroeder et al. (2018) added that planning and implementing therapy groups consisted of a core concern of caring for the group members through strategies, techniques, interventions, and activities suitable for the capacity of the group members. Once the leader screened the group members, the leader gauged the group's ability in advance and developed content and structure accordingly (Schroeder et al., 2018).

In a qualitative study of dual diagnosed patients in an outpatient facility, Priebe et al. (2017) explored how they experienced their conversations with nurses. The participants included five patients with data collected through interviews regarding their experiences of caring conversations (Priebe et al., 2017). The hermeneutical analysis

yielded three themes that included restored self-esteem, reciprocity toward safety and communion, and made suffering understandable and visible, with the primary theme of a sanctuary of safety. Priebe et al. found that caring conversations contributed to feelings of safety, alleviated elements of suffering, and aided in the restoration of self-esteem and dignity for dual diagnosed patients. Priebe et al. observed that the nurses' caring attitudes supported the dual diagnosed individual's understanding and subsequent learning that aided in developing coping strategies, thereby enabling patients to make informed decisions about their treatment. The researchers concluded that caring exchanges initiated by the healthcare professionals added to their safety experiences, determined as more significant than trust for recovery within the context of the study. Aligned with the current research, a caring attitude exhibited by therapy leaders might influence decisions toward continued treatment in dual diagnosed patients (Priebe et al., 2017).

Hale and Cowls (2015) posited that even though several healthcare professionals lead psychoeducational groups, occupational therapists (OTs) might contribute more effectively based on the observation that OTs provide a unique focus and method of group facilitation. According to the researchers, psychoeducational groups required a structure provided by facilitators that displayed skills to empower group participants to direct and carry large portions of the group discussion (Hale & Cowls, 2015). The facilitator's responsibilities included developing structured content while incorporating activities linked to occupational performance, such as participating in self-care, productivity, or leisure actions (Hale & Cowls, 2015).

Employing a qualitative design, 171 patients diagnosed with severe mental illness

and substance use participated in the study conducted by Green et al. (2015) to examine what it takes for mental health professionals to help the dual diagnosed population to overcome their treatment barriers and succeed in treatment. Data collection methods included four in-depth face-to-face interviews with participants held throughout the two-year study period. Data collection and analysis resulted in identifying three prominent themes that aided in dual recovery. The themes included the perspectives that a) attending educational groups regarding the effects of alcohol and substances served as motivation and foundation for recovery, b) reaching a point of non-substance use promoted effective treatment for mental illness as the substance use masked the symptoms of the underlying mental illness, and c) achieving substance use recovery created self-efficacy, self-confidence, personal growth, and overall improved functional capacity. The researchers concluded by suggesting that strategies by healthcare professionals charged with treating dual diagnosed patients encompassed non-judgmental efforts toward chronic disease education and adopted flexible strategies that reduced barriers to engagement to contribute toward dual recovery in the population of patients with severe mental illnesses accompanied by substance use Green et al.

The findings by Green et al. (2015) supported qualitative research by Bledin et al. (2016) that explored strategies used by clinical psychologist facilitators or co-facilitators in therapeutic group settings, including eight weekly psychoeducational groups. Bledin et al. included patients with severe chronic mental illnesses such as schizophrenia or related psychotic disorders, bipolar disorder, and personality disorders. While the researchers identified comorbid substance use as a common occurrence, the inclusion criteria did not

include a dual diagnosis. Data collection occurred through responses provided by each participant to a single question posed after each group that consisted of identifying the single most important event from each group meeting. Data collection events included 14 weekly groups over 12 months. Data analysis resulted in five overarching themes: a sense of belonging, communication, receiving therapeutic help and peer support, hope, and a focus on relationships. The researchers concluded by underscoring the value of psychoeducational group therapy in the confined inpatient setting, yet also indicated the need for continued therapy across treatment settings (Bledin et al., 2016).

### **Family Involvement in Psychoeducational Therapy**

Facilitators of psychoeducational and therapeutic groups are responsible for determining relevance specific to the individuals participating in group therapy that might promote their successful progression through treatment. In the systematic review of the literature conducted by Lawrence (2017), the integration of family and psychoeducation in the treatment of dual diagnosed patients proved helpful once medication management stabilized the symptoms of the mental illness resulting in improved functioning and coherence of the patient. Similarly, Klimkiewicz et al. (2015) suggested that therapy addresses social skills training in the population of dual diagnosed patients studied, noting that this approach aided in coping strategies and substance use recovery. Moreover, the qualitative research by Green et al. (2015) referenced narratives by individual patients successful in reaching recovery and improving mental illness disease management through the aid and support of their families.

Consistent with Wheeler et al. (2018), Palli et al. (2015) conducted an



experimental study to determine the possible influence of family integration into group therapy on the patients' severe mental illness outcomes. The treatment arm consisted of 18 psychoeducation group therapy sessions focused on illness education, communication skills training, and problem-solving. Study findings indicated a significant drop in the number of hospitalizations following the psychotherapy interventions and the improved adherence to prescribed medication regimens in the treatment arm versus the control group. The researchers concluded that psychoeducational group therapy sessions that integrated family resulted in significant improvement in a patient's mental illness (Palli et al., 2015).

According to Keller et al. (2017), family members in group therapy settings positively contributed to recovery by providing an added support element. Positive outcomes included a reduced sense of isolation, improved sense of belonging, feelings of mutual support, exposure to positive models, and the development of coping skills by interacting with others (Keller et al., 2017). Similarly, Worrall et al. (2018) conducted a systematic literature review to determine the effectiveness of support groups. The researchers sought published research that shared the perspective of support groups as people-oriented meetings that included persons with similar mental illness experiences, either personally or by proxy (Worrall et al., 2018). Study findings showed significant scientifically rigorous evidence throughout the literature reviewed, indicating the effectiveness of professionally facilitated psychoeducation groups that integrated caretakers and family support in benefiting patients with mental illnesses (Worrall et al., 2018).

Other research supportive of family integration into psychoeducational group therapies included the suggested need for consumer and family-oriented treatment established in the study by Pollio et al. (2017). The researchers examined the effect of consumer preference in a psychoeducation intervention study. They found that attempting a family-oriented approach did not hinder the treatment outcomes of the patient members of the group based on the continued inclusion of necessary information that promoted the educational and therapeutic needs of the patients. The researchers, however, noted concerns regarding such therapy strategies that might omit critical information needed for effective treatment in some cases (Pollio et al., 2017). Similarly, Nagi and Davies (2015) investigated the development of family-oriented psychoeducational treatment in low-security mental health settings. The researchers found that the five families participating in the research perceived the intervention positively. Nagi and Davies concluded the effectiveness of family-oriented interventions patterned after generic mental health settings in low-security mental health environments.

### **Facilitator Awareness and Understanding of Barriers to Treatment**

Therapy facilitators are responsible for the group participants to understand barriers to treatment according to the characteristics of the dual diagnosed population and the individual participants in the group (Priester et al., 2016). Barriers to treatment in the dual diagnosed population present challenges for the patient, their families, caregivers, and treating clinicians (Priester et al., 2016). Even so, medical and mental healthcare clinicians contribute to treatment barriers in some cases for reasons that may include inadequate training, insufficient screening methods, and provider-oriented lack of

accurate diagnoses (Lawrence, 2017; Priester et al., 2016).

According to Lawrence (2017), clinician-established barriers to advancing appropriate treatment occurred in several instances. Some mental health clinicians created barriers to treatment as they failed to document the second diagnosis due to concerns surrounding reimbursement issues. In such cases, Lawrence suggested that clinicians unable to establish a dual diagnosis further withheld recommending additional and needed long-term or follow-up treatment in the interest of effective continuity of care based on the clinician's perspective that interventions applied to one disorder may be adequate for both. Aligned with this thinking, evidence revealed in the research by Bush et al. (2015) suggested that carrying a dual diagnosis interfered with a patient's ability to find employment in some cases, contributing to decisions by some clinicians to refrain from assigning the second diagnosis, thereby proceeding with treatment according to the most prominent disorder clinically presented (Lawrence, 2017). According to Priester et al. (2016), patients untreated for any reason experienced ongoing difficulties engaging in treatment, developing a therapeutic alliance, experienced persistent low socioeconomic status, and often exhibited symptoms of depression, anxiety, and personality disorders with increased chances of medical illnesses, suicides, and early mortality.

Moreover, healthcare professionals who facilitated treatment, including group therapies, experienced adverse outcomes, as predicted by social construction theory (Morton & Hohman, 2016; Palincsar, 1998). In a systematic review, Morton and Hohman (2016) explored the published literature for evidence regarding the psychosocial impact of group leaders on the professionals that facilitated groups, including complex patient

populations such as substance use patients, victims of partner violence, and childhood abuse. Three themes emerged and included reflections on professional expertise and life experiences, conscious collaboration, and attention to safety. The findings indicated that the complexities of building collaborative relationships with group therapy participants negatively impacted the group facilitators (Morton & Hohman, 2016).

Priester et al. (2016) further explored areas that contributed to treatment barriers in the dual diagnosed population by employing an integrative review study method to synthesize the literature regarding barriers in this population and identify underrepresented population subgroups. The researchers examined 36 published works that revealed two broad categories of treatment barriers, including personal characteristics and structural obstacles. Unique features included subtypes of unique vulnerabilities and personal beliefs. Individual exposures had the interplay of the comorbid diagnoses as symptoms of one disorder contributed to the other, thereby impacting dual diagnosed patients' functioning and emotional capacities that prevented both the desire and ability to engage in therapy. Personal beliefs included a lack of confidence or trust in treatment providers, cultural issues, and experienced or feared stigma of either or both illnesses. Even those who desired treatment-experienced fear and confusion, preventing access to appropriate care (Priester et al., 2016).

