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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
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ABSTRACT

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.

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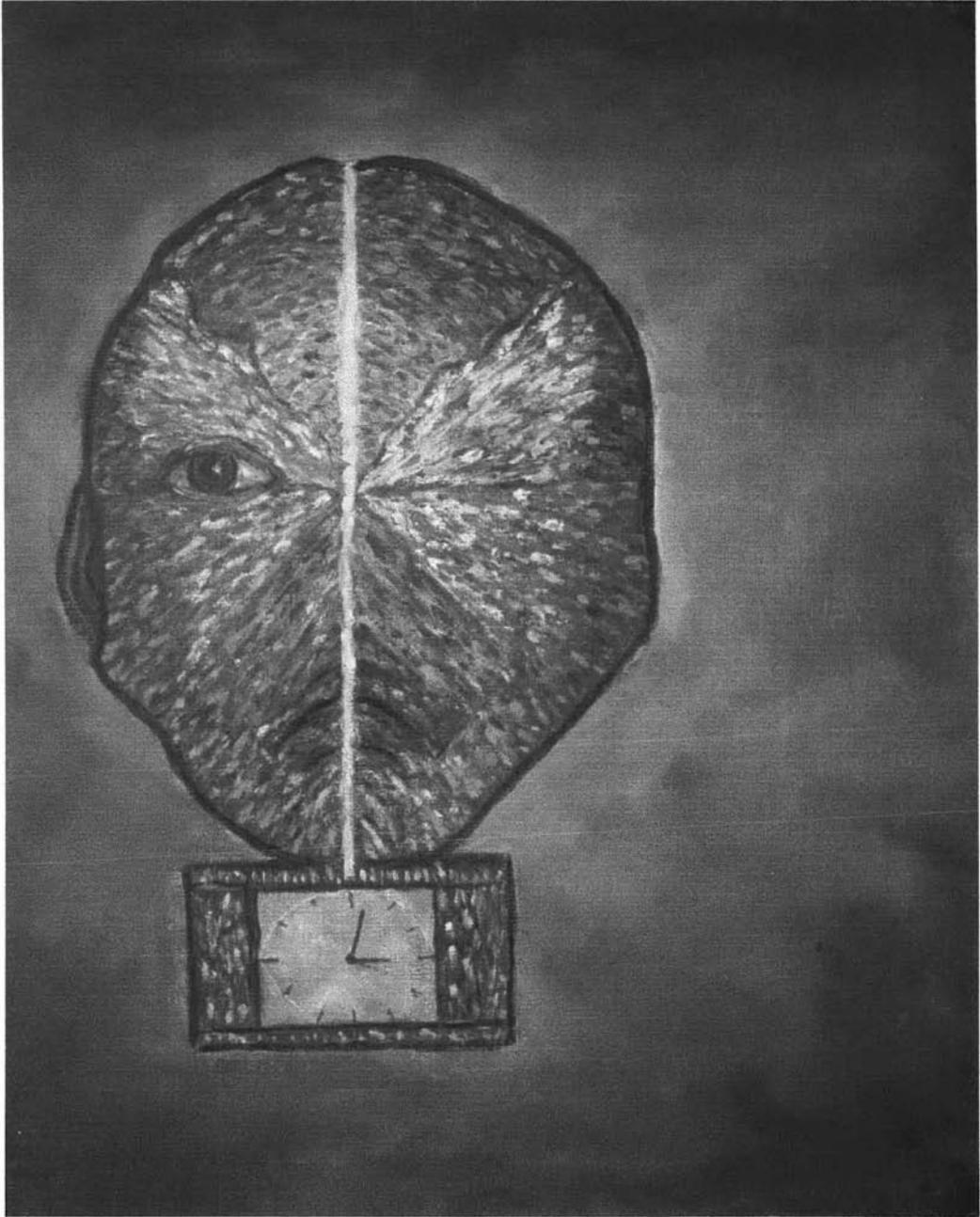
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Self portrait by patient Mary

WHAT'S PAST IS PROLOGUE

(Chapter title a quote from Shakespeare, *The Tempest*, act 2, scene 1)

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 'Joycean' sense, this experience was an 'epiphanous 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.

CHAPTER ONE: INTRODUCTION

Coexisting Disorders - the Entity

At the commencement of the research process (1996), 'dual diagnosis' was a term used in medical settings to refer to the presence of a major mental illness and substance abuse or dependence concurrently occurring in one individual. By the completion of the thesis, linguistic fashions had changed and the same entity was now being referred to in the literature and clinical practice as 'coexisting disorders'. The terms 'coexisting disorders' and 'dual diagnosis' will be used interchangeably in this piece of work.

Whatever the terminology, this is a thesis about those people who are living and working with substance use and mental illness. It is a story of courage, perseverance and invention as individuals not only overcome what looks to many of us to be insurmountable odds, but go on to *discover a life* that is richer and more diverse than they might otherwise have expected. If we can hear their stories with humility, we have much to learn about coexisting disorders in a way that will impact on the kind of 'treatment' and support we are able to offer.

Why a Study of the 'Dually Diagnosed'?

Working as a clinician in the fields of mental health and substance abuse over the last eighteen years, I have encountered the difficulties both services have had in meeting the needs of clients dually diagnosed with a substance abuse and mental health disorder.

In 1993, as a Manager in Waitemata Health's Regional Alcohol and Drug Services, I was given the task of jointly chairing an interdisciplinary, inter-service working party with psychiatrist and 'dual diagnosis' specialist, Dr Greig McCormick from Mental Health Services. The working party was established as part of a rational and consultative approach by the Regional Alcohol and Drugs Services, to formulate a protocol which addresses the needs of those clients dually diagnosed with psychiatric and addiction disorders.

In spite of a number of innovative recommendations, and subsequent attempts by (then) Northern Regional Health Authority (RHA) to purchase specialist services, significant gaps in service provision for this group remain.

In a small, informal review, by this author, of all sudden deaths of clients of Regional Alcohol and Drug services in Auckland during the period 1994/95, all (5) had a diagnosis of substance abuse disorder and mental health disorder. An independent review of policies and procedures found that the deceased were concurrently clients of both mental health and alcohol/drug services. It concluded that both services had done everything they could for their clients within the constraints imposed by their own systems. The review also concluded that the clients had not had their needs met in a satisfactory way, and pointed to gaps in both services that contributed in large part to this regrettable outcome. Neither service was set up to meet the specialist needs of this group of people, and both services had tried to fit them into their own operational frameworks. Service needs and not the client's needs prevailed in each case.

At the same time, I was on the Board of Directors of Challenge Trust, a non-government organisation contracted by the Northern RHA to provide supported accommodation and community support to level 3 mental health patients in the South Auckland area. Many of these high need, 'difficult to manage' patients had a 'dual diagnosis', were among the last to be discharged from inappropriate and expensive institutional mental health care, and made the least successful transition back into the community. Given these grim odds, the outlook for people with coexisting disorders was poor, but here was a model of care and support that was meeting with immense success. The focus of this newly established service was on the needs of the client in their totality, not their disease process (solely) or their 'inherent difficulties'. This unprecedented achievement gave me hope that maybe life could be different for the 'dually diagnosed' and that an original study was warranted.

Very little research work has been carried out in New Zealand around the issue of dual diagnosis, and nothing from a sociological perspective that takes account of the problem in its wider context.

A preliminary scan of the literature highlighted a number of issues in relation to research around 'dual diagnosis':

1. The very nature of the term 'dual diagnosis' implies a 'medical' bias. Although the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) does not deal with it as a single entity, 'dual diagnosis' is applied to those people who meet the criteria for substance-related disorders and Axis I psychiatric disorders (see Key Concepts).

2. Debate around 'dual diagnosis' has been captured by both the mental health and addiction literature over the past decade (Todd, Sellman & Robertson, 1999).
3. Consistent with this medical paradigm the literature has focussed on 'prevalence' and the individual as they present problems of 'assessment', 'diagnosis' and 'treatment'.
4. Within this medicalised clinical setting, there seems to be no systematic 'diagnostic' approach in either mental health or substance abuse services to identify those clients in need of particular assistance with coexisting disorders.
5. There is a paucity of material being generated or published in New Zealand.
6. There appears to be almost no literature on coexisting disorders as a wider health and social issue.
7. Anecdotally, the 'dually diagnosed' have a high profile in the media as being the people who either kill or are killed by police, often under tragic and dramatic circumstances. There has been no attempt to verify this or keep any systematic records about the events leading up to the tragedy or the outcome for the patient and the community s/he lives in.
8. Conversely (and also anecdotally), the 'dually diagnosed' are a vulnerable group in our society with less personal (and often material) resources at their disposal with which to manage their health and daily living.

I am not primarily concerned with the biomedical permutations of coexisting disorders or the debates about treatment. What does fascinate me is the way people 'live' with their different abilities and how they make sense of their lives in a personal and social context.

Refining the Topic

Having settled on a topic, an area for investigation, the question arises: how best to investigate coexisting disorders in a way that respects the experience of those being 'studied' and meets the criteria for a PhD? It has to be an original piece of work that contributes significantly to the scholarship of the field of study. Having partially completed a literature search, I had yet to find a theoretical and methodological position which allowed the subjects' voices to prevail.

In almost all cases, the data has been 'forced' to 'fit' a particular methodology and world view. A hypothesis was proposed and tested. Results were evaluated from a medical paradigm. Most examined an aspect of assessment or treatment and failed to take account of the complexities of the daily lives of the subjects under study.

Very little work has been done in New Zealand around the issue of coexisting disorders, and nothing of a comprehensive nature that takes account of the matter in its totality. I have a unique opportunity not only to make a contribution to health provision for this group of people, but also to develop a way of theorising about the issue that offers an added dimension of understanding.

Although it did not assist in refining the topic, I made a decision to use grounded theory methods. These methods did provide a structure and a strategy for approaching the study of people with coexisting disorders which allows the subjects' voices to prevail.

Grounded theory method provides a set of strategies for conducting rigorous qualitative research. It is a logically consistent set of data collection and analytic procedure aimed to develop theory. It consists of a set of inductive strategies for analysing data, starting with individual cases, incidents or experiences and develop progressively more abstract conceptual categories to synthesise, explain and understand the data, and to identify patterned relationships within it. Theoretical analysis is built on what is discovered as relevant to the actual world being studied (Charmaz, 1983).

Aim of the Research

The aim of this research is to use the grounded theory approach to discover the main concerns of 'consumers', health workers and families surviving and working with 'coexisting disorders' and to explain the processes they use to resolve difficulties and deal with issues. Much of the current literature (see Chapter Five, "The Field"), presupposes the focus of consumers and their families, or tests hypotheses of researcher interest. In a wider context, the aim of this research is to begin to fill the rather significant gap in the literature. It offers a distinct methodological approach to the study of, what until now has been seen as, a medical condition. By applying a broader, more sociological emphasis, it is hoped to create a unique set of data from which treatment approaches and policy documents might be developed and enriched.

The Narrative Voice

You can't have a story without a voice. As soon as you use words, you're making a series of decisions about how you'll put them together, and those decisions reflect the writer's subjective judgement as to which words sound best. You can't have a piece of writing without that subjective element, so there can't be any such thing as a completely neutral voice... (Grenville, 1990:80).

Although Grenville was talking here about writing a novel, the same principle applies to this research and researcher. Whilst it is not my intention to enter the wider debate about scientific objectivity and neutrality, Patton (1990:55) ably states a view which fits comfortably with my own position on the subject: "The ideals of absolute objectivity and value-free science are impossible to attain in practice and of questionable desirability". In my attempts to understand the world of coexisting disorders, with all its complexities and multiple perspectives, I have applied systematic and rigorous rules to both the data collection and the analysis. However, in the writing up, I have adopted a narrative style that clearly locates me in the research process. My presence is expressed and is evident in the use of first person narrative where appropriate. To adopt a formal, detached, third person narrative style is to absent myself artificially from the business of seeking "meaningful, credible, valid, reliable, accurate, and confirmable findings" (Patton, 1990:55). According to Patton (1990:55), the terms *objectivity* and *subjectivity* have lost their utility and he simply asks that the investigator adopt "a stance of *neutrality* with regard to the phenomenon under study". This means that the investigator has no pre-determined results to support, no particular perspective to push, and "does not manipulate data to arrive at predisposed truths" (Patton, 1990:55). Patton (1990:58) coins the phrase "*empathic neutrality*" to imply a non-judgemental interest in and caring about people during the data collection, but argues for credible qualitative inquiry based on three elements:

...rigorous techniques and methods at each stage of the research process, the credibility of the researcher, and a philosophical belief in the phenomenological paradigm.

This approach to the narrative voice and empathetic neutrality allows me to engage with the process without privileging the outcome.

Key Concepts

The debate about definitions will be explored more fully in "The Field" chapter. The participants in this study all had a diagnosis of Axis I, major mental

disorder and substance dependence. The major mental disorders fell into one of two diagnostic categories: schizophrenia and mood disorders with many sub-classifications in each. The other group of illnesses which require explication are the anxiety disorders. All the consumer participants experienced anxiety, from a variety of sources, as a component of their mental illness and substance abuse. For some it was primary and preceded their substance use while for others anxiety accompanied withdrawal and sobriety.

What is provided here is a 'working' definition of the key features of each broad category in the hope that this will provide an understanding of 'mental illness' and 'substance use disorders' for the uninitiated reader, and put the participants' experience into context.

Multiaxial assessment

Within the DSM-IV (1994) is a system of axes that allows for the assessment and collection of information from 'patients' in several domains. These have been designed in a way that helps the clinician plan treatment and predict outcome. "Axis I is for reporting all the various disorders or conditions in the Classification except for the Personality Disorders and Mental Retardation [which are reported on Axis II]" (DSM-IV, 1994:25). All the conditions 'suffered' by the participants in this study fell into the Axis I schema.

Schizophrenia

Schizophrenia is a broad term encompassing a large group of mental disorders. The lay understanding of schizophrenia is as a 'split personality', which refers to two separate identities. Calling schizophrenia a 'split personality' is somewhat of a misnomer. The original intention of the Swiss psychiatrist Bleuler was to convey his belief that "a split occurred between the cognitive and emotional aspects of the personality" (Stuart & Laraia, 1998:407). Today it is regarded as "a serious and persistent brain disease. It is an illness that results in psychotic behaviour, concrete thinking and difficulties in processing information, interpersonal relationships, and problem solving" (Stuart & Laraia, 1998:407). In a psychotic state the individual's perception of reality is altered. *The American Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) is used as the basis of psychiatric diagnosis in New Zealand. In order to be given a diagnosis of schizophrenia an individual must experience at least two of the following, each present for a significant portion of time during a one month period: delusions, hallucinations, disorganised speech, grossly disorganised behaviour, and, what are referred to as negative symptoms such as a limited range and intensity of emotional expression, restricted thought and

speech and lack of initiation of goal-directed behaviour. They must also have experienced, for a significant portion of time since the onset of disturbance, failure to attain the expected level of interpersonal, academic or occupational achievement. Finally these signs of disturbance must have been continuous for a period of at least six months (unless they have been successfully treated).

These symptoms are often experienced as frightening by the 'patient' and those who are trying to support them.

Mood disorders

Like schizophrenia, the affective or mood disorders cover a wide range of sub-categories, but generally refer to either depressed or elevated mood states. They fall into one of three major categories:

Major depressive episode

Major depressive episode - of at least two weeks duration during which there is either "depressed mood or the loss of interest or pleasure in nearly all activities" (DSM-IV, 1994:320). In addition to this the person must also experience at least four additional symptoms which may include:

...changes in appetite or weight, sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death, suicidal ideation, plans or attempts (DSM-IV, 1994:320).

Manic episode

Manic episode - in which there is "an abnormally and persistently elevated, expansive, or irritable mood" lasting for a week, and is accompanied by three other symptoms which may include:

...inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences (DSM-IV, 1994:328).

Mixed episode (bi-polar disorders)

Mixed episode (bi-polar disorders) - which is characterised by a period of time in which both manic and major depressive episodes occur within the space of a day, and cause marked impairment in social or occupational functioning, and

are not caused either by substance use or a general medical condition (DSM-IV, 1994:333). It is this mixed episode mood disorder that was formerly referred to, and is still used in a lay sense, as manic-depression.

Anxiety disorders

According to Bourne (1990:4) "Anxiety is an inevitable part of life in contemporary society". It is not this 'normal' anxiety that my participants are talking about in the data chapters of this thesis. They do not mean the appropriate anxiety that anticipates an exam or accompanies loss and failure. Anxiety disorders are distinguished from everyday, normal anxiety in that they involve anxiety that is more intense, lasts longer or leads to phobias that interfere with your life (Bourne, 1990:4). The most common form of anxiety experienced by the participants was **panic attacks**. These are the sudden onset of intense apprehension, accompanied by feelings of impending doom, and symptoms such as shortness of breath, palpitations, chest pain, choking or smothering sensations, and fear of "going crazy" or losing control (DSM-IV). Closely associated with this is **agoraphobia** (anxiety about or avoidance of places and situations from which escape might be difficult) and **social phobia** (where the individual becomes anxious in certain situations, often leading to avoidance behaviour). One participant in this study had an **obsessive-compulsive disorder** where she performed compulsive hand washing and cleaning routines in order to reduce her anxiety. Another was suffering from **post traumatic stress disorder** in which she re-experienced extremely traumatic past events. And all the participants had, at some time in their lives, experienced the **substance-induced anxiety disorder** that is "...a direct physiological consequence of a drug abuse..." (DSM-IV). This latter anxiety is usually experienced as part of the withdrawal process from drugs and alcohol, and occasionally as a paradoxical effect of the administration of certain types of anxiolytic drugs such as benzodiazepine.

Substance-related disorders

Diagnosis and analysis of substance-related disorders are categorised according to the generic substance eg. alcohol, amphetamines, hallucinogens (DSMIV), but there are some shared concepts across all substances. The universal understandings, which can be applied to each mood or mind altering drug (including alcohol), are those of **substance abuse**, and **substance dependence**.

Substance abuse

Substance abuse is "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of

substances" (DSM-IV, 1994:182). These 'adverse consequences' may include "a failure to fulfil major role obligations at work, school, or home...or recurrent substance use in situations in which it is physically hazardous" eg. drinking and driving (DSM-IV, 1994:182).

Substance dependence

Substance dependence covers what used to be referred as, as alcoholism and drug addiction and includes "a cluster of cognitive, behavioural and physiological symptoms" in which the person continues to use despite significant substance-related problems (DSM-IV, 1994:176). In addition, a definition of substance dependence can be applied to every class of substance except caffeine, and results in tolerance, withdrawal, and compulsive drug-taking behaviour (DSM-IV, 1994:176).

All the consumer participants in this study met the DSM-IV criteria for substance dependence for at least one substance. However, substance dependence is a medical concept and not the way in which the participants necessarily described their relationship with drugs and alcohol. The term 'substance use' will be used throughout this thesis and may refer to any or all of the participants' substance use, substance abuse or substance dependence.

Coexisting disorders

As with mental illness and substance abuse, the labelling and classification of coexisting disorders is often contentious and problematic and the debates will be explored more fully in the "Discussion". It does not appear as a definition in the DSM-IV, and attempts to codify it are based on bringing together the separate classifications of mental disorder and substance abuse. A practical approach to the problem of definition has been to apply it in a two dimensional form to people who experience difficulties with both their mental health and substance use. This two dimensional schema privileges one condition over the other. It tends to be used in an ad hoc way in the clinical setting (Warren & Wilson, unpublished paper, 1994).

More recently, Kenneth Minkoff (1996) has promoted a model developed by Richard Ries which has a high/low configuration that does not attempt to privilege one disorder over another. It is a two-dimensional typology which defines those categories based on low/high severity of psychiatric disorder and substance disorder.

Psych low/substance high, complicated chemical dependency or psychiatrically-complicated substance dependence.

This dimension includes patients with alcoholism or drug addiction who have significant psychiatric symptomatology and/or disability but who do not have serious and persistent mental illness. It applies to individuals who have both substance-induced psychiatric disorders and substance-exacerbated psychiatric disorders. Psychiatric syndromes found in this category include; anxiety/panic disorder, depression/hypomania, psychosis/confusion, PTSD (post traumatic stress disorder) symptoms, suicidality, violence, symptoms secondary to misuse/abuse of psychotropic medication and personality traits/disorder

Psych-high/substance-low (Substance abusing mentally ill). Patients with serious and persistent mental illness which is complicated by substance abuse, whether or not the patient sees substances as a problem.

Psych-high/substance-high (Substance dependent mentally ill)

Patients with serious and persistent mental illness, who also have alcoholism and/or drug addiction, and who need treatment for addiction, for mental illness or for both. This includes sober individuals who may benefit from psychiatric treatment in a setting which also provide sobriety support and Twelve-Step Programmes

Psych-low/substance-low (Substance abuse and non-severe psychopathology)

This includes patients who usually present in out patient settings with various combinations of psychiatric symptoms eg. anxiety, depression, family conflict, and patterns of substance misuse and abuse, but not clear cut substance dependence.

Other terms and concepts less germane to the central tenet of this thesis will be discussed in "The Field" chapter.

Structure of the Thesis

So far, the topic of the thesis has been introduced. Coexisting disorders as an entity was presented and a justification of it as a legitimate concern for research established. Concepts central to an understanding of the human and medical aspects of psychiatric diagnosis, and hence the thesis, were explored. The rest of the thesis is presented in the chronology in which it occurred. The body of literature which informs current thinking on coexisting disorders is included in a chapter called "The Field", with a review of the literature arising out of the data appearing towards the end. "The Results Chapters" have been set strategically between these two literature reviews.

Chapter Two, "Theory" outlines theoretical orientations in relation to two aspects of the thesis. Part one explores pragmatism and symbolic interactionism as the basis of grounded theory. Part two examines the theories of knowledge of coexisting disorders. Psychiatry and the medical model prevail, with the sometimes competing and at others complementary, perspectives of postmodernity, psychology, behaviourism and the philosophical influences of Heidegger and Jung.

Chapter Three, "Method" begins with an explanation of the basis of 'truth' that informs the research. It goes on to deal with the place of Maori in the study before introducing qualitative research as a preferred approach. Grounded theory method is chosen as a rigorous, valid and reliable process that is capable of gathering and producing high quality data and results. The concepts of credibility, competence and trustworthiness as necessary attributes in a researcher are explored in relation to this particular researcher. Finally a belief in the phenomenological paradigm as a basis for 'grounded' investigation is attested to.

Chapter Four creates an "Audit Trail" of the research process and theoretical decisions. It has been written to allow the reader to track the 'logic' of the study as it developed from a general field of inquiry to a matrix of *discovering a life*. It is divided into two sections; the first deals with the empirical decisions that were made in relation to the participants, the questions and gathering of the data. The second section follows the way the data was analysed and the conceptual codes and categories were developed out of it. Development of the basic core category was not a linear process, and the "Audit Trail" records the movement of thought as it back tracked and advanced toward the final resolution.

Chapter Five "The Field" replaces what would be, in a more traditional thesis, the literature review. It is an examination of the existing literature on coexisting disorders and locates the thesis in a legitimate field of study. It is divided into five sections, the first establishing mental illness and addiction as medical problems. The second section analyses mainstream ways of categorising and conceptualising coexisting disorders, and the third section provides an analysis from alternative perspectives. The fourth section examines diagnostic tools, methods and prevalence, and the final section outlines treatment approaches and service provision. Finally, "The Field" chapter provides a context for a discussion of the findings of this research.

Chapters Six to Ten constitute the results. The section begins with a general introduction to the results chapters. This is followed by five distinct chapters, each comprising one of the five theoretical categories that go to make up the basic core category *discovering a life*. Within each chapter, the codes and categories that go to make up the theoretical category are explicated. In order for the reader to distinguish easily between the key theoretical categories and the codes and conceptual categories that go to make them up, the following style has been adopted. The basic core category and the five key theoretical categories are written in *italics* and **bolded**. The codes and conceptual categories are *italicised* but not bolded.

In chapter Six, *intemperate insanity*, the participants' begin their story of active mental illness and substance use. They recall the importance of drugs and alcohol in their lives, and the emerging realisation of mental illness. In this chapter they reflect on both the positive and negative expressions of *intemperate insanity*. Ultimately the negative consequences prevail and lead inexorably to the next phase they described as *the crisis*.

Chapter Seven, *naked in Woolworths - the crisis*, deals with the culmination of years of *intemperate insanity*. *The crisis* is not a single occurrence or episode, but is experienced in a number of stages. These do not necessarily occur in a tidy progression of events, but have been described in this way to provide greater clarity for the reader. There is a period of *building up* where the substance use continues unchecked and the negative consequences increase in frequency and intensity. This is followed by the second stage, *overwhelming*, where the participants find events to be greater than their usual coping mechanisms can accommodate. This leads inevitably to the third stage, *breaking down*, which is marked by an inability to deal with the simple activities necessary for daily living. Finally, there is *intervention*, by a person or agency outside the individual, and for most participants this means hospitalisation. It is at this point that individuals are offered 'treatment'. *The crisis* phase of *discovering a life* is the one where families and services become the most involved. Whilst the data from 'family participants' has been integrated here, the material provided by the clinicians is dealt with in Chapter Ten, "Janus' Temple".

Shedding the armour - recovery (Chapter Eight) follows *the crisis*, marking the transition from illness to wellness. This stage of discovery is also characterised by a number of phases, beginning with *taking responsibility* for one's well-being. The most critical task of the *recovery* period is sobriety. It is the success of achieving and maintaining sobriety upon which the rest of *discovering a life* is

predicated. Once sober, the participants found they were then able to develop the skills necessary for living in a more positive relationship with coexisting disorders. *Achieving sobriety* enabled them to move on to the final stage in this transition, *incorporating* the 'dual disorders' into an understanding of who they are as individuals. It is at this point that some of the existing knowledge of coexisting disorders and recovery is challenged and the discovery paradigm begins to emerge.

Living without the armour - maintaining (Chapter Nine), accounts for the present continuing period of the participants' lives without drugs or alcohol and mental illness. It audits the daily activities of their lives and follows their journey beyond recovery into uncharted territory. *Living without the armour* is also characterised by four stages. The first, *daily reminders*, allows the participants to remember the significant events that have brought them to this point. The second, *human connecting*, paves the way for bringing new people into their lives who will be supportive of their new attempts to bring about lasting change. *Pushing the boundaries* is the most exciting phase of *discovering a life* as participants explore the uncharted territory of their worlds. Finally *giving back*, is a mechanism of thanks and gratitude for the help and generosity that has been shown to them by others on their journey of discovery. For many of the participants it was not possible to acknowledge directly those persons who had contributed positively to their well-being, but they were able to show a similar generosity of spirit to others in need.

Chapter Ten, *Janus' Temple - service provision* record and analyse issues of the 'staff participants'. Although the centrality of their concern was the same coexisting disorders of the consumer and family participants, the focus was so distinct that it could not be integrated with the other data at the point of analysis. The staff participants spoke about the events and structures that impacted on their ability to daily provide care. These involved the way services were organised (*integrated* or *parallel care*), conflicts created by the models that different clinicians used to inform their practice, and the way services were best able to meet the cultural needs of their clients. On a micro level, there were concerns expressed about the adequacy of *skills and knowledge base* of some staff members. Finally, mechanisms for *engaging* clients with services provided a hurdle to good care in some instances.

Chapter Eleven the *Literature Review* explores the literature of *recovery* and *service provision* and critiques them against the data that emerged from the participant interviews. *Recovery* is interpreted and used as a concept by three distinct theoretical paradigms; the Twelve Step, self-help and 'new age'

movements, the mental health service user movement and mainstream psychiatric rehabilitation. At the same time there are a number of common threads running through each of these divergent approaches. *The essence of recovery, the tools for recovery, and recovery as a process* will be outlined. *Recovery* has also been professionalised in the provision of service to consumers. The second section of this literature review, examines the ideas and policy documents that influence *service provision in the New Zealand context*.

Much of the mainstream literature on coexisting disorders and elements of *discovering a life*, are predicated on an awareness of 'normal'. The understanding of 'normality' as a concept in health (and society) is often taken for granted. It is an abstract and obscure concept with many interpretations that are frequently not defined. Chapter Twelve, the *Discussion*, begins with an exploration of the assumptions of 'normality'. Following this, the chapter engages discursively with the findings of the thesis, the current literature and treatment approaches to coexisting disorders. The uniqueness of the study is confirmed, and implications for clinical practice, research and policy are postulated.

Chapter Thirteen, *Conclusion*, synthesises the findings and arguments of the study and revisits the originality of the research. This originality is based on the matrix of *discovering a life* that was developed out of the data of the participants. Based on these new insights, it makes recommendations for policy, treatment and treatment staff in the area of coexisting disorders. Finally, a number of areas for further research are outlined, and although dealt with briefly here, each comprise the potential for a new and innovative piece of work that contributes to the greater knowledge of this complex and interesting field of study.

CHAPTER TWO: THEORY

Epistemology - the philosophical theory of knowledge, which seeks to define it, distinguish its principal varieties, identify its sources and establish its limits (*Dictionary of Modern Thought*).

Introduction

This thesis is informed by a multiplicity of theoretical orientations. Theory is a flexible concept from the 'lay' sense of having an idea about something to theory that "describes, explains, predicts, interprets and tests" (Glaser & Strauss, 1967). In sociology, a theory is a "statement that organises a set of concepts in a meaningful way by explaining the relationship between them" (Robertson, 1983:634). Theory exists on a number of levels from the major theoretical perspectives (such as functionalism and symbolic interactionism) that make broad assumptions about society and social behaviour, to the 'substantive' theory described by Glaser and Strauss (1967). "By substantive theory, we mean that developed for a substantive, or empirical, area of sociological inquiry, such as patient care..." (Glaser & Strauss, 1967:32). They also use the method of 'comparative analysis' to generate a second or 'formal' level of theory. This allows for sociological inquiry at a conceptual level such as 'stigma' or social mobility. Both these substantive and formal types of theory "may be considered middle-range...that fall between the minor working hypotheses of everyday life and the all-inclusive grand theories (Merton, 1957:7).

'Discovery' as a concept for people living with coexisting disorders is the sociological inquiry at the centre of this thesis. This chapter provides a brief outline of the knowledge bases that inform the work in this thesis. Pragmatism, the philosophical approach to the nature of truth, together with symbolic interactionism as a perspective of sociology in the study of human conduct, will be explored as the basis of grounded theory (Part One).

Whilst it is important to have an understanding of the epistemology or knowledge base that informs grounded theory methods, it is equally important to understand the theories of knowledge of coexisting disorders. Those contemplations which seek to define it, distinguish its principal varieties, identify its sources and establish its limits are also briefly outlined here (Part

Two). There are four key knowledge bases on which an understanding of coexisting disorders and their 'treatment' is formed: psychiatry and the medical model, postmodernism (Foucault), psychology and behaviourist approaches and recovery with its philosophical influences of Heidegger and Jung.



Part One: The Basics of Grounded Theory

Pragmatism

Pragmatism is a philosophical concept which interprets the meaning and defence of our beliefs in terms of their practical effects or content. It is more than just a stated preference or 'common sense' knowing. Pragmatism, according to Charon (1992:25-26), provides a schema for examining knowledge and beliefs in a formalised way that still allows for knowledge as an instrument for action.

As Charon states "Mead is part of that school of philosophy known as pragmatism. The ideas of this school are particularly important to Mead's approach to understanding the nature of truth" (Charon, 1992:25-26). According to Mead (1934:29) there are four basic ideas comprising pragmatism:

1. *"what is real for us in the environment always depends on our own active intervention"*. That is, knowledge about the world essentially does not impose itself on us. Things do not tell us what they are. As human beings we define the world around us. We engage in an interpretive process. Our 'reality' is always filtered through the experience and context of our lives.
2. *"knowledge for the human being is constantly being tried out in situations and is judged by its usefulness"*. If what we already know works for us, we tend to believe it and remember it. We judge ideas, facts and perspectives by how useful they are to our lives. According to Charon (1992) every situation is a test for our ideas: if they work (help us achieve our goals) we keep them; otherwise we alter them. 'Truth' is judged by what is useful to us not what is right or wrong.
3. *"the objects we encounter in any situation are defined according to their use for us."* What things mean to us depends on how we intend to use them. This applies to objects and ideas, and at any given time we 'use' what is effective for us and ignore what is not.

4. *"understanding the human being must be inferred from what he or she does"*. It is human action that social scientists can empirically observe, and from that they are then able to understand human beings. What is meaningful in this observation is the interaction between individuals, what a person does in any given situation. It is not the individual alone, or society alone that is the object of study. In addition, the social scientist needs to consider the meaning that individuals give their actions. How we interpret what we and others do is as important as the action itself.

Mead's four basic ideas comprising pragmatism are present in the data of the participants. They test what is 'real' for them in their environment, assess its usefulness to their lives, attribute meaning according to that usefulness and seek to understand their lives through action and interaction with others.

Symbolic Interactionism

While, pragmatism as a philosophy, stressed the relation of theory to praxis, symbolic interactionism developed as a perspective of social psychology and sociology in the study of "human group life and human conduct" (Blumer, 1969:1). It grew out of the scholarship of a number of intellectuals, most notably George Herbert Mead and Herbert Blumer (Blumer, 1969:1, Charon, 1992:24). The three premises on which symbolic interactionism is based are closely linked to the ideas of pragmatism:

1. human beings act toward things on the basis of the meanings that the things have for them,
2. the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows...[and]
3. these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (Blumer, 1969:2)

In attempting to clarify the nature and integrate the perspective of symbolic interactionism for his students, Joel Charon (1992:23-24) explicated four central ideas:

- Firstly, 'social interaction' as a dynamic process, not merely a person as "an actor responding to others in the environment".
- Secondly, "...we act according to the way we define the situation we are in" (Charon, 1992:24).

- Third is the focus on the 'present', not the past, ie, "we are not simply playing out personality traits we developed early in our lives" (Charon, 1992:24).
- Finally symbolic interactionism "describes the human being as more unpredictable and *active* in his or her world", that our action involves conscious choice (Charon, 1992:24).

