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The Janus Influence and Discovering a Life:
A Study of People Living With Coexisting Mental Health and Substance Use Disorders

A thesis presented in fulfilment of the requirements for the degree of
Doctor of Philosophy
in Sociology
at Massey University, Albany, New Zealand

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This grounded study examines how people who are dually diagnosed with a major mental illness and substance use disorder 'recover' their lives from a past of 'intemperate insanity' and discover a world in a rich and productive present. Thirty participants, including consumers, staff and families, took part in the study. Additional slices of data were retrieved from the analysis of six 'policy' documents and 72 hours of participant observation. All data were constantly compared and analysed using Glaser's emergent approach to grounded theory.

Research and literature on those with coexisting disorders has been dominated by the 'medical model' with a focus on assessment, diagnosis, treatment and rehabilitation both in addiction and mental health settings. Whilst these aspects of 'management' of coexisting disorders are important, this acute phase of intervention represents only a small fragment of a person's life. These people are not their disease, and the coexisting disorders are not the totality of their being.

'Discovering a life' was an emergent theme that formed the basic core category. Intemperate insanity, naked in Woolworths (the crisis), shedding the armour (recovery) and living without the armour (maintaining the change) and Janus' temple (service provision) formed the theoretical codes which made up the entity discovering a life. There also emerged a further 'natural division', a critical juncture essential to discovering a life - sobriety. Without sobriety, participants' lives took a different path which linked them back to a past of intemperate insanity.

Literary images of the Roman God Janus are used as a metaphor throughout the thesis to elucidate aspects of the participants' lives. Janus was the God of endings and new beginnings, of youth and age, and is portrayed in historical texts with a double head, one looking backwards and the other forwards. It is this need to remind themselves of the past in order to imagine the future, a need to track the metaphorical trajectory from youth to age that informs the basis of 'wellness' in the present for my participants.

Service provision in the mental health and alcohol and drug fields is aimed at early intervention, the acutely ill and early phase rehabilitation. There are clearly ways of analysing and approaching the 'illness' at this initial point of the continuum that are efficacious and cardinal to the ultimate well-being of the
individual. What I am proposing here is not an alternative to this bio-psycho-social explication, but a second-level, substantive theory that offers an insight into the way a diversity of people with coexisting mental health and substance dependence disorders integrate their human imperfections into their lives. They have found a way of accepting, rather than transcending, the human condition. At the same time, this new paradigm has implications for the way we provide a service to people with coexisting disorders. Service providers are invited to participate in a way that shifts the emphasis of intervention from ‘doing’ (tasks and skills-related activities), to ‘being’ (with a focus on integrating coexisting disorders into identity of ‘self’). A therapeutic emphasis on ‘caring’, not ‘curing’, creates an environment that allows consumers to realistically live rich and meaningful lives.
ACKNOWLEDGMENTS

Undertaking a doctorate is at times an arduous, protracted and solitary task. For a person who prefers to work in a team, it seemed that for much of the time I was the only one ‘on the case’. However, in my more sagacious moments, I knew that this was not so. In fact, this thesis has been a huge team effort. Some of you came into my life because of the thesis, while others were part of the journey that brought me to its inception. I would like to take this opportunity to thank you all.

To the participants who so generously shared their time, and their lives, I owe a debt of gratitude that can never be repaid. I only hope I have been able to ‘give back’ in a way that you all understand.

To Ian G., who brokered many of the introductions to the wonderful people who became my participants.

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This thesis was made possible through a generous grant from the Alcohol Advisory Council of New Zealand.
Self portrait by patient Mary
In 1983, Mary was in her early thirties and had been in and out of adult mental hospitals since the age of thirteen years. She had been given a diagnosis of schizophrenia and was considered to be entering the chronic phase of the 'disease'. Her life was dominated by visual and auditory hallucinations. Her perception of reality was distorted and she lived daily with the chronic, nagging, self-deprecating voices that were telling her to kill herself. They were intrusive and distressing and she found temporary relief in alcohol and cannabis. It was another ten years before the term 'dual diagnosis' would be coined.

In 1983, I was working as a nurse/counsellor in the Auckland Area Health Board’s community based alcohol and drug services. It was located in the grounds of the regional psychiatric hospital and I was approached by one of the psychiatrists who wanted help with a patient, 'Mary', whose drinking and drug taking were interfering with his ability to manage her chronic mental illness. As a means of putting some of the distress outside of herself, and as a way of helping me understand her internal torment, Mary painted a self-portrait, the photograph of which accompanies this thesis. In it, I was drawn to the off-centred relationship of the face to the page, the 'hidden' eye, the missing ear, the thick black line surrounding the head, and the splintered, divided face. I interpreted this to indicate the 'off-centred' relationship she has with herself and others, a 'one-eyed' view of her world that restricts her vision of life and its possibilities, and the inability to hear all that is being said to her. The thick black line represents a rigid boundary that creates an image of 'normal' shape to the outsider and belies the chaos and fragmentation inside her head. Her sadness is evident in the down-turned mouth and the clock (set forever at 3.00am) represents her troubled relationship with sleep and distorted time.

It offered me another paradigm from which to view coexisting disorders - that of 'insider'. Previously, my only understanding had been as nurse and counsellor. The painting brought me as close as I could get to the lived experience of mental illness and substance use disorders. It shifted my thinking from the framework of health professional to consumer. I began to understand
on a visceral (rather than intellectual) level, the melancholia, fragmentation and despair that coexisting disorders can bring.

In a secular and 'Joyceian' sense, this experience was an 'epiphaniuous moment'. Epiphany means "a manifestation" (Abrams, 1981:54) and was a term coined by early Christian thinkers to signify a "manifestation of God's presence." The Irish writer, James Joyce, adapted the term to non-religious experience to signify a "sense of radiance and revelation while observing a commonplace object...or scene" (Abrams, 1981:54). The 'epiphany' for me was a deeper and critical level of understanding that was to shift my thinking on psychiatry, substance dependence, people, and 'treatment'. It unleashed a train of thought, ideas and career decisions that has culminated in the writing of this thesis.