Structural barriers identified by Priester et al. (2016) included aspects such as the availability of service that met the needs of the patient. Other elements considered structural barriers had geographical proximity to service, transportation issues, and the lack of therapists' knowledge about integrated treatment in the nearby communities.

Trained clinicians further recognized this barrier and reported the need for appropriate staff with additional training to address the specialized needs of the dual diagnosed. Recognized by as many as 90% of healthcare professionals, the identified inadequate training and knowledge to handle patients with co-occurring disorders coexisted with the further reported lack of appropriately trained referral sources within the community. Other structural barriers that significantly contributed to the lack of patient participation in treatment included red tape, insurance barriers, waiting for racial or ethnic disparities, sexual preferences including LGBTQ, and age, appearing as populations identified as lacking in treatment or participation or without adequate research studies to evaluate the level of treatment engagement. Overall, available research regarding racial, ethnic, and sexual orientation indicated that whites were more likely to have been accurately diagnosed with co-occurring disorders and therefore referred to therapy. At the same time, the accuracy of dual diagnosis remained overlooked in all other racial, ethnic, sexual preference, and older populations. Harley (2018) found similar barriers to treatment involving geographical issues, experiences stigma, and a shortage of qualified staff. Priester et al. (2016) concluded by noting the potential need for developing training and certification standards for both diagnosis and treatment, including the role of psychoeducation group therapy facilitation, to improve accurate recognition and diagnosis and reduce barriers to treatment to more effectively address the needs of the dual diagnosed populations.

### **Summary and Conclusions**

Using a qualitative phenomenological study, the researcher aims to explore the

experiences of psychoeducational group facilitators as they educate dual diagnosed individuals. Insights are provided from the social constructionist theory (Palincsar, 1998) and group focal conflict theory. Whitman and Stock (1958) informed the identified problem of the proposed study in exploring facilitator experiences associated with understanding the lack of participation of dual diagnosed patients in therapy and interconnects to the literature included in the review. The content of the study provided evidence of the substantial literature available on psychoeducational group therapy, yet the lack of that literature that focused on the experiences of group facilitators with the diverse and complex population of dual diagnosed patients.

Initial topics discussed included the complexities of the dual diagnosis that encompassed therapy considerations, providing evidence of different treatment therapy options while underscoring the effectiveness of psychoeducational group therapy and the value of integrated care in the target population of patients. The literature presented then evolved into a description of psychoeducation group therapy, the application of psychoeducational group therapy across treatment settings, and facilitator strategies to consider in accomplishing meaningful psychoeducational group therapy sessions. Strategies focused on addressing continuity of care and promoting the integration of supportive resources, such as family, into some therapy settings.

The final section overlapped with the research discussed throughout the review in drawing attention to facilitator awareness and understanding of the barriers to treatment. Group therapy facilitators' awareness of treatment barriers is pivotal in supporting the proposed research and aligns with the study problem identified as the limited

participation of dual diagnosed individuals in available treatment modalities. Moreover, improving awareness of barriers to treatment interconnects and supports the study aim to attend to the gap in the research literature involving the need to advance knowledge and understanding regarding psychoeducational group therapy facilitator experiences with the diverse and complex population of dual diagnosed patients.

### Chapter 3: Research Method

The problem explored is the high turnover rate of group facilitators in psychoeducational groups and why group facilitators may struggle to retain dual diagnosed individuals in psychoeducational groups despite their known effectiveness. Engaging dual diagnosed individuals in treatment is a complex and multifaceted process that requires facilitators to obtain the necessary recovery-oriented skills and attitudes to deliver good service (Dixon et al., 2016). This qualitative phenomenological study explored the psychoeducational groups' facilitators experience working with dual diagnosed individuals. This study also explored the experiences of psychoeducational group facilitators when dealing with dual diagnosed individuals. Based on the problem and the purpose, the phenomenon of interest would be the perceptions of facilitators dealing with dual diagnosed individuals in psychoeducational groups.

In Chapter 3, the focus of the discussion is the methodology and research design used to address the research questions of this study. I present the details of the different methods, processes, and techniques used to address the two research questions. A summary is presented at the end of Chapter 3 to transition to Chapter 4.

#### **Research Design and Rationale**

This study had three research questions aligned with the purpose of the study to explore psychoeducational group facilitators' experiences when dealing with dual diagnosed individuals:

- RQ 1: How do psychoeducational group facilitators experience working with dual diagnosed individuals?



- RQ 2: To what extent does the group setting or workplace affect group facilitators' experiences when dealing with dual diagnosed individuals?
- RQ 3: How do psychoeducational group facilitators perceive the needs of dual diagnosed individuals in terms of their retention in psychoeducational groups?

The research design applied to answer the research questions was the phenomenological design. Phenomenological research is considered appropriate for studies that involve making sense of individuals' lived experiences to address issues within a phenomenon (Giorgi, 1994; Moustakas, 1994), allowing for relevant insights from the pooled information (Giorgi, 2017). The phenomenological approach was used in this study to understand and interpret the experience of psychoeducational group facilitators dealing with dual diagnosed individuals and how group settings inform their experiences.

Other research traditions were considered but not chosen for this study because of misalignment with the purpose and research questions. Grounded theory is inappropriate because there was no need to develop a theory (see Glaser & Strauss, 2017). Ethnographic design was not suitable for this research because exploring the ethnicity or culture of the participants was not the focus of this study (see Ingham-Broomfield, 2015). Narrative design was not appropriate for this research because there was no need to organize experience data in chronological order to address the study's research questions. Therefore, phenomenology was chosen as the most appropriate research design to address the purpose of this study because I was able to explore the life experiences of the group facilitators in terms of their feelings.

### **Role of the Researcher**

As an observer, the researcher serves as the main instrument for data collection (Fusch & Ness, 2015; Kaplan et al., 2017; Nelson et al., 2015). I served as the main instrument for data collection for this study including recruiting participants, collecting data, and analyzing data. During the recruitment phase, site permission was obtained from the managers of the facilities where the participants were recruited. Because I recruited participants, the primary consideration was minimizing conflict of interest (Engward & Davis, 2015; LeCroix et al., 2017). To do this, recruiting members of my immediate social network was avoided (e.g., family members, friends, relatives, colleagues, or work subordinates). Participants received copies of the consent form to ensure that psychoeducational group facilitators interested in participating in this study knew their rights and roles before signing as study respondents.

During the data collection phase, I personally conducted semi structured interviews with psychoeducational group facilitators. I was also responsible for developing the interview guide for this study to provide structure to the interview process and to prevent me from asking questions vulnerable to biased responses. Because the interview guide is researcher-developed, another responsibility was to ensure the validity of the instrument through an expert review (Balkar, 2015; Lincoln & Guba, 1985). I confirmed that asking irrelevant or leading questions were eliminated with a validated interview guide during the interviews by developing questions that are appropriate to the study and the participants.

Another responsibility of the researcher was minimizing the influences of

personal biases. I may have had personal opinions, perceptions, and beliefs about the topic that may influence the study's findings. Bracketing allowed me to recognize all personal opinions, perceptions, and beliefs, including the study's expected findings (see Henfield et al., 2013). Through this process, I was aware when making conclusions aligned with personal biases without any support based on the actual data collected from the participants. To address other ethical issues, I ensured that the raw data collected were never altered purposefully or without the participants' consent through member-checking. Member-checking allowed participants to review their interview transcripts and interpretations to ensure that their responses transcribed and interpreted correctly (see Birt et al., 2016). I also used Atlas and NVivo for the data analysis.

## **Methodology**

### **Participant Selection**

#### ***Target Population***

The purpose of this study was to explore the lived experiences of facilitators of psychoeducational groups while educating dual diagnosed individuals. Therefore, the target population of this study was facilitators of psychoeducational groups in the United States. Psychoeducational groups' facilitators were chosen because of their alignment with the topic of the study. Therefore, the members of the selected population for this study had the relevant knowledge and background that would be useful in addressing the problem and research questions of the study (see Malsow, 1943; Morse, 2004).

#### ***Sampling Technique***

I chose purposive sampling. Most qualitative studies use purposive sampling

because of its suitability in collecting relevant and effective participants for the study (Barratt et al., 2015). Purposive sampling is a non-probability sampling technique that researchers commonly use to recruit qualitative data collection methods (Barratt et al., 2015; Etikan et al., 2016). This technique involves recruiting specific individuals based on specifically targeted characteristics, which made up a list of eligibility or inclusion criteria (Barratt et al., 2015; Etikan et al., 2016). Because of the alignment of the chosen individuals to the topic of the study, the participants recruited through purposive sampling are most likely to provide relevant information that was essential to addressing the research questions of the study.

### ***Sampling Criteria***

The participants of the study would be assessed for eligibility based on a set of inclusion criteria. The criteria for inclusion into the study are ) case managers, qualified mental health professionals such as therapists, credentialed alcoholism and substance abuse counselors, social workers, mental health counselors, or psychologists with at least one year of experience who facilitated psychoeducational groups, b) have treated dual diagnosed individuals for at least one year, and c) currently treating a group of dual diagnosed individuals with a clean license if necessary I chose the first criterion in alignment with the target population. The second and third criterion ensures that the participants have sufficient experience interacting with and treating dual diagnosed individuals in individualized and group contexts. Only those who satisfied all the eligibility criteria were included in this study as participants. I determined if potential study participants fulfill the eligibility criteria by asking a set of screening questions

during the recruitment phase.