Whilst this is not a piece of work based on symbolic interactionism as a research strategy, symbolic interactionism does theoretically inform the grounded theory method. The grounded theory method gives the researcher a unique opportunity to explore coexisting disorders from a heretofore neglected perspective, with the exciting possibility of making new discoveries. It places the participants firmly in the centre of the research and gives the researcher an insight into what is meaningful for them. The four central ideas of the theory resonate in the lives and actions of the participants and play an important part in the basic social process of 'discovering a life'. The participants' lives are very much a product of 'social interaction'. They were not passive recipients of treatment by others. They were all active in defining their own situations and lived very much in the present (even if the past was an important part of the present). Their individual actions involved conscious choice, both positive and negative. By the time they entered this study they had all made the choice to abstain from all mood and mind-altering substances. At other points in their lives they had made the choice to continue to abuse drugs and alcohol, even when it contravened the best advice of the 'experts'. The tapestry of symbolic interactionism is present at every level of data and analysis. It is the theoretical understanding on which this thesis sits, and out of which 'discovery' of life grows.

Whilst Glaser (1998:11) acknowledges grounded theory is "not a 'best' methodology that replaces or supplements other methodologies" it none-the-less stands on its own and meets the criteria set for this project of being scientifically rigorous and participant centred (rather than hypothesis driven).

Second-level Theory

In *Theoretical Sensitivity*, Glaser (1978:73-82) introduces the researcher to the concept of theoretical coding. This is the means by which data from many hours of interviewing is systematised and raised to the level of a mid-range theory (in this case '*discovering a life*'). There are many schema by which the data can be organised and Glaser (1978:73-82) lists eighteen coding families with some comment on their use. I began with a somewhat arbitrary selection

of the six "C's" schema. In an analytical sense, the six C's describe a process, allow for explanatory attribution and imply some ordering or movement from cause to consequence. The application of a causal-consequence/process model to the preliminary coded data, lent itself to theory generation by "developing ... hypothetical relationships between conceptual codes" (Glaser, 1978:55). From a purely pragmatic point of view, this is the coding family that is being and has been used by other ground theory researchers in New Zealand. Because Glaser (1978) did not fully explain the meaning of the six C's I relied heavily on Strauss and Corbin'[s] *Basics of Qualitative Research* (1990:96-97), dictionary definitions and the work of Sally Hutchinson (1993:180-212) for clarification.

The six C's are as follows:

Causes - what produces an effect; antecedent; invariably followed by a certain phenomenon.

Context - refers to the environment or setting where the behaviour occurs - background; connection; frame of reference.

Contingencies/Contingency - uncertainty of occurrence; chance occurrence; something that may happen at a later time; dependent on an uncertain event; something incident to another. **Contingent** - ie, *with* or *upon*; conditional; controlled by; dependent; subject to.

Consequences - refers to what comes by causation or follows by logic (from something preceding); as a result of.

Covariances - includes connected variables without forcing the idea of cause (covariances according to Glaser (1978:74) change the way we look at and interpret the main theme).

Conditions - or qualifiers - refer to those factors essential for the actualisation of the social psychological processes under study (Hutchinson, 1993:208).

In terms of this study, these six C's shaped the way the researcher thought about the data and tried to fit the participants' material together to give each experience more power than it would otherwise have had on its own.

Summary

The philosophical understanding of pragmatism informed, not only the grounded theory of this study, but also the methodological approach. It distinguishes this thesis from all other research into coexisting disorders in that it locates itself in the lives of the participants as they understand and interact with the world in which they live.



Part Two: The Epistemological Soup that Nourishes an Understanding of Coexisting Disorders:

To theorise about 'coexisting disorders' is to theorise about the human condition. In the mainstream literature, it has been artificially separated from the totality of human existence and medicalised as a distinct entity. The authoritative *Diagnostic and Statistical Manual of Mental Disorders IV* (1994:xxi), defines a mental disorder (which includes substance use disorders) as:

A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (eg. a painful symptom) or disability (ie. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

However, the *DSM IV* (1994:xxii) definition is accompanied by an acknowledgment that "a common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have". Necessary to the people component of a study on coexisting disorders is a 'post-modern' view of 'self' as informed by Foucault, (1965, 1973). The importance of the philosophical influence of Martin Heidegger (1962), needs to be examined. The recovery approaches of Carl Jung (1963), must be acknowledged as significant theoretical informants to many treatment methods. Furthermore, for this study, the influence of sociocultural theories in the New Zealand context is acknowledged in the tendency of participants to incorporate aspects of the Maori 'Whare Tapa Wha' (Durie, 1994), model into their well-being. Each of these will be discussed here in turn and the relevance of their theoretical contribution to the study outlined. However, first a number of theoretical hypotheses that fit broadly into the medical model must be discussed.

Psychiatry and the Medical Model

A recent literature review of aetiological theories of coexisting disorders (Todd, Sellman & Robertson, 1999) proposes several theoretical hypotheses that can be accommodated within the medical model. These include a genetic model (Todd, Sellman & Robertson, 1999:33), a neurochemical model (Todd, Sellman & Robertson, 1999:34), biological reinforcement models, and theories of temperament, character and personality.

Psychiatry, comes out of an epistemological assumption that moves towards mental health via ownership, responsibility and involvement. It is based in realism and objectivity and is reliant on classificatory systems to provide external validation of its reality. In its purist form, the focus of psychiatry is on disease, illness and symptoms. Treatment is based on the individual's disabilities and intrapsychic functioning. It (the treatment) is often provided in institutional settings or the outpatient clinics of those institutions. The relationship between the doctor and the individual is one of expert-to-patient respectively. 'Symptoms' are medicated until they are controlled, decisions are made by the physician and treatment is prescribed out of those decisions. The emphasis of care is on dependence and compliance by the 'patient' (Stuart, 1998:244). This is consistent with the epistemology of the medical model and remains a development of it.

The assumptions on which the medical model are based are outlined in Chapter Five 'The Field'.

The Genetic Model

A gene is a biologic unit of heredity, self-reproducing, and located at a definite position (locus) on a particular chromosome. Genes make up segments of the complex deoxyribonucleic acid (DNA) molecule that controls cellular reproduction and function. Genes play an important role in heredity because they control the individual physical, biochemical, and physiological traits inherited by offspring from their parents (Miller & Keane, 1978:413).

The genetic model accounts for familial transmission of alcohol dependence, drug use disorders and a range of mental disorders (Todd, Sellman & Robertson, 1999). One of the goals of a genetic approach to understanding coexisting disorders is to "elucidate the mechanisms for non-random associations between diseases" (Merikangas & Stevens, 1998:46). There are three key mechanisms by which genetic transmission is investigated: familial aggregation, twin studies and adoption studies. However, these studies have

mainly been conducted with a focus on one substance or mental disorder alone. According to Merikangas and Stevens (1998:41) "while a great deal of research has addressed the familial patterns of alcoholism and drug abuse, the familial patterns of comorbidity among substance abusers has received scant attention." Merikangas and her colleagues (1998:44) have recently completed a large-scale family study designed to examine the mechanisms for comorbidity between alcoholism, drug abuse and anxiety disorders. They acknowledge the complexity of the problem of psychiatric comorbidity among substance abusers and suggest "preliminary findings reveal a lack of shared underlying factors...[and suggest] there may be some vulnerability factors that predispose to the development of dependence on specific classes of drugs (Merikangas & Stevens, 1998:44).

The Neurochemical Model

This model has its explanatory origins in the chemistry of the nervous system. According to Todd, Sellman and Robertson (1999:34):

...neurochemical theories attempt to explain coexisting disorders in terms of the relationship between a drug's effect on neurotransmitters and neurohormones and the underlying neurochemical changes that accompany many psychiatric disorders.

Neurotransmitters are the substances released at the synapse of a neuron that induces activity in susceptible cells. Neurohormones are those hormones stimulating the neural mechanism. Specific evidence for a neurochemical interaction between substance use and psychiatric syndromes in humans is lacking, but there is a considerable amount of circumstantial evidence to suggest that these mechanisms are important (Todd, Sellman & Robertson, 1999:34).

The Biological Reinforcement Model

This model considers the effects of psychoactive drugs on various neurological pathways that control behaviour. In a review of the evidence of addictive drugs as reinforcers on memory systems, White (1996:921) distinguishes between positive reinforcement as "the undertaking of an action because it leads to pleasurable feelings" and negative reinforcement where action is taken to avoid negative states. In a more recent study (Bechara, 2001), addiction is linked to decision-making through the hypothesis that it involves a flaw in the brain's decision-making centre. People who abuse alcohol or drugs often behave similarly to people who have experienced damage to a part of the brain

called the ventromedial prefrontal cortex (VM), which is involved in decision-making. When given a choice to do something that will bring them immediate pleasure but will lead to negative consequences later, they often opt for instant gratification.

Todd, Sellman and Robertson (1999:36) acknowledge that all these models have some explanatory power, but none are comprehensive and all appear to explain only one aspect of 'dual diagnosis'. Because this study is derived from the consumers' perception of coexisting disorders, the medical and psychiatric models are not applied to their data. To do this would be to focus down on the signs and symptoms of psychiatric illness and substance use, and fail to analyse them in the broader context of 'human being'.

Theories of Temperament, Character and Personality

Over the years, there have been a number of attempts to link the role of personality and personality pathology with addiction (Verheul, van den Brink & Ball, 1998:317). This reached its height in popularity in the 1970s. However, theories about personality being a predisposition to substance abuse have subsequently been criticised because "a multitude of retrospective and prospective studies [have] consistently failed to identify a unique type of pre-addictive personality" (Verheul, van den Brink & Ball, 1998:327). Recent attempts to revive the 'personality' argument as an explanatory model have focused on two theoretical propositions. The first is the "developmental behaviour genetic model [and according to this model] proneness to develop substance-use disorders is based on heritable variations in temperamental dimensions...that mediate or shape the behavioural development by means of ongoing and reciprocal interaction with the social environment" (Verheul, van den Brink & Ball, 1998:329). The second personality-related theory of addiction is the 'affect regulation' to enhance positive mood states or alternatively for symptom relief (Verhuel, van den Brink & Ball, 1998; Todd, Sellman & Robertson, 1999). This latter purpose is often discussed as the 'self-medication' hypothesis. Whilst this hypothesis is limited in terms of explaining causality, it may have relevance in terms of the maintenance of coexisting disorders (Todd, Sellman & Robertson, 1999). These authors acknowledge it has not been studied in depth, but argue it seems reasonable that any positive effects substance use has for an individual will tend to reinforce substance-taking behaviour and may need to be addressed in treatment. For the participants in this study drugs and alcohol were an acknowledged symptom relief and mood enhancer (see Chapter Seven, Positive Expressions of *Intemperate Insanity*).

It is out of the theories of temperament, character and personality that the behavioural interventions arise. Behaviourism comes out of the school of psychological thought that studies observable and measurable behaviour. J.B Watson is credited with the development of classical conditioning of involuntary behaviour in a clinical context, but it was the work of B.F. Skinner that explored the relationship between voluntary behaviour and the environment (Stuart, 1998:612). It leaves out of account consciousness and introspection, and its theoretical frames of reference avoid subjective notions. Behaviourist approaches inform many of the skills-based intervention strategies of the early phases of 'recovery', and sit alongside some of the idealistic, existential notions of recovery. Cognitive behavioural therapy, with its focus on relapse prevention and coping skills, forms an important part of early intervention in coexisting disorders (Verheul, van den Brink & Ball, 1998). According to these authors (1998:347), cognitive behavioural therapy for the "two disorders shares several central intervention techniques, including self-monitoring, problem solving, assertiveness, managing thoughts and feelings and homework." These therapies assume that learned voluntary behaviours will be strengthened by positive consequences. The cognitive aspects of therapy aim at re-framing core negative beliefs and "maladaptive cognitive schemas" (Verheul, van den Brink & Ball, 1998:346).

Although theories of temperament, character and personality arise out of schools of psychological thought, they fit broadly into the medical model. The focus is on diagnosis and identification of pathology, the therapist is 'expert' and the interventions are based on symptom relief and palliation of the effects of 'pathology' (Mckeown, 1971:6-7; Armstrong, 1989:119).

The 'People' Component

The Foucault Effect

Whilst this thesis is not a postmodern treatise, postmodernism does have an epistemological influence when it comes to the 'self' in relation to coexisting disorders. Each model that forms the basis of analysis and 'treatment' sees the 'self' from its own perspective. The medical model sees the 'self' as 'patient', "someone who is ill or undergoing treatment for disease" (Miller & Keane, 1989:757). 'Treatment' is provided by 'expert' help in the form of the doctor and other health professionals, and puts the 'patient' in the position of powerlessness over their own state of being. Being a 'patient' implies a set of rights and responsibilities or obligations. According to Parsons, (cited in Armstrong, 1989:7) these rights "temporarily excuse [the patient] his or her normal role" and deem the 'patient' not to be responsible for his or her illness.

In return they (the patient) “must want to get well”, and “must cooperate with technically competent help”. This theoretical understanding of health and illness leads inexorably to a ‘treatment’ outcome that systematically excludes the ‘patient’ from an analysis of their problems and possible solutions that may or may not include traditional medical intervention.

By contrast, in an interview with Ian Hacking (1986:235), Foucault argued that “we constitute ourselves as subjects acting on others - as agents, that is, not as victims”. Hacking (1986:325) speculates that Foucault had written enough about what we say and do to other people, and had now become preoccupied with what we say and do to ourselves. According to Hacking (1986:325) “where previous nominalists thought of the self as making up its own categories, Foucault did not imagine that there is any self, any ego, any I waiting to do that”.

In addition to the domain of power that we exercise is the “account of ourselves in relation to truth through which we constitute ourselves as subjects of knowledge” (Hacking, 1986: 325). It is *we* who are doing it, not having it done to us. To leave out the inner monologue (what I say to myself), and the self-discipline (what I do to myself), is in Hacking’s view “to omit the permanent heartland of subjectivity. It is seldom force that keeps us on the straight and narrow; it is conscience. It is less knowledge produced in the human sciences that we use as our guide in life than self-knowledge” (Hacking, 1986:325).

It is this subjective, individually constructed intuitive knowledge, this postmodern view of self, that forms the basis of the consumer participants’ relationship with their coexisting disorders. They had become immersed in what they were saying and doing to themselves, and how that impacted on their daily lives. This way of thinking seems to fit with Heidegger’s (1962) notion of ‘being’ or *Dasein*.

The Philosophical Influence of Martin Heidegger

In trying to answer the philosophical question of ‘being’, Heidegger (1962) embarked on an analysis of the entity that has some prior understanding of things: human existence or *Dasein*. *Dasein* is used untranslated in Heidegger (1962:27) to mean *being there*, though in traditional German Philosophy it is used more generally to stand for almost any kind of ‘Being’ or ‘existence’ that belongs to *persons*.

Dasein is found to have three main “existentials” or basic structures shared by every “*existentiell*” (specific and local) way of living (Heidegger, 1962:76).

Dasein finds itself *thrown* into a world not of its choosing, already delivered over to the task of living out its life in a concrete context. This 'facticity' of our lives is revealed in the moods that let things matter to us in some way or other eg. the burdensome feelings of concern that accompany being a parent in our culture.

As *projection*, *Dasein* is always already taking some stand on its life by acting in the world. Understood as *agency*, human existence is 'ahead of itself' in two senses: (a) our competent dealings with familiar situations sketch out a range of possibilities for how things may turn out in the future, and (b) each of our actions is contributing to shaping our lives as people of specific sorts. '*Dasein*' is future-directed in the sense that the ongoing fulfilment of possibilities in the course of one's active life constitutes one's identity or being. Thus my actual ways of treating my children throughout my life define my *being* as a parent in the end, regardless of what good intentions I might have.

Finally, *Dasein* is *discourse* in the sense that we are always articulating or - 'addressing and discussing' - the entities that show up in our concerned absorption in current situations.

Taking a stand on our own being, we constitute our identity through what we do. Our 'being' is made more concrete through our involvement in the world. "The embeddedness of our existence in a cultural context explains our inveterate tendency towards inauthenticity" (Audi, 1999:372). Audi implies that as we become initiated into the practices of our community, "we are inclined to drift along with the crowd, doing what 'one' does, enacting stereotyped roles and thereby losing our ability to seize on and define our own lives" (Audi, 1999:372).

It is in the context of *Dasein* that the participants of this study define themselves, not as patients but as complex human beings. Part of their make-up is of major mental illness and addiction, but these do not define them. They are not their illnesses and 'coexisting disorders' is not who they are.

Recovery and the Influence of Carl Jung

Much of the data and discussion in this thesis arises out of the 'recovery' tradition. 'Recovery' is not a homogenous enterprise: there is no single definition or single recovery approach. There are a number of recovery approaches that have different emphases. Whatever the approach or emphasis, the underlying epistemological assumption is 'experience'. There is no objective 'truth'. Recovery stresses abstract principles, personal power, independence

and health. Having conceded the multiple realities of 'recovery', I must also concede that 'recovery' as a concept did not develop in a vacuum. It is informed by ideas generated in a debate between the psychiatrist and psychoanalyst Sigmund Freud and Carl Jung. In the early twentieth century Jung disputed Freud's psychoanalytic theory of personality and the preservation of psychic equilibrium. Jung practiced a form of 'analytic psychology' according to which "man's behaviour is determined not only by the conflicts already present in his individual and racial history (the personal and collective unconscious) but also by his aims and inspirations" (Jung, 1963:337). It is Jung's particular brand of psychology that helps to inform the ideas and practices of contemporary psychotherapist and writer Thomas Moore.

Moore (1994:xii) argues that "modern psychologies and therapies often contain an unspoken but clear salvational tone" with the implication that if only we could learn to be more "assertive, loving, angry, expressive, contemplative or thin" then our troubles would be over. He used as his model a self-help book of the middle ages that "didn't promise the sky" (xii) but offered "recipes for good living and... suggestions for a practical, down to earth philosophy of life." Moore explores "this humbler approach, one that is more accepting of human foibles, and... sees dignity and peace as emerging more from that acceptance than from any method of transcending the human condition" (xii).

Moore's expression of Jungian psychotherapeutic ideas captures the way the participants spoke about and made sense of their lives. Neither Moore nor the participants saw 'recovery' as being synonymous with health. Whatever brand of 'recovery' the participants practiced, they each relied on the universal principles of hope, choice, empowerment and personal meaning. They based their ideas and understanding on 'experience' and narrative justification not an 'objective reality' that could be measured against a deterministic physical brain event.

Sociocultural Theories

In reaction to the traditional models that sought explanations within either the host or the agent, the sociocultural model emphasises the "significance of social factors (peer pressure, family factors) and sociocultural setting (social acceptance, substance availability" (Verheul, van den Brink & Ball, 1998:319).

In the New Zealand context, Todd, Sellman and Robertson (1999:36) extrapolate from some of the commonly discussed Maori conceptualizations of health proposed by Durie (1994) to expand the understanding of Western

traditions. These models of health are characterised by their holistic nature and focus on the interaction of various elements of a persons life (for discussion see Chapter Five 'The Field'). Western theoretical traditions of holism and holistic medicine embrace some of the ideas of family, social supports, and the spiritual dimension of the individual. Holism challenges the notion of linear cause and effect and draws on systems theory for its explanations (*Dictionary of Modern Thought*). It embraces four fundamental principles:

- The whole is greater than the sum of its parts
- Use a wide range of interventions
- Involve the patient/client in their own care and
- The spiritual, physical and psychological health of the practitioner is an important component in the outcome of the inter-action between health professional and client.

Todd, Sellman and Robertson (1999:36) acknowledge that in spite of there being no currently published empirical validation of these 'holistic' models and conceptualisations, "they continue to be applied in clinical settings by Maori and some non-Maori practitioners". 'Holism' is an essential part of the 'community recovery' model developed by Bridgman, Dyall, Bidois, Gurney, Hawira, Tangitu, Huata, Webster and Heron (2000) for use in the New Zealand context (for discussion of this concept see Chapter Twelve, 'Literature Review'). Both Maori and Pakeha participants of my study had embraced a holistic approach to their 'wellness' that included understandings of taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side) and taha whanau (family).

Summary

Out of the psychiatric model of care, a hybrid model of psychiatric rehabilitation has been developed. With its focus on wellness and health, partnership with the patient, and emphasis on strengths, self-help and interdependence, a transition from psychiatry to recovery can be seen in embryonic form. However, the emphasis of psychiatry is still on health and wellbeing and the absence of 'disease' as opposed to the integrative acceptance of recovery. Perhaps, with the eclecticism and metamorphosis of both psychiatric and recovery approaches, a new epistemology will emerge that takes account of both previous and purer epistemologies.

The final epistemology was that generated by the consumer participants as they struggled to make sense of their reality. Some accepted psychiatric objectivity whilst others opted for the idealism of recovery. However, dichotomies are problematic and most consumer participants lived with a fluid understanding of their state of being that transmuted moment by moment, day by day.

When applied to coexisting disorders each knowledge theory leads to divergent ways of understanding the issue, and subsequently to treatment or intervention strategies. But by the very nature of coexisting disorders of mental illness and substance abuse, both discursive fields need necessarily be applied. Much of the debate and controversy raised by the participants in this piece of research has been about application of the models emerging out of the diverse epistemological 'truths'. All the participants (consumers, staff and family members alike) have taken up a position on a continuum from recovery exclusively to psychiatry exclusively, and every location inbetween. For some, their position depended on the needs of the consumer at the time of presentation to 'treatment'. All the consumer participants had at some time in their 'illness careers' experienced symptoms of acute mental illness. When this coincided with presentation to an acute mental health unit, staffed by psychiatrists and nurses, then the medical model with its psychiatric epistemology prevailed. Conversely, consumer participants who chose a Twelve Step path to wellness were influenced by a particular brand of recovery that grew out of the Alcoholics Anonymous self help movement. However, most participants were exposed to an overlap of both psychiatric and recovery models. This reflected the fluidity of the relationship between the two disorders (mental illness and substance abuse). They existed together, in an often ambivalent union, with one or other model prevailing depending on the predominant symptomatology of mental illness or substance abuse.

Another contributing factor to the epistemological pre-eminence of one model over another was the training and workplace orientation of the staff participants. In a rather broad generalisation of their professions, the psychologists and nurses operated out of a biopsychological model that was heavily influenced by psychiatry. The social workers and counsellors, by contrast, were more impelled by the sociocultural model that draws more heavily on the epistemology of recovery.

Whilst the staff participants operated at various levels of comfort with both models, it was the client group who most successfully negotiated the 'inter-model space'. They were less wedded to a polemic position and took a more

pragmatic approach to the usefulness of particular strategies at particular points in their lives.



Conclusion

This chapter has introduced the reader to the theoretical orientations of the thesis. There are two domains which require consideration: the 'theories' that inform the grounded method, and the theories that allow the reader to make sense of coexisting disorders.

The grounded theory methods of Barney Glaser (1978; 1992; 1996; 1998) are based on the philosophical concept of pragmatism and the social psychology of symbolic interactionism. The central ideas of these theoretical constructs ground the study in the world of the participants with no pre-conceived hypotheses or 'facts' to be verified.

The second group of theoretical orientations offer a framework from which to understand 'coexisting' mental health and substance use disorders, and the means by which they are 'treated' or 'embraced'. Understanding these phenomena occurs on a continuum beginning with the medical model and its various genetic, neurochemical and biological permutations. Post-modern awareness of 'self' is captured by Foucault (1963, 1973) and the philosophical influences of Martin Heidegger (1962) inform understandings of the participants' 'being'. The psychotherapeutic approaches of Carl Jung (1963) and the contemporary writer Thomas Moore (1994) best describe the paradigm shift made by the participants in their own journeys of 'discovery'. Finally, as with the other theoretical orientations, sociocultural assumptions serve as explanatory models of the development of, and maintenance and recovery from, coexisting disorders.

CHAPTER THREE: METHOD

Though this be madness, yet there is method in't (*Hamlet*, 1601,
act 2, scene 2. 1)

Introduction

According to Glaser (1998:45), "the choice of an appropriate method is in the eye of the researcher". My own predilections for method were a consideration in selecting a methodological approach to this research. I had to take into account the research 'question'. What information was I trying to get at, and for what purpose?

I wanted to redress an apparent imbalance in the research literature on coexisting disorders towards empirically based evaluation that focused primarily on 'outcome' measures. According to Leininger (1985:2), "until recently, the Western scientific method has been viewed as *the major* and only valid and reliable way to approach knowledge and understand people". It focuses on the empirical, systematic and objective analysis of selected variables using an 'a priori' theoretical scheme.

Leininger (1985:3) joins a rapidly burgeoning chorus of voices who challenge the view that "quantitative, scientific methods are superior and the most legitimate means of discovering nursing phenomena...". Although this thesis is not exclusively a nursing inquiry, it is influenced by my nursing training and experience. It is the human and social aspects of 'coexisting' disorders that form the basis of my investigation, not the physiological or epidemiological.

In preferring qualitative methods, I am not arguing for a more legitimate status, simply a different one. That is, the right of knowledge generated through qualitative investigation to take its place alongside that of positivistic science, and claiming a synergistic total of understanding of coexisting disorders when the two are combined.

However, prior to the consideration of method, two fundamental issues in relation to 'truth' and researching Maori need to be addressed. This chapter begins with these, before going on to attend to the substance of the selection of method. It explores the advantages of **grounded theory** as a rigorous, valid and reliable process that is capable of gathering high quality data for this piece of

research. Credibility of the researcher is established and a philosophical belief in the phenomenological paradigm outlined.

Truth

Truth is a scientific concept that deals with the quality of those propositions that accord with 'reality', specifying what is, in fact, the case. It is also a philosophical concept that takes 'true beliefs' as a good basis for action - "and takes this to be the very nature of truth" (Audi, 1999:930).

The 'truth' of the information in this thesis has been questioned in a number of contexts. The first challenge came on application for ethical approval from the then Northern Region Health Funding Authority. I was wanting to research a group of people marginalised on the borders of mental health services and alcohol and drug treatment services. I had been meticulous in my preparation of criteria for inclusion, the conditions under which they would be interviewed and support structures for consumers distressed in any way by their participation. However, the focus of the ethics committee's concern was the notion of 'truth'. One of the committee members asked "How do you know that these people [with coexisting disorders] will tell you the 'truth'?"

The second challenge came when I presented the data to my colleagues as a means of triangulation. One asked me if I was given 'well-practiced' stories. I have no real way of knowing, but I do know that for the participants I saw in other contexts (of recovery meetings) the stories I got were raw, detailed and intimate and not the well-practiced stories they shared in meetings.

Participants spoke their 'truth' to me as it was for them in that moment. It may have been different prior to the interview and it may be different now. All I can present is a snapshot of the 'truth' as I gathered it in that instant, and the 'truth' of the thesis is a pattern of interchangeable incidents that have been brought together as a conceptual abstraction - a category. The data has been sifted through the 'truth' of the grounded theory methodology, and will become part of the 'truth' of the reader, as it is read both as a thesis and publications coming out of it.

The word 'truth' is used advisedly in this context to reflect the concerns of the ethics committee and my colleagues in the health profession. Perhaps the word 'truth' has been confused with 'experience' and 'narrative', terms which would allow the reader to attribute wider understanding to the data.

Researching Maori

There are a number of issues in relation to Maori and Pacific peoples with regard to coexisting disorders.

First, the decision was taken not to research Maori and Pacific participants from iwi and fono-based services. The debate about indigenous and ethnic research is sensitive, ongoing and linked to the wider *Treaty* issues. There are also issues of ownership of information and intellectual property that are yet to be resolved between Maori and universities. Until these debates are resolved, I do not wish, as a Pakeha researcher, to cross boundaries that are in dispute. In addition, there are a number of iwi-based mental health and substance abuse treatment facilities who denied me access because of my own Pakeha credentials. After consultation with a number of Maori consumers, I made a decision to include Maori participants accessing mainstream services, and models of intervention that employed Maori 'treatment' principles from within mainstream services. These people took the view that a service did not necessarily need to meet all of their needs. Having taken what they wanted from a mainstream service, they felt they were in a better position to explore their ethnic origins from a Maori provider. Much of the success of all the participants of this research has been their ability to successfully utilise the tools and philosophies of a number of approaches, including the Whare Tapa Wha (Durie, 1994) model that was developed for Maori, and adapted by both mainstream and Pacific services.

Qualitative Research Methods

The qualitative type of research refers to the methods and techniques of observing, documenting, analysing and interpreting attributes, patterns, characteristics, and meanings of specific, contextual or gestaltic features of phenomena under study (Leininger, 1985:5).

Thomas (1999:15) has developed a "general inductive approach [that] reflects common patterns used in qualitative data analysis". Whilst it is not my intention to use Thomas' method here, his explanation of it serves as a useful introduction to qualitative methods *per se*. Inductive logic forms the basis of qualitative methods that:

...begin with specific observations and build toward general patterns...the strategy of inductive designs is to allow the important analysis dimensions to emerge from patterns found in the cases under study without presupposing in advance what the important dimensions will be (Patton, 1990:44).

Thomas (1999:12) in using the general inductive approach, developed a series of objectives that can be applied across a number of qualitative strategies. He argues that there needs to be a clear link between the research objectives and the findings which are derived from the raw data. These links need to be both transparent and defensible, and “extensive and varied raw...data” need to be condensed into a summary format. Finally, there is an expectation that a “model or theory” would emerge from the raw data.

According to Patton (1990:461), “the credibility issue for qualitative inquiry depends on three distinct but related inquiry elements” (rigorous techniques, researcher credibility and philosophical belief in the phenomenological paradigm) and I want to structure the rest of this chapter using his framework:

1. Rigorous techniques and methods for gathering high-quality data that is carefully analysed, with attention to issues of validity, reliability and triangulation

Beneath the integument of qualitative inquiry, there are a variety of theoretical traditions and orientations, each with a different focus and methodological strategy. According to Patton (1990:88), ethnography developed out the anthropological tradition and focused on the ‘culture’ of the people under study. Phenomenology arose out of philosophy and asks “what is the structure and essence of experience of this phenomenon for these people?” (Patton, 1990:88), while ethnomethodology allows sociologists to inquire about the ways people make sense of their everyday lives so as to behave in socially acceptable ways (Patton, 1990:88). Symbolic interactionism gives the tools to social psychologists to recognise what common set of symbols and understandings have emerged to give meaning to people’s interactions, and systems theory asks “how and why does this system function as a whole?” (Patton, 1990:88). Each theoretical tradition brings with it a particularised methodology, and whilst this inventory is by no means exhaustive, it orients the reader to the methodological possibilities that need to be considered when undertaking a piece of research.

According to Glaser (1998:45), “the time has come for a methodology that focuses on the interest of the participants in favour of that of the researcher”.

The ambition of this research is to document and interpret from the frame of reference of the people with coexisting disorders (and those living and working with them). I did not want to begin with a pre-determined hypothesis that would be ‘proved’ or ‘disproved’ within a positivist framework. In addition, I wanted to be able to theorise about what mattered to these people and from this develop some insights and strategies that might inform ‘treatment’ and

policy - a kind of 'bottom-up' approach. This is akin to the concept Zohar (1997:69-70) refers to as the "Vacuum vs Quantum Vacuum":

...in old paradigm science...Newtonian scientists are preoccupied with...objects, with their observation, manipulation, and control. They think that objects are all that is...New paradigm science sees that the universe is an interwoven pattern of dynamic energies. Objects are just surface manifestations of a deeper, underlying source. Quantum or complexity scientists are preoccupied with hidden patterns, with unseen connections, with synchronicity and evolution.

I was also seeking to add to the body of knowledge about coexisting disorders in a unique and creative way, and I wanted to do it in a manner that was credible, rigorous, valid and reliable.

People with real problems such as in...health ...are becoming disenchanted with preconceived research that forces findings which are independent of the reality and relevance they wish explained. (Glaser, 1998:44-45)

The grounded theory approach (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998) grew out of the symbolic interactionist tradition of the Chicago School of qualitative research, and the quantitative research methodology and theory generation at Columbia University (Glaser, 1998:32). It is the "systematic generation of theory from data acquired by a rigorous research method" (Glaser, 1998:3). It has been well tested and proven as a viable method for health research (Glaser, 1998:4,7), and the rigour of grounded theory "is as stringent as it is in the more forcing or quantitative methods of survey and control oriented research" (Glaser, 1998:11).

Militating against the use of the grounded theory approach is a critique of the method. Limitations of grounded theory seem to arise from its application rather than the method itself (Wilson & Hutchinson, 1996). One area of concern is that researchers become 'methodologically muddled', applying a number of strategies from various qualitative, naturalistic and interpretive methods that each have "their own philosophical underpinnings, methodologic and analytical strategies, and outcomes" (Wilson & Hutchinson, 1996:122). This muddled methodology gives rise to studies that are descriptive and do not generate theory. Methodological 'muddling' is always a possibility in any piece of research, and attempts to lessen this likelihood have been instituted via careful attention to the original texts of grounded theory.

Other issues are more particular to the method itself, with "generational erosion" (Wilson & Hutchinson, 1996:123) giving rise to a hybridising of the method by researchers with no first hand contact with grounded theory's originators or their students. "Under analysis" and conceptual processes that are so general they could "apply to any experience or phenomenon" further place the integrity of the method at risk and lend credibility to the argument that grounded theory is insubstantial (lightweight) and unscientific (Wilson & Hutchinson, 1996:124). Although some of the conceptual codes and categories generated in this research could be applied across a range of experiences and phenomenon, they are sufficiently unique as to pertain specifically to people with coexisting disorders.

Whilst Glaser (1998:11) acknowledges grounded theory is "not a 'best' methodology that replaces or supplements other methodologies" it none-the-less stands on its own and meets the criteria I set for my project of being scientifically rigorous and participant centred (rather than hypothesis driven). It allows me to honour the lives of the individuals for whom 'coexisting disorders' were a part.

Grounded theory method provides a set of systematic procedures for shaping and handling data. The goal of grounded theory is to generate a theory that accounts for a pattern of behaviour which is relevant and/or problematic for those involved, ie. "instead of using data to test theory, [it is used] to develop theory" (Glaser, 1998:37). The process entails simultaneous involvement in data collection and analysis phases of research.