### ***Sample Size***

The appropriateness of sample size for qualitative studies was dependent on the data saturation point (Fusch & Ness, 2015; Tran et al., 2016). The data saturation point referred to when a researcher has satisfied the following criteria during data collection and analysis: a) no new information, b) no new codes, and c) no new themes have emerged with the addition of new interview data. According to scholars, data saturation is achieved with a range of 10–30 participants (Boddy, 2016; Malterud et al., 2016). For this study, 8–12 psychoeducational group facilitators of individuals with dual diagnoses would be recruited for data collection. However, I would draft more participants if needed to achieve data saturation.

### **Instrumentation**

The main instrument of data collection for this study was the interview guide (See Appendix B) Researchers use semi-structured interviews because of the ease and effectiveness of this option when collecting in-depth data because of the follow-up questions that interviewers may ask (Kallio et al., 2016; Katz, 2015). Therefore, the main instrument for data collection would be an interview guide. The interview questions would be developed based on existing literature relevant to the topic of the study.

As part of the role of the researcher, the validity of the findings must be ensured. To do this, I performed an expert review. An expert review is a process that researchers use to ensure that the questions during data collection will be relevant and valid for the study (Balkar, 2015). I asked three experts from each of the following fields to participate

in the review: a) psychoeducation, b) treatment of individuals dual diagnosed, and c) qualitative research. Each expert had at least ten years of professional experience of practice in their respective field. These experts were different from the participants of the interviews. During the review, the experts assessed the guide questions for the discussion using the following criteria, including a) appropriateness of word usage and sentence structure, b) understandability of the questions and c) completeness of the questions in addressing the research question of the study.

### **Procedures for Recruitment, Participation, and Data Collection**

#### ***Establishing Contact with Participants***

Before initiating direct contact with the participants, I would first obtain site permission. I would contact the heads of facilities catering: (hospitals, residential homes, Alcoholics Anonymous, Narcotics Anonymous, and rehabilitation centers). to patients with dual diagnoses to ask for their permission to invite their teachers as participants of this study. Upon providing their authorization, the heads of the facilities would list potential participants with their respective email contact information

#### ***Recruitment Procedures***

After initiating contact with participating facilities(hospitals, residential homes, Alcoholics Anonymous, Narcotics Anonymous, and rehabilitation centers). ough site authorization, I would begin inviting participants. I would send invitation emails to potential participants, including information concerning a) researcher's background information, b) purpose of the study, c) potential benefits and significance of the study, d) the intent to recruit the recipient of the letter, and e) characteristics of participants (i.e.,

eligibility criteria). The interested potential participants would be asked to reply to the email. If the recipient accepts the invitation to participate, they would provide an active mobile number and the best time to receive a screening call from me to discuss the purpose of the study and the inclusion and exclusion criteria

Informed consent forms would be sent through email to facilitators interested in being participants in the study. The consent form would reiterate the research topic, research procedures, the purpose of the study, the potential risks and benefits of the study, and their right to withdraw their data and their participation at any point in the study. Interested participants must read and sign the consent form if they agree with the discussion presented in the document. The participants must send the signed consent form to participate in the study and then interviews would be scheduled for eligible participants.

### ***Data Collection Procedures***

Each participant was interviewed once. The interviews were held in neutral and private locations to limit potential distractions and to ensure the confidentiality of the participant's responses. All of the interview sessions would be audio-recorded to allow thorough review and analysis. Additionally, the audio recordings would be supplemented with detailed notes (Taylor et al., 2015). Each interview would last for approximately 1 hour and will be composed of three phases, including a) introduction, b) question-and-answer, and c) conclusion. In the introduction, the topic of the study would be discussed. The nature and purpose of the interview would also be explained. Finally, the flow of the session preparing the participant for what is about to happen in the discussion would be

discussed. In the question-and-answer phase, questions using the items listed in the interview guide would be asked. For in-depth data collection, follow-up questions whenever needed would be asked. More information would be asked to address the research questions entirely and comprehensively through the answers to follow-up questions. However, there would be a limitation to the follow-up to a maximum of three questions for each main item in the interview guide. I could then avoid prolonging the interview session with unnecessary questions.

After asking all the questions in the interview guide (See Appendix B.), the participants would be made aware that there are no more questions for them. The participants would then be allowed to make comments, provide more information relevant to the study, and ask questions about the interview. If needed, questions from the participant would be addressed, and thank the participant for their time to end the conversation. Participants would be informed of their right to withdraw their data at any point in the study.

### ***Data Preparation***

Each interview was transcribed immediately after each session. An audio player would be used to listen to the interview recording to facilitate a more straightforward transcription. During the same time, a one-page summary of the interview with initial interpretation of the findings would be prepared. Both the summary and interpretation would be completed within a day after the interview upon transcribing the data by writing the participants' interview verbatim.

After finishing the transcriptions and initial interview guide, member checking



would be conducted. Each participant would be given a chance to review the transcript and initial interpretation of their interview (Birt et al., 2016; Varpio et al., 2017). During member checking, each participant would receive a copy of the transcript and initial interpretation through email. The participants had seven days to review the contents of the documents for accuracy and correctness. Participants were instructed to contact me and discuss inconsistencies in the transcripts and initial interpretations. Changes to the data would be made based on the outcome of the discussion with the participants.

### **Data Analysis Plan**

The interview questions were based on existing literature relevant to the topic of the study, which would ensure that the data collected were aligned to the study's goals. The analysis of the interview data would follow Kleiman's (2004) phenomenological process, which consists of a review of the transcriptions through a global perspective followed by an analysis with insight into the participants' individual views, and the conflation of meaningful information from the separate transcripts. Data would be analyzed using Interpretative Phenomenological Analysis (Smith et al., 2009). IPA is a data analysis approach that studies the personal insights of a given phenomenon to gain an in-depth understanding of their lived experiences (Smith et al., 2009).

When using IPA, the principles of interpretive phenomenology, mainly when applied to research, must be observed (Yardley, 2000). According to Yardley (2000), there are four principles of interpretive phenomenology, including a) sensitivity to context, b) commitment and rigor, c) transparency and coherence, and d) impact and importance. This approach highlighted the significance of individual accounts as the

findings of IPA are firmly rooted in the evidence from the words of participants (Smith et al., 2009). To perform IPA, the following steps would be taken: organizing the data, immersion into the data, generating categories and themes, coding the data, developing interpretations, examining and searching for alternative meanings, presenting the findings of the research study. Each interview would continuously be validated and referenced against one another to confirm any conclusions and ensure that all participants' views were well-represented in the resulting analyses.

### **Trustworthiness**

Addressing issues of trustworthiness is essential to improve the validity of the findings of the study. Lincoln and Guba (1985) described four concepts basic to managing reliability. These concepts are credibility, transferability, dependability, and confirmability.

#### **Credibility**

Credibility refers to the truth of the data or the participant's views and the researcher's interpretation and representation (Lincoln & Guba, 1985). To improve credibility, the researcher would perform member checking. The researcher could verify the accuracy of conclusions with participants through member checking, thus enhancing the study's credibility (Lincoln & Guba, 1985). Moreover, the researcher performed an expert review of the data collection instrument. Balkar (2015) claimed that a researcher could improve the validity of an interview protocol through an expert panel review.

#### **Transferability**

Transferability correlates to external validity (Lincoln & Guba, 1985). Ensuring

transferability involves performing processes that will help future researchers and readers quickly evaluate the applicability of the results to another setting through replication (Lincoln & Guba, 1985). To improve transferability, procedures, and findings of the study in a detailed manner would be discussed. By performing this process, the output for the analysis could be expected to be helpful in other settings or related studies.

### **Dependability**

Dependability refers to the reliability of the study (Lincoln & Guba, 1985). To improve dependability for this research, the researcher conducted an audit trail. An audit trail involves generating detailed documentation of the processes and outputs relevant to Connelly's (2016) study. With an audit trail, future researchers and readers could easily understand and assess the reliability of the study.

### **Confirmability**

Confirmability is a measure of the objectivity of the study (Lincoln & Guba, 1985). To improve confirmability, the researcher must minimize subjectivity. Using an expert-reviewed data collection instrument, the researcher could ensure that the data collected would be valid. Through this process, the researcher could also minimize researcher bias during data collection. Therefore, performing an expert review would help improve confirmability.

### **Ethical Procedures**

An essential responsibility of a researcher is addressing ethical issues when using human subjects for a study (Makhoul et al., 2018). A necessary means of addressing ethical issues was obtaining approval from the Institutional Review Board (IRB) before

beginning recruitment. The IRB would assess the proposed methods to assess if the rights of the participants would be violated through the study. Another critical way to address ethical issues would be the informed consent process. The potential risks and benefits of participating in the study could also be included in the informed consent. All participants must read and sign a copy of the informed consent before conducting data collection. Participants who signed the consent forms approved by the IRB which describe the study purpose, procedures, voluntary nature of the study, risks and benefits of being in the study and privacy would be allowed in the study.

To address issues related to confidentiality, pseudonyms would be used to keep the identity of participants confidential. Moreover, participants would be assured that their responses would be kept confidential by ensuring that all documents would not include names or any information to identify the participants. All the data collected and used for this study would be stored electronically on an external drive. All electronic documents would be password protected. After finishing the study, the electronic files as well as all the written and printed files would be placed in a locked cabinet to which only the researcher has access. All the data would be kept on file for five years after completing the study. After five years, all the relevant data would be destroyed through shredding or permanent deletion. All participants would be volunteers. Facilitators would not be forced to be a respondent of the study. Any participant may also quit the study at any time without any consequences or difficulty. No incentives would be given to participants. The participants would be exposed to minimal risk of harm.

### **Summary**

The purpose of this qualitative phenomenological study was to explore psychoeducational group facilitators' experiences working with dual diagnosed individuals and how the group setting is perceived to influence their experiences. Based on the contents of Chapter 3, data would be obtained from 8–12 psychoeducational group facilitators who have been working with dual diagnosed individuals for at least one year. The participants would be recruited using purposive sampling. Data would be collected through individual, in-depth, semi-structured interviews that would be conducted face-to-face. The interviews would be audio-recorded for transcription at a later stage and would be analyzed through IPA. The results from implementing the procedures discussed in Chapter 3 would be presented in Chapter 4 such as sampling and data collection process and data analysis; presentation of emergent themes.

## Chapter 4: Results

This study was conducted to investigate the life experiences of group facilitators conducting psychoeducational groups with dually diagnosed individuals. This chapter discusses the expert panel evaluation, the research study's sampling strategy, research topics, the demographics profile of the study's participants, data collecting and analysis techniques, themes creation, reliable evidence, and outcomes.

### **Expert Panel Review**

An expert team reviewed and validated the research questions for this study. When a researcher wants to define the scope of their qualitative research, expert panels are used (Wu & Lu, 2014). Since my research study focused on the experiences of group facilitators working with a sensitive population of individuals, I thought it would be preferable to enlist the help of a knowledgeable group of individuals who have training in and experience with the population under study. A psychologist, a social worker, and a consultant in the field of education were part of the panel. They noted that the questions were too broad, which would not allow me to obtain the responses needed to address the research questions. Therefore, they recommended and helped me narrow the questions to more specificity and focus.

### **Demographics**

To better comprehend the life experiences of the group facilitators leading psychoeducational groups for those with dual diagnoses, this section describes each study's participants. There were 11 individuals chosen and prescreened during the recruitment period. The following requirements had to be satisfied by those who wanted

to take part in the study:

- Have experience facilitating psychoeducational groups
- Have worked with dually diagnosed clients for at least one year.
- Participants must be either a social worker, mental health counselor, case manager, CASAC worker, or/and psychologist.

Eight people were eligible to participate in the study following the prescreening stage.

The other three were not qualified because they had never worked with people with both diagnoses despite their prior expertise in leading groups. All participants provided feedback when asked about the group facilitators' experiences working with dual-diagnosed patients in various settings, including hospitals, residential treatment facilities, AA/NA meetings, and rehabilitation centers, as well as about the retention of dual-diagnosed patients in treatment.

One Hispanic/White participant and seven African Americans worked in these settings in the city of New York. Pseudonyms were used to identify the study participants: Melvino, Peterpan, Kristy, Marquise, Paty, Ronie, William, and Missy. Melvino has two adult children and is a certified social worker with a long experience in clinical work in the mental health sector, including working with people who have dual diagnoses. Peterpan, a CASAC employee with an MA in counseling, serves as the director of a single-occupancy residential facility for those with mental illness and substance misuse issues. Marquise is another case manager who is working on obtaining her CASAC soon. Ronie has a MA degree in psychology and works in a rehabilitation center. Kristy is a case manager who works with people with two diagnoses. She is

married with kids. Paty is a social worker with a license who works in a hospital. William is a psychologist. Missy works as a case manager in a residential/shelter and has an MA in mental health counseling.

### **Data Collection**

This qualitative, phenomenological study was conducted to learn more about the life experiences of group facilitators who lead psychoeducational groups for people with dual diagnoses. The findings of this study provide an overview of the group facilitators' overall life experiences as they lead psychoeducational groups for people with dual diagnoses. The findings are also intended to give mental health officials the evidence they need to support improving training for group facilitators. Because substance abuse is becoming an epidemic, new policies may ensure that group facilitators are more mentally prepared for their tasks and less likely to suffer from clinical burnout while supporting this population in their recovery. The findings may also help group facilitators better appreciate the difficulties faced by dual-diagnosed individuals and their difficulties leading psychoeducational groups as well as help improve group facilitator training to reduce stress-related burnout.

I evaluated the consent forms that the group facilitators who were eligible to participate in the study received and signed for their records. Data collection was composed of eight semi structured interviews. Each participant underwent one in-depth, semi structured, face-to-face interview. Each participant had access to a private, comfortable room for the interviews. The interviews lasted 30 to 40 minutes, and there was no payment to the participants. Using an audio recorder, I captured each participant's



interview. Through Otter, a specialized service, the interviews were professionally transcribed. The transcription was coded and examined in the data that had been gathered.

### **Data Analysis**

The data were analyzed and coded using the IPA process. I examined, characterized, evaluated, and positioned the participants' lived experiences about running psychoeducational groups for dual diagnoses because the experiences varied from group facilitator to group facilitator. They understand a phenomenon aids in analyzing and interpreting how it could impact participants' knowledge, experience, and individual educational experiences (Noble & Smith, 2015). As a result, group leaders could describe how they believe their personal experiences leading psychoeducational groups could address more avenues or provide resources for better aid to those dual-diagnosed.

I repeatedly listened to the audio file and reviewed the transcript, taking note of any original descriptive claims (see Ravitch & Carl, 2016). It was possible to grasp each transcription better by analyzing it separately before spotting patterns that revealed codes and emerging themes (see Saldaña, 2014). Additionally, I gathered the data and created a spreadsheet for each participant that contained their answers to the nine interview questions. This spreadsheet made it easier to spot trends and understand how they contributed to the themes. This method made redundant data obvious and assisted in locating new ones. Five themes emerged from the participant responses following the data analysis. In this investigation, no discrepancies might have introduced conflicting information or led to contradicting outcomes.

## **Evidence of Trustworthiness**

### **Credibility**

It is crucial to design the research process by selecting competent participants, gathering and analyzing data gathered, and discussing the findings to guarantee the integrity of the phenomenon based on the data acquired. This study verified reliability before, during, and after each interview. The study was voluntary, and participants could leave at any point. To elicit more information that might have been pertinent to the phenomenon, participants were also asked probing and follow-up questions based on specific responses over a prolonged period throughout the interview. During the interview sessions, participants were asked to offer additional thoughts or points of view and to utilize reflective techniques to analyze their comments objectively.

### **Transferability**

To verify the study's validity, other researchers must be able to follow its procedures and conditions and get results that are comparable to those obtained in it. The study's findings must be reflected on, comprehended, and interpreted in light of the researchers' personal experiences (Cope, 2014; Nowell et al., 2017). In this study, the context and presumptions of the investigation that produced these results were described in detail using the interviews. To enable other researchers to conduct a similar study, the criteria for participant selection and a thorough description of the participants' lived experiences were also supplied (Lincoln & Guba, 1985; Nowell et al., 2017).

### **Dependability**

Dependability guarantees that the data obtained does not show any bias that might

affect the accuracy of the conclusions (cite). Dependability refers to how accurately and consistently the data support the study conclusions drawn from the interview (cite). For any other researcher who might want to repeat the method based on the same context as the research was conducted, I made sure that it was rational, traceable, and documented. Interviews with the participants were recorded using an audio voice recorder, Otter.ai. The data were then transcribed based on how I understood their experiences, ensuring that personal perspectives did not affect it.

### **Confirmability**

The research study must account for the participants' experiences. It signifies that the information's validity is essential because it is based on the actual experiences of individuals (Lincoln & Guba, 1985). Participants were given free rein to express themselves through open-ended questions. Each participant interview was recorded on video and saved on an external hard drive, a computer, both with a secure password. I labeled each response during the data transcription process to ensure no data were expressed based on irrational views or ideas. I also avoided asking the subjects open-ended questions that would have influenced their perceptions and instead asked them for definitions of concepts they did not understand.

### **Results**

This study focused on group facilitators conducting psychoeducational groups for dually diagnosed individuals in New York City hospitals, residential, group homes, and NA/AA settings. This research highlights the struggle of group facilitators conducting psychoeducational groups to those dually diagnosed. Data were collected from eight

participants via a semi structured interview with open-ended questions. These interview sessions were conducted via Otter.ai recording and transcribing devices. Thematic coding was performed with NVivo. The results helped me understand the challenges or benefits of conducting psychoeducational groups. Results were categorized into five themes, and a total of 205 quotes were extracted and coded from the eight interviews (see Table 1).

**Table 1**

*Theme and Research Question Alignment and Global Coverage*

Theme	Theme's Global Coverage	Research Question Alignment
1) The therapist must create an open and welcoming environment	22.4%	1) What are psychoeducational group facilitators' experiences working with dually diagnosed individuals?
2) The therapist can engage with patients and understand and help them	19.0%	
3) Identifying factors that lead to or reveal addictive behavior	19.0%	
4) The effectiveness of inpatient versus outpatient treatment is not clear	20.0%	2) To what extent does the group setting of the clients affect group facilitators' experiences when dealing with dual-diagnosed individuals?
5) Retention issues are primarily based on the patient's behavior and attitude	19.5%	3) How do psychoeducational group facilitators perceive the needs of dually diagnosed individuals in terms of their retention in psychoeducational groups?

**Research Question 1**

What are psychoeducational group facilitators' experiences working with dually diagnosed individuals?