From the moment I began to collect the data I also began the analysis phase of the research. The data included policy documents, field notes and interviews. After each interview, I would transcribe the tape and/or go over my field notes, and begin the line by line coding. This form of 'open coding' (Charmaz, 1983:109, Glaser, 1992:38) is the process of categorising and sorting data. According to Charmaz (1983:111) "codes...serve as shorthand devices to *label, separate, compile* and *organize* data" (original spelling and emphasis). Codes occur along a continuum of "simple, concrete, and topical categories to more general, abstract conceptual categories for an emerging theory" (Charmaz, 1983:111).

In choosing 'grounded theory' as a methodology, Glaser (1998:49) advocates that "researchers should be sure of their ability to conceptualize". Whilst I lay modest claim to an ability as a conceptual thinker I found that during this

initial coding phase, I moved between conceptual and descriptive modes. For example, when 'Henry' was telling me about taking his medication, I coded:

Oh...It was at random sort of...if I forgot one day I wouldn't worry about it...if I started feeling better I thought 'oh well I can have another smoke...you know...everything's cool.

descriptively as 'poorly compliant with medication taking'.

By contrast, when Henry was talking about needing support to stay well, I coded:

I'm not just going to shut myself off and think 'oh well I can do this one'. I can't do that so I'm reaching out for help and hopefully one day I could help others by helping myself.

as 'reaching out', and began to think about it as a possible conceptual category. In this way, creation of analytic codes and categories are developed from the data and not from preconceived hypotheses.

A second and selective round of 'focused coding', raises the sorting of data to a conceptual/analytical level. It develops categories rather than summarising large amounts of information (Charmaz, 1983:116). Categories are either taken from the natural language of the participants eg '*taking responsibility*' or the researcher's analytic interest, in this case, the notion of 'recovery'. Following Charmaz (1983:116) I went back and took a limited set of codes that were developed in the initial phase, and applied them to a large amount of data. I originally developed about twenty five codes from each set of interviews, and reduced these to 4 (from each set of interviews) for this next phase of the coding, by grouping them according to categories (rather than it being simply a label for a topic). I used the *in vivo* codes *connecting*, *escaping*, *coping* and *surviving* from the consumer interviews, and treated them as categories. I developed another category, *intemperate insanity*, both from my own analytic interest and from the natural language of some of the participants. I then went back over the data and re-examined it in relation to the newly developed categories. "Researchers...use focused coding to break up the category. They develop sub-categories which explicate and exhaust the more general category" (Charmaz, 1983:117).

"After developing their set of focused codes, the researcher may use knowledge of the literature to expand and clarify the codes and to sensitise themselves to ways of exploring the emerging analysis" (Charmaz (1983:117). I was beginning to reflect on the number of accounts by all the participants when

'recovery' was at issue. With a seemingly boundless reserve of literature on 'recovery' and 'normality', where to begin (and which literature to privilege)?

I began with four bodies of literature:

1. Wolf Wolfensberger (1972) developed his ground breaking model of 'normalisation' in the context of 'human management' of the mentally retarded. Wolfensberger (1972) explores 'normalisation' as a 'human management strategy' by which individuals or agencies 'acting in socially sanctioned capacities' enter into the 'functioning spheres' of individuals, families or larger social systems in order to establish or maintain personal behaviours and characteristics which are as culturally normative as possible. This philosophy was generalised to the field of 'mental health' and Wolfensberger's principles were used to inform the development of community treatment services for the mentally ill in New Zealand. The language of his model was co-opted to promote the notion of 'normalisation' in the community.
2. I turned to the literature on 'recovery' because many of the participants were actively working a Twelve Step programme and integrated the language and concepts that grew out of it into their lives. Alcohol and drug services, whilst offering a wide range of treatments and therapies in New Zealand, also base much of their knowledge and understanding on the principles of 'recovery'.
3. Inspired by the 'self-help' approach of many of the participants to the management of their lives with coexisting disorders, I asked each of them to tell me about the books they had been reading. The books were many and varied but their essence was captured for me by the writings of Thomas Moore. Moore (1994), in *Care of the Soul*, argues that the trouble with some of the modern therapies is that they aim at goals that are fantasies of normality or unquestioned values (Moore, 1994:37). Through these 'therapies' people are "tantalised by images of some ideal normality and health that may always be out of reach" (Moore, 1994:9). The aim of soul work, he argues, is "not adjustment to accepted norms, or to an image of the statistically healthy individual" (Moore, 1994:xvii), but a humbler approach that is "more accepting of human foibles, and sees dignity and peace emerging from that acceptance than from any method of transcending the human condition" (Moore, 1994:xii). As the reader will see in chapter twelve, the 'Discussion', many of the participants, although appearing to be psychologically and spiritually 'healthy' had been striving fruitlessly for some idealised 'norm'.

A fourth body of literature based around Bryan Turner's *Medical Power and Social Knowledge* (1987) and *Regulating Bodies* (1992), was reassigned to the chapter (five) that explores 'The Field', on the basis that it did not 'fit' with the theoretical perspectives that were being generated by the data. Turner's model is based on the 'conflict' position premised on a power differential between doctors and patients. My theory development was more concerned with the minutiae of the every day lives of my participants and did not lend itself to a 'meta-analysis' at this stage. This is not to say that the data could not be re-mined for a view on power differentials between health care providers and consumers at a later date, or that the data could not be subject to the scrutiny of a meta-theory.

Memo-making (writing analytic notes to explicate and fill out categories) is the crucial intermediate step between coding data and writing first drafts. By way of illustration, early in the analysis of the data I had developed a tentative code 'doing ordinary things' and out of that the conceptual category 'making meaningful use of time'. Below is the memo I created in order to explore these two ideas at an analytical level to try and expand my theoretical grasp on the material:

Am already changing my mind about theoretical code 'doing ordinary things'. It seemed like *the drinking years* and *achieving sobriety* were theoretical codes arising out of the core category (a normal life), but when I come to put it into a framework, already it looks wrong. *Achieving Sobriety* is a critical juncture, a social psychological process. I need to go back to the data and look for conceptual categories that fit the theoretical code *doing ordinary things*. Will try *making meaningful use of time*, and *self-esteem* (this latter still doesn't seem quite right, but it is a word used by the respondents, and conveys something about the 'personal' that makes for a normal life). Maybe it is not the most judicious strategy to use a verb to describe *a normal life* because *normality* is a way of *being* as well as *doing*.

The process and detail of memo making is explored more fully in chapter four 'An Audit Trail of the Research Process'.

Theoretical sampling (for theory construction not for representativeness of a given population) serves to check and refine emerging conceptual categories. I began to sample for the basic core category *becoming normal*, but quickly ran into problems when I tried to construct theory around it. The theoretical codes I had developed from the data, and the conceptual categories that went to make up each code, did not adequately account for the social process of *becoming*

normal. What they did do, however, was illuminate the irresolvable paradox of *normal* as a concept. I needed to go back into the data to determine what the participants were telling me about their lives. Eventually the basic core category *discovering a life* emerged and the data matched with a construction of theory around this.

In the grounded theory approach an exhaustive literature review is delayed until after the data has been analysed and it is used in a way that leads to the critique of existing theory and creation of new theory. The body of writing on *discovering a life* is found mainly in travelogues and adventure brochures, and whilst these capture the essence of *discovering a life*, they are not appropriate to the health context of this thesis as a basis for analysis and theory construction. The ideas generated by the participants in this study have moved beyond the 'normalisation' literature. So although this is discussed in the literature review, it is not the focus of intense review. The recovery and self-help literatures have been chosen for further critique.

Having made a decision to take a qualitative approach to the research, my research design, data collection and analysis were further prescribed by the choice of 'grounded theory' practice. The only cardinal decision remaining was which was it to be - the Strauss or Glaser method?

Strauss or Glaser?

In 1967, Barney Glaser and Anselm Strauss published their ground breaking work *The Discovery of Grounded Theory - Strategies for Qualitative Research*. It turned social science investigation on its head. Their development of a 'grounded' approach to social research, allowed for the generation of theory not simply 'verification'.

However, by the late 1980s, Glaser and Strauss had a serious ideological falling out (Glaser, 1992). Glaser (1992:2) argued that Strauss had strayed so far from the logic of grounded theory that it constituted a whole different method. He accused Strauss of "piling up tons of fractured rules" producing "a forced, preconceived, full conceptual description" which is not grounded theory.

One of the reasons for selecting 'grounded theory' as a methodology, was to move away from the perceived forcing and preconception that other methodologies imposed. It seemed to be consistent with this train of thought and decision making; to go with Barney Glaser's interpretation of the method. He demanded less structure in a way that allowed the data to truly 'emerge' whilst at the same time applying scientific rigour.

2. The credibility, competence, and perceived trustworthiness of the qualitative researcher

Credibility (believability, integrity, plausibility, reliability). These are character traits that one is more likely to find as part of the 'person specification' in a job description. Credibility is a judgement that is made about one by others. Patton (1990:427) argues that "because the researcher is the instrument in qualitative inquiry...information about the researcher [must be included]". He concedes there can be no definitive list of questions to establish investigator credibility but does argue for a 'principle' to "report any personal and professional information that may have affected data collection, analysis, and interpretation - either negatively or positively..." (Patton, 1990:427). Some of the areas Patton (1990:427) suggests might be useful in establishing credibility include experience (both personal and professional), training, perspective and connections to the people or topic. The group of people with whom it was most important for me to have 'credibility' were the consumers. If I could not establish myself as 'credible' in their eyes, I felt the whole project would be seriously compromised. How does one let others see you are credible?

Links to a university gave me **academic credibility**. The participant information sheet (Appendix 1 & 2) gave potential subjects some information about me and my project, and invited them to contact my supervisor if they had any questions that it might not have been appropriate for me, as the researcher, to answer.

Approval from two independent ethics committees gave my project (and by inference, me) **ethical credibility**. The process of passing a prospective thesis through an ethics committee provides a measure of screening of both the project and the researcher. Whilst there is no 'iron-clad' guarantee, the participant can assume some level of honesty and integrity on the part of the researcher, understand the recourse (or not) that is available should things go wrong, and make an informed choice about whether to participate. Further, 'ethics approval' is always conditional on the participant being able to withdraw from the study without penalty (see Appendix 1). As a final act of ethical good faith I was required to sign a sworn statement in front of a Justice of the Peace.

Professional credibility is achieved through my status as a registered nurse, and the holder of a current practising certificate. I was, at the time, employed part-time as a counsellor in a CHE (Crown Health Enterprise) based alcohol and drug service, and my clinical performance was reviewed formally and

annually. Whilst status as a practising clinician was not a pre-requisite to becoming a researcher, it added 'credibility' to the role.

Personal credibility came through recommendation (via a snowball sample) and my willingness to disclose (where appropriate) my own life experiences and 'wellness' strategies. This is evident in nearly all the interviews.

Competence (ability, adequacy, appropriateness, proficiency, skill, suitability) is more objectively measurable than credibility. One can only become competent through training and practice. Training as a researcher has taken place at every level of academic study, commencing with a compulsory methods paper at stage one. It has been judged on a yearly basis since then, through the examination process of the University. Competence as a researcher culminated in the completion and judgement of my Masters thesis by examiners both internal and external to the university, each of whom had demonstrated competence in their own fields of expertise. Competence is established at every phase of the research process, beginning with the research question and design. Competence as an interviewer and field worker was enhanced by the experience I brought to the project from my training and work as a counsellor in mental health and addictions services. Again, this had been independently evaluated and deemed to be of satisfactory standard. Competence in *this* project is yet to be evaluated.

Perceived trustworthiness of the qualitative researcher is determined by both the personal and professional attributes of the individual. Trustworthiness will be established by the reactions of the participants, changes in the researcher during the course of the study, the predispositions and biases of the researcher, and in training and preparation (Patton, 1990:473). As a precursor to securing both personal and professional 'trustworthiness', I relied heavily on my long and reputable contribution to mental health and addictions services in Auckland, the extensive network of people I had built up, and the considerable reserve of goodwill they had toward me.

Patton (1990:474) raises the concerns about 'evaluator changes' in the context of 'going native' - a term that is more familiar in anthropological research. In essence, 'going native' involves the researcher being 'absorbed' into the culture under study, "and, therefore los[ing] their sensitivity to the full range of events occurring in the setting" (Patton, 1990:474). Denzin and Lincoln (1994:212,439) acknowledge that changes will occur and that it is important to acknowledge and "record" these changes. In fact Denzin and Lincoln (1994:439) go further to argue that "to be insensitive to shifts in one's own attitudes opens the way for

placing naïve interpretations on the complex set of events under study". In my own case, I applied techniques of 'limit' and 'boundary setting', learned in my training as a nurse and counsellor, to maintain professional 'distance'. At the same time, I have an enormous passion for and commitment to the subject matter and the people with whom it brings me into contact. I am able to declare my partisan involvement both through rigorous application of the grounded theory method and the decision I have made to 'write' myself into the research process.

3. A Belief in the Phenomenological Paradigm

Phenomenology was adapted by Alfred Schutz (1970) to investigate the assumptions of every day life. As a method of inquiry, it focuses on the taken for granted knowledge that social actors share (Bilton, Bonnett, Jones, Skinner, Stanworth & Webster, 1996). The "phenomenology of everydayness" is supposed to lead us to see the totality of human existence, including our moods, our capacity of authentic individuality, and our full range of involvements with the world and with others. Heidegger (1962), holds that there is no pregiven human essence. Instead, humans, as self-interpreting human beings, just are what they make of themselves in the course of their active lives.

This study shares with the phenomenological paradigm the symbolic interactionist perspective. Symbolic interactionism developed as a position out of social psychology and sociology in the study of "human group life and human conduct" (Blumer, 1969:1). It grew out of the scholarship of a number of intellectuals, most notably George Herbert Mead and Herbert Blumer (Blumer, 1969:1, Charon, 1992:24). The three premises on which symbolic interactionism is based are:

...human beings act toward things on the basis of the meanings that the things have for them...

...the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows...[and]

...these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969:2)

In attempting to clarify the nature and integrate the perspective of symbolic interactionism for his students, Joel Charon (1992:23-24) explicated four central ideas. Firstly, 'social interaction' as a dynamic process, not merely a person as "an actor responding to others in the environment". Secondly, "We act

according to the way we define the situation we are in" (Charon, 1992:24). Third is the focus on the 'present', not the past ie. "we are not simply playing out personality traits we developed early in our lives" (Charon, 1992:24). Finally symbolic interactionism "describes the human being as more unpredictable and *active* in his or her world", ie. that our action involves conscious choice (Charon, 1992:24).

This is not an empirical piece of work based on phenomenology or symbolic interactionism as a method or theory. However, I wanted to acknowledge the presence of both as important informants of the grounded theory method and the 'ordinariness' of the lives I am studying. The four central ideas of the symbolic interactionism resonate in the lives and actions of my participants and play an important part in the basic social process of '*discovering a life*', as does the 'common-sense' understanding of everyday life and the way it feeds back through social action.

Conclusion

This chapter has briefly outlined the selection of a methodology (grounded theory methods) for this thesis, and justifies the method as one that uses rigorous techniques, generating high-quality data and theory. Brief examples have been used to illustrate the way in which simultaneous involvement in data collection and analysis have been applied in this context. Greater clarification is sought in Chapter Four 'An Audit Trail of the Research Process'. Researcher credibility and philosophical belief in the phenomenological paradigm are established. These, along with other epistemological underpinnings have been explored in the Chapter Two, 'Theory'.

CHAPTER FOUR: AN AUDIT TRAIL OF THE RESEARCH PROCESS

Introduction

This chapter tracks the decisional process of the thesis in two domains. Firstly the process of empirical decision making that was required to generate a sample, ask questions, record the information and analyse the data. This includes the ethical considerations that were taken into account when researching a marginalized group of people. The second set of decisions are theoretical ones. How did I come to the basic core category? Where does the literature belong? The chapter comprises a mix of writing styles that represent notes to myself extracted from the academic diary I kept of the process, memos, a fast writing exercise (italicised for ease of recognition) and the text of the chapter.



Empirical Decisions

Ethical Considerations

The 'ethic's of researching a disenfranchised group had been attended to early in the process (before the fieldwork began) and the proposed research had passed through two ethics committees - the Massey University Human Subjects Ethics Committee and the (then) Northern Regional Health Authority Human Subjects Ethics Committee. Some of the original issues that required protocols included confidentiality, privacy and safety of participants. These are consistent with the guidelines subsequently put out by the Mental Health Commission (Peterson, 1999), and address issues of informed consent, confidentiality and anonymity. However, as the research progressed, it became evident that another dimension of ethical deliberation required attention - what to do with the participants who had initially agreed to take part, but for what ever reason (see below) were now unable to participate. The Peterson paper (1999:8-9) also addresses issues of sampling and who should be "weeded out". In order to avoid unnecessary distress to the potential participants, I arranged a meeting with each of them, together with their key worker, explained the dilemma I was facing (that I needed to be more satisfied they

could properly give 'informed consent') and offered them an opportunity to participate as and when their health allowed within the next calendar year. One participant did this, and a second acknowledged that his mental health would probably not be sufficiently stable to fit with my time constraints. In the weeks following the meetings, I contacted each of the key workers to ensure there were no ongoing consequences that required further attention. There were none. The potential participants were pleased to have been asked and expressed regret that they could not have been helpful on this occasion.

Generating a Sample

Generating a sample proved to be a major stumbling block in the beginning fieldwork. The first obstacle was a personal reluctance on the part of the researcher to request assistance from an unknown group of people to participate in the study. The second, loosely related issue is the research of an already disenfranchised group of people who are frequently marginalised in a multiplicity of services. It was difficult to find a way to appropriately acknowledge or compensate the time and energy they were giving to the project. In addition, the study of coexisting disorders was one of the emerging 'hot topics' in the 1990s and I ran the risk of trying to access an already over-researched group.

Early on, I approached a good friend working 'in the field' and she assured me finding a 'sample' group to interview would be no problem. She had a young client who was doing really well and was willing to approach him on my behalf. After the interview, I had a phone call from his mother thanking me for the time I had spent with her son. She told me "that was the most therapeutic thing that has happened for him since he has been ill". When I asked what it was that he had found so useful, she explained it was the opportunity to tell 'his' story his way. I didn't have a barrage of questions for him that revolved around getting information about his 'illness'. I had no format that artificially categorised and organised his life, and no timeframe in which it had to be collected. This was a theme that was to repeat itself many times over during the course of the study with the people I interviewed and negated earlier fears about asking for participant involvement.

Finding the numbers

"The way of the superior man is threefold, but I have not been able to attain it. The man of wisdom has no perplexities; the man of humanity has no worry; the man of courage has not fear" (Confucius, 1956, *Analects*, ch.14.v.30)

Once over the initial hurdle of approaching potential participants, I expected finding an interview sample to be the least of my worries. The population of people with coexisting disorders is increasing. My network of colleagues within the 'field' meant I did not have to go through the usual rituals and impediments of overcoming the resistance of individual gatekeepers and organisational systems that an unknown researcher might have faced.

I made my approaches in a methodical way, first identifying major 'sample' groups (clients/consumers and health professionals) and the services they operated from. In the first 'sweep' I decided to limit the target services and people to a bounded geographical location (Auckland) with a view to extending the catchment area to include the whole of the Northern Regional Health Authority's jurisdiction if I needed a greater numerical sample or there were significant sample 'gaps'.

With this strategy in mind, I wrote an initial covering letter to staff in the 'identified' units (Appendix 3) and within a short space of time had interviewed sufficient health professionals to get a density of data required for the project.

The research intention was well received by staff and everyone I approached agreed to be interviewed. They also agreed to identify a consumer group who might be willing to participate in the study.

After three months, I had interviewed three consumers. What I failed to take into account was the 'state of being' of the individuals who presented at CHE (Crown Health Enterprise) and NGO (non-government organisations) services at this particular point in their lives. Most were too 'unwell' to allow ethical participation in the study, and, of those who agreed to meet with me, most cancelled many times because of 'illness' and the interviews never took place.

Snowball Sampling

Inability to generate a sufficient sample was becoming problematic and I could see this piece of work sliding towards the refuse heap of PhDs and research projects that meet a premature and untimely demise. I shared my concerns with a friend (Ian G) whom I knew had many years of sobriety, and a lot of social contacts in the world of addiction. He thought he knew someone with a 'dual diagnosis' who might be willing to talk to me and agreed to make an initial approach. According to Davidson and Tolich (1999:111) to generate a snowball sample " you begin with a small number of respondents and ask them to recommend other people who would be relevant to the research". There are

a number of reasons why a researcher may choose this type of non-probability sampling (where some people may have more chance of being included in the sample than others). Davidson and Tolich (1999:111) identify three reasons: one "when the lack of a sampling frame makes it impossible to achieve a probability sample", the second "when the target population is unknown" or thirdly (as happened in this piece of research) "when it is difficult to contact people any other way". Having made a decision to move away from trying to generate a sample from within treatment services, snowball sampling became an obvious means of accessing potential participants from the community. "Having identified a small band of likely informants, these informants are relied on to generate contact with other people who share the activity the researcher is interested in exploring" (Davidson & Tolich, 1999:111). Ian introduced me to Teresa, and she became my fourth and most crucial informant. She introduced me to others who introduced me to others, and so a "snowball" sample was generated.

The 'participants'

"I'm happy to talk to you as long as you understand that some times I'm really inappropriate" Teresa

I was not sure how to interpret this missive. Did it mean she was not suitable to interview? That I could not rely on her information? Or that I might be shocked by her behaviour? Uncertain about what to expect, but feeling it could not be outside my realm of knowing, I moved tentatively towards my next interview. Teresa is an engaging, energetic woman in her sixties. I believed her when she told me she was an 'alcoholic' but couldn't reconcile the image of the woman I saw in front of me with my experience of people with a major mental illness. I spent a delightful morning at her place, and, after the interview, began to understand why she had had multiple admissions to psychiatric inpatient and outpatient units (and was still under the care of a psychiatrist). Teresa was the first of my 'snowball' sample. It was through her that I was introduced to many of the others. I began with ten consumer participants and, after the first round of interviews, added another five to redress a gender imbalance, increase the density of the data and to ensure I had achieved saturation. It was easier to recruit women for the study, and, after the first round of interviews, I had had only two male participants. A strategy of targeting male participants through their male therapists was used for the second recruitment drive. By the end of the study, I had successfully engaged seven male and eight female consumer participants. They ranged in aged from twenty four years to sixty two years with a mode of forty years. All the

participants had a history of major mental disorder and diagnoses included schizophrenia, bi-polar disorder, anxiety disorder and depression. Most had more than one diagnosis. All the participants abused more than one substance, and, with the exception of one, all abused alcohol. The other mood/mind altering drugs of choice were benzodiazepines, opiates and marijuana, although many had experimented with a range of substances.

The 'worker' participants represented staff from services offering care and support in a variety of settings. These included Government and NGO alcohol and drug services, mental health services and specialist dual diagnosis services. With the exception of one from a therapeutic community, all were working in community outpatient settings.

Family members were harder to access. Those I did interview were not linked to the consumer participants. Even with many years of mental health and sobriety behind them, consumers were still alienated from their family of origin. Some were in the process of trying to reconnect with significant others but had either not been successful or were not willing to compromise delicate negotiations by asking for participation in the study.

2. The questions?

The grounded theory method does not begin with a hypothesis. It does not set out to 'prove' or 'disprove' a theory or test an idea. It does not have a contrived set of questions, and, as such, I did not go to the interviews armed with a questionnaire. It begins with a general area of interest. I wanted to know what it was like for people to 'live' with 'coexisting disorders' - be that a personal or working relationship. I wanted them to tell me about the things that were important to them - not what I, or the literature felt, should be paramount.

In the first round of 'interviews', I began by inviting the participants to "tell me what it is like for you living/working with..." Here I would particularise my language for the audience. For health workers I used the term dual diagnosis or coexisting disorders. For the consumer group I would try and pick up on the language they used to describe their situation as they saw it - sometimes this would be 'dual diagnosis', 'your problem', or it may be as specific as the diagnoses they had been given (eg. manic depression and alcoholism). I am not sure 'interview' is the proper term to apply to this phase of the research process. What happened between the participants and myself might more correctly be described as a conversation, or an interlocution. It did not quite

have the informality of a conversation, but I wanted to emphasise the 'exchange' nature of the interaction, and declare my role in it.

The second and subsequent round of interviews involved a much more focused approach. Questions were formulated for theoretical sampling (for theory construction not for representativeness of a given population), to check and refine emerging conceptual categories. By this stage the concept of 'discovering life' was beginning to emerge as the core variable, and I wanted to test and refine it as the basic core category.

3. Recording the Data

"In frontline research by a solo researcher doing grounded theory my advice is: **DO NOT TAPE INTERVIEWS** (Glaser, 1998:107)

All previous learning and training as a researcher instilled in me the imperative of using a tape recorder to collect my data. I felt uneasy subjecting this group of participants to the additional pressure of technology, but persisted in the face of methodological correctness. It was not long before my resolve was put to the test. Participant no. 3 was keen to be interviewed but absolutely adamant that I could not tape the interview. The "pervasive distrust and suspiciousness" (DSM-IV, 1994:634) that is characteristic of people who experience paranoia challenged my quest for methodological purity and invited me to be creative in my response. I continued with the interview. I reasoned I could always discard it at a later date. He consented to my taking notes and we stopped frequently to ensure that I had accurately recorded his meaning. He was an articulate, thoughtful respondent and there was no sound methodological reason for excluding his data.

Within a fairly short space of time, two further participants refused to be 'taped' whilst at the same time insisting on being interviewed. Why was their information less legitimate than that provided by others who were prepared to be taped? And if I were to discard the untaped interviews, it would exclude a slice of data provided by people who otherwise met the criteria for inclusion in the study. It was with considerable relief I discovered Glaser's text *Doing Grounded Theory* (1998) and found a whole chapter on 'taping'. He argues cogently and robustly that "one of the strongest evidentiary invasions into grounded theory is the taping of interviews" (Glaser, 1998:107). His rationale is that taping is necessary "as complete evidence for substantiating or verifying a finding" (Glaser, 1998:107) in circumstances where descriptive completeness is mandatory. Where the focus is on "theoretical completeness" (Glaser, 1998:107) (as in grounded theory) only those notes written down after an interview to be

later used for "constant comparisons" (Glaser, 1998:107) are required. However, as a beginning 'grounded' researcher I made the decision to tape where I could.

4. Analysis of the Data - Nudist, NVIVO or No

"The Analytical Engine weaves algebraic patterns just as the Jacquard loom weaves flowers and leaves" (Ada Lovelace 1815-52, of Babbage's mechanical computer).

The question about whether or not to use computer packages to assist qualitative analysis was first publicly debated in the 1980's (Buston, 1997). Those arguing for the automation of aspects of qualitative data analysis point to the ability of the chosen package to search for, retrieve and hierarchically structure words, phrases, text segments, memos and indexes. This, it is argued "ease[s] the researchers workload, save[s] time and generally enhance[s] the power of qualitative analysis" (Buston, 1997).

Reservations centre on "the alienation of the researcher from his/her data...[and]...encouraging or even forcing the researcher into adopting certain procedures" (Buston, 1997). Wilson and Hutchinson (1996:122) also caution against relying on computer programmes to "identify core variables based on frequency alone rather than integrative power".

This debate, and the decisions that arise from it, can be focused on the issue of coding in the grounded theory context. According to Glaser (1978:55) "coding gets the analyst off the empirical level by fracturing the data, then conceptually grouping it into codes that then become the theory which explains what happens in the data". In short, how do you handle large bodies of information in a way that is systematic and remains true to the original text? Intimate contact with the data is an important strategy that allows the researcher to stay in contact with the participants' voice. This was best achieved through transcribing my own interview tapes and the manual processing and coding of data.

Each method of data analysis (manual or mechanical) brings with it its own set of advantages and disadvantages. There is no one perfect formula, simply a reasoned approach that takes account of the circumstances of the research and the researcher.



Theoretical Decisions

Introduction

This section traces the creation of the theory *discovering a life* from the raw data and initial coding to the final tapestry. Theory development was not a linear process and the rest of this chapter tracks through the fissures and blind alleys of decision making to the ultimate conclusion. Whilst not a complete record, there is sufficient here to illustrate the way in which analytical decisions were made.

A Normal Life - (basic core category - working model No. 1)

After the initial round of open coding, *a normal life* seemed to emerge as the basic core category. It was the phrase or concept used most consistently by all the participants to explain their ongoing psychological and social concerns, ie. the way they thought about themselves and the relationship they developed with their wider social networks. I made a decision to follow this basic core categorical thread to its logical conclusion.

To find the elements of a '*normal life*', I "carefully scrutinize(d) participants' statements and actions for patterns, inconsistencies, contradictions, and intended and unintended consequences" (Charmaz, 1983:112). I asked of the data "what are people doing? what is happening?". In looking for processes that might constitute a *normal life* there appeared to be a *being/doing* dichotomy.

In order to have a base-line against which to measure my data, I began with definitions of 'normal', 'life', 'being' and 'doing'.

Normal: Accustomed, acknowledged, average, common, conventional, habitual, natural, ordinary, popular, routine, run-of-the-mill, rational, reasonable, sane, well adjusted, conforming to standard, regular, usual, typical, free from mental or emotional disorder

Life: Existence, being, entity, aseity, self-existence, monad (ultimate unit of being), vitality, viability, human, human being, individual, soul, behaviour, conduct, lifestyle, way of life, the human condition, state of functional activity and continual change peculiar to organised matter (*Oxford English Dictionary*).

Being: Existence, life. Existence in some relation of place or condition. Standing (in the world). Substance, constitution, nature. That which exists, existing, present (in the time).

The philosopher Martin Heidegger (1962) has written a substantial body of work on *being* (for a discussion of this in relation to the themes of this thesis see Chapter Two) and according to his analysis, by taking a stand on our own being, we constitute our identity through what we do.

Doing (verbal substantive - stands by itself). **Do** to put forth (action or effort); to perform; to perpetrate; to execute (*Shorter Oxford English Dictionary*). Accomplish, achieve, act, carry out, complete, conclude, perform, produce, transact, undertake, work, bring about, cause, create (*Collins Thesaurus*).

The frame of reference used for managing the data was a pragmatic one. I decided to 'test' *being* and *doing* as theoretical codes, and drew up a schema from one of Glaser's eighteen coding families (Glaser, 1978:74).

In *Theoretical Sensitivity*, (Glaser, 1978:73-82) introduces the researcher to the concept of theoretical coding. For a brief discussion on his coding families in this body of work, see Chapter 2 (Theory) page 20. Glaser (1978:55) had also described the six C's as the "bread and butter theoretical code of sociology" and its foundation of "sources, reasons, explanations, accountings [and] anticipated consequences" (Glaser, 1978:55) seemed to provide a solid framework for systematising the data I had accumulated.

A table was drawn up for each of the conceptual categories, and I experimented with the data and the relationships between them.

"The table segments remained empty. The 'indicators' and the 'concepts' did not correspond in a way that 'grounds' the concepts in the data. I needed to go back to the task of theoretical coding. It may be as Glaser (1978) warns, that I had responded to an impression and 'forced' the data to fit what seemed like an attractive solution" (author's diary notes). Ultimately the six C's schema informed the researcher's thinking about, but did not provide a structure for "explanatory attribution and...some ordering [of] movement from cause to consequence" (Glaser, 1978:73). It allowed the researcher to make connections between the data of individual participants and the conceptual codes developed out of this data. It further facilitated an understanding of the "hypothetical relationships between conceptual codes" (Glaser, 1978:55).

Back to the data in search of theoretical codes. "*The drinking years*" and "*achieving sobriety*" were the two distinctions that the participants made in relation to *a normal life*. So I put these into the framework in place of *doing ordinary things* and *not doing*.

'*Achieving Sobriety*' does not 'work' as a theoretical code. "*Achieving Sobriety*' is a critical juncture. I need to go back to the data and look for conceptual categories that fit the theoretical code *doing ordinary things*. Will try '*making meaningful use of time*', and '*self-esteem*' (this latter still doesn't seem quite right, but is used by one of the respondents to convey something about the 'personal' that makes for *a normal life*). Maybe it is not the most rational decision to use a verb to describe *a normal life* because *normality* is a way of *being* as well as *doing*.

I seem to now have found my two theoretical codes, *being* and *doing*, and need to decide on my conceptual categories. Am still struggling with the sheer volume of information and uncertain about how to process it. Have decided on the following strategy: to thoroughly review one interview script to decipher the conceptual categories. I will then try and apply them to another interview and so on...until I have settled on the final conceptual categories. Have gone back to the definition of a **conceptual category**

Had made a decision to let go of the 'doing/being' polemic on the basis that I could not make it work and I seemed to be 'forcing' the data to fit the categories. However, having let it go now for a month or so, I can now see a way of allowing it to fit in the theorising about '*a normal life*'. Will look at it on a continuum with 'doing' at the entry point - 'doing drugs' and 'getting out of it' ⇒ the crisis ⇒ which leads on to 'being' sober ⇒ 'being' normal (author's diary notes).

A Normal Life - (basic core category - working model no. 2)

1. Doing Ordinary Things (Theoretical code)

1.a. The Drinking Years (Conceptual category)

2. Being Normal (Theoretical Code)

2.a. Tired of Being This Way (Conceptual Category)

2.b. Getting into Recovery (Conceptual Category)

A Breakthrough?

What follows is a piece of 'fast writing', an exercise designed to overcome 'writers block'. It has been italicised to distinguish it from the text of the thesis. *Testing out the possibility of analysing my data using **Managing a Life** as the basic core category. **Becoming Normal** and **a normal life** don't seem to fit. There are too many contradictions. It is 'normal' for my participants to drink and drug take in a problematic and pathological way. It is not 'normal' for most of the population to*

abstain from alcohol consumption, and yet, for my sample, it is the key to a 'normal life'. It is 'normal' for my subjects to be on a benefit, yet this is not a statistical norm. Talking about 'a normal life' is fraught with inconsistencies and unresolvable tensions. In this exercise, I stay out of coding and do some fast writing about what I think is happening and how these people are managing a life - staying with the conceptual/ getting a sense of trajectory from illness to wellness.

*There are two distinct phases in their lives that the consumers talked about **drinking/drug taking and recovery**, with some notion of a **crisis** in between, something that brings them to the point of wanting to change their lives in a very substantial way.*

No one really talked about a 'normal' life before the drinking and drug taking - either they got into it as teenagers, or they used drugs and alcohol to blot out a life that was traumatic and painful. It was not so much the nature of the crisis that was important, but the place that it brought people to, ie. reflecting on what their lives had been, where they had got to and what needed to change (on the basis that they couldn't keep going as they were).