***Theme 1: The Therapist Must Create an Open and Welcoming Environment***

Theme 1 offered the most significant proportion of quotes (22.4%), focused on describing how group facilitators must have a free judgment place where dually diagnosed individuals can feel comfortable sharing their stories. Many participants

claimed that the therapeutic environment must be welcoming and open; creating such an environment is equivalent to successful therapist-patient interactions and patient success. Missy stated that communication is vital in this regard, claiming that “you try to communicate it as sensitively and respectfully as possible.” Missy went on to state that the environment is vital to building trust:

Suppose you have an environment that is well-lit, more welcoming, and has vibrant colors; if you also have people at the front desk who will greet them and treat them like human beings, that could set the tone when the therapist and the patients are working in concert with one another that helps to build therapeutic trust.

Missy added that listening also helps that relationship grow, stating, “if people just listen to a little bit, they could get a clearer idea of where the patient is [and] what they want to work on.” Peterpan continued that line of thinking, stating, “[What] might be difficult is the environment. How is it going to get it to affect them differently? What challenges do they have? You meet challenges and navigate those challenges of getting them comfortable.” Peterpan continued discussing the importance of a good environment:

The setting may have a lot to do with it regarding being comfortable receiving information. Let’s say you’re in a great location. Nice ambiance. And it’s cold, and there’s no heat. So yes, that’s going to create a situation [where] people are more concerned with staying warm than even listening to the material.

Kristy echoed those sentiments, addressing the need to avoid forcing the patient into anything:

Depending on where they are in the moment, that's what I deal with. Moving forward and I always tried to make it cater to what they want to do. I don't want to force anything on them because when you force it on them, I notice they are very resistant, making it a little harder for me to do things with them.

Melvino's comments aligned with Kristy's; he stated that "I always respect their individuality because everything doesn't fit everybody." Paty added, further highlighting the need for a welcoming and open environment:

Maybe your demeanor is not allowing them to feel comfortable; it's the staff. Perhaps it's my personality. Sometimes one has to change the topic depending on what they want to focus on, then channel this to a therapeutic focus/common goal to measure therapeutic progress.

Missy and William provided some final content concerning the environment, stating that the therapists' attitude is essential. William said,

I believe that you must be very clear in your perspective and diagnosis abilities by making sure that you do not have any kind of an attitude where you feel like you're stressed by working with that particular individual because studies have shown that diagnostic accuracy goes down a significant amount if you are having interpersonal or transference issues with your patient.

Missy added,

When I was in graduate school, it was a drug treatment program. It created a somber, melancholy mood instead of a more lighted area. The facilitators are more encouraging and engaging in hearing those dynamics to make a difference.

Broadly, participant comments under Theme 1 showed that communication, mood, attentiveness, and attitude were all critical factors in creating an open and welcoming environment for the patient. In doing so, this facilitates better relationships and more effective treatment. Theme 2 continues the discussion of the connection between therapist and patient. Participants described how engagement and understanding were crucial to successful treatment.

***Theme 2: The Therapist can Engage with Patients and Understand and Help Them***

Theme 2 provided 19.0% global coverage and primarily focused on how the therapist and the patient benefit from engaging and meaningful connections, leading to a better understanding of the patient's needs. Melvino commented that the therapist should be "meeting the client where they're at as individuals" so they can "develop a relationship with them." Kristy furthered the idea of personal engagement, claiming that "if you are talking to them, you're patient with them, allowing them to make their own decisions." They continued with, "I have been overly supportive of them, and that's what they need;" and, "all I could do is just be supportive and give her the knowledge that I have tried to talk to her or keep her engaged and make sure she goes to her appointments and just hope for the best. Missy noted that engaging with patients had positive effects, including improving their outlook:

I've had patients coming in twice a week; that's rewarding because they want to help and feel like they're getting the help. And I feel like that I am making a positive impact on them, because they come in [and] say things like, I feel better after I've spoken to you or you give me feedback. So I would say being able to

work with someone willing to try and do the work; I'm going to help them understand it.

Missy added that “you try to encourage them to look at this [treatment] to form a real partnership, a therapeutic partnership—I think that's the main ingredient—you have to understand what it is that needs to be changed.” Peterpan discussed how those aspects made them feel as a therapist, ostensibly strengthening the bond between them and the patient; they offered that “it's good to get a reward when I feel that I've reached one or two clients because change is positive for them.” Peterpan also discussed the importance of working and engaging on an individual level:

It [engagement] has to happen on an individual level; you [must] deal with the individual, regardless of the setting; it has a lot to do with the connection that both the facilitator and the recipient [patient] have. Diagnose individuals; that's the most important [thing] to get out of this level—good solid communication.

Kristy's view aligned with Peterpan's; Kristy indicated that “you get to meet individuals; you get to understand them on another level, the person, the individual.” Marquise said, “Everybody needs encouragement, how you're gonna [sic] get there. You're letting them know that this is what the future can give” Ronie stated that “One of the most rewarding aspects of working with dual-diagnosed individuals is identifying the symptoms attached to their diagnoses while understanding their needs and working with them to achieve their goals.”

Theme 2 conveyed the participants' feelings that engaging the patient is essential. Further, rewards, not just for the patient but the therapist, can follow high-quality



engagement and subsequent understanding. Theme 3 shifts from aspects concerning direct support to the therapist working to understand their behavior.

***Theme 3: Identifying Factors That Lead to or Reveal Addictive Behavior***

Theme 3 provided 19.0% global coverage and is the last of three themes connected to re-search question 1. Participants provided content for this emergent theme focused primarily on the paths and challenges in looking for addictive behavioral traits. Missy began by discussing how appearance was a clue:

I was writing about how they would neatly dress because that does, in a way, speak to whether you are suffering from depression, sometimes you're closer to [disheveled], or you're not always concerned about your appearance or certain daily things you don't pay attention to.

Ronie acknowledged a similar stand-out train concerning hygiene; they explained that a patient "may not have good hygiene (smell bad) including dental care; sometimes they have brain damage due to drugs." Appearance may give way to outright signs of addictive behavior based on apparent substance abuse while in treatment; William detailed that patients "may not be totally sober, so they may still be engaging in the behaviors that are an outgrowth of substance abuse or substance dependence." Marquise made a similar comment, stating that "everybody's mental capacity is different; substance abuse, it could be alcohol, it could be whatever drug." Melvino added that "you have to take them away from the substance and be able to give a concentrated effort on enlightenment."

Kristy detailed a particular patient's issues, stating, "I have dealt with an

individual that he was just drinking and using heavily. He had other stressors happening at the time. And right before I went on leave, he decided to go into treatment.” Kristy also stated that meeting others with similar issues may present a way to diagnose the problem; they explained that “they come here and they meet other individuals that are using and abusing heavily. Depending on their mental state and what they’re dealing with at the time, they start to use, or they want to get away.” Kristy further stated that such behavior can influence the group; they claimed that “depending on if they’re under the influence at the time, you could get a really negative effect and it can affect the group as a whole.”

Peterpan brought up the idea of ascertaining their mental state as a way to determine if addictive behaviors might be an issue; they claimed that “the severity of their mental illness” can provide hints. Marquise added that auditory hallucinations may also expose the addictive behavior; they stated a patient once explained that “my mother’s voice” was present, causing them to “use some type of substance.” They continued, discussing the same patient who stated, “I see spirits, you know? Something’s going on.” Paty extended those ideas into a path explaining why some behaviors might not be diagnosed, stating that they see “a lot of personality and mood disorders: borderline, bipolar, narcissism, psychopathy, [that] go undiagnosed, especially in substance use disorder outpatient/inpatient centers,” and further, that such patients may be “unpredictable, and have mood swings,” and “not be compliant with their medication [or] going to group consistently.” William added that the therapist must “identify the emotional factors and psychological diagnoses outside of being a chemical abuser or

addicted that contributes to the drug taking and seeking behavior.” Marquise made similar comments, noting that addictive behaviors may be present when the patient is indifferent: “They even say that nobody cares about me. Nobody cares. So I’ll just do whatever I want to do. Nobody cares.” Melvino provided a good conclusion to Theme 3, explaining that helping them become self-aware of the issue may be an effective way to essentially self-diagnose:

The most challenging thing, I would say, is getting them self-aware and to see the need to be in the original residential setting and to address the glaring issues, the underlying issues that would have them engaged in the use of alcohol and drugs. This is an adult population, and they’ve been using for a long time, long history of substance abuse, which impacts the mental aspect of their lives, and to get them to understand that is very difficult.

Theme 3 featured rich content on what therapists have endured in understanding and identifying addictive behaviors. A central concept from the emergent theme is that there are many ways that can be achieved, both by the therapist and patient alike. Theme 4 is presented next and aligns with research question 2, which focuses on how group settings affect the facilitator.

### **Research Question 2**

To what extent does the group setting of the clients affect group facilitators’ experiences when dealing with dual-diagnosed individuals?

### ***Theme 4: The Effectiveness of Inpatient Versus Outpatient Treatment is not Clear***

Theme 4, the only theme connected to research question 2, produced content

covering 20.0% of the total quote count. The theme is also the only emergent concept presented here that left questions unanswered due to the participants' provided thick content but lacking in richness. Nonetheless, the quote pool for theme four is focused on the dichotomous nature of participant responses and the effects on the facilitators.

William offered a succinct quote exemplifying that summary: "There are similarities, but there are differences." Missy explained some details concerning the inpatient setting:

In places like inpatient psych wards, there's more patient supervision and probably more staff support. Maybe there's greater accountability when it's an inpatient setting or a psych ward-type setting as opposed to an outpatient; then you might not have security people might be a little bit laxer in being mindful of, let's say, someone, having a psychic break. And if necessary, if someone is really out of control, you have security or orderlies or people trained to do damage control.

Missy countered that inpatient outpatient facilities may be more effective:

In substance abuse facilities, where you had to really diagnose people, [they] seem to come back more frequently, for their groups, even mandated people even though they were man-dated. I found that [in] my experience, outpatient facilities had the greatest retention of patients. Residential settings are [the] most difficult, particularly if they're permanent.

Peterpan noted that outpatient facilities might see irregular attendance based on the time of the month:

You get a minimal number of people attending, mainly based on the months'

time—if it’s at the beginning of the month when most people get subsidies and money, then attendance is thin. In the middle of the month, you have more attendance because they don’t have any money; they’re not addressing one of their diagnoses, either getting pills, drugs, or alcohol that feeds their chemical dependency.

Peterpan continued, clearly indicating that the modality of delivery of services argument was not clear cut; they espoused that “you can’t say the hospitals are better or the residential place better; [you] meet the individual where they’re at even through his group, but each of them in each participant is an individual.” Peterpan added more content to Theme 4, further explaining that a person’s background may be the deciding factor in which modality works:

Some come from very influential backgrounds; they had money, so the [inpatient] setting was great for them. I’ve worked in settings where it’s completely the opposite. And I don’t know that it matters because it depends on the severity of the disease.

Peterpan added that the inpatient experience may even be detrimental, claiming that they “find that sometimes too much treatment on the inside institutionalizes the person and make them become dependent on that going back and forth; that’s where you have the recidivism.” William supported that claim by stating, “an inpatient facility may allow for more intensive treatment, and [an] outpatient facility might contribute to a lack of compliance.” Kristy countered Peter and William in stating that staying in treatment is helpful; they said, “I guess I would say yes because of what I see here at [facility name

redacted]. I think they stay in treatment if they have good support.” Melvino seemed to support that claim of the efficacy of inpatient treatment in asserting:

I have a chance to interface with them. I have an opportunity to really develop a therapeutic alliance, where we work in tandem, you know, that’s the more significant difference. I pre-fer this because, again, I have them—a captured audience and I can develop a relationship with them.

Marquise appeared to lean on the idea, similar to Peterpan’s comments, that perhaps the individual is the deciding factor in modality effectiveness; they explained that “As far as residential, different types of residential that I’ve worked in, they’re all different; everybody’s level is different.” Further, Marquise saw this as a limiting factor in how they could deal with a patient, expressing:

Residential is different. All we can do is [call] down; we have problem crisis intervention, but there’s so much that you can do; we can’t physically give them shots, we can’t physically restrain them, we call 911 to have them evaluated. It’s a limit to everything, but [at] the hospital, all the services are there.

Paty went further in stating that the people they care for the patients (taken to mean family and friends, as well as the therapist) can feel used if they remain in inpatient settings simply to avoid responsibility:

When the clients become comfortable in being institutionalized, fed, a roof over their heads, and not worrying about going to work, to pay bills, or receiving monies from the government, they do the bare minimum or nothing at all. They know they get a free pass because of the dual diagnosis. When they take

advantage of the illness they have and [do] not want to get better and be a responsible [and] productive person contributing to society in both personal and professional realms when they take advantage of their friends and family members, they manipulate them, and they (the people that genuinely care for them) are taken advantage of.

Ronie felt that they could work more effectively in inpatient settings:

Working with dual-diagnosed individuals in hospitals, residential, rehabilitation centers, and AA/NA settings differs from working in an individual session due to the different variations that the individual may exhibit in an individual setting rather than in a setting with other individuals present. In addition, working one-on-one with a dual-diagnosed individual, you can identify their symptoms and assist them in managing them more effectively.

Theme 4 described the variable nature of the participants' content on the effectiveness of each modality: inpatient and outpatient. Additionally, participants noted concepts affecting them related to the efficacy of their treatment, being "used" by patients, and being able to develop relationships. A discussion of future project possibilities to research more deeply into this theme is presented in chapter 4. The final theme, theme 5, centers on patient retention and features content from the participants that indicates it is primarily the patient's responsibility to self-retain.

### **Research Question 3**

How do psychoeducational group facilitators perceive the needs of dually diagnosed individuals regarding their retention in psychoeducational groups?

***Theme 5: Retention Issues are Largely Based on the Patient's Behavior and Attitude***

The final theme that emerged from the participant interviews provided 19.5% global coverage and focused on patient retention. The adjective essentially was included in the theme title since during the coding and theme-generation process; the researcher felt that most participant quotes leaned towards patient self-retention, although participants did mention (albeit to a much lesser degree) that they bore some responsibility for retaining the patient. Missy provided one of just a few quotes detailing that responsibility:

They have a negative view of mental health services and behavioral health services, and you have to wean them off the negativity and build a rapport with them because it can cause them to distrust any kind of mental health service.

Mark continued that link of thinking, claiming it could be both the therapist or the patient upon whom the responsibility rests; they explained that “It could be the demeanor in how staff acts. And it could be the client as well. You just don’t have any willpower to stick out for that long without something inside of you.” However, Marquise stated it is a “team” effort; they said, “you need a whole team to make you move forward to being better.” Finally, addressing the lack of agreement concerning responsibility, Kristy offered that “we could give them all the tools and in-formation they need, but it’s up to them to use it,” which seems to indicate that the therapist is re-sponsible for providing the means (which can certainly be seen as an effort in support of retention), but the patient must use those tools.

Missy placed the ability to self-retain with the client in stating that “some of them



might be physically but emotionally and mentally someplace else,” and “a lot of them say that’s some-place that they never want to go back to; that implies they have a choice.” Peterpan added that “the guarantees come in what a person wants out of life because there is no guarantee,” but “one out of three is going to repeat, at least you know some are going to make it; it’s a choice for the individual to participate.” Peterpan continued, providing an example of a particular patient:

I’ve had a client recently who came from prison. He had been grouped up in the hospital because he had mental [and chronic] illnesses. Getting him to go to treatment or accept treatment was challenging because he had been in prison, and he felt the treatment was not something you wanted until you knew your preference.

Peterpan’s example hints at the patient needing to make the decision, a sentiment echoed by Kristy: “I will tell the person themselves because if they’re not ready to better themselves, then what’s the point?” Kristy also exemplified that reasoning by describing a particular patient; Kristy said, “And I said, do you want to go to treatment? She’s like, no, I’m going to keep using.” Marquise provided an example in counter to Kristy’s, detailing how a patient self-retained:

Someone who was going through some episodes that he just came into the office and said, I need this, even though I’ve asked him in the past, and he said, No, I’m fine, but he just came to me and said, I need this; help me; they go back to you—can you help me again?

Paty seemed to support those examples, stating that the motivation must come

from within:

It has to come with intrinsic motivation from the individual to change and if there are people in a support system that keep them accountable or someone that looks up to them. It's not the setting that matters; it comes from within the individual's level of motivation to change and take care of themselves.

Theme 5, while leaning towards self-retention, offered some content that assigned at least some responsibility to the therapist. Regardless of the assignment, retention was mentioned by several participants as essential in getting the patient treated successfully.

### **Summary and Transition**

This phenomenological study investigated the experiences of dual-diagnosed psychoeducational group facilitators. The research involved one in-person interview with eight prescreened participants designated as facilitators of psychoeducational groups. Eight male and eight female group facilitators who worked in a mental health environment in New York City were participants in the study. This chapter analyzes the study's findings, sampling strategy, research topics, data-gathering techniques, data analysis steps, evidence of reliability, and emerging themes. To give information on the specific group facilitators as they connected to the experiences of the psychoeducational group facilitators, I have provided excerpts from the interviews. The study's results connected to the group facilitators' opinions and experiences, offering suggestions for the information in this study related to the viewpoints and experiences of the group facilitators and offering tips for how to include better psychoeducational groups for the benefit of people with du-al diagnoses. More research on this population is required to

identify further difficulties and highlight the facilitators' experiences leading psychoeducational groups. I analyze the results, discuss the study's limitations, discuss the implications for social transformation, and make suggestions for further research and policy implementation in Chapter 5.

## Chapter 5: Discussion, Conclusions, and Recommendations

This qualitative phenomenology study was conducted to explore group facilitators' professional experiences when leading groups for dually diagnosed individuals. For those with dual diagnoses, having skilled psychoeducational group facilitators is crucial to recovery and treatment adherence (Brown, 2019). But group facilitators may need a better working environment with sufficient supervision to manage stress and avoid turnover (Brown, 2019), which affects care continuity and quality of services (Glisson & James, 2002; Knudsen et al., 2003; Mor Barak et al., 2001). The study addressed what may contribute to high turnover by focusing on the life experiences of psychoeducational group facilitators for populations with dual diagnoses. five main themes were (a) open and welcoming group environment, (b) understanding and engaging with patients, (c) addictive behavior, (d) inpatients versus outpatient's treatment, and (e) retention issues and patient behaviors.

This chapter outlines significant findings and provides interpretations. Through comparisons of studies that validate, refute, and extend our knowledge, this chapter also links the literature from Chapter 2 and gives the study more legitimacy and a solid foundation. The study's implications and suggestions are also presented to encapsulate the investigation's main points.

### **Interpretation of the Findings**

This section provides an interpretation of the results. Raw data included (a) facilitators' experiences. The broad analysis of the literature revealed a consistent theme that implied that little data were collected about the life experiences of group facilitators

conducting psychoeducational groups.