*The two other concepts I need to try and make sense of are **being and doing**. These were described in both the positive and the negative. Without exception, they all described their lives in terms of doing/not doing something or being/not being. For example, one respondent knew he was becoming unwell because he was voice hearing and was not sleeping (not doing sleep), or was being paranoid. Another knew that 'taking medication' would make him well, as would 'not smoking' [dac] and "being spiritual", and being insightful.*

*If I am talking about managing a life, what is it that people are managing? Respondents talk about managing their 'wellness' - ie. their mental health. This means taking medication, monitoring for symptoms and seeking help when they recognise all is not well. Managing a life also means not drinking and drug taking. In order to do this, my respondents have engaged with some kind of 'daily management' programme - attending twelve step meetings, reading 'recovery' literature, staying sober 'one day at a time'. It has also meant living in a stable environment (often on their own because community/relationship living has been problematic), and only having people in their lives who were good for or understood their 'recovery'. This meant interacting with either health professionals or other people in the twelve step fellowship. I suppose the **being** here involves being spiritual, being honest (with themselves and others), being connected to a wider universal experience/understanding.*

One of the key features of this basic social process seems to be a paradigm shift from depending on external forces ('health professionals' to tell you how to 'be well', or

taking the medication that was prescribed, and accepting the 'medical model' analysis of your illness) to internal processes of taking responsibility for one's own recovery and well being - this being different from the 'blaming'/responsibility-assigning/dumping that sometimes happens in health services which sees people as the authors of their own demise through some kind of moral reprehension/decrepitude, and some how deserving of the fate that has befallen them.

Other aspects of *managing a life* involves 'managing' on a benefit rather than going into a work environment that was too stressful or not good for their sobriety - several of the women talked about having difficulty finding work that suited their personal rhythms, ie. they had trouble starting work before 11.00 am because the medication they were on made getting up earlier difficult. One of the problems with starting after 11.00 am is that the kind of work that was readily available involved working in bars or cafes that sold alcohol and were full of drinking/drug using patrons.

One of the things that militated against achieving happiness in this 'new' life was not conforming to the statistical 'norms' of society, ie. not being in a relationship, not having children, not owning a home, not being in meaningful employment. I am not sure how to, or even whether to, attend to these regretful/negative aspects of people's reflections on their lives. They did not seem to be significant in *managing a life* - I suppose only time will tell when I go back into the data and see how this stuff does or doesn't fit in as the case may be.

The following is again taken from the academic diary notes of the researcher and tracks the next phase of the analytical process.

"Using *Managing a life* as the basic social process, I will code the data:

The 'drinking years' → the crisis → taking responsibility → early recovery → maintaining the change and integrating the 'coexisting disorders' into self (as opposed to transcending/excising this aspect of the human condition).

As another form of triangulation, Bigus' (1996) will be used to see if I can make sense of 'managing a life' in terms of the schema he has devised for 'becoming alcoholic'.

'Disengaging' (from active participation in normal social networks) is his first theoretical code and might roughly correspond to my 'drinking years'.

'Entry and receptivity' make reference to entering the rehabilitation milieu and might be captured by my category of **crisis**.

'Accepting the label' (a realising experience which enables the drinker to define self as 'alcoholic') could correspond to **taking responsibility**.

'Working on it' describes the way priorities have taken a life shift from sustaining a drinking career, to long time rehabilitation and might correspond to my concept of **early recovery**."

'Trying to get out' (of the alcoholic career) and return to normal social networks involves short term goals and long term plans and might fit with my ideas about **maintaining the change** and **integrating** the 'coexisting disorders' into self (as opposed to transcending/excising this aspect of the human condition). I will argue that the success of my consumer participants depended not on their trying to 'get out' of their state of being, but 'embracing' it. To help me with this thinking I have drawn on a number of sources. Embracing the monster of substance abuse and mental illness was metaphorically captured by Mary Shelley's *Frankenstein* (1969:145):

'Embrace your monster' - Frankenstein. The Being continued. Let him live with me in the interchange of kindness; and instead of injury, I would bestow every benefit on him with tears of gratitude at his acceptance. But that cannot be; the human senses are insurmountable barriers to our union. Yet mine shall not be the submission of abject slavery. I will revenge my injuries: if I cannot inspire love, I will cause fear; and chiefly towards you my arch enemy, because my creator, do I swear inextinguishable hatred. Have a care: I will work at your destruction, not finish until I desolate your heart, so that you shall curse the hour of your birth.

Shelley's reference to Prometheus prompted me to explore his life as a point of reference for the developing analysis of the data. Stories about the Demi-God Prometheus are told differently in different texts. However, there are two aspects of his being that have metaphorical significance for this piece of research. The first is his role as the bringer of fire to earth, fire whose "beam dispel[s] the dread of darkness and...warmth remove[s] the chill of winter" (Murray, 1988:206). Fire was seen as an "emblem of the life of man" with the possibility of both illuminating and extinguishing life. Alcohol is often called 'fire water' - with the same possibilities.

The second significant contribution of Prometheus to this metaphor is the state of torment in which he lives as a consequence of 'stealing' fire from the God Zeus. He was chained to a rock on Mount Caucasus, where a vulture preyed on his liver, which regenerated as fast as it was devoured.

This state of torment might have been brought to an end at any time by Prometheus, if he had been willing to submit to his oppressor...but that he disdained to do...[and he became] the symbol of magnanimous endurance of unmerited suffering, and strength of will resisting oppression" (Holme, 1981:42).

One of the certain consequences of drug and alcohol abuse is damage to the liver (which is an organ that has regenerative powers) and mental illness brings with it 'unmerited suffering'. 'Recovery' is the bringer of light to the soul and relapse brings with it the literal possibility of extinction. Many people with co-existing disorders live in a 'state of torment' that has the potential to be brought to an end by a process of 'surrender' to the oppressor (addiction and mental illness) - via step one of Alcoholics Anonymous: "...admitted we were powerless over alcohol that our lives had become unmanageable".

Finally, in a Twentieth Century interpretation of the *being/doing* dichotomy, Dana Zohar (1997:69-70) argues Vacuum vs Quantum Vacuum:

...in old paradigm science, the universe is a still, cold, and silent place. Black emptiness fill the space between visible objects. Newtonian scientists are preoccupied with the objects, with their observation, manipulation, and control. They think that objects are all that is. Newtonian organisations and Newtonian leaders concentrate on *doing*, on setting goals, and achieving results, on technique. New paradigm science sees that the universe is a vast pool of seething potentiality, an interwoven pattern of dynamic energies. There is no emptiness. Objects are just surface manifestations of a deeper, underlying source. Quantum or complexity scientists are preoccupied with hidden patterns, with unseen connections, with synchronicity and evolution. They are filled with the adventure and excitement of *becoming*. New Paradigm organisations are rooted in their vision. Their leaders focus on *being* as well as *doing*.

In a chapter entitled "The Concept of Servant Leadership", Zohar (1997:152) argues that "Traditionally the East has emphasised cooperation and trust; the West, competition and control. A "good man" in the East has a quality of *being*. In the West, a "good man" is usually measured by his quality of *doing*."

Theoretical Memo - Dealing with the 'Staff' Data 26.06.01

Have tried to fit this data into the categories that came out of the consumer participants' interviews as another slice of data. The difficulties I am having are the issues that staff raise, and the language they use to describe them is very service focused and in spite of my best efforts, the data does not fit easily into

the existing framework. In the interests of keeping the project moving, I have made a decision to write it up separately and to reassess it. It may be, as with the consumers' data, that a pattern begins to emerge in the writing up that suggests a way of using it that is consistent with grounded theory methods and honours the information that staff have provided. It makes sense to write it up in the 'recovery' chapter, as this is the point at which the staff I interviewed fitted into the picture, ie. the clients they were dealing with were no longer in the acute phase of their illness, but had moved into the early phase of 'recovery' and been referred on from an acute mental health unit to a follow-up programme.

Theoretical Memo - The Janus Reign - 26.06.01

I have been thinking about the title for the thesis and the key theoretical components. The Hazelden (1982) readings talk about moving more securely to mental health as a stable condition. In their schema, this involves looking back to the past and forward to the future - yesterday, today and tomorrow. That made me think of Janus (looking backwards and forwards) and about how all the participants had talked about their 'recovery'. Even when I directed questions to the 'present' and how they were managing their 'recovery', they all went back to the past. This seemed to be an important 'part' of the present that reminded them where they had come from and where they could go back to if they did not continue to manage the present. According to Murray (1988:132-133):

Janus was a deity...from the earliest times held in high estimation by the Romans...giving his name precedence in their prayers, and invoking [his] aid previous to every undertaking. To him they ascribed the origin of all things, the introduction of the system of years, the change of season, the ups and downs of fortune, and the civilisation of the human race by means of agriculture, industry, arts and religion. According to popular belief, Janus was an ancient king who had come in remote early times from Greece to Latium, there instituted the worship of the gods and the erection of temples, and himself deserved high honours like a god, for this reason, that he had conferred the greatest boon upon mankind by his instructions in many important ways. The beginning of everything was a matter of great importance to the Romans, and Janus was the god of a "good-beginning". Janus opened and closed all things. He sat not only on the confines of the earth, but also at the gates of heaven. Air, sea, and land were in the hollow of his hands. The world moved on its hinges at his command. In accordance with this belief, he was represented, seated, with two heads, one being that of a youth, to indicate

'beginning' the other that of an old man, to indicate the 'end'. In his left hand is a key to show that he opens at the beginning and shuts at the end; the sceptre in his right hand is a sign that he controls the progress of every undertaking. The story runs, that the Sabines having once made an assault on the newly built town of Rome, a spring of boiling water suddenly appeared, and was the means of destroying these enemies. On this spot a temple was erected in honour of Janus, the gates of which stood open so long as Rome was at war, and were closed with great ceremony and rejoicing only in times of general peace. Hence the temple of Janus with its gates shut became a very emphatic symbol of peace.

Theoretical Memo - Recovering a Life 08.07.01

I have been thinking about a name for the core category and hence the thesis. The categories 'a normal life', 'becoming normal', and 'managing a life' have variously been used. Each of these seemed right at the time, they represented the phase I had got to in the data analysis. But as I moved through the processes of open coding to selective coding and finally theoretical coding, each of these basic core categories have failed to account for all the data. The theoretical codes did not connect the substantive codes together in a way that lead to a conceptual model of the relationships between them. The basic core category 'managing a life' has failed to take account of the importance of the past in the way that it has become significant to the participants. 'Recovery' is defined narrowly and/or amorously in the literature. That is, it is either used as a term to refer to a narrow period of time between the 'acute' phase of the illness and discharge from the service, or it is used as a formless entity that takes on a number of identities in different situations. Most often people use the term to describe something they are 'not' rather than a positive state of being. Numerous people I have met and worked with over the years will say that they are 'in recovery' but often this will mean that they are not acutely unwell or are not drinking and drug taking. In addition to being an original piece of work because it looks at coexisting disorders from a sociological perspective (rather than a medical one), using qualitative methods (rather than the usual quantitative or evaluative ones), the point of difference for this thesis is its examination of the notion of 'recovery'. **Recovering a life** operates on three dimensions:

1. Resurrecting/salvaging something that one once had prior to the onset of 'illness'. This gives the concept a sense of history.

2. It implies a progression or movement from one state of being to another (ill to well) and finally...
3. It allows me to take a concept that is already in common usage and mine it for understanding and detail. I can push the limits of comprehension, and expand the usefulness of the concept. Hopefully I will also provide a frame of reference for applying it that will make it a more relevant tool in both the mental health and alcohol/drug fields of understanding.

Theoretical Memo - Discovering a Life? 28.07.01

To 'discover' is to find out something which has previously been unknown, to become aware, or expose to view (*Concise Oxford Dictionary*). I began to explore the 'recovery' literature yesterday and realised that my participants were talking about 'discovering' a life, not 'recovering' a life.

When we maintain the assumption of permanent psychiatric disability, even if we focus heavily on quality of life, we reinforce an identity of fragility, unpredictability, and negative difference, along with an assumption that on-going success is inevitably linked to the reliability of skilled professional help over time, a tenuous proposition at best (Curtis, 1998).

According to Curtis (1998), 'recovery' is about breaking free from these ideas and assumptions of psychiatric disability. It is my contention, however, that the participants who are 'getting well' best, are those who do acknowledge that mental illness and substance dependence are life-long, but not necessarily permanently disabling, and have found a way of honouring their presence and integrating them into their 'being' and personhood. Once done, this frees them up to discover who they 'really' are and what they are capable of. It is not simply breaking away from negative perceptions and ideas, but actively embracing new ways of being and entering uncharted territory. They have truly embarked on a journey of 'discovery' that is consistent with the Miller and Rollnick's (1991) idea of maintenance as 'continuing to change'.

I keep coming back to the 'paradigm shift' that Zohar talks about, the shift from 'doing to being'. Need to explore this further.

I am not sure where to go with this, whether to search out literature on 'discovery', or use my data to critique the 'recovery' model, or to do both, ie. develop a 'discovery' model that builds on and supersedes the concept of 'recovery'. Will stick with the 'recovery' model in the meantime on the basis that my data will inform the final theoretical outcome, and there will be a certain honesty and integrity with it. The other 'reality' I need to factor into the

equation is that of time. My final deadline is drawing inexorably closer, and I do not have the luxury of endless analysis. At some point I need to make a decision and go with it supported by the best evidence I have.

Theoretical Memo - The Janus Influence 23.07.01

Have changed the name of the title on the basis that the 'Janus' metaphor is more an 'influence' than 'holding sovereignty over' or to make a word play on the word 'rein' as in 'guiding' 'checking' or 'managing' (*Concise Oxford Dictionary*). The notion of 'influence' as 'acting on' another more conveys the social movement of 'discovering a life', that still leaves the participant at the centre their own existence.



Conclusion

This chapter documents the process of some of the practical and theoretical decisions that were made during the course of the fieldwork and writing up phases of the thesis. It attends to decisions that were made about generating a sample, the structure and content of the interviews and the ways in which the data were recorded and analysed. The 'struggles' with the data were also recorded in an effort to demonstrate how the final theoretical decisions were reached.

CHAPTER FIVE: THE FIELD

Because half a dozen grass hoppers under a fern make the field ring with their importunate chink, whilst thousands of great cattle, reposed beneath the shadow of the British oak, chew the cud and are silent, pray do not imagine that those who make the noise are the only inhabitants of the field. (Edmund Burke *Reflections on the Revolution in France*, 1790)

Introduction

The traditional approach to thesis writing is to “study the literature in a substantive area before one starts the research” (Glaser, 1998:67). According to Glaser (1992:31), this enables the researcher to ascertain any gaps that may need to be filled, identify hypotheses to be tested, and ideas that necessitate expansion or further consideration, ie. “descriptive and verificational” studies. The grounded theory method has a clear mandate with regard to the literature: “do not do a literature review in the substantive area and related areas where the research is to be done” prior to the commencement of the research (Glaser 1998:67). Because of the nature of the grounded theory approach to research (see Chapter Three “Methods”) it is important to keep the researcher as ‘uncontaminated’ as possible. “It is hard enough to generate ones own concepts, without the added burden of contending with the derailments provided by the related literature...” (Glaser, 1992:31). Couched in more positive terms, Glaser (1998:68) sees not reading the literature as part of the “grounded theory empowerment. It is one more dimension of freedom to discover”.

The field of mental health and addictions is saturated with research material of a particular type, and the Burke quote prefaces this chapter to alert the reader to the fact that there are ways of seeing coexisting disorders other than through the gaze of this body of literature. The mainstream literature is reviewed here as a way of providing a context for the study and an understanding of the baseline from which the research began. The information was retrieved from a variety of sources, beginning with a search of the on-line data bases PsycLit, Medline, Index New Zealand and Health Plan (Health Planning and Administration). The key words ‘coexistent disorders’, ‘dual diagnosis’, ‘comorbidity’, ‘mental disorders, mental health and drug/alcohol usage’ were applied. Medline and PsycLit yielded the greatest volume of information, but

privileged mental health (over substance abuse) as the basis from which to begin analysis. In order to redress the balance, a library search was made of the comprehensive range of addictions studies journals. This yielded a smaller volume of none-the-less valuable information. Books were consulted for the historical aspects of the chapter, and medical texts were used to provide information about some of the technical detail of mental illness and substance abuse. Local (New Zealand) policy statements and statistical data were gleaned from documents and websites set up by the Alcohol Advisory Council of New Zealand, the Mental Health Commission and Statistics New Zealand. Unpublished articles and papers were used only where necessary to provide information that could not be gleaned in the public domain.

This chapter provides a scope of the existing 'field' of knowledge that locates this piece of research in a credible domain of inquiry, demonstrates and acknowledges what has gone before and sets the scene for my own original and innovative piece of work.

The chapter has been structured in five sections to help the reader navigate the considerable body of literature that informs current, mainstream thinking on (and around) coexisting disorders. The material has been grouped in a way that brings some cohesion to a diverse range of writings on the topic. The chapter opens with an **analysis of mental illness and addiction as medical problems** and a brief historical review of mental illness, alcoholism and drug addiction. Each paradigm on its own comprises a significant body of work. What I want to do here is provide an overview sufficient for the reader to understand the context out of which the thesis developed, beginning with an explication of the medical model on which the literature is prefaced. This is followed by an account of the development of the *Diagnostic and Statistical Manual of Psychiatric Disorders* (DSM) and a short chronicle of mental illness and drug and alcohol use in New Zealand. An **analysis of co-existing disorders** forms section two of the chapter and introduces the reader to ways of thinking about mental illness and substance abuse as one entity. In the third section (**alternative analyses**) a critique of the medical assumptions of coexisting disorders is offered. A transition from 'patient' to 'tangata whai ora' as a way of naming people with coexisting disorders is tracked. Section four (**diagnosis**) begins with an outline of the DSM axial schema and allows the reader to develop an awareness of the broader context of diagnostic thinking. Prevalence studies indicate the magnitude of the problem in the general and 'illness' populations. In section five the **treatment** issues (both systemic and specific) are outlined. Finally, an overview of policy documents which inform the 'care' of

people with coexisting disorders in the New Zealand context brings the reader back to the local nature of the study.



1. Analysis of Mental Illness and Addiction as Medical Problems

Early, 'Medical' Approaches to Mental Illness

The literature of Babylonia and Assyria (after 3000 BC) records episodes of 'hysteria' and 'delirium', and early Greek mythology refers to episodes of hallucination, demon-produced madness and frenzy (Martindale & Martindale, 1971:7).

It is difficult to know how this equates to our understanding of disorders of the mind, but all the terms refer in some way to a functional disturbance of the nervous system, and point to the existence of something we now call mental illness.

Wily and Stalworthy, (1962:8) observe that "supernatural influences and demonical possession were the orthodox explanations for mental illness into the 18th Century". Mental illness was seen as a manifestation of evil and many of the remedies were developed around rites of exorcism and performed by priests (Wily & Stalworthy, 1962:3). It is only since the latter part of the eighteenth century that mental illness has been seen as a medical problem. It became increasingly accepted that mental disorders were primarily a medical specialty. Accurate descriptions of mental disorder began to be published, and by the end of the eighteenth century the first hospitals for the mentally ill were in existence (Wily & Stalworthy, 1962:8).

The 'medicalisation' of disorders of the mind forms the basis of our understanding of mental illness today and influences treatment strategies.

The Medical Model Today

If you talk to God, you are praying; if God talks to you, you have schizophrenia. If the dead talk to you, you are a spiritualist; if God talks to you, you are schizophrenic. (Thomas Szasz, *The Second Sin* 1974 'Schizophrenia').

Research and writing on coexisting disorders, is predominantly found in the psychiatric and psychological literature and is singularly informed and dominated by the medical model. According to Todd, Sellman and Robertson (1999) "the use of the disease model has a long and contentious history in the

alcohol and drug field, but is widely accepted as an important part of conceptualising dysfunction within the mental health field”.

Like much ‘received wisdom’, the medical model is seldom explicated or even critically understood in texts - it is simply taken for granted that people know and understand what it is. It has a legitimacy that is rarely called upon to justify itself, although Todd, Sellman and Robertson (1999) do attempt to explain their use of it:

...When we use the term “disease model”, we use it in the modern sense to depict a categorical or nomothetic construct which has underlying biological determinants. In other words, the disease model involves conceptualising dysfunction by identifying those features common to most people who experience a specific “disorder” or diagnoses, and identifying the biological factors which are aetiologically related to those features or diagnoses.

Whilst Todd, Sellman and Robertson (1999) acknowledge that the disease model is incomplete and one also needs to consider the individual or “ideographic” aspects of a person’s dysfunction, their explanation does not fully identify all the permutations and consequences of this way of thinking. Mckeown (1971:6-7) makes some attempt to describe the medical model in a more capacious way when he identifies the six aspects of the traditional medical task as:

1. The diagnosis or identification of disease,
2. The pathology or understanding of disease,
3. The prevention of disease,
4. The cure of disease,
5. The estimation of the prognosis or anticipation of the probable results of disease and
6. The palliation or alleviation of the effects of disease.

An understanding of the ‘medical model’ rests heavily on the understanding of the concept of ‘disease’. Armstrong, (1989:118) concurs with Todd, Sellman and Robertson (1999) that “...a knowledge of the nature and characteristics of disease...is usually couched in biological terms”. Miller and Keane (1978:300) describe ‘disease’ as “a definite morbid process having a characteristic train of symptoms”.

To break the term ‘disease’ down into its constituent parts (dis-ease) in the frame of reference outlined above ignores three factors:

- 1) The claim of the medical profession to an exclusive skill in identifying disease,
- 2) The ‘objective’ status usually afforded disease as against the more subjective experience of the patient

and 3) the existence of pre-symptomatic diseases which do not immediately cause dis-ease (Armstrong, 1989:119).

The medical model is inherently flawed in that it views dis-ease from one perspective only. The exclusivity in identifying disease is claimed by the single group of people (doctors) who stand to gain the most by what Eliot Freidson (1988:63) calls 'credentialism'. According to Freidson (1988:63):

...the most impressive form of credentialism works to produce an occupational cartel, which gains and preserves monopolistic control over the supply of a good or service in order to enhance the income of its members by protecting them from competition by others.

In addition to economic power, this type of exclusivity brings other rewards such as status and political advantage.

In privileging the 'objective' status of diagnosis over the 'subjective' experiences of the 'patient' is to assume a power imbalance in favour of the doctor. According to Freidson (1988:1), it creates "a new form of domination over our lives...a new form of social control...leaving us helpless and dependent on others for guidance in the conduct of our lives". Even without Freidson's alarmist analysis the privileging of 'objective' over 'subjective' knowledge leaves the 'patient' uncertain about the value of their interpretation of their own life experiences.

Closely linked to Armstrong's second point (above) is his third point, the neglect of pre-symptomatic disease. Without the full-blown status of a 'disease' and its constituent parts, it is difficult to legitimate a consultation with health professionals, and 'patients' are left wondering if anything is wrong at all.

A person who is ill or is undergoing treatment for 'disease' is called a patient (Miller & Keane, 1978:757). Even that carries with it emotional baggage that implies a set of rights and responsibilities or obligations. According to Parsons (cited in Armstrong, 1989:7), these rights "temporarily excuse [the patient] his or her normal role" in society (eg. as employee, parent, partner), and deem the 'patient' not to be responsible for his or her illness, ie. they did not neglect their health in a way that would 'cause' illness. In return, they (the patient) must want to get well, and must cooperate with technically competent help (Parsons, 1976). In Parson's schema, this understanding of health and illness leads inexorably to a 'treatment' outcome that relies on outside 'expert' help and systematically excludes the 'patient' from an analysis of their problems and possible solutions that may or may not include traditional medical intervention.

By contrast, the *Patient Code of Rights* (Appendix IV) has been adopted in some form by all health care providers in the New Zealand setting. It attempts to reinforce the normal role as human 'being' within a dehumanising medical setting. Although 'patients' are required to "co-operate with health staff in [their] treatment" (Appendix IV), the *Code of Rights* outlines the way in which they should be treated as individuals (with dignity, cultural sensitivity and respect), and have the right to 'informed consent' before they agree to treatment. The *Code* (Appendix IV) also advises the consumer about advocacy and complaints services should they wish to question the service they are receiving.

Within the 'medical' frame of reference, the need for a classification of mental disorders has been clear throughout the history of medicine. External 'experts' need to agree upon standards of definition in diagnosis in order to 'treat' the passive 'patient' who presents as being 'dis-eased'. However, there has been little agreement on which disorders should be included and how they should best be organised. The many nomenclatures that have been developed have differed in their relative emphasis on phenomenology, aetiology and prognosis as defining features. Additionally, the various systems for categorising mental illness have differed with respect to whether their principle objective was for use in clinical, research or statistical settings.

DSM IV

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was developed in the United States out of a need to collect statistical information. The 1840 census reflected the first official attempt to gather data about mental illness (DSM-IV, 1994:xvi). By 1921, it was still primarily a statistical tool (for gathering information across mental hospitals), but some effort was made to render it clinically useful: "the American Psychiatric Association subsequently collaborated with the New York Academy of Medicine to develop a nationally accepted nomenclature" (DSM-IV, 1994:xvi). This nomenclature was designed primarily for diagnosing inpatients with severe psychiatric and neurologic disorders. One of the early seven categories of mental illness was 'dipsomania' the precursor of the more modern term 'alcoholism', which in turn has been replaced by the more generic 'substance abuse' and 'substance dependence'. A further three relate to mental illness as we know it today. Mania, equates with the manic phase of bi-polar disorder, melancholia with depression and monomania with "psychosis on a single subject or class of subjects" (Miller & Keane, 1978). The final three, paresis, dementia and epilepsy, whilst originating in the nervous system, are now known to be 'organic' in nature

with identifiable structural changes in brain and nerve tissue. Later editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) were developed with the benefit of empirical research and clinical trials and:

...introduced a number of important methodological innovations, including diagnostic criteria, a multiaxial system, and a descriptive approach that attempted to be neutral with respect to theories of [a]etiology (DSM-IV, xvii).

The multiaxial system involves an assessment of several elements, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axes in the DSM-IV multiaxial classification:

Axis I Clinical Disorders (including substance abuse/dependence and major mental illness

Axis II Personality Disorders & Mental Retardation

Axis III General Medical Conditions

Axis IV Psychosocial and Environmental Problems

Axis V Global Assessment of Functioning

It is the Axis I diagnosis that is of concern in this piece of research, but only as an historical artefact. None of the axial diagnoses are current, and except for the diagnosis that gave rise to the proper and ongoing prescription of medication, they were irrelevant to the consumer participants.

Mental Illness in the Pakeha New Zealand Context

In New Zealand, prior to the 1840s, the mentally ill were sent to gaol for their own and others protection. The construction of the first 'lunatic asylum' in Wellington in 1844 signalled a change in society's view of mental illness from a law and order problem to a humanitarian problem. Some of the history of the treatment of the mentally ill in New Zealand has been recorded in a history of the professionalisation and legitimisation of psychiatrists. According to Brookes and Thomson (2001:167) by the "late 1940s, the notion of psychiatrists as mere 'keepers of lunatics' was no long apposite". In New Zealand, psychiatry had been established as a legitimate branch of the medical profession and, by association, mental disorder a legitimate medical illness. However, the "degree of professionalisation...was not accompanied by a commensurate improvement in standards of care in the nation's mental hospitals, or by the development and utilisation of humane, effective treatment" (Brookes & Thompson, 2001:167).

Both the 'treatments' offered to psychiatric patients and the circumstances under which they have been cared for in New Zealand have followed international trends in the Western world. Arguments about whether "lunatics and inebriates" should be placed in prisons or hospitals have been raised since 1882 in New Zealand (Mason, 1988:11).

The question of the environment in psychiatric hospitals has also come under scrutiny from a variety of sources. According to Mason (1988:135), there was "periodic public outcry about deplorable conditions" and the development of ideas about 'stigma' and 'the sick role' led to an acknowledgment of the effects of institutionalisation on the chronicity of individuals. This acknowledgment and attempts at addressing these issues, combined with the introduction of anti-psychotic drugs lead to a reduction of many of the distressing symptoms of mental illness. The anti-psychotic drug chlorpromazine was discovered in 1952 and "produced significant behavioural changes in psychiatric patients [that] revolutionised psychiatric care" (Laraia, 1998:588). According to Laraia (1998:589) more recent developments in antipsychotic drugs have had the effect of both reducing the "positive" symptoms of mental illness (the excess or distortion of normal function) and "exert[ing] therapeutic action in treating the negative symptoms" (the diminution of loss of normal function) without significant side effects. This makes the medication more acceptable to 'patients' and reduces the nonadherence that was common in the early days drug treatment.

These advances, combined with ideas generated by the civil rights movement around the world, questioned whether it was "ethically responsible to lock people away for the rest of their lives" (Mason, 1988:135), and led to a number of inquiries and investigations into psychiatric hospitals in New Zealand.

Issues that have arisen, and continue to arise, out of incidents with psychiatric hospitals and patients, have focussed attention on the relationship between the health system and the criminal justice system, the relationship between psychiatric hospitals and the community and the fiscal implications of providing a service to a group of people with high dependency needs.

The history of the treatment of mental illness in New Zealand continues to be written. This thesis is a contribution to the way we think about, and behave towards people with coexisting disorders of mental illness and substance use.

Alcohol

According to Sourina (1990:3-4), "fermented drinks date back thousands of years [and] although the exact nature of their original discovery remains open to speculation, it seems likely that they predate agriculture". Our consumption of alcohol has generally been associated with ritual and festivity. Each society or community develops its own rules around alcohol consumption and these rules involve the conditions under which drinking takes place, the amount of alcohol that is consumed, and the consequences of that consumption.

Early concerns about the negative effects of alcohol were social rather than medical. According to Sourina (1990:20), by the beginning of the eighteenth century "drunkenness was upsetting the social order in that the lower classes, thought to be the sole indulgers in alcoholic excess, were becoming unruly". It was another hundred years before the medical argument became more coherent and gained ascendancy. It was not until a Swedish doctor, Magnus Huss, drew together diverse findings and systematised their study, that the condition of alcoholism was identified within a medical context. According to Sourina (1990:41) Huss "established that this new disease, in forms that took the same guise, affected all countries and all classes of society".

Since the inception of the *Diagnostic and Statistical Manual of Psychiatric Disorders*, alcoholism has been classified within the broad parameters of 'mental disorders' or 'psychiatric illness' along with drug addiction under the diagnostic class 'substance-related disorders'.

I can find no statement within the DSM IV document to explain why 'substance use' and 'substance induced' disorders have been included as a mental disorder. It can only be left to speculation that this classification relates to the psychiatric-like symptoms brought about by substance intoxication, withdrawal, and dementia (following long-term abuse).

The history of alcoholism and the means proposed to remedy, reduce or prevent it is inevitably complex. Like mental illness, the problems created by the excessive consumption of alcohol have attracted the interest of doctors, theologians and law makers. At the beginning of the third millennium, medical doctrine prevails.

Alcohol Consumption in New Zealand

Alcohol was unknown to Maori in pre-European New Zealand. According to analysis by Maori sources (Awatere, Casswell, Cullen, Gilmore, & Kupenga, 1984), alcohol was introduced by the European as a tool for colonisation and

became part of the bargaining process which led to the alienation of land. The initial Maori experience with alcohol was negative and prompted the use of the term 'wai piro' (stinking water). By contrast, "many of the migrants to Aotearoa...had long cultural histories with this drug" (Warren, Griffiths & Huguens, 1989). Like other countries, the use of alcohol in New Zealand was restricted by seasonal availability, rituals or religious ceremonies, but the early arrival of sealers and whalers set a standard of heavy drinking here that has come to be known as a 'binge style' of drinking (Warren, Griffiths & Huguens, 1989).

Pakeha and Maori women joined forces in the 1880s and 1890s to fight the soaring alcohol problems (Warren, Griffiths & Huguens, 1989). The major group to make an organised protest was the New Zealand Women's Christian Temperance Union (Wood, 1985). Since the 1920s other groups have been formed that influence the debate on the use and abuse of alcohol in New Zealand. The Alcohol Advisory Council (ALAC) was set up in the 1980s to provide a moderate voice that would mediate the powerful liquor industry and the prevailing 'abstinence-based' alcohol treatment programmes. In the millennium the Alcohol Advisory Council continues to offer a range of strategies and guidelines in the complex area of alcohol production, supply and retail (www.alcohol.org.NZ).

In New Zealand, alcohol consumption is the norm with most adults (89%) currently drinking some alcohol each year. Drinking patterns vary with gender and age, with the heaviest drinking being done by young men twenty to twenty four years of age. Alcohol is consumed most commonly in private homes, but is also often drunk in bars and sports clubs. Total alcohol consumption per capita has been falling since 1990, but recently it has begun to rise again. Drinking problems, including dependence on alcohol, affect people's lives and the lives of those around them. Although New Zealand has adopted the World Health Organisation's (WHO) recommended upper limits for drinking (beyond which it is known to be unsafe), these may be too high for those people with mental illness, particularly those taking tranquillisers and anti-depressants (www.alcohol.org.NZ).

Drugs in the New Zealand Context

Drug use in New Zealand has been more difficult to track than the use of alcohol. Apart from alcohol, tobacco and those drugs prescribed by a doctor for medical use, most recreational drugs used in this country are illegal. There are two key documents that assist the reader in understanding current patterns and they give a profile of two populations of drug users. The first, *Drug Use in*

New Zealand (Field & Casswell, 1999), surveys a random sample of (approximately) five thousand people in the general population, aged fifteen to forty five years. It compares the results of regional surveys of drug use carried out in 1990 and 1998. The second document, *Alcohol and Drug Problems in Community Clients at Auckland Regional Alcohol and Drug Services* (Paton-Simpson & Mackinnon, April 2000), tracks drug use in a population of people presenting for treatment in a community setting. The most common drug of use in the general population (after alcohol and tobacco) is marijuana, with fifty two percent in 1998 saying they had tried it (*Drug Use in New Zealand*, 1999:6). Of those presenting for treatment, alcohol is still the most problematic drug with cannabis second. Thirty five percent of the Paton-Simpson and Mackinnon study (April 2000) presented as having a problem with cannabis, half that number with opiates and about ten percent had problematic use with amphetamines. As might be expected, 'other' drug use in the general population was less, with only four percent having used stimulants in the previous year and 0.6% having used opiates.

Paralleling the alcohol and drug consumption of the general population, alcohol was the drug of choice for the consumer participants in this study followed closely by the use of marijuana. Although most of the participants had experimented with a variety of drugs (including opiates, amphetamines and hallucinogens) it was the alcohol and marijuana that ultimately proved to be the most problematic for them.

Marijuana Use and Mental Illness

The causal relationship between marijuana use and mental illness continues to be a source of speculation for researchers and clinicians. In a 1972 study, Halikas found a high prevalence of psychiatric problems in young marijuana users (most of which had preceded marijuana use). In a seven year follow-up study, Weller, James and Halikas (1985) documented the relationship between repeated marijuana use and psychiatric illness in chronic users. They found there was not a significant increase in the total number with a diagnosable illness, but felt there were sufficient methodological problems to require further studies to confirm the results.

The issue continued to be debated, and further studies in 1988 (Mathers & Ghodse) suggested that the capacity for cannabis to cause severe neurological or psychological damage had been over-estimated. However, it was also felt that there was no adequate evidence to suggest that cannabis was not harmful particularly in marginalised and vulnerable groups. 'At risk' groups were.

identified in this study as “those whose cultures have been damaged, the anomic, the socially disadvantaged and the severely psychiatrically ill”. Later studies (Mathers, Ghodse, Caan & Scott, 1991) established an increase in the likelihood of psychotic symptomatology in acute admissions to a psychiatric unit in patients with a history of life-time and recent cannabis use. Although the correlation between experimental cannabis use and the onset of psychosis remains weak, the results of the Mathers study does establish that cannabis use is common amongst people who become psychiatric in-patients.

Summary

This section has introduced mainstream literature and ideas about mental illness and addiction as medical problems. It explores the medical model as the basis for analysis of problems from a medical perspective and cites *The Diagnostic and Statistical Manual of Mental Disorders* as the diagnostic authority for mental illness and substance use disorders. A brief history of mental illness and alcohol and drug use is located in the New Zealand context. A description of current patterns of use (of both drugs and alcohol) provide the reader with an understanding of the social environment in which people with mental illness are having to make decisions about substance use.



2. Analyses of Coexisting Disorders

Taffeta phrases, silken terms precise, / Three-piled hyperboles,
spruce affectation, / Figures pedantical. Shakespeare *Loves
Labours Lost* [V. 11. 869]

Working definitions of coexisting disorders for this thesis have been outlined in the introduction to this thesis. This section tracks some of the thinking about coexisting disorders and explores the literature as it attempts to define and categorise them.

Attempts to define the problem have been recorded as far back as 1951 in a report of the Swiss Federal Commission against alcoholism (Jellinek, 1960:217). It acknowledges alcoholism as being “secondary to nervous and character disorders” in many cases, and argues that “these primary troubles must be treated at the same time as alcoholism itself”. However, it was not until the 1980’s that systematic attempts were made to classify ‘co-existing disorders’ (Smith et al., 1992:3).

Wright and Mattick's Categorisation

Wright and Mattick (1992) developed a categorisation that, up until recently, has been commonly accepted as the principal nomenclature which includes:

1. a primary substance use disorder with psychiatric consequences,
2. a primary psychiatric disorder with secondary substance abuse,
3. a dual primary diagnosis where the two conditions have no aetiological connection, although once established, may interact to exacerbate each other, and
4. a dual diagnosis that reflects a common underlying aetiological factor.

Using Wright and Mattick's (1992) categorisation, some the literature of the early 1990s deals with coexisting disorders according to primacy.

When Mental Illness is the Primary Problem

In this scenario, the psychiatric disorder is deemed to have existed first, independent of any substance use disorder. In researching coexisting disorders among people with schizophrenia some researchers (Castaneda, Galatner, Lifshutz & Franco, 1991) argue that, like addiction in people without schizophrenia, addiction in people with schizophrenia constitutes a separate disease entity. However, the substance abused makes a difference to the symptom aggravation in the Schizophrenia. According to Castaneda et al., (1991), cocaine is felt to aggravate the symptoms of schizophrenia more often than alcohol.

When Substance Abuse is the Primary Problem

Whilst some researchers (Castaneda et al., 1991) argue that substance abuse makes a difference to symptom aggravation in schizophrenia, others (Hays & Aidroos, 1986) argue for alcohol abuse as an aetiological factor in some schizophrenia-like psychoses. Given the biochemical nature of the drug alcohol, this is not a popular argument. Alcohol is a central nervous system depressant, not an hallucinogen, and psychotic symptomatology is usually associated with withdrawal after excessive consumption, or reduction in consumption.

Rejecting the Notion of Primacy for Treatment Purposes

Nunes and Hasin (1998) argue neither of the above approaches is useful when thinking about an individual with both disorders. The primary/secondary distinction implies a cause and effect relationship, and while it is technically possible and relatively simple, it has limited validity in predicting treatment responses. Ridgely (1993) argues for both disorders to be given primacy.

Defining Coexisting Disorders - Diagnostic Language

'Dual diagnosis', 'comorbidity' and co-existing 'disorders' are terms that have emerged from the diagnostic language of mental health and alcohol and drug service providers in the 1980's. There is broad agreement (Drake, McLaughlin, Pepper & Minkoff, 1991; Ortman, 1997; Todd, Sellman & Robertson, 1999) that the terms dual diagnosis and co-existing disorders are generally used interchangeably, and that they refer to individuals who experience both psychiatric and substance use disorders. However, within this broad agreement, the terms have "come to have different meanings in different contexts" (Todd et al., 1999). Drake et al. (1991) argue that because no consensus has emerged around a single rubric, authors should specify in detail the population they are discussing. A further note of caution to the unwary researcher of coexisting disorders: a 'trawl' of the literature using the key word 'dual diagnosis', also brought up articles on those people who are 'developmentally and psychiatrically impaired' (Gabriel, 1994), and an analysis of child and adolescent medical-psychiatric units (Wamboldt, 1994). These latter interpretations of 'dual diagnosis' do not apply to the participants in this study, and the literature is not considered.

The latest version of the *Diagnostic and Statistical Manual of Psychiatric Disorders* (IV,1994) still addresses the matter of substance abuse disorders and psychiatric disorders separately. Smith, Taumoepeau, and van Helden-Stevens (1992) in their overview of comorbidity in New Zealand raise the issue of 'multiple morbidity' as a more useful conceptual framework. It would allow for the inclusion of the effects of substance use/abuse on psychological, physical and social functioning and *vice versa*.

Summary

All attempts to define and categorise coexisting disorders fall within the broader 'medical model'. This construct accepts drug/alcohol and mental health problems are 'diseases' which are progressive in nature and which exhibit physiological and/or psycho-social symptomatology (Jellinek, 1960).

3. Alternative Analyses

Co-morbidity, as an entity, has not come in for alternative analysis by theorists. However, there are examples in both the mental health and substance abuse fields of different interpretations that might equally be applied to coexisting disorders. Some of the more significant ones are included here on the basis that they contribute to the current thinking in the management of people with coexisting disorders.

Alternative Analyses of Mental Health/Illness

Mental Illness as a Cultural Construct

Thomas Szasz, wrote about mental illness from a 'cultural' context. In his early work, *The Myth of Mental Illness* (1961), he used a social model to critique the prevailing views. Instead of focussing solely on the individual (as with the medical model) Szasz looked to the social conditions. According to his analysis, "behaviour considered normal in one cultural setting may be eccentric in another and psychotic in a third" (Stuart & Laraia, 1998:58). Szasz argued (1961) that society has to find a way to manage its "undesirables," so it labels them mentally ill. People who are labelled in this way are often unable or unwilling to conform to society's norms. Having labelled them, society can now call them 'patients' and 'treat' them, against their will if necessary. At the time of his writing in the 1960s, the most common response to mental illness was confinement. Confinement performed the dual function of removing the 'deviant' members from society and exerting control over their behaviour. "If these people then conform to social expectations, they are considered to have recovered, and are allowed to return to the community" (Stuart & Laraia, 1998:58).

Szasz (1961) distinguished between the biological component of illness and the social role that is the focus of deviance. He did not necessarily see the 'patient' as a helpless victim in this process of illness-making and argued that they had a role to play in the scape-goating process. He believed that people are responsible for their behaviour and can choose whether or not to conform to society's norms. Any theoretical perspective, taken to its logical conclusion, will contain within it remedies and solutions. Szasz (1961) believed that a therapist can help a 'patient' only if the 'patient' requests help and participates actively in 'treatment'. This is the view of all the approaches to intervening in alcohol and drug problems. Although we have an *Alcoholism and Drug*

Addiction Act (1966) that compels people into treatment, there is also provision for them to be discharged from the Act (and the treatment centre) if they refuse to participate.

Mental Illness as a Public Health Issue

The 'public health' approach argues that situations such as poverty, family instability and poor education can predispose a person to mental illness. New Zealand researchers Waldegrave, Frater and Stephens (1997) make a strong link between poverty and poor health outcomes. The Mental Health Commission (1998:23) reflects this public health approach in advocating for prevention programmes aimed at lessening the likelihood of mental health problems in the future by reducing "violence in all its forms", risk-taking behaviours in youth and alcohol and drug problems.

Alternative Analyses of Addiction

In a similar way, commentators on alcohol and drug problems have proffered alternative approaches to their understanding and management.

Game Theory

Claude Steiner (1971) argued that "alcoholism is neither incurable nor a disease". Based on the theory and practice of transactional analysis, Steiner argues for an understanding of alcoholism as a decisional one involving 'scripts', 'roles' and 'transactions' not disease. Using the 'script' theory, an alcoholic is someone who decided early on to lead a self-destructive life based on a 'game' of "alcoholic" with a predictable course and outcome. Whilst transactional analysis is still a useful tool in the 'treatment' of alcoholism (Midgley, 1999), Steiner erroneously based his assumptions of 'cure' on a 1967 study of the return to normal drinking by a number of individuals who had previously reported heavy drinking. The science of research into alcoholism is now more sophisticated. Rather than seeing drinking as a polemic of alcoholic and non-alcoholic styles, problems are viewed as occurring on a continuum from abstinence to dependence, with 'social', 'hazardous', and 'problematic' drinking in between (Alcohol Advisory Council of New Zealand, 1996). The group on which Steiner based his understandings of 'cure' would probably not be classed as 'alcoholic' or 'dependent' drinkers today, but fall into the category of 'hazardous' or 'problematic' in their alcohol consumption.

More recent interpretations of transactional methods (Pentz, 1999) focus on multi-dimensional changes leveled at the individual. These include

interactions between the person (including physiological responses, skills and beliefs), the situation they are in (including peer influences, social norms and opportunities) and the environment (media influences, access and availability of prevention resources), (Pentz, 1999:557). This analysis gives rise to the possibility of intervention programmes at both personal and social levels. Pentz (1999:556) proposes a model of integrative transactional theory (ITT) which "posits the cumulative and redounding influences of personal attitudes and behaviour on social group norms and support and, consequently, on community norms, media, fiscal resources, and policy change."

Family Systems Theory

'Family systems' strategy (Satir, 1972; Minuchin, 1974) is a tool that modifies the present, unlike other therapies that explore and interpret the past. According to Minuchin (1974:14) "the therapist joins that system and then uses himself to transform it. By changing the position of the system's members, he changes their subjective experiences". Put simplistically, it is a therapeutic version of 'rocking the boat'. If one member of the family shifts position then the others are compelled to change roles or alter their place within the family structure in order to maintain equilibrium.

However, this approach has two serious limitations. One is the expense of working with one family over a long period of time in a publicly funded health system that is looking for a 'brief intervention'. The other is the same problem encountered by the 'game theorists': if a family member has a physiological dependence on alcohol (or drugs), or has a mental illness with a clearly identified physiological component, then no amount of re-orientation of their position within the family is going to change it. A family therapy approach may make the problem more manageable, particularly for those family members in a supportive role. An example of the way in which this has been applied recently is in reducing the potential long-term effects alcohol abuse has on children (by and alcoholic parent). Rivers (1994:234) argues that family therapy approach allows "the family to openly discuss and resolve emotional issues surrounding drinking...and the children to change and modify their perceptions of the drinking member".

More recent family systems approaches have tried to address these limitations by including drug and alcohol problems as a core issue in therapy (Sheehan & Owen, 1999; O'Farrell, 1993). Concrete behaviour changes are expected and focus on family rules about drug-using behaviour. Urine-testing may be used as "tangible evidence of progress" (O'Farrell & Fals-Stewart, 1999:290).

Addiction as a Problem of Decision-Making

With the advent of more sophisticated laboratory testing, a neurological explanation of addiction has been advanced. Dr Antoine Bechara (2001), suggests that some people who are addicted to alcohol or drugs may have problems with their decision-making skills. In a study conducted at the University of Iowa, a majority of alcoholics and drug addicts scored as poorly on a test measuring the ability to make decisions as people with damage to a brain region that helps control decision-making. People who abuse alcohol or drugs often behave similarly to people who have experienced damage to a part of the brain called the ventromedial prefrontal cortex (VM), which is involved in decision-making. For instance, Bechara (2001) found both groups of people often deny they have a problem or are unaware of it, and, when given a choice to do something that will bring them immediate pleasure but will lead to negative consequences later, they often opt for instant gratification.

Defining the Person with Co-existing Disorders - Alternative Language

That which we call a rose, By any other name would smell as sweet. *Romeo and Juliet* (1595) act 2, sc. 2, 1.118 Shakespeare.

What to call a person with 'coexisting' disorders? Clearly the medical model has coined and claimed the term 'patient', and references to people with coexisting disorders in the medical literature are as patients.

As late as 1990, recipients of mental health services were still calling themselves 'patients' (presentation to the Fourth International Congress on Women's Health Issues, Massey University), but it was beginning to be used interchangeably with 'client' or 'claimant'. Users of mental health services have continued to assert power over their treatment by re-defining themselves as 'consumers', while users of alcohol and drug services continued to be referred to as 'clients'. In a recent review of dual diagnosis training on behalf of the Mental Health Commission in New Zealand (January 2001), the term 'consumer/tangata whai ora' has replaced all previous uses of the words 'patient', client and claimant. 'Tangata whai ora' derives from the Maori language to mean 'people seeking wellness'. In a glossary accompanying the document, 'consumer/tangata whai ora' is used as a generic term to denote people who are users of mental health services. The document acknowledges "they may be referred to by various descriptive terms in the range of mental health settings".

In this thesis, where people are talking about themselves, the term 'consumer' will be used. Where staff participants are talking about 'consumers' the

language of the interviewee will be used. Generally this is also 'consumer', but some participants working in long-term mental health settings may use the terminology of the treatment environment, 'patient'.

The term 'tangata whai ora' has not yet been adopted into popular usage. It has only recently been introduced into the lexicon, and only in a mental health context. About half the staff and consumer participants in this piece of research came from alcohol and drug treatment settings and continue to use the term consumer or client.

Summary

Just as the language and constructs of mental health and addictions have been applied to thinking about coexisting disorders, so can alternative paradigms be utilised. The cultural and public health constructs of mental health can be linked with the game and family systems theories of addiction to create an alternative framework for understanding and managing coexisting disorders.



4. Diagnosis

The diagnostic concerns of the literature reviewed were with Axis I only. Within this parameter, a diverse range of approaches to diagnostic tools, their reliability and validity in different settings, the necessity for distinguishing between sub-groups and the methodology of diagnosis were discussed. The headings used in this section represent an artifice of organisation. Frequently literature on coexisting disorders addresses more than one issue and information has been extracted to illustrate a particular point in the literature.

The Typical Dual Diagnosis Patient?

Some researchers (Weiss, Mirren & Frances, 1992) caution against belief in *the myth of the typical dual diagnosis patient*. The label 'dual diagnosis' implies a homogeneity that does not exist among this diverse group. The heterogeneity of patients who are dually diagnosed poses problems for treatment settings. Lehman, Myers, Dixon and Johnson (1994) argued for the necessity of *distinguishing between sub-groups*, and developed a diagnostic framework that would assist in matching clients to treatment. They argue that the risk of over-diagnosing schizophrenia in the presence of substance abuse has to be balanced against missing a diagnosis of major mental disorder. Other researchers (Smith & Hucker, 1994) argue for careful clinical assessment to clarify the primary diagnosis.

The Diagnostic Tools

In an effort to improve the accurate identification of comorbid disorder in substance abusing populations, Ross, Swinson, Larkin and Doumani (1994), compared diagnoses made by the Computerised Diagnostic Interview Schedule (C-DIS) and a Structured Interview Schedule administered by a clinician. The C-DIS, while not successful as a diagnostic instrument, has potential as a screening tool. A consensus diagnosis based on repeated interviews and all available information was acknowledged as likely to produce the most valid diagnosis. Chappel (1993) supports the view that simultaneous treatment of the addictive and mental disorders does not happen often. He argues for the "need for training in the diagnosis and treatment of this complex group of patients", and suggests a system of cross-training for both psychiatrists and specialists in addiction medicine. A more comprehensive understanding of the complex relationship between psychiatric illness and substance use disorders is essential, even when there is no clear understanding of the causative pathology (Walker, 1992a; Decker & Ries, 1993). The latter have identified the key DSM IV psychiatric disorders and examined the substances most likely to be used/abused in each, and isolated the ways in which alcohol and other psychoactive substances of abuse interfere with psychiatric medication. In a local study of psychiatric registrars, Dr Greig McCormick (1989) found that no matter what tools they used or how specific the training, less than fifty percent of admitting officers even asked the question about substance use.

In an alcohol and drug treatment context, assessment and diagnosis of substance related problems is comprehensive (ALAC, 1996). Screening is carried out on a general population to identify those who may have alcohol or drug related problems from those who may not. Diagnostic instruments are used by treatment workers to gain a more formal understanding of the extent of the alcohol or drug problem, and evaluation instruments monitor the change in the client over time (ALAC, 1996:4-5). There is no specific tool developed for assessing the alcohol and drug component of a 'dual' problem, but clinicians may choose one that is particularly suited to their client group.

Reliability and Validity

Questions have been raised about the *reliability and validity* of psychiatric diagnosis in substance abuse treatment settings. Kransler, Mason and Modesto-Lowe (1998) found that whilst clinicians showed good validity for diagnosis of substance use disorders, comorbid diagnosis showed generally poor validity. They argued that this could be improved by adding elements to the structured interview schedule of the clinician's usual assessment. In a more

general review of diagnostic methods, Nunes and Hasin (1998) argue that reliability of diagnosis is dependent on information given by the patient and the criteria used for assessment. When determining the reliability of the information given by the patient, Kate Carey (1997) cautions that one needs to take into account the state of sobriety of the respondent. In addition, the aspects of the task that might enhance or detract from accurate responding also have to be considered. These might include issues such as confidentiality, rapport with the assessor, clarity of the questions asked, and the likelihood that the self-report will be verified. Carey (1997) considers two final indicators of reliability - the motivational factors, for instance, to obtain treatment or avoid arrest, and fear of judgmental attitudes. Cognitive processes (such as impairment of attention, comprehension or retrieval) will affect the accuracy of the assessment.

Validity is examined on two measures. Face validity asks the clinician to determine "does it make sense?". For instance, in order for a depression to be primary it has to occur before the onset of any substance use. Concurrent validity is the ability of the diagnosis to predict other concurrent clinical characteristics such as the severity of symptoms, the level of disability and family history.

Cultural Assessment

"Cultural assessment has been identified as a particular need for some Maori within Mental Health [and alcohol and drug services] in New Zealand" (ALAC, 1996:11). It assesses a person in the context of their culture, in relation to the 'illness' they are suffering and is intended to complement all other assessments. The principles and guidelines for cultural assessment are consistent with the principles and practices of the *Treaty of Waitangi*. These involve acknowledgment of the mana whenua (importance of the land), maintenance of kawa (protocol), strengthening of the taha wairua (spiritual side) of the individual and their whanau/hapu (family/sub-tribe), ensuring the wairua of the institution or service and developing the whakapapa (cultural identity) of the individual (ALAC, 1996:15-17).

The Methodology of Diagnosis

Methodology employed in the diagnosis of coexisting disorders is variable. Weiss, Mirren and Griffin (1992) in a review of fourteen studies found the differences in the timing and nature of the interview, and abstinence criteria at the time of interview, affected the diagnosis that the patient ultimately received.

Prevalence

Prevalence in medical terms is the total number of cases of a specific disease in existence in a given population at any one time. Prevalence figures for coexisting disorders have been derived in two ways.

Firstly populations of substance abusing patients at an addiction, treatment and research center have been studied for evidence of additional psychiatric diagnosis. Ross, Glaser and Germanson (1988) found levels of comorbidity to be high, with seventy eight percent of her study experiencing a life time psychiatric disorder in addition to substance use, and sixty five percent with a current mental disorder. Kranzler et al. (1998:107) in a review of three 'large sample' American studies on prevalence of comorbid disorders and alcoholism, acknowledged the relationship to be complex, making estimates of prevalence difficult. In the ECA (Epidemiologic Catchment Area Study) mood disorders were found to be present in 13.4% of individuals with alcohol abuse or dependence. Conversely, 21.8% with a lifetime mood disorder also had a lifetime alcohol-use disorder (Kranzler et al., 1998:110). In summary, they also found considerable sex differences, with women being four times more likely than men to receive a diagnosis of mood disorder. There was also a sex differential with respect to the order of onset of the diagnosis, with alcoholism being the antecedent diagnosis in seventy eight percent of men with comorbidity, while in women major depression was the antecedent diagnosis. Onken et al. (1997:1) argue that "drug use disorders are frequently associated with mental disorders". They also cited the ECA study to show that "over half (53%) of individuals who have a lifetime diagnosis of a drug use disorder also have a lifetime diagnosis of a mental disorder".

In a local study, Pearce and Mellsoop (1987), reported the high figures of additional psychiatric disorders in ninety five percent of patients with DSM-III-R diagnosis of either alcohol dependence/abuse presenting both to a psychiatric unit and alcohol treatment centre.

Secondly, studies of the psychiatric population (both chronic and acute) also suggest high levels of substance use co-morbidity. Tsuang and Lohr (1994) reviewed the incidence of alcohol use disorder among patients with schizophrenia. Findings in the literature they surveyed are inconsistent, but, in their own study, they found a higher incidence of alcohol misuse (34%) among people living with schizophrenia than for the general population. Smith and Hucker (1994) argued that substance abuse by people living with schizophrenia was usual rather than exceptional. Caton, Shrout, Eagle, Opler and Felix (1994) found concurrent diagnoses of psychiatric disorder and substance abuse in fifty

one of one hundred consecutively admitted young chronic patients; and Barbee et al. (1989) found a life time diagnosis of alcohol abuse related disorder in forty seven percent of their study population. Lehman, Myers, Corty, and Thompson (1994) also found consistently high (55.9%) rates of comorbidity in studies of patients admitted to public mental hospitals, but over half of these did not have a life time history of independent mental disorder. Khalsa, Shaner, Anglin and Wang (1991) recorded the prevalence of 'dual diagnosis' in a psychiatric evaluation unit and found twenty six percent had a psychiatric diagnosis only, thirty four percent had a substance use disorder only, and thirty nine percent had a history of both psychiatric and substance abuse disorder.

Local estimates of prevalence are also sparse. The KADE (Kingseat Alcohol and Drug Education) project in South Auckland was established in response to the clinical perception at Kingseat Psychiatric Hospital that substance abuse played a part in approximately one third of the acute area admissions. Attempts to quantify this have been difficult. A review of discharge summaries from 1989 (n=689) was compromised by an absence of information in half of them. Given this omission, 29.2% of the summaries identified alcohol and drug use as a problem of some kind.

A spot review by Dr A. Samuels in an acute admitting ward at Carrington Psychiatric Hospital (1992) showed that sixty percent of the patients on the ward at that time had diagnosable substance abuse problems. A less formal survey of nine outpatient psychiatric units in Auckland in 1993 (Warren & Wilson, 1994), produced an estimate of anywhere between five percent and eighty percent (mean 20%) of their current clients with an identifiable substance abuse problem. Both alcohol/drug services and mental health services in Auckland admit to offering a service to people with coexisting disorders. Neither routinely asked the question about mental health or substance abuse respectively so estimates of prevalence are at best an educated guess.

Mueser, Yarnold, Levinson, Singh, Bellack, Kee, Morrison and Yadalam (1990) summarise the difficulties with estimating prevalence and point to methodological shortcomings, including lack of diagnostic rigour, adequate sample size and simultaneous assessment of different types of substance. They argue that the prevalence of substance abuse in schizophrenia is comparable to that in the general population.

Summary

Attempts to estimate the prevalence of coexisting disorders both in the general and illness populations have been problematic. Findings are at best

inconsistent, and at worst, unreliable, both here in New Zealand and internationally. Feed back from the 'service provider' participants would indicate that numbers are high in alcohol and drug, and mental health treatment settings. More work remains to be done on every facet of these estimations.



5. Treatment

The literature that comes under the heading 'treatment' falls broadly into three categories: services that provide treatment (service provision), sub-populations of people being treated (sub-populations) and treatment approaches. Each of the three will be considered separately below.

Service Provision

Problems with Parallel and Sequential Approaches to Treatment

By the late 1980s, it had become increasingly clear that "the traditional approach of treating dually diagnosed clients through separate mental health and substance abuse service systems was inadequate for persons with severe psychiatric disorders" (Mueser, et al., 1997:86). Interest for this thesis topic was generated by the difficulties experienced in providing psychiatric care for people with coexisting disorders from a substance abuse treatment centre. A wide range of problems occur "with the parallel and sequential approach to treating comorbid and psychiatric and substance use disorders (Drake et al., 1991; Polcin, 1992; Ridgely Goldman & Willenbring, 1990). According to our own New Zealand study (Sellman & Eggleston, 1991) finds that "comorbid clients are falling between the cracks of the system" of both mental health and substance abuse services who are "unaware how to combine" treatment of both conditions effectively. Ridgely et al. (1990) argued that "the poor outcome of these clients appears to stem from barriers within the traditional service system in which mental health and substance abuse services have separate and parallel programs [*sic*], staff training, models of treatment and recovery, and funding streams".

Most of the literature outlines substance abuse treatment in a mental health setting. Nigam, Schottenfeld and Kosten (1992) describe the successful use of an "adjunctive group psychotherapy for substance-abusing patients with major psychiatric disorders". This was initiated in an attempt to redress the known poorer outcomes for psychiatric patients when they are also abusing substances. Without a clear understanding of the causative pathology, Walker

(1992b:223) proposes a treatment model based on recognition of the interactive and interdependent nature of the two disorders. Although this was a useful first attempt to link mental illness and substance use/abuse, in a way that led to the consideration of both, this two dimensional understanding has been superseded by Ries High/Low typology (see Chapter One pp. 12-13).

Integrated Service Provision

In light of these poor treatment outcomes for people with coexisting disorders, service providers are “moving toward integrating both substance abuse and mental health treatment into comprehensive programmes” (Drake et al., 1991; Minkoff, 1989).

In a move to integrate treatment services, the Department of Psychiatry at Bellevue Hospital, New York established a substance abuse division (Galanter, 1993). Substance abuse in the psychiatric population had reached ‘epidemic’ proportions and drug use was “often implicated in precipitating acute symptoms and additional hospitalisations” (Galanter, 1993). This was one of the earliest attempts to integrate psychiatric care with peer-led milieu therapy, professional psychiatric techniques, and Twelve Step programmes. Ridgely (1993) describes a ‘hybridized’ approach that implies people will receive treatment for both disorders concomitantly within one setting. It permits titration of specific treatments for each disorder when both are present, and eliminates the burden of prescribing and delivering treatment to clients across multiple agencies and service systems. Regardless of the environment in which it is provided, the goal of treatment needs to be the recognition and control of problematic behaviour, the education of patients about their illness and the necessity of taking responsibility for its management. Finally there must be provision of opportunities for positive community activities and relationships to foster stability and recovery (Minkoff, 1989).

Todd et al. (1999:59) assert that the considerable body of literature which has been published on the treatment of patients with coexisting disorders “is comprised mainly of personal opinion, descriptions of models of treatment and descriptions of single site treatment programmes”. They do acknowledge, however, that “there appears to be a consensus emerging in the literature supporting an integrated approach to treatment” (Todd et al., 1999:59). This model has not been “vigorously studied” but it does seem to be supported by “a number of experienced clinicians and seems to work in practice” (Todd et al., 1999:59). According to Mueser et al.. (1997:91) the common ingredients of integrated mental health and substance abuse treatment programmes are:

...the same professionals provid[ing] mental health and substance abuse treatment, case management, assertive outreach, group interventions, education about substance abuse and mental illness, and motivational techniques, behavioural strategies, family/social network factors, stage-wise treatment [and taking a] long-term perspective.

From Case Management to Care Management

Within services in Britain there has been a change away from 'case management' to 'care management' that has shifted the emphasis of service delivery away from the 'case' or person, to the 'care' that was to be managed (Coulshed & Orme, 1998). This was an attempt to make care across a range of services seamless for the consumer and their significant others. To assess the effectiveness of the 'managed care' approach, Leon, Lyons, and Christopher (1998) compared patterns of psychiatric hospitalisation utilisation between people with and without coexisting disorders. They found that, although the patients with coexisting disorders spent fewer days in hospital, they were re-hospitalised at a higher rate than the control group. The authors (Leon, Lyons & Christopher, 1998) concluded that the 'revolving-door' utilisation of hospital facilities is also present in managed care environments. However, Minkoff and Regner (1999) found that the managed-care approach was successful in helping the patients maintain sobriety, with nearly fifty percent still sober at the ninety five-day follow up.

Sub-populations

Internationally, research on and treatment for 'sub-populations' of people with coexisting disorders is becoming more prevalent.

(a) The Homeless

Studies of the homeless in New York City (Caton, Shrouf, Eagle, Opler & Felix, 1994) explored the illness course and life experiences of the 'post-institutional generation' of patients suffering from severe mental illness. They found unusually high rates (60%) of alcohol and drug abuse. In a study of 'meal-line' populations (Kahn, Hannah, Kirkland, Lesnik, Clemens & Chatel, 1992), most of whom were homeless, researchers found alcohol and drug use were reported by ninety three percent of the subjects, severe mental illness was found in fifty four percent and coexisting disorders in twenty nine percent.

(b) War veterans

Similar results were obtained from a study of war veterans from the Veteran's Affairs Medical Centre in Northport, New York. Kovaszny (1991) found that about sixty percent of that population had coexisting mental illness and substance abuse disorders.

No research has been done locally on sub-populations of the homeless or veterans, but there is no good evidence to predict that the results would be different here.

Pregnant Women

Alcohol is a known teratogen (an agent that causes physical defects in the developing embryo). There is a growing awareness and literature about the effects of a pregnant mother's alcohol and drug use on the unborn child (Curtis, 1994). The La Leche League (1997) has also expressed concern about the effects of alcohol on the babies of breast feeding mothers. Similarly, mental illness has been the focus of study, both in the way it affects the mother (Coverdale, McCulloch, Chervenak, Bayer & Weeks, 1997), and the unborn child (Seeman, 1996). Particular concern has been expressed about the use of drug therapy in the mentally ill mother during pregnancy and lactation (Abou-Saleh, 1996; Althuser, Cohen, Szuba, Burt, Gitlin & Mintz, 1996). The focus is on the dilemma posed by the need of the mother for psychotropic medication and the risks to the baby from teratogenic effects. Current recommendations are that "psychotropic medications should be used during pregnancy when the potential risk to the fetus [sic] from exposure is outweighed by the risk of untreated maternal psychiatric disorder" (Althuser et al., 1996:601). Having said this, the authors acknowledge little is known about the potential for long-term behavioural abnormalities in the children of mothers exposed to psychotropics, and that long-term, follow-up studies are required.

While much of the focus has been on the teratogenic effects of alcohol and certain drugs on the unborn child, other literature concentrates on the needs of the mother. Severe mental illness can profoundly affect an individual's ability to parent. Jacobsen, Miller and Kirkwood (1997) outline the components of a comprehensive parenting programme for this group, and, whilst they do not focus specifically on those people with coexisting disorders, they do acknowledge that "active addiction" is a risk for abuse, neglect and child mistreatment. Grella (1996:319) acknowledges that "few programmes are designed specifically to meet the needs of women who are pregnant or parenting and who have co-occurring alcoholism and other drug dependencies

and mental illness". They face the same difficulties as other consumers with treatment systems that are organised separately and often use opposing treatment approaches. In addition, Grella (1996:338) argues that the:

...specialised nature of their needs, relating to pregnancy, labour and delivery, postpartum adjustment, and child care have traditionally been overlooked by both mental health and addiction treatment providers who are not versed in these issues.

Treatment Approaches

There are a number of treatment approaches to coexisting disorders. Although operating from a medical paradigm of understanding, the literature surveyed did not focus on the pharmacological intervention necessary for the management of the 'acute' phase of the illness. It did however, cover 'treatment modalities' in a range of settings from inpatient treatment units to community outpatient facilities. None of the 'treatments' is a 'cure', and the literature concentrates on the psycho-social aspects of intervention that allow the 'patients' to better manage their lives with coexisting disorders. There are a plethora of intervention strategies. Outlined here are the key approaches.

Transtheoretical Model of Change

This is a model developed by two psychologists Prochaska and Di Clemente (1984) for use by people trying to stop smoking. It describes a series of changes through which people pass in the course of changing a problem. It works on the principle of motivation as a 'state of readiness' and gives the clinician a number of strategies with which to assess and assist the change process. This successful approach was extended to include intervention with all addictions (Miller & Rollnick, 1991) and further refined as a tool for allowing clinicians to be more specific in their intervention strategies with mentally ill substance abusers (McDuff, Muneses & Todd, 1998; Velasquez, Carbonari & DiClemente, 1999). This approach constructs stages and processes of change in relation to both disorders (mental illness and substance abuse) acknowledging these may be different at different times for each.