Regarding the first research question, which sought the experience of psychoeducational group facilitators' experiences working with dually diagnosed individuals, three major themes emerged: therapists must create an open and welcoming environment, therapists can engage with patients and understand and help them, and identifying factors that lead to or reveal addictive behavior. In the second research question, I sought to understand the extent to which group setting of the clients affect group facilitators' experiences when dealing with dual-diagnosed individuals. Results indicated that there are differences in the effectiveness of the in-patient settings of psycho-education compared to the outpatient settings. Psychoeducational group facilitators explained that they have a better chance of providing psycho-education to inpatients than outpatients. The third research question addressed how psychoeducational group facilitators perceive the needs of dually diagnosed individuals in terms of their retention in psychoeducational groups. The results showed that despite leaning toward self-retention, the content provided allocated at least some blame to the therapist. Participants indicated that retention of the dually diagnosed individuals was majorly determined on their behavior and attitude.

***RQ 1: How do Psychoeducational Group Facilitators Experience Working with Dual-Diagnosed Individuals?***

In respect to this research question, it emerged that therapist must create an open and welcoming environment. The findings are in consistent with the available literature that document that the process of psychoeducation is complex and requires that

facilitators and therapist become welcoming to their patients. Numerous barriers such as scarce resources, time restraints related to the recommended number of sessions versus the actual number of sessions attended, and oversight by outside providers can reduce therapy time and minimize the role of the facilitators (Dixon et al., 2016). Despite these barriers, a key approach for the facilitators is to ensure that they are friendly to the patients to create an ideal rapport for a fruitful therapy (Raphael et al., 2021).

Additionally, mental health professionals may have preconceived notions about the types of patients who should receive care or exhibit a lack of professionalism regarding recovery-oriented elements included in psychoeducation therapy sessions (Dixon et al., 2016). The implementation of a successful therapy session for dually-diagnosed patients requires a cordial relationship between the facilities and the patient (Bachrach & Chung, 2021; Dixon et al., 2016).

Another theme that emerged was that with proper engagement therapist can engage with patients and understand and help them, which demonstrate the effectiveness of this engagement for dually-diagnosed individuals. The findings conform to the findings from studies (Green et al., 2016; Lawrence, 2017; Klimkiewicz et al., 2015; Wheeler et al., 2018; Worrall et al., 2018). For instance, according to Lawrence (2017), when group facilitators engage and help in the integration of family and psychoeducation in the treatment of dually diagnosed patients, there is greater impact particularly when the medication management stabilized the symptoms of the mental illness resulting in improved functioning and coherence of the patient. Similarly, Klimkiewicz et al. (2015) found that the input of the group facilitators in the therapy sessions helps in improving

the effectiveness in provision of the social skills training, provision of coping strategies, and substance use recovery. Facilitators also play a role in enhancing individual patients successful in reaching recovery and improving mental illness disease management through the aid and support of their families (Green et al., 2016). Adequate engagement of the facilitators can also reduce the number of hospitalization and improve adherence to the prescribed medication (Wheeler et al., 2018).

The third theme in respect to the first research question was that there are numerous factors that lead to or reveal addictive behavior. The findings are based on the assertions by the group therapist facilitator, which adds value to the available literature. Research has indicated that for dually diagnosed patients, 18% of them had addiction problems (Bonniem, 2017). Addiction to drugs is a complex issue that affects individuals from all walks of life (Crunelle et al., 2018). For dually diagnosed patients, who have both a mental health condition and substance use disorder, the factors that contribute to addiction are often intertwined and interconnected (Sayed et al., 2020). Consistent with the findings from the study, scholars have explored the various factors that contribute to addiction, such as brain chemistry (Crunelle et al., 2018), a combination of genetic and environmental factors (Asheh et al., 2023), and suffering from mental health conditions such as anxiety, depression, and PTSD (Adan & Torres, 2021). For dually diagnosed patients undergoing psychoeducation, addiction is a key problem caused by many factors (Sayed et al., 2020).

While understanding that group facilitators in psychoeducation engage also with families and friends, it is also important to highlight that they can also contribute to

addiction. The influence of friends and family who engage in substance abuse can also increase a person's risk of addiction (Sarkhel et al., 2019). If an individual has friends or family members who use drugs, they may feel pressure to use drugs themselves or may view drug use as normal behavior (Sarkhel et al., 2019). This could be aggravated if there are chances of stress for the patient. Chronic stress can result in feelings of anxiety, depression, and other negative emotions, and for some individuals, substance abuse can become a way to cope with these feelings (Priebe et al., 2019). There is congruence between the current study and previous researches that group facilitators face problem of dealing with dually diagnosed patients who face addiction. However, this adds more insight since the findings are based on the perception of the group facilitators, who are directly involved with provision of psychoeducation.

***RQ2: To What Extent Does the Group Setting of the Clients Affect Group Facilitators' Experiences When Dealing with Dual-Diagnosed Individuals?***

Concerning RQ 2, the findings revealed themes that indicated and confirmed the effectiveness of inpatient versus outpatient treatment. The findings corroborated earlier studies that revealed that group settings play a major role in the recovery of those dually diagnosed. For instance, McCallum et al. (2015) described treatment settings that provided programs for dually diagnosed patients, including therapy interventions like psycho-educational group therapy, which a review of 18 studies indicated are components of the care continuum for this population of patients. But the differences between the inpatient and outpatient influence the effectiveness of the psychoeducation (Oute et al., 2022; Sofer et al., 2018). In addition, Sánchez Morales et al. (2018) indicated



that availability for crisis stabilization, intensive support for substance abuse, residential mental health, and abuse programs in inpatient health facilities helps in improving efficiency of the psychoeducation among the dually diagnosed individuals. The findings from the study confirm the literature that the psychoeducation settings could influence the impact of the programs, particularly based on the differences between inpatient and outpatient.

Findings also indicated that the progression of care for those with dual diagnoses across treatment settings presents additional challenges for treatment professionals, including group facilitators. Efforts to establish trust and group participation in one environment may suddenly shift the patient out of the comfort of one setting and into the unfamiliar surroundings of another, adding to treatment barriers in the context of continuity of care (McCallum et al., 2015; Priester et al., 2016). In addition, dual-diagnosed patients present more difficulties for health care professionals to manage, including higher rates of relapse, ongoing and worsening functional impairment, poor outcomes across all diagnosed conditions, additional costs to the health care system from readmissions and service usage, higher risks of dropping out of treatment, and higher risks of falling through gaps in treatment transitions (McCallum et al., 2015).

***RQ 3: How do Psychoeducational Group Facilitators Perceive the Needs of Dually Diagnosed Individuals Regarding Their Retention in Psychoeducational Groups?***

The findings reveal retention issues largely depend on the patient's behavior and attitude, but therapists and group facilitators can understand the patients to be more helpful to them. The findings resonate with the already existing literature. For example,

Gitterman and Knight (2016) found that although retention of the dually diagnosed depends on the patients; behavior, and attitude, the success of the groups and the relative simplicity of execution, as mediated by the facilitator, contributed to the popularity of psychoeducational group therapy. Similarly, Chilton et al. (2018) indicated that the successful implementation of the psychoeducation majorly rests on the ability of the facilitator and therapist to coordinate the group and meet the expectations of the various stakeholders. Such undertaking requires a careful analysis and understanding of the needs of the different members of the group (Zolnikov et al., 2018).

Gitterman and Knight (2016) asserted that Champe and Rubel's (2012) presentation of the group focal conflict theory (Whitman & Stock, 1958) was accurate when they claimed that if facilitators adhered to strictly to the curriculum's content, participants' capacity to comprehend and internalize the knowledge was enhanced. In line with the findings from the study, Fantuzzi and Mezzina (2020) indicated that best outcome of the psychoeducation was attained when there is flexible delivery of the curriculum and, increasing group involvement and collaborative learning that involves patient interactions with the group leader and each other had positive impacts. When used properly, psychoeducational groups gave people with dual diagnoses new coping mechanisms and opportunities to examine their emotions to understand the causes of their problems (Fantuzzi & Mezzina, 2020). In concise, the findings from the current study are consistent with the already available literature on the role of the group facilitators in understanding the behavior of the dually diagnosed individuals for greater retention. Nonetheless, it adds more insights bearing in mind that the study was based on the

facilitators' perspective.

### **Limitations of the Study**

There were limitations that were beyond the control of the researcher. First, this study was conducted using a smaller sample size since this was a qualitative study. A smaller sample size prevents the findings from being generalized or extrapolated. In addition, a smaller sample size may increase the chances of assuming a false premise (Hennink & Kaiser, 2022). It is suggested that in addition to increasing the sample size, the participants' years of experience should increase to obtain adequate data relating to the life experiences of those group facilitators. The researcher had proposed to include 11 participants in order to increase the probability of attaining data saturation point, but only nine participants were included in the study. Participants in this study were selected within the same locality, which further demeans the intent of generalizing the findings to other parts of the United States. To reduce the effect of the small sample size, the researcher carefully followed the selection criteria for the selection of the participants (Ross & Bibler Zaidi, 2019). In addition, based on the findings from this study, further research could be conducted based on quantitative research methods.

This study applied a qualitative study, where interpretation by the researcher could be biased by preconceived ideas. This is the researcher is a profession on the same field. It is imperative to address the issue of biasness since it may damage to the study by distorting the observations and interpretations (Bergen & Labonté, 2020). The researcher applied made attempts to reduce the effect of biasness through member checking and bracketing. While the researcher provided the transcripts to the participants for validation

and approval (member checking), the interpretation of such data lied on the researcher who may have a preconceived ideas about how psycho-education group facilitators engage in their daily operations.