Assertive Community Treatment

The assertive community treatment model, rather than being a technique, is based on the persistence of clinicians to engage their clients, the trust that clients develop in their clinicians, and the extent to which the clinicians become 'guides' to the world of psychiatric and social services in a way that facilitates

clients to 'community adjustment' (Chinman, Allende, Bailey, Maust & Davidson, 1999).

The Twelve Step Self-Help Model

The role of Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and other drug related Twelve Step groups as a therapeutic intervention for people with coexisting disorders has been contentious. It is an abstinence-based approach that struggles to come to terms with the necessity of people with coexisting disorders to continue to take medication. Health professionals have shown a reluctance to refer people with coexisting disorders to AA because of fears that the AA group will discourage them from taking prescribed medication (Meissen, Powell, Wituk, Girrens & Artega, 1999). The authors (Meissen et al. 1999) attempt to assess, in a scientific way, the attitudes of AA contact persons to the participation of people who are dually diagnosed with substance abuse and mental health disorders. Although the majority of respondents (93%) thought that these people should continue to take their medication, more than half (54%) felt it would be better if they participated in a group especially designed for persons with a dual diagnosis, even though they acknowledged that such groups were often not available (Meissen et al., 1999). Fortunately, the Hazelden Centre (an addiction research and treatment facility based on the twelve steps of AA) has been willing to develop programmes that embrace people with coexisting disorders based on the Twelve Steps, psychotherapy and prescribed medication (Hazelden Foundation, 1993). They have developed a prescriptive programme for people with coexisting disorders based on the Twelve Step approach, but make modifications that allow participants to continue with their medication. Humphreys, Huebsch, Finney and Moos (1999) evaluated the positive outcomes for the client when a Twelve Step self-help approach was combined with professional treatment services and found that each enhanced the effectiveness of the other.

Psycho-Education

Psycho-education is an approach that has evolved out of the psychiatric treatment setting and involves the teaching of the patient (and family) about mental illness and the coping skills that will help with successful community living. Ahrens (1998) examined the success of this model in an acute psychiatric setting and advocated its application to the outpatient setting for people with coexisting disorders. Its 'strength-building' approach allowed the patients to construct a meaningful path of recovery for themselves from the multiplicity of treatment approaches that were available.

Therapeutic Communities

A therapeutic community is an inpatient environment that is described as a 'community' with its own cultural norms for behaviour, values and activity. It is a controlled environment where patients can safely experiment with new skills, behaviours and ways of relating. Mierlak, Galatner, Spivak, Dermatis-Jurewicz and De Leon (1998) studied a modified therapeutic community and found those that completed a six month stay were more likely to have less inpatient psychiatric hospitalisations and more success in finding work. It is a similar model to that which Odyssey House in New Zealand runs for people with coexisting disorders.

Maori Models of Health

Although a number of 'Maori' approaches to health have been applied to people with coexisting disorders, none has been specifically developed for them. Todd, Sellman and Robertson (1999:90) note that:

...main stream conceptual frameworks are not incompatible and in fact may be very congruent with those used by many Maori, but flexibility of application is required for their successful integration with culturally-based approaches.

Prominent Maori academic and psychiatrist Mason Durie (1994) invites mainstream health services to examine their structural arrangements on a continuum of bicultural goals from unmodified mainstream to independent Maori institutions in their search for a better outcome for Maori. Durie (1994) also proposes a number of Maori health perspectives, in particular Te Whare Tapa Wha. This compares health:

...to the four walls of a house, all four being necessary to ensure strength and symmetry, through each representing a different dimension: taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), [and] taha whanau (family).

This approach has successfully been combined with trans-theoretical models of change in treatment settings for the dually diagnosed in both Auckland and Northland.

Prognosis

Alcohol and drug use disorders in severely mentally ill individuals tend to persist over many years (Bartels, Drake & Wallach 1995). Two factors contributing significantly to 'chronicity' and revolving door admissions to

psychiatric hospitals, are alcohol/drug problems and medication non-compliance (Hayward et al., 1995). Muser et al. (1997:86) argued that less than 5% of clients receiving treatment from traditional mental health systems became abstinent each year, indicating a very slow rate of recovery. This is a significant issue, and one that will be returned to in the discussion of the findings of this thesis. Minkoff (1996) argues that abstinence is so important to the recovery of people with coexisting disorders that it is worth taking time to get there. However, in most mental health settings, failure to achieve abstinence quickly is seen as a treatment failure.

Policy

It has been said that the mark of a civilized society is the way it cares for people who are disabled or dependent - what is conventionally known as 'social policy' (Shannon, 1991:2).

Policy covering care for people with coexisting disorders is embedded in broader health policy. There are a number of policies which inform and guide service provision and principles and best practice within it. The most specific is the *Assessment and Management of People with Co-existing Substance Use and Mental Health Disorder*. This was developed to be read in conjunction with the *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* and the *National Alcohol Strategy for New Zealand: Minimising the Harm 1999-2003*. Equally important is *Te Tiriti o Waitangi (The Treaty of Waitangi)* which forms the basis of all health policy documents in Aotearoa New Zealand, and the *Maori Health Policy* which has been developed out of it.

Summary

Each way of analysing and understanding coexisting disorders brings with it its own approach to treatment. None is mutually exclusive and aspects of several treatment modalities are usually combined to offer a consumer the most effective support within the confines of the medical model paradigm. This also applies to Maori models of health which have been integrated into mainstream treatment services and used to inform clinical practice.

Conclusion

This chapter (The Field) represents that part of the thesis that would traditionally be called the literature review. Because coexisting disorders draws on the knowledge and literature of both mental health and addictions, 'The Field' is necessarily expansive. Whilst it is not possible, within the confines of a thesis to explore the issues in any great detail, it is important for

the reader to get a 'feel' for the topic area. The material that is presented and discussed in this review, is, in the main, based on a tacit acceptance of the medical model. It is by no means exhaustive but does represent the principal bodies of literature on coexisting disorders. It covers five key areas of concern: 1. Mental illness and addiction are located within the 'medical' paradigm, and a brief history of mental illness and alcohol and drug use in the New Zealand context is outlined. 2. Co-existing disorders are simultaneously analysed as an entity and distinct disorders with unique permutations depending on the nature of the mental illness and the substance(s) used. 3. Alternative analyses of both mental health and addiction are provided by a cultural construct, sociological perspectives and psychological models. 4. This is followed by a matrix of key concerns including diagnosis and prevalence. 5. Finally, treatment strategies, service provision and policy making conclude the chapter and attend to the last of the key bodies of literature on coexisting disorders. This chapter provides a background to the thesis, locates the work in a credible field of study and creates a setting against which the literature arising out of the data will be pursued. The grounded theory approach does not presume the outcome of this thesis will fit comfortably into the existing literature. For this reason, the literature arising out of the data and discussion is dealt with separately.

THE RESULTS CHAPTERS

This introduction has been written 'after the fact'. The interviews have been transcribed, the data coded line by line, theoretical codes and categories developed, and what I present here would, in a more traditional thesis, be called the 'results'. In this grounded piece of work, 'the results' are slices of data, taken directly from the participant interviews. The data has been coded and analysed to a point of theoretical abstraction in order to elicit the main concerns of people living and working with coexisting mental health and substance dependence disorders. Each of the five chapters represents a theoretical code that emerged out of the data. Each code is developed using the building blocks of conceptual categories. When combined in an analytical sense these theoretical codes and their conceptual categories serve to construct a picture of the basic core category, *discovering a life*. For ease of recognition, the basic core category and the key theoretical concepts will be written in *italics* and **bolded**. The lower order conceptual categories will be *italicised* alone.

When asked to talk about living with coexisting disorders, I had expected participants to recount their present circumstances and strategies for living. However, they all began with the events leading up to and surrounding the crisis that eventually brought them to the place they are in today. It seemed to be important to their process of '*discovering a life*' to look forward from the past. Not to re-live the past or wallow in it, but as a reminder of where they have come from, the mistakes made and the lessons learned. This also fits with a paradigm shift (that has predominated their thinking about mental illness and substance abuse) from 'dis-eases' to be treated, ameliorated, cured and expunged to aspects of human 'being' that need to be integrated, nurtured and '*discovered*' as part of everyday life.

Whilst a linear trajectory of the relationship between substance use and mental illness and the participants' lives is being presented, this is somewhat of a stratagem created for theoretical clarity. For the consumers, the sequence of events and relationships between them is much more confused. In the telling, they vacillated between time, space and intensity of experience and there was not necessarily a discrete beginning and end. It was more an existential morass that required an artifice of boundary in order for a reader to make sense of it. I

have divided the trajectory of *discovering a life* into five distinct theoretical codes that each describe and theorise about an aspect of this *discovery*. Many of the participants used 'battle' language to convey the progress of their lives, so I have picked up on this theme in the naming of the chapters and the metaphors I use to elaborate data. One of the participants in particular used the metaphor of armour to denote protection and vulnerability. I have taken poetic license with this martial theme and applied aspects of the story of the Roman God Janus to the data on service provision.

Intemperate Insanity was the point at which the participants began their 'story' and covers the period of life where they were actively engaged with their mental illness and substance dependence. The outcomes of these relationships with their illness processes dominated life and living with both positive and negative consequences from the participants' point of view.

It is in this next chapter that one of the participants introduces the idea of her protective armour first cracking then falling off, leaving her unprotected and vulnerable, hence *Naked in Woolworths*. She used these metaphors to convey the inevitable crisis that arose out of her *intemperately insane*, unrestrained substance abuse and mental illness.

The end point of the crisis, for all the participants, was intervention by an outside force, most often a family member, which resulted in engagement with a 'treatment' service. This began a process of *Shedding the Armour* or *recovery*, from mental illness and substance abuse.

Recovery, convalescence and restoration commenced with treatment following *the crisis*, and dominated this next phase of *discovering a life*. Although there was no timeframe for the period it took to *shed the armour*, it was generally agreed amongst the participants that it spanned up to two years.

It was also at this point that staff from the treatment services became involved in the participants' lives, but they conceptualised the *recovery* period so differently that I have dealt with their data in a separate chapter *Janus' Temple*.

Living without the armour is the final step in *discovering a life* and is a present-continuing state of being. It conveys the picture of a life in which the changes made during the *recovery* period have been *maintained* and the adventure of *discovery* embraced.

Discovery was the configuration of life events and ways of being that replaced the *intemperate insanity* of previous years for all my participants. It was a

sustainable, life-enhancing way of living that increased the likelihood of continued sobriety and mental well-being and decreased the likelihood of relapse into *intemperate insanity* and further admissions to an institution.

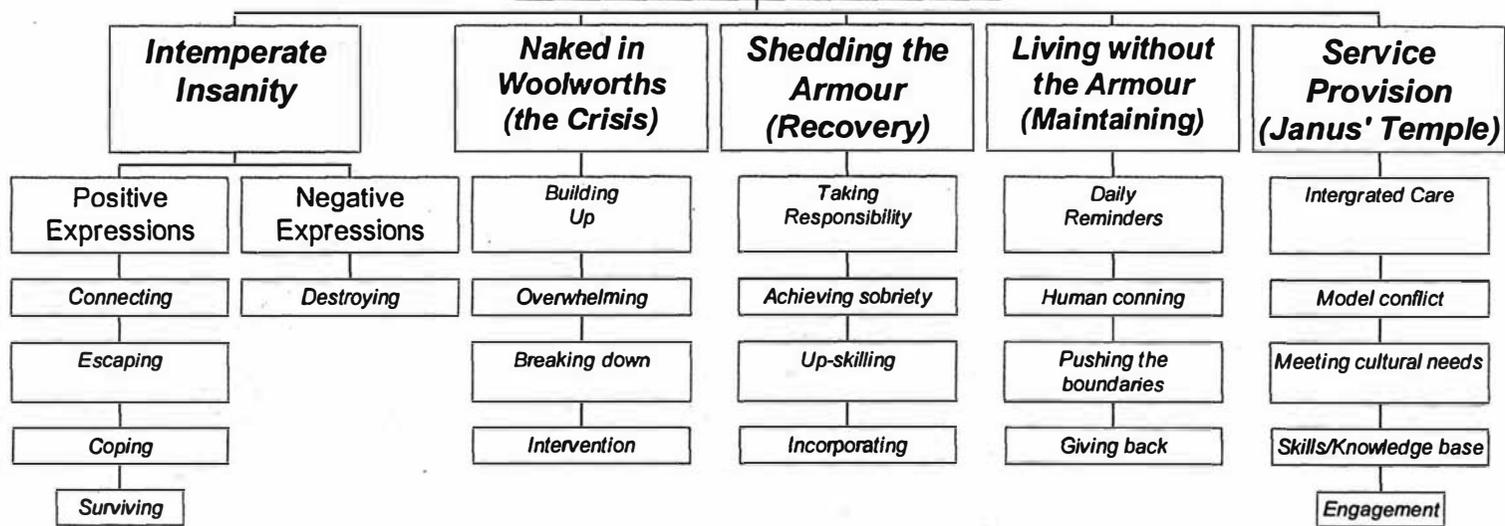
The next five chapters separate these theoretical codes of *discovering a life* (*intemperate insanity, being naked in Woolworths, shedding the armour, Janus' Temple and living without the armour*) and examines the elements that go to make up each. Connections will be made between one code and the next, so a picture is generated for the reader of a trajectory of life beginning with mental illness and substance dependence (and all the insecurities that go with these coexisting disorders) to a life that is lived well with all its rich diversity.

An analysis of the matrix, *discovering a life*, will be picked up in the **Discussion**.

A 'data map', on page one hundred and one, provides a visual orientation to the concepts that comprise *discovering a life*.

Data Map

Discovering a Life



CHAPTER SIX: INTEMPERATE INSANITY

I am doing it
the it I am doing is
the I that is doing it
the I that is doing it is
the it I am doing
it is doing the I that am doing it
I am being done by the it I am doing
it is doing it

R.D. Laing *Knots* (1970)

Introduction

Discovering a life is a continuous, cyclical process whereas the causal-consequence model, used as the basis for this thesis, although described as a process, implies a beginning and an end. Although a 'life' has a beginning and an end, it is the bit in the middle that I am researching. Not a chronological 'bit in the middle' but the 'bit' in those people's lives that have been impacted by substance use/abuse and mental illness. Therefore, *intemperate insanity* presents an unnatural starting point arising out of the data ie. it is where the participants started their stories in order to make a distinction between the 'then' and the 'now', to demonstrate a trajectory of 'progress', and provide a point of reference for *discovering a life*.

This title *intemperate insanity* replaces an earlier appellation 'the drinking years' which was too limiting in scope and unable to fully describe and theorise about the chaos of mental illness and substance dependence. The rationale for creating this theoretical code, *intemperate insanity*, has come out of the data provided by 'consumers' and families.

Categories include positive and negative examples and consequences of mental illness and substance use/abuse, and fit together to create a theoretical picture of *intemperate insanity*.

The epoch of *intemperate insanity* was dominated by episodes of mental illness and substance abuse. The onset and timeframe varied from participant to participant, but for most, it had its genesis in the teenage years. Both the abuse of mood/mind altering substances and mental illness were simultaneously seen as the 'problem' and the solution. Respite from the worst excesses of either the symptoms of mental illness or the consequences of substance abuse came with enforced abstinence during periods of hospitalisation and medication of the symptoms of mental illness. Whilst this provided some form of temporary relief, the solutions created their own set of problems and both 'illnesses' lay as a spectre waiting to re-manifest at the most inopportune times. *Intemperate insanity* was not always a negative experience for the participants. For many, it served a useful function in their lives that allowed them to maintain equilibrium under difficult circumstances.



Participant Data - Positive Expressions of *Intemperate Insanity*

The positive expressions of *intemperate insanity* include *connecting*, *escaping*, *coping* and *surviving*.

Connecting

Connecting occurred on a number of levels. *Social connectedness* was a universal experience, as participants organised their social lives around drugs and/or alcohol. For some, it marked the end of the working day by socialising with the 'mates' they worked with. There was a *routine (social connectedness)* of people they saw regularly, and relationships were often superficial and transitory. Ian remembered:

When I started a new business...very early on I got into the routine of having a few drinks after work. We used to have a few drinks and a few laughs...it was a way of keeping the blokes together on a [building] project.

As a young woman, Gina "went out with a guy who drank and I drank with him...we went to parties and we'd have good fun". Alcohol was a *routine* part of their social fabric and "when the relationship finished, the booze finished too".

Many years later, as a married woman, Gina joined her husband on *routine* drinking occasions that were part of an evening's entertainment. For them, this

was a way of making *social connections* that enhanced his business opportunities:

As my husband got a little bit more successful in his industry there was more going out for dinners and things like that. We entertained clients or potential clients and there was always a lot of alcohol. It was an important part of the way we did business.

Alcohol and the *social connectedness* that went with it was seen as a way of "inject[ing] a bit of excitement into the system" for people who saw their lives as otherwise lacking vitality. Alcohol was also seen as a way of making the participants feel they were more interesting as people, thereby enhancing the quality and quantity of *social connectedness*. They developed the perception that their desirability as social companions was increased. This was not always supported in reality and will be discussed under the negative consequence *alienating*.

Drugs also provided a vehicle for *social connectedness* - especially for the young. Henry started smoking marijuana at age fourteen with his mates. This peer group affiliation or *social connectedness*, around the acquiring and taking of drugs and alcohol was an important ritual in the transition from adolescence to adulthood (Wyllie & Casswell, 1991).

Ian also "used to smoke a lot of dope when I was young", but found the rewards of *social connectedness* with his peer group were soon outweighed by the unpredictable response of his body to the drug:

It [marijuana] would send you high and you never knew when you'd come down...use dope to get high and have a good time with your mates and you'd expect to be fairly normal the following day. Well, I could be smoking pot and then a week later I'm still out of it.

In addition to the *routine, social connection* was seen as a means of *celebration*. Ian recalls the "roof shout" as a way of *celebrating* the phase in a building project when the roof is completed. As the contractor, he would "put on a few beers" for his staff and provide 'takeaways' that would be eaten on site, as a way of *celebrating* the completion of this stage of the project.

Teresa recalls the celebration that went with her fiftieth birthday:

My friends from way back took me out for my birthday and I was the life and soul of the party...you know...drink, drink, drink.

This was followed soon after by further *celebrations* when she travelled to see her daughter overseas. The leaving party extended into the flight where "they served whatever I wanted...it was a wonderful airline".

A *spiritual connectedness* was experienced by those who took mood/mind altering drugs (especially marijuana and LSD). Henry described intense images and voices of family members, neighbours and acquaintances connecting with him "spiritually":

It was more prevalent when I was smoking marijuana...it used to bring it on really intense and the voices would take on the images of like my family members or my neighbours or people that I knew...I thought that was life...I thought people could talk spiritually through that sort of thing without having to actually be there or actually physically talking to me...I thought that's the way life was...you know the spirituality side of life.

Spiritual connection in this context was intangible and Henry thought voice hearing and visions was the way his *spiritual connection* with other people manifested. Although this experience was explicable in a temporal context (ie. psychosis as part of schizophrenia and use of hallucinogens), he recognised and interpreted it as relating to the soul. He incorporated these occurrences into a belief system of telepathic communication between people in a positive and life-enhancing way.

Escaping

Escaping (distraction or relief from reality) was seen as different from *coping* in that the goal was to 'get away from' rather than 'contend successfully with' their life problems. *Escaping* occurred in two domains; the first is in the physical sense of "getting away from what's going on during the day", for example, a physical removal from the source of the stress and problems in the work setting. This is linked closely to the function of *social connectedness* and both intents might be served by the same outing. For Ian, alcohol allowed him to temporarily *escape* the routine and monotony of long hours of work:

Alcohol became a drug of convenience that would sort of inject a bit of excitement into your life. I would work all day and then at night I would be working out the quotes [for tenders he was hoping to secure] and after a long time you begin to notice the lack of excitement in your life - so the alcohol injected that back in...it's escapism really, just a way to block out what you don't want to face.

The second form was *escaping* in the metaphorical sense of “getting out of it”; altering one’s internal reality. Henry saw it as a positive ‘growth’ experience, giving him entry to realities he might not have otherwise accessed:

The drugs, LSD, speed, ecstasy and all that sort of opened my mind to things I wasn’t aware of...that sort of opened the doorway [to life] all the more.

For a few hours, Ian would alter his state of consciousness with “anything that would knock me out...that would just put a wall between me and reality”.

For Norman the ‘wall’ between him and reality was more permanent as the drugs he was prescribed for his anxiety and depression kicked in:

This anaesthetic that took ten years to put me out. It was like no other, my mind was numbed. Auto-pilot kicked in, the physical apparition was still there.

Coping

Coping (to contend successfully with; deal competently with situation or problem) was another positive dimension of *intemperance*. Alcohol and drug consumption was a strategy for coping with personal pain. After a lifetime of depression and anxiety, Norman finally sought help from his doctor in the form of prescribed drugs. He recalls in verse form:

When I go back the pain is immense. The feelings of hurt that I feel are intense. This shy little boy grew to be an even more shy and insecure teenager. Everything hurt, rejection the most, even when not there. Twenty years ago I cried out for help. The doctor said “take this, it will help”. It did for a while.

Substance use was seen to provide temporary support for changes in the workplace, dealing with success and failure in business, the death of a family member, the break-up of a marriage and bankruptcy.

Gina was an integral part of her husband’s business and during the period it was expanding and growing “found alcohol [was] an easy means of coping with change”.

But more often than not, drugs and alcohol were used to cope with painful life events. Verity, Gina and Teresa used alcohol and drugs to *cope* with the death of an immediate family member. Teresa remembers the events surrounding the death of her father:

...and then out of the blue my father died..I was full of resentment because of the way things were handled [by the family]...I coped by drinking...my daughter was horrified because she caught me drinking in the morning..liqueurs... but it helped me manage.

Verity's mother and father died suddenly, within two days of one another, at a time when there were a number of other stressors in her life:

There was no therapy, no grief or anything, so my son gave me my first blast of heroin. It helped me handle life.

Gina's sister died unexpectedly at age forty. Gina felt very conflicted in her relationship with her sister, and drinking was a way of *coping* with her inner turmoil:

We [my sister and I] had been...not close, we had been close geographically, we had been close as far as talking to one another you know regularly. But I didn't actually like my sister very much and so it was a huge...drink after she died.

Drinking allowed Gina to go on *coping*, not only with the inner turmoil of her life but also the external realities of her existence:

The next year my husband and I split up and the business was a mess financially...it was just one fairly major stress thing after another. But strangely enough, in that immediate period I coped. You know, I sold the house, the business, got separation, buried my sister...I did all this stuff.

Surviving

Surviving (continuing to live or exist) strategies allowed the participants to go on living even when life seemed despairing. Drugs and alcohol no longer served as *coping* mechanisms. They described *surviving* as a primordial drive that kept them going when circumstances were so overwhelming that rational and intellectual thought was not possible. At this point, they were not actively suicidal (ie. they did not have a plan or the means to kill themselves) but they felt they had nothing to live for. *Surviving* allowed them to carry out the basic functions of daily living (eating, sleeping, maintaining a shelter over their heads) even if these were somewhat erratic in frequency and quality.

After successfully *coping* with the death of her sister, the break up of her marriage and the collapse of the business she ran with her husband, Gina found that alcohol, although not a useful long term solution, allowed her to go on *surviving*:

I did all this stuff [that allowed her to cope] but it was really three years later it all caught up with me. It was another crisis [that involved the death of a client] and I was there when he died and did a bit of the cleaning up and after went to his parents with the police and did all sorts of stuff...and he was the same age as my son...From there on in it was just give me another drink. I don't want to know, just leave me alone.

Graeme recalls going into survival mode after the break-up of a relationship:

I'd gone through a relationship break-up, quite a traumatic one. It was really messy and I was really depressed and I hit the booze to help get through it. I ran around all day in a dressing gown - I couldn't work, I was just really tired and I was being late for work and then my boss rang me on the Saturday and said take a few days to cool off and give me a ring but don't hold your breath. So I started drinking in a big way...sticking your head in the sand but in this case sticking your head in a bottle and it will all go away.

When it did not go away, in a moment of despair, Graeme contemplated suicide:

All I was seeing was this brick wall and I couldn't see my way around it. I can't even see into next week. Just like the days run into each other like you wake up in the morning and you think oh! another day, a day like the one before and the one before that. I thought this is it now you know. I'm not even forty two and my life's over. I actually know a couple of people who've done it and you see the grief and everyone else is left to clean up the mess.

Although the alcohol compounded the depression and complicated his life, it also enabled him to *survive* these bleak moments.

Ultimately, *survival* was a process not a state. It allowed people to live through seemingly unlivable times. *Intemperate insanity* is not a terminal illness and there came a point in all the participants' lives where their circumstances improved sufficiently for them to be able to see a way forward.

Summary

In summary, *connecting*, *escaping*, *coping* and *surviving* were all seen by the participants as positive attributes of substance use. With the exception of Henry, mental illness did not provide the same positive experience. Through their substance use, they were able to *connect socially* and *spiritually* with other people. It gave them a point of contact (from their perspective). Drugs and

alcohol were also seen as a *coping* strategy that allowed the participants to go on living their lives during periods of stress and change. Substance use allowed them to face up to and 'deal with' or respond to the problems created by every day living. It was not seen as the solution exclusively, but it was an important part of the overall response to the problem.

Escaping was different from *coping* in that it allowed the participant to get away from life and its problems. This was achieved literally by physical removal from the site of stress (eg. work) to be with friends in a congenial social setting lubricated by alcohol or drugs. For others the *escape* was a metaphorical one, by drinking/drug-taking to oblivion they changed their relation to reality. *Social connectedness* was also a form of *escaping*, but the participants did not put this emphasis on it.

Finally alcohol and/or drugs allowed people to *survive* at points in their lives when all *coping* strategies were exhausted and death seemed a realistic option. All the consumer participants had considered suicide at some point in their lives and most had made more than one attempt.



Participant Data - Negative Expressions of *Intemperate Insanity*

Introduction

Although *connecting*, *escaping*, *coping* and *surviving* were not always life-enhancing strategies, they did allow the participants to go on living and to have some positive experiences in what was otherwise a life of pessimism and despondency.

The negative aspects of *intemperate insanity* were experienced as *alienating* and *destroying*.

Alienating (estranging, turning away from) occurred in two domains - *alienation* from *self* and *alienation* from *others*. Participants had the most awareness and the most to say about *alienation* from *others*. *Alienation* was accomplished through *harassing*, *terrifying* and *withdrawing*.

What started out for some as trying to establish human connection resulted in a *harassment* (trouble or worry) that *alienated* others the most. The very way they went about trying to bring people into their lives at best estranged them and at worst actively antagonised them. In seeking support from her friends

during troubled times, one participant, Anthea, reflected rather sadly that "you can't make someone love you...they [friends] keep putting me off when I ring them up at night, upset...[they] tell me to ring the PDN's [Psychiatric District Nurses] in the morning". When she was well, she lived a rather solitary, self-sufficient existence, voluntarily excluding people from her life. However, when her mental health was compromised, and her illicit drug taking got out of control, she had a tendency to ring her friends up in the middle of the night and want to talk. They found these 2.00am. phone calls inappropriate and unacceptable and rather than interpret them as seeking help or support, saw the unrelenting disruption to their sleep as *harassment*. Rather than complicate her life further by confronting her annoying behaviour they would try to persuade her to have contact with her local Community Mental Health Unit instead.

Ian managed to *alienate* all his friends family and work mates by *terrifying* them with his outbursts of rage. His moods were the hardest to manage when he had forgotten to take his psychotropic medication or when he was drunk. What started out as a quiet 'after work' drink with his mates would turn into a *terrifying* experience for all concerned:

I'm pretty calm most of the time, but if somebody gets me agitated it's going from calm to being absolutely...um and I feel it coming on...I mean I'll be in control of the situation and next thing you feel you're starting to tremble and you feel the anger building up and you're totally out of control, and ah...terrifying people...just shouting at them...and it's not normal, what I consider myself to be normal.

In fact, it was the social isolation generated by these outbursts of temper that finally motivated Ian to seek professional help. His friends, family and workmates refused to be around him because of his unpredictability. One of his workmates finally plucked up the courage to tell him the reason why no one would drink with him any more - they were all *terrified* of him and afraid of what he might do in an uncontrollable rage.

Other participants *alienated* themselves from people in a less violent way, by *withdrawing* from social life. Gina compounded fits of depression with bouts of uncontrollable drinking. During these phases she would lock herself in her room for up to seven days at a time:

I was drunk for the whole of December and right through to the middle of January...My children were there, but when the door was shut they knew not to disturb me... It was after a seven day binge...I couldn't understand why people were

complaining because I wasn't hurting them...how could they [the children] be so selfish, I'd spent years raising them and now when I want a little time to myself to live my life which consisted of a crappy little bedroom and a cask of bloody wine...

Graeme felt that others, at best, did not understand what was happening to him, and, at worst, judged his mental illness when he was unwell. Rather than expose his vulnerability he *withdrew* at the times when he most needed support:

You can feel very isolated and alone if you're around people that don't understand it [mental illness] or don't suffer from it or don't know anybody who has...especially being a man...a lot of men would see it...thinking it's like a weakness rather than an illness and a sort of self indulgent thing...like the man's got to be seen to be strong and he's the one that you lean on not the one that does the leaning.

Destroying

Destroying (breaking down, demolishing, making useless) relationships, jobs health and self-esteem was a distinct and more final act than *alienating*. All the participants had destroyed a primary relationship through their drinking, drug-taking and bouts of mental illness. With the exception of two, who had managed to establish new relationships in their present phase of 'wellness', all the participants were now living on their own. Most were estranged from their families, some for more than twenty years. The *destruction* to social relationships brought about by the mental illness and substance abuse was often irrevocable and far-reaching. Ian still feels bitter that his first wife left him on the advice of doctors, and has only recently had any contact with his teenage daughter:

I split with my daughter's mum after my first major incident in hospital...she couldn't come to terms with the thought of having a partner who was going to have a...major mental illness...my first wife and her family decided that the wife would be better if she made the break early...the doctors managed to get it through to my partner, the fact that it was a terminal problem - never got through to me though.

Teresa told a long and convoluted story of *destruction* that her mental illness and alcohol dependence had on the relationship with her daughters, her siblings and their partners. In the early days of her mental illness, her siblings had sought counsel from a family friend who also happened to be a psychiatric nurse:

They thought I had embezzled some money out of mum. They were ringing her [the nurse friend] on a daily basis and what she advocated was tough love, and so I got lashings of that from my brother and sister-in-law. And it just broke me. I was totally gone. My brothers had a family meeting and this one brother was voted to tell me "we want time out" and they haven't spoken to me since.

Teresa linked this disaffection from her siblings to the time of her mother's death ten years earlier, but it was the alcohol that caused the *destruction* of her relationship with her daughters:

...they were horrified when they found out about my drinking and, when I came back from a trip overseas, the family were waiting for me. They had spoken to the doctor and they had decided to commit me to... [names an alcohol and drug treatment centre] and I was terrified...so like it was all this mishandling on the part of my daughters and my sister-in-law who was quite ferocious.

Five years on and Teresa has managed to repair the relationship with one daughter, but her relationship with the other appears to have been irreparably damaged.

From the perspective of family members, the situation can often be more frightening and just as damaging. A recent summary of research on the consequences of substance abuse in the mentally ill (Drake, et al. 1991:5) indicate there is more "verbal hostility, disruptive behaviour, aggression, poorer management of personal affairs...more severe symptoms, more suicidal behaviour and more treatment non-compliance". Katie talked about the destruction her son's illness and substance dependence caused in the wider family:

Families need support just to sort of get their state of affairs...as to how they want to tackle the situation, what they want to do, how far each member is prepared to go...because we felt we were being torn apart here, because I was trying to understand the illness, the rest of the family were focussing on the behaviour and we ended up being at real cross purposes...because I didn't have the words to express what I was feeling, I found it easier for me to isolate myself.

Katie's family was at the same time chaotic and rigid in response to her son's illness, and whilst she had become enmeshed in his problems, other family members were wanting to disengage. She found this difficult to cope with and

although she remained engaged with her son and his problems, she 'disengaged' from the rest of the family.

Sciacca (1995:15) acknowledges that "a dually diagnosed individual can throw the best of families off balance". Zac felt "when it was really bad" his only response was to leave the family:

It got to the stage where I'd get in the car and I'd look through me [sic] passport and I thought "stuff it"...I did tell my wife how deep it was affecting me and a couple of times it went through my mind "is it worth it" but I've got nowhere to go.

According to Evans and Sullivan (1990:129) "family members can make either a negative contribution toward the maintenance and exacerbation of the client's problems or become a key to the solution". However, some members of the family just want to 'disengage' and get on with their own lives. This was particularly true for Henry's siblings. His brother and sister had stopped bringing their friends home because the behaviour of their ill sibling became so unpredictable:

We just want to get on with our lives...preferably without Henry in the picture...which is sad...but as time goes on, that's the way we see it.

Likewise, Anthea's siblings were supportive for many years, but when it became evident that she wasn't going to return to 'normal' they distanced themselves from her and gradually withdrew from her life; "...they don't even come and see me on my birthday or at Xmas."

All the family members I spoke to were struggling to understand and come to terms with the situation they found themselves in, but with little or no support, their responses were inevitably reactive, self-interested and often extreme.

Summary

The negative elements of *intemperate insanity* were *alienating* and *destroying* significant and potentially supportive relationships. The most significant and potentially damaging were those relationships with family members. Researchers (Evans & Sullivan, 1990; Sciacca, 1995) agree that individuals and families with a dually diagnosed member experience at least twice the problems of those with one disorder, and that this is further complicated by the functionality (or lack of it) of the individual and the family before the advent of the coexisting disorders.

Conclusion

The period of *intemperate insanity*, represented the interval in participants lives that was marked by active chemical dependency and psychiatric disorder. This lasted from weeks to years, depending on individual circumstances. These coexisting disorders were often most active at a time when participants were also experiencing life-cycle events and other disruptions to their lives, such as the transition from adolescence to adulthood, the death of a family member, the failure of a job or break up of a relationship. Participants experienced the consequences of *intemperate insanity* in several ways.

They re-framed them in a positive light, arguing that the substance use allowed them to *connect* with others on a *social* or *spiritual* level that would not have been possible without either. Substance use allowed them to *cope* with the difficulties they were having in their lives, and when they needed respite from their problems, drugs and alcohol provided an *escape*. Finally when the *coping* and *escaping* functions were no longer effective, and the prospect of suicide was a realistic and attractive solution to their problems, substance dependence allowed them to *survive* in the most literal sense.