In this study, the researcher focused on the self-reports from participants. A self-report study is one in which the researcher gathers data from participants by requiring them to respond to the questions without any interference (Dang et al., 2020). While self-report has been merited as it allows the participants to share their experiences, it has the limitations that it may be difficult to determine whether respondents are honest and truthful in their response (Dang et al., 2020). This means that the researcher may have wrong conclusions if the respondents provided inaccurate and false information. The problem is aggravated by the fact that there is no tool that could be used to determine the honesty of the participants in research. However, to reduce the impact that would be associated with self-report, the researcher set in measures to ensure trustworthiness of the data.

Another limitation was that researcher included some participants who were inexperienced. For a qualitative study, the experiences of the participants are essential in respect to the phenomenon under study to provide relevant and valuable information. In this case, while minimum experience in the field required by the researcher allows more flexibility in finding participants, the more seasoned workers would have brought more substance to the study regarding their struggles and expertise. The implications of the study are covered in the following part, along with suggestions for best practices and discussions of good social change at the right level of interest.

## **Implications**

Findings from this study indicated that for dually diagnosed patients, inpatient psycho-education is more efficient. These findings can be used to create more successful public training programs regarding developing policies on improving the life experiences of group facilitators for dually diagnosed. The policy could outline and emphasize the need for more in-patient facilities that will allow a more effective psycho-education. On the same note, such policy creation will help provide those who conduct psychoeducational groups with better training to assist in the recovery success rates of the dually diagnosed and prevent relapses and recidivism.

The participants reported the importance of retention for dually diagnosed patients and that it largely depends on their behavior and attitude. These findings may form basis for the development of healthcare policy that seeks to improve the facilitation of psycho-education processes and improve the retention of the dually diagnosed patients for greater effectiveness. For instance, based on the findings, policies should be made regarding the continued training and development of the group facilitators and psycho-educational professionals to help them in improving retention of dually diagnosed patients. The developed policies should be in tandem with the appropriate guidelines for the psycho-education as dictated by the findings from this study.

The study findings' indicated that one-on-one psycho-education settings are more effective for the dually diagnosed patients. To attain this, it would require more facilitators of psych-education and greater propensity of this profession, a move that requires more funding and development of policies. In light of this, the study has the

potential to have an influence on financing policies connected to the treatment of persons who have been diagnosed with dual disorders. While the study has uncovered that there is need for more one-on-one therapy, which require more financing to help the design and implementation of efficient psycho-education treatments, it forms basis for the formation of appropriate policies. The study has the potential to influence public policy, particularly as it relates to the welfare of the psycho education facilitators.

The findings of the study should also be used to develop future public awareness campaigns on how to better the work environment for the group facilitators. In this study, the findings have shown that for therapists' open and welcoming environment helps in enhancing effective psycho-education. On the other hand, the study's findings highlighted the significance of how the group facilitators are not adequately equipped for their roles as facilitators because many training manuals are not updated to the new integrated model that they use to treat dually diagnosed. As a result, many stakeholders, the authors of psychoeducational group policies, and administrators ought to have a stake in improving oversight of and advocacy for more control over the type of training they offer the group facilitators.

### **Implications for Positive Social Change**

Findings from this study indicated that there is need to treat dually diagnosed patients with special care and be open and welcoming to them. As such, due to the fact that previous studies had shown that this was a neglected public health issue, the findings forms basis for improvement In this case, the findings may: (1) increase public mental health awareness for dually diagnosed to have better treatment for their diseases and (2)

add to the body of knowledge already available regarding psychoeducational groups and group facilitators. The information gathered and analyzed from the participants' responses revealed themes that may be used to design evidence-based policies at the municipal and federal levels to address this public mental health issue. The information from the study can also be used to guide staff members' public mental health training for this population's group facilitators in all mentioned settings.

The results indicated that for effective psycho-education, there are several practices that could be applied such as having good communication with the patients, being open to them, and enhancing their retention throughout the process. These findings may be used by therapy providers to individualize psychoeducation to match the requirements of each patient. This can increase the efficacy of treatment by ensuring that patients get instruction tailored to their own circumstances. Secondly, it may lead to improved outcome by increasing engagement and motivation through identifying impediments to engagement and motivation based on patients' opinions of psychoeducation. Furthermore, psychoeducation facilitators may attempt to overcome the obstacles that were identified in this study and increase patients' participation in psychoeducation, which can lead to improved treatment outcomes. This study is based on the perceptions of the psychoeducation therapist and when their needs are met and stakeholders understand their point of view, it may lead to better service delivery to patients with dual diagnosis.

### **Methodological, Theoretical, and Empirical Implications**

The study has no methodological, theoretical, or empirical ramifications. The

identified population was sufficient and reasonable for addressing the gap in the literature outlined in Chapter 2 as it relates to the life experiences of the group facilitators conducting psychoeducational groups for dually diagnosed. The identified population included mental health workers facilitating psychoeducational groups for dually diagnosed patients. The study demonstrated that qualitative interviews provide a valuable method for gathering information on this topic.

The findings from this study have indicated how the psycho-educational counselors should act when dealing with dually diagnosed patients. Therefore, the findings validate the JD-R model regarding the job demand. According to the JD-R model, an employee should have physical and psychological effort to meet the job demands (Demerouti et al., 2001). In this case, psycho-educational counselors are not only required to put their physical efforts when dealing with dually diagnosed patients, but rather put emotional and psychological efforts to meet the demands of these special group of people. Furthermore, the findings have indicated that for the successful and effective psycho-education, there is need for the patients to have greater retention. This adds another dimension on the mutual role of cooperation between the job provider and the beneficiary of the service for effective delivery. This could have implication on research to improve on the existing theoretical framework such as job-demand model, to include the aspect of the service/job beneficiary.

### **Recommendations for Future Studies**

This study was conducted on a smaller sample size, focusing on a limited area. The implication of this was that the findings could not be generalized to populations in



other settings, contexts, or geographical locations. Based on this limitation, further studies could be conducted on the same topic to include participants from a large sample size using a quantitative study. To conduct a study using a larger sample size, the use of a quantitative survey based approach or archived data may help to get findings that may be generalized to larger populations.

This study highlights the perceptions of the psycho-education facilitators regarding their experiences in handling dually diagnosed patients. Scholars have demonstrated some of the challenges that they experience and the need to facilitate effective engagement with dually diagnosed patients. However, there is need for further researcher to explore on the exact approaches that could be used by psycho-education facilitators to ensure that they provide quality and effective therapy to dually diagnosed patients.

The findings from this study have indicated that psycho-education counselors need to be open and communicative to their employees for effective process. However, the research does not provide basis and workable approaches that could be applied to facilitate psycho-education therapist to be more communicative and open during their sessions. As such, further researcher could be conducted to provide data on how counselors can be open and welcoming to their dually diagnosed patients. The researcher hereby recommends a conduct longitudinal study to explore this topic.

### **Summary**

The possibility for psychoeducational group facilitators to conduct influential groups for the dually diagnosed is impacted by multiple factors. Few studies have

examined the effectiveness of psychoeducational groups without considering the group facilitators' life experiences. The study emphasizes the need for a more in-depth investigation of these workers and the settings in which they conduct the psychoeducational groups. The social change initiatives anticipated from the study's findings can help develop future public education campaigns, efficient training, and strategies for encouraging the dually diagnosed to attend these groups, which is part of their treatment.

According to the results of the study, public mental health regulations regarding bettering these group facilitators' life experiences must be established to set standards for assisting dually diagnosed in their recovery. The following suggestions are based on the findings of the study.

1. Update the training manual by integrating treatment for the mentally ill and sub-stance abusers.
2. Provide better incentives to the group facilitators to avoid the high turnover, which prevents continuing care for the dually diagnosed.

Dually diagnosed make up a sizable portion of the American population. Since the dually diagnosed are a group that tends to increase, they should be given more attention so that their recovery can be successful. Group facilitators have the willingness to work with this population. Still, they often lack the tools to do their job efficiently, such as updated training and better incentives at work to keep their loyalty to their workplace. Suppose the federal government and states that oversee those agencies that treat this population do not implement the proper rules; in that case, the rate of relapsed

individuals and recidivism will continue to grow significantly.

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## Appendix: Interview Guide

RQ1) What are psychoeducational group facilitators' experiences working with dually diagnosed individuals.

1. What is the most rewarding aspect of working with dually diagnosed individuals?
2. What is the most challenging aspect of working with dually diagnosed individuals?
3. What do you do daily or weekly to prepare to meet and work with dually diagnosed individuals?

RQ2) To what extent does the group setting of the clients affect group facilitators' experiences when dealing with dual-diagnosed individuals?

5. How do you think working with dual-diagnosed individuals in hospitals, residential, rehabilitation centers, and AA/NA settings differs among those settings?
6. Of differences, you discussed in the previous question, which do you think most affects how you deal with dually diagnosed individuals and why?
7. Do you think a particular setting can influence the outcome of psychoeducational groups for dual-diagnosed individuals? If yes, why? If no, why not?

RQ3) How do psychoeducational group facilitators perceive the needs of dually diagnosed individuals in terms of their retention in psychoeducational groups?

8. Which setting (hospitals, residential, rehabilitation centers, AA/NA) do you think guarantees the most retention of dually diagnosed individuals in treatment? Why do you think that setting guarantees the most retention?
9. What do you think is causing the lack of retention of dually diagnosed in treatment?
10. What do you think are the most important considerations a dual-diagnosed individual needs to remain in treatment?