The negative consequences of *intemperate insanity* invariably outweighed and outlasted the positive experiences. With the passage of time, substance abuse and mental illness, the participants became *alienated* from themselves and others and finally the relationships that had been the most meaningful to them were *destroyed*.

Because as human beings we live in relation to others through communal groups and kinship networks, the *intemperate insanity* inevitably impacted on others, and they quickly became part of the problem or part of the solution. According to Evans and Sullivan (1990:129) "families with a dually diagnosed member experience at least twice the problems of those with a family member with one disorder". Family members were the most affected, and whilst they struggled to support their loved one through this turbulent period, they often did so with little or no knowledge and support of their own. The period of *intemperate insanity* frequently came at a time when family members were struggling with issues of their own. Attempts to manage the problems created by substance abusing, mentally ill parents, siblings or off-spring invariably compounded serious dysfunction and disruption that was already present in the family.

Evans and Sullivan (1990:131), present a model of family response to coexisting disorders that has two axes, one of chaos versus rigidity, and the second of

enmeshment versus disengagement and according to Evans and Sullivan (1990:131):

Unhealthy families tend toward the extremes in their functioning. Chaotic families are unpredictable in their behaviour, with seemingly inconsistent rules governing their interactions. Rigid families, in contrast, respond in overly determined ways and are inflexible in their responses ... Members of disengaged families have little interaction and keep emotional distance [while] ... members of enmeshed families ... interact too intensely and have poor boundaries.

Family members are mainly absent from the literature on coexisting disorders, and generally marginalised in favour of the 'identified patient'. Although this is not a study about family exclusively, families form an important part (either positively or negatively) in the lives of the participants with coexisting disorders.

However favourably the consumer participants saw *intemperate insanity* initially, it was ultimately a destructive and negative experience for them all. Despite the best efforts of themselves and others, it led relentlessly and irrevocably to a *crisis*. The nature and consequences of this *crisis* will be examined in the next chapter *Naked in Woolworths - The Crisis*.

CHAPTER SEVEN: NAKED IN WOOLWORTHS - THE CRISIS

There must be something the matter with him because he would not be acting as he does unless there was, therefore he is acting as he is because there's something the matter with him

R.D. Laing *Knots* (1970)

Introduction

A crisis is often thought of as a single event, a turning point or a key moment. *The crisis*, as a conceptual category, relates closely to Bigus' (1996:17) 'realising experiences'. In his grounded study "Becoming Alcoholic", Bigus (1996:17) identifies 'realising experiences' as moments in which a drinker comes to have a major revelation regarding the implications and/or meaning of his/her drinking behaviour. "At such moments, past behaviours, incidents...are re-evaluated in the light of the present revelation...the past as well as the present comes to acquire new meaning". The function of the 'realising experience', according to Bigus (1996:17), is to facilitate "receptivity to rehabilitation... which in turn leads to drinkers' lives becoming increasingly centred in the rehabilitation milieu". So it is with my participants, that *the crisis* served to bring new meaning and understanding to their mental illness and substance dependence in a way that led them to *discovering a life*.

Crisis also has a broader meaning - critical time or extremity. For my participants their *crisis* was both a key moment and a 'critical time' where life was being lived on the edge. In this chapter, the participants recall crisis events and their responses to them. I have chosen examples from the participant interviews, which are necessarily individual and artificially circumscribed, to illustrate a concept. However, none of these events or circumstances stands alone. They are part of a wider tapestry of life that has a past and a future in addition to the present they are retelling. Many of the occurrences used to

explicate *the crisis* in this chapter, will be expanded and contextualised in subsequent chapters.

The Crisis came inevitably at the end of a long period of *intemperate insanity* in the lives of the participants, that had compromised not only their mental health, but their physical well-being. It was part of a pattern of crises, each a critical event on its own, but compounding in a synergistic way, like some drugs, to exceed the sum of their individual effects. All the participants had contemplated or attempted suicide at least once, as a solution to earlier crises. On this occasion there were a number of single events, that compounded to culminate in a cataclysmic episode, resulting in 'outside' intervention. They could no longer keep their mental illness and substance abuse a secret, either to themselves or others. Under the mounting pressure of repeated *crises*, their *coping* and *surviving* strategies became enfeebled and ultimately ineffectual. Existing treatments and interventions failed, and they were truly at a crossroads in their lives.

For all the participants there was a period of *building up* to the crisis, where life events intensified. These events became *overwhelming* as existing coping mechanisms failed. There was a period of *breaking down* that represented a disintegration of the body, mind and spirit, and finally there was an *intervening*, by some external agent.



Participant Data

Building up

Introduction

The *building up* period often comprised a series of events over a period of time. Two mechanisms were significant to the *build up*: the unanticipated outcome of a normal *experimenting* with drugs and alcohol as part of the passage to adulthood and a *triggering* of memories of past traumas by current circumstances. The *experimenting* and *triggering* characteristics of the *build up* were roughly bounded along gender lines. *Experimentation* was part of the male experience (regardless of the current age of the participants), and *triggering* was an occurrence described mainly by the women.

Experimenting

To experiment with is to 'be empirical, seek experience, feel one's way, proceed by trial and error'. Adolescence is a time of transition to adulthood. Drinking and drug-taking is part of a wider pattern of risk-taking, and young people's experimentation with drugs and alcohol may be perceived as an important step towards the adult world (Wyllie & Casswell, 1991; Pape & Hammer 1996; Alcohol Advisory Council of New Zealand, 1997). However, the very nature of adolescent substance use creates its own set of problems that often distort the developmental process and prevent the transition to 'healthy' adulthood.

Tony, Henry and Ian were young men *experimenting* with drugs and alcohol as part of the transition to adulthood. In each case it coincided with an unknown familial vulnerability to dependent substance use and the onset of a major mental illness. Henry was the youngest of all the participants and had more access to a wider range of drugs than the others:

Back then, in the early stages of my use, everything was pretty normal. I smoked a bit of 'dac', and there was other drugs like LSD, speed, ecstasy and all that...everything was pretty sweet for about four years ... then really through the roof paranoia ... the way I was thinking was totally messed up ... it was a real critical stage.

A subsequent diagnosis of paranoid schizophrenia was confirmed.

Ian was about eighteen when he first started running into trouble. His drug of choice was alcohol, and he was working as a self-employed builder when he had his first manic episode. Stress combined with excessive alcohol consumption and an unknown (to him) family history of bi-polar affective disorder came together in an ill-fated combination that was to impact on the rest of his life:

I was self-employed and that's when the sleeping problems...not sleeping and stress came on...I was swinging backwards and forwards with manic depression...you're predisposed to it, and I wasn't aware that it was running in my family...they were in total denial, and they still are...my mother held this information, and...she didn't want to accept that fact that I was manic depressive and that it had come down through her family.

Tony had a restrictive, religious upbringing where a trans-generational history of alcohol abuse and mental illness was kept carefully hidden. No one in his

immediate family drank or took drugs, and significant relatives were never spoken about. Eager to gratify an adventurous spirit typical of the *experimental* years of adolescence, Tony left school at the age of sixteen, and set out to explore the world. He got no further than Sydney. His first contact with alcohol he describes as “rapturous”. He drank daily and drank to oblivion. He has little recollection of his time in Australia, but he does remember a brother being sent over to bring him home. He has vague memories of experimenting with his sexual orientation, and having unprotected sex with a man he met in a bar. He is covered in scars he has no memory of receiving, and his alcohol and drug consumption continued to serve as a *coping* mechanism long past the *experimentation* of his youth.

Graeme had a history of both mental illness and substance abuse, which began with *experimental*, underage drinking at sixteen years. He left school at age fifteen, and by his sixteenth birthday was drinking in the pub with his father and workmates. This coincided with his first major bout of depression at eighteen, but he “didn’t recognise” the impact his drinking was having on his mental health or the long-term devastation it would cause.

In a context of achieving developmental milestones, *experimentation* is the ‘norm’. It is usual (in New Zealand) for most (69%) young people to experiment with drugs and alcohol from the age of fourteen years. However, most people have moved past this *experimentation* phase by the time they reach their late twenties or early thirties (ALAC, 2001). Unfortunately, for a small group of people this does not happen. They continue to use problematically or (in the case of the consumer participants of this thesis) dependently. It is often only with the benefit of hindsight that a more serious and sinister interpretation can be placed on the consequences of these excesses of youth.

Triggering

Trigger - cause, bring into being, (Concise Oxford Dictionary). For those participants who experienced a *triggering*, each event on its own was sufficient to cause great distress and disruption to the flow of life. However, it wasn’t the event in itself that tipped them over into *crisis*, but a connection with past unresolved trauma brought back to consciousness by the event. A history of child sexual abuse was a common theme. Most felt it had been buried or covered over, but an event in the ‘now’ *triggered* a memory that made it as real as the day it happened. Gina recalls her childhood:

Historically...I was badly abused as a child...and the source of that abuse actually died...it was my father and he passed away.

The death of her father was the *triggering* event that brought back memories of the abuse she thought had been forgotten. The effect was to leave her feeling 'off balance', in a vulnerable state that contributed significantly to the *build up*.

The same woman recalls:

...and I'm coping with that [the death of her father] really well...but my husband was also an abuser...my second child is a result of being raped by my husband so it's not as if this is all new to me...but it was like I had to get to forty five before all the fucking foundation blocks were kicked away and I was literally brought to my knees.

The single event of her father's death had unlocked a flood gate of unresolved issues and hidden feelings, that combined with the current struggles of her daily life to give them new intensity and meaning.

Teresa was also *triggered* by the unexpected death of a controlling, abusive father; "and then my father...out of the blue my father died". It was the death of her father that brought back memories of abuse and the family arguments after his death that threw her back into the middle of her family dysfunction. This event contributed significantly to the *build up*, left her feeling *overwhelmed*, and made the *breakdown* more imminent:

...because at this stage my mother had inherited my father's money and she wasn't too good and she was sort of going into a bit of senility so my brother was handling everything, and I was so resentful of the way things were handled.

Another woman, Verity, was the second youngest child in a large family. She suffered abuse at the hands of both parents and her older siblings. By the time she started school she had been removed from the family home and put into 'welfare'. The abuse continued in various forms until she met and married her husband before she was twenty. This was the beginning of a new life and "memories of my past life became just that - a memory. My new circumstances helped erase that unhappy part of my life". The next sixteen years "were great years", but a cluster of events in her mid thirties, changed Verity's life "so drastically that it was going to be with me for the next ten years". Within the space of a week, she was delivered of a stillborn child in her ninth month of pregnancy and both her parents died. In the face of inconsolable grief and physical ill health, her buried biography of abandonment, neglect and abuse flooded back and "I started creating this fantasy world where I could escape to where nobody and nothing could touch or hurt me ever again".

Summary

The phase of *building up* to *the crisis* is usually marked by one of two precursors. The first is a normal, life stage *experimentation* with drugs and alcohol. However, when other life events and the onset of mental illness coincide with the alcohol and drug abuse that frequently characterises the *experimental* phase, a synergistic response is generated that exceeds the sum of the individual effects of each occurrence. The second precursor is that of *triggering* of old memories by present events. *Triggering*, not only brings back memories, but the feelings of helplessness and hopelessness that were engendered at the time of the original event. This creates a stress response that, as for *experimentation*, often combines with present circumstances to create a consequence that is greater than any repercussion one might experience from a single event. The *build up*, as the phrase implies, usually precedes something bigger, and, for the participants of this study, it fed into the second phase of *the crisis, overwhelming*.

Overwhelming

Introduction

Overwhelming was the second phase in *the crisis*, and occurred when the participants felt submerged, crushed or totally overpowered by their problems. This phase also had two components - *being exposed* for who they 'really were' and *being overpowered* by external events. The key constituent in the *overwhelming* was the fear and reality of being 'found out', of not being able to keep the problems a secret any more.

Being Exposed

Expose (decorticate, uncover, disclose). *Being exposed* was experienced in a number of ways by the participants. They each feared the 'uncovering' of dark secrets and human frailties. Gina had, what she interpreted as an *exposure* event in the supermarket:

My biggest fear was being exposed. It wasn't a physical thing, it was emotional and intellectual thing. It went on for a long time ... I didn't want people to know [about the problems].

She felt she was losing her identity, not just in the present, but also the status and pride that went with being part of her family. She believed she was being exposed for the pretender she felt she was:

I perceived myself naked under this thick leather embossed armour. Big plates...and it was all over me...and what happened was it started to fall off and this big one that was on my shoulder fell onto the floor and I thought when this falls off I'm going to be naked...what I felt that day was I was truly losing my identity, totally losing my protection.

This feeling of being *exposed* escalated rapidly into feeling *overpowered* when the participants felt they could no longer manage their problems or conceal them from the outside world. With the fear of loss of identity and their protective psychological mechanisms, came the fear of being found out. Gina again recalls: "I lived in fear of someone knocking on the door or ... ringing on the phone."

Graeme found it difficult to accept his vulnerabilities as a male and was afraid of being exposed and similarly judged by others:

Big boys don't cry...a lot of males are really immature, emotional retards...it's kind of...yeah, a lot of men would see it [depression] as a weakness, rather than an illness and a sort of self indulgent thing.

Summary

Feeling that their human frailties had been *exposed*, and having a sense of being *overpowered* by ordinary life events, left participants emotionally fragile and vulnerable. This state led inexorably to the third phase of *the crisis, breaking down*.

Breaking down

Breakdown (disordered reason, mental instability, weakness, indisposition)

Although for most participants *the crisis* came at the end of a long period (often years) of *intemperate insanity* and *build up* (over months) there was, in most cases, a single incident that they variously described as a *break down* or a *crash*. They used the words *breakdown* and *crash* interchangeably in the old fashioned, lay sense of failing to cope with the ebb and flow of daily life. This was usually accompanied by, what they recognised in retrospect as 'depression'.

Teresa recalls her response to a prolonged period of drinking, drug-taking, mental ill health and family conflict:

I crashed..I was absolutely shattered like a...like a glass thrown against the wall...my mind was going along at a

hundred miles an hour, repeated thoughts, repeated speech, inappropriateness, grandiose ideas...

For Norman, *the crash* came after he stopped taking drugs and alcohol:

Everything dead for twenty years, now the bandage and bondage removed. All the rot is exposed and mixed up with new feelings. Wake up to pain and it's all in my head. Spinning, buzzing, screaming, how long to endure. With my eyes shut tight. I watched the coloured lights go crazy in the pictures of my mind.

For Gina, the realisation of a *breakdown* came with hindsight:

I was pretty unwell...and in talking to my psychiatrist and psychologist and a lot of people I have spoken to, I think I had a breakdown. You know, what they used to call a nervous breakdown.

It was more difficult to decipher from Gina just what this *breakdown* involved but, going back over her data, it would seem that after a number of stressful life events, she went on a drinking binge, and spent seven days locked in her room not emerging to eat or even use the toilet.

As with Gina and Teresa, Henry's *breakdown* came at the end of a ten-day binge of drug taking:

I was a chronic user...I used to smoke every day...copious amounts too...not just one joint...maybe three or four...and there was other drugs like LSD, speed, ecstasy, and all that. I didn't have any idea how this would end for me...I was so messed up upstairs [pointing to his head] it was like things weren't computing...I thought I can't go on like this...I'm having a breakdown...I thought about killing myself.

Summary

The breakdown marked the point in the participants' lives where they could no longer cope with the exigencies of daily life, and their ability to cover up or conceal their struggle was also lost. By this time their failure to conduct life as 'normal' had come to the attention of those around them, usually a family member, and the stage was set for *intervention* by sources outside the family.

Intervention

Introduction

Intervention (interjacency, stand between, intercede, mediate)

Intervention usually came in the form of coercion by the family or compulsion under an Act of Parliament, but always an agent external to the participant, to accept treatment. In the first instance this was often a family member, as they reached the limits of their own coping with yet another 'drama'. For some the instigator was a parent, and for others a son or daughter. Having initiated an *intervention*, many family members then came up against the barrier that is often encountered by people with coexisting disorders - accessing appropriate treatment. According to Drake et al. (1991) they do not fit into existing treatment systems, are more likely to be treatment non-compliant or receive inadequate treatment for both disorders.

Graeme found difficulty in accessing help for his mental health illness and alcohol and drug dependence. He was referred by his General Practitioner to a mental health centre for the treatment of his depression, "but they wouldn't see me until I got something done about my drinking". The alcohol and drug clinic felt they couldn't "offer me anything because I was so depressed." A compromise was finally reached when he was admitted to a mental health facility and attended alcohol and drug counselling as a day patient.

Conversely, the staff in these centres had difficulty fitting someone with dual mental health and substance dependence disorders into the health provision brief of their service. Victoria works in an alcohol and drug treatment centre:

I saw this guy with schizophrenia, and I did some neuropsych testing on him but how do you prove that the way he's functioning is head injury, mental illness or the fact that he's drinking a lot.

The same counsellor felt compelled to offer *intervention* to another client who had been "pushed about from one service to the next" because she didn't "actually want to perpetuate that ping pong effect." She found it "hard to refer on when there's no one to refer to." However, what she was able to offer by way of treatment was ultimately not suitable for the client: "She's had all this therapy, but she's not really able to benefit from it."

Tony's parents had him committed to an institution, under *The Alcoholism and Drug Addiction Act*, to try and break the self-destructive cycle of drug and alcohol abuse. However, Tony's problems were compounded when he "freaked out" at being there and tried to escape through a plate-glass window. His break-out was interpreted as an attempt at suicide, he was re-classified as mentally incompetent, and long after his successful treatment for alcohol and drug abuse, he was detained under the *Mental Health Act*.

For Teresa, it was a three-step intercession. The first came when Teresa's doctor recognised her dependent use of alcohol to cope with the break-up of a marriage and advised her to stop drinking and take a holiday to see her daughter overseas:

he said to me I'll put you on a sickness benefit if you promise you'll give up the drinking...[but] I know nothing about alcoholism...I don't pretend to know anything.

Teresa continued to drink, and unable to cope with her mother's perpetual drunkenness in a strange country, and with little access to resources, her daughter *intervened* by putting her on a plane back home. However, this was not sufficient to stop Teresa from drinking and on arrival back in New Zealand, the death of her father brought Teresa her into contact with family who had not seen her in some time. It was her brother who took the final step of having her committed for treatment. She was admitted first to an alcohol and drug treatment unit, but quickly decompensated and was transferred to a psychiatric hospital:

So the next thing I was up in ward 10 and I was totally manic...I got an interview with a psychiatrist and he said manic depressive schizophrenic and I said I'm leaving here, so he got on the phone to my family about getting a court order.

Teresa's *crisis* ended with her admission to a psychiatric unit under compulsory treatment order. She was deemed to have lost the capacity to make a rational decision for her own well-being, and the judgment to receive treatment was temporarily taken out of her hands.

For Henry, the *intervention* was even more dramatic. It was initiated by his parents, but involved the police, neighbours, his employer and mental health services. Henry's mother recalls:

We actually ended up having to call the police because Henry got quite violent as well and we did call the police...family members were afraid...his brother was afraid...his brother was originally stuck behind the bedroom door thinking if Henry was going to go storming in there he would have a chance of waking up...

He was taken to a psychiatric inpatient unit for compulsory treatment, under committal.

Summary

Intervention by an outside agency occurred at a time when the participant had reached the end of their ability to *cope* and they *broke down*. This frequently coincided with the *breakdown* of their social support systems when significant family members had reached the limits of their ability to cope with the ongoing, and seemingly irresolvable problems. However, rather than the solution it was supposed to be, *intervening* frequently created another set of problems. As family members sought appropriate treatment for their loved one, and treatment centres struggled to provide an appropriate *intervention*, the health and well-being of the participants/clients was often further compromised. Participants were either denied service, 'pushed' from service to service, or, in an attempt to avoid this 'ping pong' effect, were offered an *intervention* that did not always best meet their needs.

Intervention was the final event in the four-part episode that had become *the crisis* and paved the way for movement on to the next phase of *discovering a life, recovery*.



Family

Much of the family data is dealt with in this chapter on the *crisis* because this is the phase that families were in when interviewed for this study. It needs to be noted here that the concerns of the family seemed to be very different from the concerns of the consumers and the staff. There were many reasons, but for my participants it has to do with the divergent life cycle and motivational points the families were at. I interviewed the two groups at very distinct points in the 'recovery' process. The consumers were clearly in the maintenance phase of having been through a number of crises and relapses, and had reached a point in their lives of acceptance and integration. Part of the 'unfinished business' of the consumer group was to reconnect with family. All the consumers acknowledged how damaging years of untreated mental illness and unrestrained substance use had been on family relationships. Many of them also harboured resentment at the treatment they received from family members during their periods of 'unwellness' and subsequent attempts to 'make amends'. For some, the damage was so enduring that consumers felt it could never be repaired. So, for a variety of reasons, it was not the families of these particular consumers that I interviewed.

The families that made themselves available to me were those whose family members I had originally tried to access as consumers, but because of their level of 'unwellness' had been unable to participate. The concerns expressed were those of a family whose loved one had been (relatively) recently diagnosed (within the last five years) and they were still coming to terms with what a diagnosis of coexisting disorders meant to all of their lives.

Families used a lot of 'battle' language to describe their lives. They felt embattled trying to support a son/daughter in distress while coping with their own distress. They found it difficult to access help and support for themselves because they are not the 'identified' patient in most services. They were looking for help in two domains. Most needed to understand what was happening with their son or daughter and how they could get the best help for them. At the same time, families were using this crisis to make changes in their own lives and take the opportunity for some 'personal growth'. Whatever the motivation for help-seeking, family members felt they were battling both mental health and alcohol and drug services.

Battling the *Privacy Act* and/or the *Health Information Privacy Code* (HIPC) (1994) was a notable cause for concern. The *Health Information Privacy Code* was introduced in July 1994 as a code of practice which modified the Information Privacy Principles set out in the *Privacy Act*. The code was issued with the fact in mind that "much health information is collected in a situation of confidence and trust". The *Privacy Act* was set up to govern issues relating to the collection, storage and use of personal information. It is legalistic in its interpretation and rightly aims to protect the interests of the 'identified' client in any health service. However, family members felt it was unreasonably interpreted and applied at times; they found it difficult to get any information about their adult son or daughter from the agency that was treating them.

Equally frustrating was their inability to 'give' information. One mother found her input was not welcome when her son went to doctors. She felt she had information that would positively contribute to the overall picture the health professionals were trying to build up of her son.

The parents felt that a *Privacy Act* that was designed to protect the 'patient' actively militated against comprehensive understanding and treatment of the condition. It increased their fear that the doctors might miss seeing an important sign or symptom with fatal consequences. They also had some questions about whose rights were paramount. One step-father had great

concerns about his step-son's compliance with medication, and was fearful of the consequences of not taking it:

...every time I see him [step-son] I ask "have you taken your medication?" And he says "yes" he has, so you've got to believe him. You hear about cases like the one in Wellington where somebody stopped taking medication. I wonder if there's a way of giving a person a drug which is long-term acting. It might be taking people's so called rights away if they don't want the injection but...if somebody's bleeding to death you don't let them bleed to death you give them blood to replace it...I mean good God, they can do it with women with hormones...there must be some way of doing it.

At the point of acute unwellness of their family member, many primary caregivers complained of chronic sleep deprivation:

When [son] was bad I wouldn't get to sleep...I probably wouldn't sleep all night wondering what the hell he was going to do...I was totally exhausted...I needed a thousand hours of sleep but you never catch up on the sleep that you lose.

Also most of the parents talked about the stigma they or their family member experienced as a result of the mental illness and substance abuse. One parent found himself increasingly isolated from friends and family because he was no longer prepared to talk about his son:

...he's got something wrong with his brain. It's just another organ, it's a mental illness and the stigma, that's what people are going to look at...even when he's in a well period, they're going to look at him and think "oh well he's a nut case" and I'm not prepared to step out and take that risk that people are going to understand...it would have to be somebody that I know really, really well, and that I could trust that they would not look at him in any other way.

However, for much of the time, what in fact they were describing was discrimination. According to the *Mental Health Foundation Training and Induction Manual to Counter Stigma* (1998), stigma is "a mark or sign of shame disgrace or disapproval". Discrimination, on the other hand, is "to select, choose or act on the basis of preconceived opinions. Unfavourably or less favourable treatment based on preconceived opinion, bias or partiality".

A mother described how other people's fear of someone with mental illness further magnified the discrimination:

...people become very wary of them [consumers with coexisting disorders] and then it isolates that person even more because people aren't confident to actually form relationships with him.

The same mother went on to describe how people have stopped coming to the family home "the kids wouldn't bring any friends home" and "no one from the church visits any more...we just come home on our own".



Conclusion

The *crisis* sits at a point in the lives of the consumer participants between *intemperate insanity* and *recovery*. It begins with a *build up* of stress and burden, which is *triggered* by an event or series of events external to the participant. For some it arose out of a phase of developmental *experimentation* with drugs and alcohol. Participants soon found themselves and their coping mechanisms *overwhelmed* by the enormity of the problem and their response to it, and experienced a *breakdown* of physical, mental, and spiritual integrity. This *breakdown* took many forms but, without exception, resulted in *intervention* by an outside agency (most commonly initiated by a family member). Participants had reached this point several times previously in their lives. The crisis passed and the consumer resumed life as before until the next crisis. However, on this occasion, the participants engaged with a process of *recovery*, the mechanics of which are described in the next chapter.

Why was this not just another crisis in a life lived lurching from crisis to crisis? Before I move on, I need to be able to hypothesise how the participants sustained the shift from *the crisis* to *recovery*. This was not the first *crisis* or the first *recovery* for any of them. In fact, all of them (even the youngest) had been through the process at least four times. On each previous occasion, once the crisis was over, they quickly settled back into old patterns of living, drinking, drug taking and behaving, until the next inevitable crisis.

I began the search for a single significant event, person, therapy, intra-psychic experience or social interaction that might explain the enduring existential shift that appeared to have occurred on this occasion. Using any of these schema as a basis for analysis, I could not find an explanatory pattern in the data or even a clear cut account from individuals that would allow me to theorise about the relative durability of their present 'recovery' state.

One possible explanation can be found in the 'transtheoretical model of change' developed by two psychologists J. Prochaska and C. DiClemente in the 1980s. They sought to understand how and why people change, either on their own or with the assistance of a therapist. They have described a series of stages through which people pass in the course of changing a problem. According to Miller et al. (1991:14-15), these stages seem to apply equally well to self-change and to therapy-assisted change ie. in or out of therapy, people seem to pass through similar stages and to employ similar processes of change. Within this approach motivation can be understood as a person's present state or stage of readiness for change. Key to my analysis is the understanding that change is "an internal state influenced by external factors" (Miller et al., 1991:15). The Prochaska-DiClemente model was developed out of their original research with smokers and is drawn as a wheel with four, five or six stages. The fact that it is a wheel reflects the reality that in almost any change process, it is normal for the person to go around the process several times before achieving a stable change. In their research, Prochaska and DiClemente (1984) found that smokers ordinarily went around the wheel between three and seven times (with an average of four) before finally quitting for good. And so it was for my participants, that it had taken an average of four crises, four hospitalisations and as many attempts at achieving sobriety, before they were able to leave the cycle of crisis and temporary respite, and enduringly maintain a more stable life.

Whilst it is not my intention to simply replicate Prochaska and DiClemente's work under different conditions with a different client group, it does 'make sense' (in Glaser's grounded way) to use it to explain this small part of the process of 'managing a life' in my participants.

Having set the scene for moving forward, I will use the next chapter to explore the transition through *recovery* to the ultimate goal of *discovering a life*.

CHAPTER EIGHT: SHEDDING THE ARMOUR - RECOVERY

Sir, My pa requests me to write to you, the doctors considering it doubtful whether he will ever recuvver the use of his legs which prevent his holding a pen. (Fanny Squeers, *Nicholas Nickelby*, Charles Dickens, 1986)

Recovery (the act or process of recovering or being recovered) - Recover (regain possession or use or control of) - Retrieve, make up for, cease to feel effects of. Come or bring back to health, or normal state, (Shorter Oxford English Dictionary)

Introduction

In keeping with the 'armour' metaphor introduced by one of the participants in *the crisis* (to describe the vulnerability they felt as their protective shield fell away), *shedding the armour* denotes a more controlled and natural process of *recovery* - 'parting with' old ideas and behaviours and replacing them with healthier ones. *Shedding the armour* also marks the transition into the next phase of *discovering a life, recovery*. *Recovery* as a concept is well researched and developed (Deegan, 1998; Copeland, Curtis & Palmer, 1996; Curtis, 1997). It has been claimed by both mental health and substance abuse treatment providers as a legitimate 'therapeutic' approach, and adopted by consumers from both services. There is a wide body of literature that has grown out of empirical research in both areas (mental health and substance dependence), and this will be discussed in the literature review. However, I want to say a sufficient amount about 'recovery' as a concept here, to provide the reader with a context from which to understand the participants' data.

The goals and processes of my participant group embrace a wide range of ideas and interventions that simultaneously accept and transcend the human condition. Each person has chosen a path that is best suited to their individuality and circumstances, and each, in their own way, is living a richly elaborated life. However, there are some common themes emerging from their data. For this group of people with coexisting mental health and substance dependence disorders, 'recovery' marks a trajectory through four distinct stages. It follows sequentially from the beginning point they identified as *intemperate insanity*, which in turn led to *the crisis*. By now they are able to

see *the crisis* as the culmination of a wider set of behaviours and lifestyle decisions that have been impacted by both mental illness and substance misuse/abuse. This first phase of *recovery* involved *taking responsibility* for the patterns of life, drinking, drug-taking and mental illness that had brought them to this point. Participants no longer saw each event or incident as a one off aberration in an otherwise exemplary existence. *Sobriety* was the most single, critical attainment for each of the participants; not just sobering up as they had done many times before, but incorporating *sobriety* into their lives as a way of being, a life-style change, a philosophy by which their lives would now be lived.

Timing and timeliness are crucial ingredients in making change, and each participant was able to identify a particular instance or event that precipitated long term sobriety. Miller and Rollnick (1991:197) describe this mechanism in the 'determination' phase of the motivational wheel:

Most individuals in this stage will make a serious attempt at change in the near future, and may have made an attempt to modify their behaviour in the recent past. They appear to be ready for and committed to action.

In addition to *taking responsibility* for changing disruptive life patterns and achieving *sobriety* the participants had the task of *up-skilling*, learning new ways of doing things, experimenting with new ways of being or re-visiting successful strategies, long forgotten. Finally they had the task of *incorporating* these new skills and understandings into their daily lives.

Recovery is not something that happens in isolation. It is of necessity an intensely social experience. Although the outcome might be individualistic, the process is not. The stage/process of *recovery* follows *the crisis*, and the last phase of *the crisis*, *intervention*. Strong commitment and determination alone does not guarantee change, and it is at this point that others become involved. For each participant, this involvement meant engagement with 'treatment' services and *recovery* was frequently a collaborative effort between staff and consumers. The data collected from staff participants is mainly dealt with in a separate chapter, *Service Provision*, but there was some material that provided another layer of understanding in the concept of *taking responsibility*. Generally speaking, the staff had such a different way of contextualising 'recovery' that their focus on some of the meta issues such as 'integrated care', model conflict and professional development of staff made it difficult to fuse with the data generated by the consumer participants.

In summary, *recovery* comprises the natural progression of movement from *the crisis* to its final phase of *incorporating* the newly acquired skills and understandings into *discovering a life*. It involves *taking responsibility* for the problems (caused by *intemperate insanity*), and the damage that it (the problem) has caused to the individual's life, *sobering up* (abstaining from all un-prescribed mind/mood-altering drugs), *developing skills* appropriate to this new existence, and *incorporating* the 'illnesses' into images of self, in a way that allows for a balanced and fulfilling life.

Recovery as a concept

The concept of recovery has its origins in a number of theoretical traditions. Psychiatric rehabilitation is "the process of enabling a mentally ill person to return to the highest possible level of functioning" (Stuart & Laraia, 1998:865). Stuart and Laraia (1998:211) have drawn up a model that has a focus on wellness and health (not symptoms), and is based on the individual's abilities and functional behaviour. Care is offered in "natural" settings, as opposed to treatment in institutional settings. The relationship to caregivers is "adult-to-adult" (not expert-to-patient), and medication tolerates some illness symptoms i.e. there is not an expectation that the person will be entirely symptom-free. Being medicated is a trade off between symptom management and reduction of side effects. Decision-making is a partnership between the treatment provider and the patient, and the emphasis of rehabilitation is on strengths, self-help and interdependence.

Recovery as a concept arising out of addiction treatment had its origins in the Twelve Step movement. In 1935, two doctors identified themselves as alcoholic, at a time when alcoholism was seen as a terminal disease. Instead of giving up all hope they began a self-help approach, Alcoholics Anonymous (1976), from which hybrid Twelve Step programmes have been subsequently developed. The Twelve Step programme has its basis in religion, psychotherapy, and the medical model. The medical model component of this twelve step based recovery programme views 'addiction' as a disease that is "progressive, and the alcoholic who continues to drink will slide towards social, psychological, physical and spiritual destruction and eventually death" (Mosby, 1995:72-73). However, the solution in the Twelve Step setting is the fellowship of other recovering persons rather than professional help. This was one of the early 'empowerment' approaches to a human problem, endorsed by some health professionals, wherein the power to solve that problem was seen to reside within those who had the problem instead of an outside 'expert' or professional.

Finally recovery as a concept has been informed by Thomas Moore's expression of Jungian psychotherapeutic ideas (see Chapter Two - "Theory") and developed by Patricia Deegan (1995, 1998), combining her talents as an academic and consumer. Within this holistic genre recovery is, at the same time, a concept of intricate complexity and inordinate simplicity. According to Patricia Deegan (1988:91), "the concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness [and substance use disorders] are human beings". This takes recovery out of the domain of dis-order and dis-ease and brings it into the realm of being 'human'. Deegan (1988:92) went on to define 'being human' as "unique, awesome, never to be repeated...to be a question in search of an answer", and saw recovery occurring in this context.

Although he does not define what it means to be 'human', the twentieth century psychotherapist Thomas Moore (1994:xii) sees 'recovery' as an approach of "accepting ...human foibles...and sees dignity and peace as emerging more from that acceptance than from any method of transcending the human condition".

Moore (1994:xviii) identifies a polemic in goals of recovery with one being "adjustment to accepted norms or to an image of the statistically healthy individual". This is achieved through a process of "shallow therapeutic manipulations aimed at restoring normality of tuning a life according to [the] standards...of ...the adjusted personality".

The second goal, which Moore (1994:20) espouses, "appreciates the mystery of human suffering and does not offer the illusion of a problem-free life." Deegan (1998:92) concurs, recovery is a process, not an act, and "the goal of the recovery process is not to become normal [but] to embrace our human vocation of becoming more deeply, more fully human."

This polemic is clearly articulated by the participants' data in this chapter as they struggle with their own *recovery*. The second goal of 'becoming more fully human' is picked up and explored in depth in the chapter *Maintaining - Living Without the Armour*.

The Origins of Recovery

'Recovery' as a process in the alcohol and drug context has been described using one of two models. The first is one of temporal, linear time in which recovery is seen as a series of stages. According to Crawford, (1986:45-51) while every recovering person is unique, recovery itself has clear stages, and

every recovering person goes through them. These 'stages' are described on a timeline of calendar days, weeks or months, and attainment of each stage is measured in behavioural outcomes. The second model is one of "soulful" and "spiritual" living that deals with "everyday problems without striving for perfection or salvation" (Moore, 1994:xii). This, according to Moore (1994:xii) leads to "a richly elaborated life, connected to society and nature, woven into the culture of family, nation and globe" - a sense of our existence in a wider, universal context. The participants in this study have incorporated both understandings into the translation of 'recovery' in their own lives.

'Recovery' in the mental health setting grew out of the models of psychiatric rehabilitation and community support (Anthony,1993). Spaniol (1994, cited in Miller, 2000) describes 'recovery' as:

...a process by which people with psychiatric disabilities rebuild and further develop their important personal, social, environmental and spiritual connections, and confront the devastating effects of discrimination through personal empowerment.

Participants in this study have also been exposed to the psychiatric models of recovery and insights from this paradigm are recognisable in the way they speak about their own recoveries.



Participant Data

Taking Responsibility

Taking responsibility for the destructive life path of each individual was the first step to their 'recovery'. For years, each of the participants lived a life of *intemperate insanity*, wreaking havoc in their own and others' worlds. For much of the time, the individual saw nothing wrong with the way they behaved, in fact, if there was a problem, they saw it as the intolerance of others to their way of living.

Initial 'treatment' concerns are focused on stabilisation and safety, but when these have been achieved, usually within the first few days (or sometimes weeks) the client/consumer is accessible to recovery strategies.

The degree to which staff were able to assist clients in *taking responsibility* depended, in some measure, on the focus of the service where the intervention took place. In addition, the knowledge and skill-base of the staff were crucial

to the initiation of this (*taking responsibility*) process. Ivan, one of the staff participants from a specialist dual diagnosis setting commented that:

We deal with the more chronically mental side...we pay close attention to a referral from the inpatient unit because at that stage there is a chance that they might be stabilised in their psych disorder and they might be able to develop an insight into their drug use at that stage and take responsibility for changing it.

Where services are specialised mental health or alcohol and drug, it sometimes becomes too difficult to help the client *take responsibility for* the 'other' problem. Yvonne, who has worked in both services explains that "If people haven't got dual diagnosis in their mind, then they can deny it because its more work so they can deny it."

She goes on to recount that one colleague working in a mental health setting suspecting that their client had a problem with benzodiazepines responding with "Oh, I don't know whether to rock the boat and even look at it, even acknowledge it."

Timing and timeliness were crucial factors in the willingness to *take responsibility for* a problem. As Yvonne states, readiness to change has to be weighed up against "Lack of motivation, severity of psych disorder and relationship to what drug they're using."

In reflecting on the chaos that had become her life, Gina started to put the pieces together, and *take responsibility for* seeing her response to mental illness and substance abuse as a pattern, rather than a series of isolated, distinct events:

You know, all that stuff [the problems], where is this going to lead me? I recognise it now, and I didn't used to recognise it...I feel as though I can do something to change it now that I know what it is.

Henry likewise *took responsibility for* making the links between his drinking, drug taking and non-compliance with his mental health management, and the consequences of lost jobs, relationships and admissions to psychiatric hospitals:

I thought that's the way life was...but...it wasn't actually life...that's a very big false reality there you know. I didn't take it as seriously as I should of and this time round that's when it really dawned on me thinking...you know...this is it mate...you've got to pull your weight and do the right thing or else you're not going to get nowhere.

In addition to accepting the consequences, the task of *taking responsibility* includes repairing the damage done by *intemperate insanity*.

Henry talked about "the ripple effect" that his mental illness and substance abuse had on "the family and everything":

I didn't think it could happen to me, but the worst thing about it is...now I'm at the end of all this I'm having to do the mopping up...you know like slowly rebuild what I've got to do.

Achieving Sobriety

Miller and Rollnick (1991:ix), in their groundbreaking work on addictive behaviours, argue that "a defining characteristic of addictive behaviours is that they involve the pursuit of short-term gratification at the expense of long-term harm." *Achieving sobriety* is a necessary first step away from instant gratification. If old patterns were not to be repeated, something had to change. Without exception, the most critical and significant change was *sobriety*. Although *sobriety* is a term that has traditionally been used to refer to the absence of alcohol in an individual, I am using it here in a more generic sense to also include being drug-free. Alcohol is as much a mood/mind-altering substance as any other drug (licit or illicit) and it is a historical anomaly that alcohol and 'drugs' have been considered separately, particularly in legislative documents that deal both with the manufacture and sale of drugs and alcohol. The separation of alcohol and drugs has similarly been reflected in treatment settings and carries with it a whole semantic and philosophical debate of its own - a debate I want to do nothing more than to note here. The important point for this thesis is that abstinence from all mood and mind altering drugs is the key element to the '*recovery*' process, whatever its form and setting.

Ian had struggled for years with his mental health:

I only worked half the time...the rest of the time I was in and out of hospital, which meant I spent a lot of time with psychiatrists and what-have-you.

He made the connection at a young age, between his mental illness episodes and marijuana, but it would be another seventeen years before he made the same connection in relation to alcohol:

I used to smoke a lot of dope when I was young, but that was far too unpredictable, and I twigged really early on...but alcohol, because it goes through your system much faster

became a sort of drug of convenience that would sort of inject a bit of excitement into the system.

Ian was finally willing to consider *sobriety* as an option after he had lost all his friends and been bankrupted for a second time. It was a short-term solution, "just until I got back on my feet", but the rewards of not drinking were so profound that it was not something he wanted to go back to. He came out of bankruptcy and turned his business into a profit-making success, his friends and family wanted to be around him and he has significantly reduced the amount of psychotropic medication he takes whilst at the same time experiencing better mental health than he has in years.

Tony came straight out of a mental institution into a community alcohol and drug rehabilitation setting. During his time in hospital, he had had no access to alcohol and "[*sobriety*] enabled you to see what a wonderful thing living was". He made a lifestyle commitment to abstinence from non-prescribed drugs and alcohol, and on discharge reorganised his life with *sobriety* at the centre. He has been alcohol free for fifteen years and drug free for five:

Gina also wanted a better quality of life:

Drugs and alcohol were not having the kick they could have, and I think at that point it was just part of this conscious decision..I was going to live with some quality...but I knew nothing about AA [Alcoholics Anonymous]. I just knew that's where the drunks went...and strangely enough, you know I talk about it as something of a spiritual moment...I looked it up in the phone book...and having made that decision, something lifted.

Gina too made a lifestyle commitment to *sobriety*, and it is now six years since her last drink and unprescribed drug.

Xanthie chose *sobriety* after a particularly turbulent admission to a psychiatric unit:

I read back through my journal...I always kept a journal. I can see how unwell I am...and I think this is not good...I didn't associate alcohol with my illness until now...so I started to go to AA.

Like Ian, Graeme had no intention of choosing *sobriety* as a lifestyle. He saw his problem as depression and stopped drinking because that was the only condition under which the psychiatrist would see him:

I actually started going to [he names a community alcohol and drug treatment centre] not because of my drinking, but because of my depression...but then I realised it's a bit of a chicken and egg thing I suppose...I do drink when I am depressed and then I get more depressed.

Sobriety not only allowed Graeme to manage his depression more ably, but it gave him insight and awareness into its mechanisms:

I have that awareness because I can identify situations...what I can do is a sort of learning process and I try not to put myself in situations where it's going to happen again.

Marijuana was Zac's drug of choice, and like the other male participants in this study, did not see long-term sobriety as part of the solution to his problems. He had experienced an episode of mental illness overseas and prior to coming back to New Zealand thought a temporary respite from drinking and drug taking would allow him to continue as before:

I thought, I'm going to stop all this stuff and clear my head...when I got back I thought 'yeah' I'm getting better now so it's alright to have a smoke and that...I thought it was all coming right...I thought all I needed was just a little bit of a break, but it wasn't the case...the case was my days of smoking and drinking are over.

Verity felt there was nothing wrong with her drinking and drug taking as long as her grandson (for whom she had sole care) didn't see her 'using'. She carefully planned her 'using' to coincide with the times he was at school, asleep or with friends. She recalls with shame that:

One day I misjudged the time and was in the middle of a session when he came home with a couple of friends early from school. The look of hatred on his face is something I will never forget...at that moment I felt so bad about what he had seen that I prayed God would strike me dead rather than see the hate in his eyes he had for me. That was the turning point for me.

Although Verity saw *sobriety* as the solution, the reality of it was too hard for her to tackle on her own and she entered a therapeutic community which specialised in long term rehabilitation from drugs and alcohol.

By now Teresa was taking *responsibility for* the devastation alcohol and drugs had caused in her life, and understood that *sobriety* was a crucial part of the solution; it was something that she struggled with for two years:

I've been sober nearly five years, but it was actually two years of struggle...and I think it was because it is very hard for a alcoholic to stop drinking. It is not natural because you are physically addicted and it's a mental obsession...plus the other reason it was hard is that my mind was so unbalanced.

Up-skilling

To have a *skill* is to have an expertness and a practiced ability. It is not that this participant group were without *skill* in many areas of their lives, but they lacked the *skill* of living *soberly*. Not just living without drugs and alcohol, but making meaningful use of their time and maintaining significant relationships. For many dependent drinkers and drug takers, obtaining, using and recovering from the consequences of, alcohol and drugs becomes a way of life (DSM IV-R). This occurs at the expense of the development of healthy life-skills and social systems. For those who had used drugs and alcohol as a way of relieving stress and solving problems, new skills and strategies had to be learned and practiced.

Yvonne, one of the staff participants talked about "the notion of *upskilling* and the fact that some of this is about them [the consumers] being able to take responsibility in their everyday lives". Miller and Rollnick (1991:197) identify "anticipation of problems and pitfalls [as] a solid problem-solving skill", and a

...solid realistic assessment of the level of difficulty, and a calm dedication to making this change a top priority in the current life plan [are] good indicators of commitment to change...Commitment without appropriate coping skills can create a tenuous action plan (Miller & Rollnick, 1991:197).

One of the parents, Katie, talked about the need to *upskill* in order to learn how to live with and support a family member who is dually diagnosed with a mental illness and substance dependence:

When you first start having to deal with this sort of thing [coexisting disorders] you lack the skills..I needed help to understand what was actually going on with [son's name] and because we lack the skills I can see there could have been things that could have been handled totally differently, but when you're living in a family situation where you've got siblings as well, it's very very difficult to co-ordinate things, because not everybody's going to want to have as much involvement, or as much commitment to the situation...as the mother.

For Graeme this phase of recovery meant learning and putting into practice meaningful communication and relationship skills. He reflected back on his

relationships with his wife and children during the period of *intemperate insanity*:

When I think about it, I was so focused on my drinking and depression, that we stopped talking, we just couldn't communicate. I have had to learn how to listen to them, and talk about what is important to me.

Although this relationship did not survive the *recovery* period, Graeme says "we are actually quite good friends now; we talk more than in the last few years we were married". In this *up-skilling* phase, Graeme wanted to learn how to form relationships that weren't so "dysfunctional":

I used to attract women who had been in abusive relationships or they'd been given a hard time by some male in their life and they used to take it all out on me. I was the whipping boy.

Likewise, Teresa learned how to surround herself with people who were going to be supportive and not destructive: "this is my turf and I hand pick who comes here - I've got this team around me who I feel one hundred percent comfortable with."

Graeme has successfully completed a *skills* course to learn how to parent more effectively and says he has a better relationship now with his four children than he has ever had: "they used to baby sit their dad, but now I can be a proper father to them."

For Teresa, it was a matter of learning some inter-personal coping skills:

I learned to hustle for the best recovery that I can and I have also learned to avoid confrontation or people, places and things; anything that upsets me I will just walk away.

Part of this new skills programme involved "dropping my mask", but before she could do this, Teresa had to work on her "self-esteem": "I was trying, but underneath I had no self-esteem...I had no idea I had all this work to do on myself".

The final area that most of the participants needed to *up-skill* in was preparation for employment. Graeme had been on an invalid's benefit for a number of years and had worked in casual and labouring jobs prior to that. He wanted to make the most of this new opportunity to *up-skill* into a more rewarding occupation:

I have been working with my case manager and an occupational therapist to try and get back into the work

force...I've been doing bits and pieces but I feel more than ready to go back full time. I've sat my HT (Heavy Traffic) license and I hope to get a job driving.

Tony also undertook more training as a way of *up-skilling* for the workforce. He felt he couldn't go back to his previous employment as a librarian and wasn't eligible for an unemployment benefit. His wife was working full time and deemed by Work and Income New Zealand (WINZ) to be the main income earner. Employment, for Tony, is important for his mental well-being and self esteem. He *up-skilled* as a 'second language' teacher and has found satisfaction in his new vocation.

Verity has previously worked and trained as a nurse, but with a history of drug convictions felt it was not something she could go back to. An important part of her *recovery* was *up-skilling* as an addictions counsellor, working with people like herself.

Up-skilling is an important dimension of *recovery*. Once sobriety had been achieved, participants needed to learn, not only how to fill the time that had been taken up drinking and drug taking, but to live productively. Each participant had a unique set of skills to be learned and mastered, but there was a common core of communication, relationships, parenting, employment, and self esteem (not necessarily in that order). Some were process skills such as 'developing self-esteem' that required the participants to re-think how they saw themselves. Others were more concrete that involved formal learning and led in every instance to meaningful employment. Most of the participants already had a basic skill set that allowed them to carry out the activities of daily living (such a keeping house and managing money). However, for all of them it involved a re-focus of their energies away from drugs, alcohol and mental illness to a set of priorities that included purposeful relationships with friends, family and employment.

Incorporating

Thomas Moore (1994:18-19) differentiates between care and cure. He argues that "cure implies the end of trouble. If cured you don't have to worry about whatever was bothering you any longer. But care has a sense of ongoing attention". It is this sense of ongoing attention that is captured by the code *incorporating*. This *incorporating* phase of *recovery* involves two key elements. The first is *incorporating* new learning and behaviours into the routine of daily life. The second successful strategy is for participants to find a way of constructing an identity that includes mental illness and substance abuse - to

incorporate mental illness and addiction into their very 'being' in a way that strengthens, not undermines identity.

Some of the participants had, in previous attempts at *recovery*, opted for the 'cure' approach with the result that they were soon back in the cycle of illness and recovery. Ian reflects:

The first three admissions to [names a psychiatric hospital], I came home thinking that we're cured by the time we get through the medication.

He thought all that was required of him was to complete the medication he had been prescribed and his reward would be a cure. This is consistent with the medical model approach (Miller & Keane, 1989:757) elaborated in the chapter "The Field".

Using the 'medical' frame of reference, Ian had every reason to expect that he would be 'cured'. He was cooperative, wanted to get well and had sought technically competent help. However, this theoretical understanding of health and illness leads inexorably to a 'treatment' outcome that relies on outside 'expert' help and systematically excludes the 'patient' from an analysis of their problems and possible solutions that may or may not include traditional medical intervention. It wasn't until his fourth admission that Ian came to a different understanding:

I was totally unaware that the drug I was coming out on was a lifelong exercise...or at least ten to fifteen years minimum. They just failed to get that through [to me] although the guy I was under was pretty good I thought...they never mentioned it. It was a need to know basis...it was just come every three months to get another prescription and you'll be fine. It was my fourth time around that [I understood] this is permanent and you learn to live with it or you'll have a lot of trouble in your life...if you don't get a handle on it [the illness]...if you're not prepared...it will always keep you down.

Ian was beginning to pick up on the theme of 'ongoing attention'. He was developing an understanding that there is no end. "Conflicts may never be fully resolved. Your character will never change radically, although it may go through some interesting transformations. Awareness can change, but problems may persist and never go away" (Moore, 1994:19). According to Moore (1994:19) to adopt a 'care' rather than a 'cure' approach is to "appreciate the mystery of human suffering and does not offer the illusion of a problem

free life...the uniqueness of a person is made up of the insane and the twisted as much as it is of the rational and normal”.

Xanthie has also come to understand the lifelong nature of her ‘dual diagnosis’ and has stopped seeking solutions in external realities:

Often I used to think if I could fall in love [I would get better] but its not really the case, I was not really capable of a healthy relationship...I’m managing my illness much better...like I know people who go off their medication and they want to come off their medication, but I don’t care if I’m on medication for the rest of my life.



Conclusion

Recovery is the phase of *discovering a life* that is the most public. It is the point in the consumer’s life where they formally engage with treatment services. This involves input from health professionals in the form of ‘treatment’, advice, therapy and support. The focus for both consumers and service providers is on ‘restoring health’ but this focus is manifested in different ways for each participant group.

For the consumers, it is a personal journey that involves *taking responsibility* for the problem, and the damage that it has caused to the individual’s life, *sobering up* (abstaining from all un-prescribed mind/mood-altering drugs) developing *skills* that allow for sober living, and *incorporating* the ‘illnesses’ into images of self, in a way that allows for a balanced and fulfilling life.

On a temporal time-line, this phase took about two years, after which time the participants were ready to move into the lasting phase of *discovering a life: living without the armour*.

CHAPTER NINE: LIVING WITHOUT THE ARMOUR - MAINTAINING

To maintain (cause to continue, continue one's action in, take action to preserve in good order).

Introduction

The *maintenance* phase of *discovering a life* follows sequentially from the period of *recovery*. For most of the participants (on a temporal time-line) *living without the armour* emerged two years after *the crisis*. The key behavioural outcome was *sobriety* and by this time abstinence from all mood and mind-altering drugs (including alcohol) was well established. Their mental health was stable and, with the exception of one, all the participants had been discharged from formal treatment services back to the care of their community General Practitioners (GPs). This *maintenance* phase falls outside the realm, responsibility and literature of 'health', yet is it integrally a part of it. If the participants are unable to *maintain* their recovery and *discover a life*, then they inevitably relapse back into the health system. This has been well documented as 'revolving door' syndrome (Mason, 1988) and often requires intense and expensive care.

Living without the armour responds roughly to Miller and Rollnick's "maintenance" phase of changing addictive behaviours (1991:199). They argue that "the real test of change for most problem behaviours, especially the addictive behaviours, is long-term sustained change over several years. This last stage of successful change is called 'maintenance'." (Miller & Rollnick, 1991:199). 'Maintenance' implies that there is some kind of a plan of action that requires maintaining, or that the individual has come to end of the road of change and now wants to stay the same "nothing must be altered...lest it break the 'spell' of their sobriety or their new behaviour pattern" (Miller & Rollnick, 1991:315). However, in their early writings on transtheoretical approaches to change, Prochaska and DiClemente (1984:28) argue that "maintenance is not an absence of change, but the continuance of change". For the participants of this study *living without the armour* conveys the idea that they were simultaneously able to be in the present and continue to change in the future. It

means more than simply *maintaining* the changes they have made in their lives, it is about *discovery* of the unknown in their lives.

It was also the point at which all the participants exited the health service as clients or consumers to continue their change process in another configuration. Verity states that:

I have come to the end of this part of the journey. I'm aware that a relapse is possible even though I've finished the programme. It has empowered me to believe in myself to make the best of what I have. I know my triggers and set ups and intend to seek help a.s.a.p if I am unable to deal with it myself. I know that I'm not alone...I just need to reach out.

Verity chose to re-engage with treatment services but this time as a service provider, not as a recipient of care.

With the exception of Henry, all the participants had a well-established relationship with 'maintenance' - some for nearly twenty years. How they achieved that was as individual as the number of participants, but there were some common themes and they were all committed to the continuance of change.

Daily reminders (remembering the past) of what and where they had been, and a daily commitment to sobriety helped them to look forward from the past. Nourishing *human connection* reinforced their commitment to change. *Pushing the boundaries* of their minds, capabilities and outlook on life gave them new interests, new understandings and an opportunity to test out the limits of their capabilities. And finally *giving back* was a way of saying thank you to others who had helped and supported them through their journey.



Participant Data

Daily Reminders

If *maintaining* the change (according to Prochaska & DiClemente, 1984:28) is about continuing change, it requires a strategy that is simultaneously constant and flexible. The participants in this study were committed to long-term *sobriety* as the foundation of their existence. In order for them to succeed, *sobriety* had to be the one constant because without it, they were unable to access life-enhancing resources. Staying *sober*, was a delicate balance of *remembering the past* and *being in the present*. Teresa reflects:

I mourn for what I have lost. I've learnt to live in the day like in AA, yesterday has gone, I am powerless over that, I am powerless over tomorrow. Today is all I have got...so what I'm learning to do is live in the day and get quality in my life.

Remembering the past is part of a strategy to prevent 'relapse' or a return to old patterns and behaviours. Remembering where they have come from and what brought them to the place they are in today is one of the mechanisms the participants used to help prevent them from going 'back there'.

According to Miller and Rollnick (1991:200):

...relapse...is always possible [and] can occur for many different reasons. Individuals may experience a particularly strong, unexpected urge or temptation and fail to cope with it successfully. Sometimes relaxing their guard or testing themselves begins the slide back.

It is this 'slide back' that kept my participants determined to *maintain sobriety* and participating in *daily reminders* in the present.

Unlike Teresa, Tony chooses not to use AA to support him in his sobriety: "I feel out of kilter in a group so I prefer talking one to one". However, this does not stop him from sticking to a regular programme of prayer, meditation and therapy:

...daily readings - a combination of secular and religious... there's a danger that you'll get caught up in your own reflection - praxis - you need to combine therapy with practice - integration and adoption.

Miller and Rollnick (1991:200) find that "the threat of relapse or of a return to the old patterns becomes less frequent and less intense" as the new behaviours become firmly established. However, after nearly twenty years, Tony needs to maintain his vigilance and finds that "it's been a long, hard slog...and sometimes it gets a bit much". He still worries when he goes to job interviews that his record of *intemperate insanity* will follow him and prospective employers will not understand the changes he has made.

Although Xanthie does use AA she still remembers the past as a way of staying sober in the present:

I had a horrible time when I was drinking...life was a real nightmare...I'd walk home and people would stop their cars and think I was street walking...it was really horrible and I

don't have to put up with that any more...I'm scared to ever drink again.

Ian has made the connection between his drinking, bankruptcy and the severe bouts of depression in his life:

I remind myself when I'm really stressed at work and having a drink seems like a quick fix, that it's just escapism...alcohol is a depressant, it doesn't pick you up at all, it's a straight out depressant. I need to remind myself what the effects of alcohol are. Also the combination of lithium and alcohol have contributed to quite a few bad decisions which cost me money in business. When I spend time looking back and think about the two bankruptcies I've had I know I should have been making those [business] decisions totally alcohol-free.

In addition to *remembering the past*, most of the participants had a reading list of self-help material they used as *daily reminders* for conduct in the present. The readings were as diverse as the people who participated in the study, some religious, others secular and many 'new age'. Most used a combination of readings, meditations and reflections depending on their need for the day. Typical is this example taken from the Hazelden Meditation Series that combines Twelve Step philosophy with new age awareness:

Variety in experiences is necessary for our continued growth. We mistakenly think that the 'untroubled life' would be forever welcome. It's the deep waves of life that teach us to be better swimmers. We don't know how to appreciate the calm without the occasional storm that pushes us to new limits of ourselves. The calm following the storm offers us the time we need to become comfortable with our new growth. We are ever changing, refining our values, stepping gingerly into uncharted territories...Our inner selves understand the journey; a journey destined to carry us to new horizons; a journey that promises many stormy seasons. For to reach our destination, we must be willing to weather the storms. They are challenges hand picked for us, designed to help us become all that we need to be in this earthly life.

Human Connecting

For most of the participants, their relationship to drugs, alcohol and mental illness, had replaced their most significant human relationships. Drugs and alcohol in particular had become their closest friend, their primary relationship. It was all consuming and connectedness with others was mediated by it. *Human connecting* involved several strategies. 'Dis'-connecting from old acquaintances who were likely to undermine their resolve to *maintain* the

change, re-connecting with those who were likely to be supportive, and establishing new connections with people who came into their lives as a result of the positive life-changes. In connecting with other human beings the participants had to focus on different priorities. Ian "re-found fishing and bought a small boat...I focused on fishing instead of going to the pub or having a beer". The focus on fishing also brought him into contact with a new network of friends, friends whose lives were not centred around drugs and alcohol:

...Many people believe that treatment for alcohol problems ceases as soon as a drinker shows that he or she can stop drinking and remain abstinent for a longer period of time than the previous attempt. Families, friends or employers may explicitly discourage clients from seeing themselves as still having any difficulties, or from expressing doubts about what they have achieved thus far. (Miller & Rollnick 1991:200)

It is for this reason that people who are *maintaining* the change need to distance themselves from those who might undermine their progress and surround themselves with people who understand and support what they are doing. As Teresa notes:

I needed most to feel that I was not alone, and going to a weekly group helped me realise this...what this [maintenance] group gives me is an extended family that understands my limitations, frustrations, and victories in my mental illness.

Xanthie talks about the 'then and now' of her *human connecting*:

I go to AA but not for a social event, I go there to stay sober. I've made a few friends in AA and I made even more when I was making my amends [to people wronged in the past]. I've never really had that before so I feel like I've got more friends now than I ever had when I was drinking because I used to drink and be totally lonely...go out and be drunk on my own and be surrounded by people but be totally lonely...I'd be hostile and defensive.

The *integrating* of mental illness and substance dependence into their identity as human 'being' continued to be an important part of *maintaining* the wellness, but it was no longer central as it had been in the early stages of *recovery*. In the first two years, my participants often had restricted social networks as they let old 'using' friendships go and had not yet established new ones. Much of their *human connectedness* had been with health professionals (doctors, nurses, psychologists and support workers), and/or other 'recovering' people they had met in the Twelve Step fellowship of Alcoholics Anonymous. In this transition period, Teresa remembers the friendship and support she received:

I felt one hundred percent comfortable with Peter [the director of the treatment centre she had been in], I feel one hundred percent comfortable with Rosemary [her GP], with my sponsor who is a very strong woman who has overcome a lot in her life. I've known her since 1992 and I ring her every week, she's a doctor's nurse and she's a very busy lady. I don't talk to her a lot now, but in the beginning, I was talking to her every day.

Xanthie was also dependent on the friendship of health professionals while she made the transition from patient to person:

I'm friends with my psychologist. She's done her masters in psychology and a lot of her friends have done their masters in psychology and I have become friends with them.

With the passage of time, sobriety and increasing mental health, social networks were broadened. However, they seldom included old drug and alcohol using acquaintances. *Human connection* was made around sobriety and new interests.

Pushing the Boundaries

Pushing the boundaries was the description some of the participants gave to the opportunity they had at this phase in their lives to explore new ways of being, talents, hobbies and options. With a minimum of two years sobriety behind them and the resolution of some of the neurophysiological impairment caused by dependent alcohol and drug use, participants found they had not only time (that they used to dedicate to alcohol and drug use), but the mental agility to tackle new learning.

For some people, this was formal and career-focused. George, a man in his fifties who had left school at the age of 14 years, was now more confident of his ability to stay sober, and spent the third year of his 'discovery' in a new start programme at university. Encouraged by the success of the year, he enrolled as a full-time student:

This is something I always wanted to do but never thought I would have the chance. I thought I was dummy when I left school...I'm amazed I've got any brain left after the amount of pills and booze I've taken over the years.

George continues to enjoy *pushing the boundaries* and is constantly surprised by his many talents and abilities. This discovery has given him a new zest for life and after many years on a sickness benefit is now thinking about a career.

Tony also used his sobriety to get a second chance education, and after graduating with a Bachelors degree in languages and social science went on to train as a teacher of English as a second language.

Verity was taking advantage of the opportunities her 'maintenance' of wellness brought to *push the boundaries*:

If someone had said to me two years ago where would I be, what would I be doing, I would have said most probably dead. [Now] I am getting some formalised training in counselling and then I go on to do a postgraduate course. I haven't done study of any sort for at least twenty years so I need this course to re-establish a study mode and apply time-management. This is the highest and the best 'stone' I've ever had in my life and I'm going to carry on striving for goals and achieving the best that I can and the best that I'm capable of.

Xanthie was at times despairing of ever being able to come off a sickness benefit, but used her time to focus on a re-discovered talent for music:

You know there's a lot of talk about people on a sickness benefit being alcoholics and drug addicts...that it's a life style thing...I thought you cheeky buggers, as if alcoholism and drug addiction aren't diseases in their own right...I have to juggle my money a bit but basically I scrape by...I am working really hard on my music [composing and performing] and if I make it in the music industry great...but if I don't I'm maintaining myself.

Gina was looking to expand her personal understanding of the world and explored the existential nature of her being:

I wanted to experience life...I wanted to make good sound decisions for myself based on rawness and feeling it and knowing it and knowing that I'm doing what's good for me...and that's big...and now I've started philosophy class and I have found that extremely beneficial for my mental and emotional well-being, I've done it all year, philosophy...its a personal philosophy, not like, you know, learning about philosophers. I'm plodding through life at my own speed which I've never experienced in my life before...it's always been at someone else's direction...the kids, my husband, my business, my home, my family, my friends. And I find that wonderfully empowering to do this at my own speed and I hold that very precious and very dear. So anything that threatens that I actually get quite miffed about, and go to some lengths to keep it out of my life. So that's my plot for wellness if that makes any sense...I'm on a benefit at the moment

because it's energy draining having to work and its a full time job getting well isn't it? Like it's not something you could do after work. It's actually a full time job getting well.

For all the participants, *pushing the boundaries* and discovering new and old talents, left them better placed to move to the next phase of *living without the armour, giving back*.

Giving Back

The notion of *giving back* was universal to all the participants. It arises from step twelve of the alcoholics anonymous and hybridised programmes and says:

Having had a spiritual awakening as the result of these steps, we tried to carry this message to others, and to practice these principles in all our affairs (*Alcoholics Anonymous*, 1955).

The sentiment of *giving back* had many translations and took many forms.

Without exception, the main reason for agreeing to participate in this research was that others might benefit. Verity felt strongly that "only a consumer knows what a consumer needs" and that her voice needed to be reflected in my study. Henry reflects the sentiments of all the participants who believed this - that research was a way of 'giving back' indirectly to others who had given to them:

I hope my story makes a difference to other people like me with mental illness and the drugs and alcohol. I didn't think anything like this would ever happen to me, and I want to reassure others that things can get better providing they get treatment and stay away from drugs.

Verity and Teresa regularly talk to the students in my 'coexisting disorders' classes about their experiences as 'consumers' and I am always moved by their generosity of spirit, and the candour with which they are prepared to answer what are, at times, very personal questions.

Verity has just completed her training as a counsellor and is "currently facilitating a dual diagnosis workshop once a week."

Others have become 'sponsors' in the twelve-step programme, a type of mentorship for others not so far along the path to recovery. This equates to Miller and Rollnick's (1991:314) task of being a guide who "needs the qualities of a companion and the skills of someone who knows the route". They describe a road where there will be "unexpected obstacles that the traveler will have to

learn to cope with or avoid. The guide, in turn, will need to encourage and assist, and to recognise where there may be hidden dangers”.

Teresa has become a sponsor for a number of reasons, but one of the things that she says motivates her is:

I want to get a handle on my life and I want to keep it. I also would like to think that other people didn't have to learn the hard way, the way I did.

She hopes that by sharing some of her experiences and acting as a guide to others, she will be able to not only stay on track herself, but help others negotiate the pot-holed road that is *discovering a life*.

'Giving back' for Tony had a wider meaning than simply the message of sobriety. He felt that by teaching English as a second language he could:

Help and support others in a strange land speaking a strange language, not unlike how I felt as I was trying to negotiate my way from adolescence to adulthood. In a round about sort of way, I am helping people in a fashion I would like to have been helped - a bit of translating, a bit of mentoring and a bit of a buffer between them and this world that has become their own.

Giving back wasn't always a direct gift to those who had provided the necessary help and support. Some of those people had moved on to different jobs, travel overseas or had left the health field completely. For the participants in this study, *giving back* had a meaning that acknowledged the wider context of their illness and recovery.



Conclusion

Living without the armour is a present-continuing state of being. Participants have reached a point in their lives where the *intemperate insanity* of mental illness and substance abuse is no long a daily reality. They have come through *the crisis* and made a *recovery* that is stable and lasting. *Living without the armour* involves simultaneously maintaining the changes they have made in their lives, and managing ongoing change to their best advantage. This present continuing phase of their lives involves four distinct strategies. The first is *daily reminders* (of the progress they have made from the days of *intemperate insanity*) and the ongoing commitment to sobriety (one day at a time). The second involves *human connection* that supports and reinforces their commitment to change. *Pushing the boundaries* of their minds, capacities and

philosophies allows them to move forward in their lives in exciting and adventurous ways. And finally *giving back* is a way of acknowledging the support and assistance they had received on their journey. They were not always able to *give back* to the people who have given to them so this task was often a more existential one of giving to others in similar need.

This is the final phase in the five-phase chronicle *discovering a life*. It is an ongoing story that I am compelled to leave at this point by the constraints of the study. But for the participants, the *discovery* continues to provide challenges and rewards on a daily basis.

CHAPTER TEN: JANUS' TEMPLE - SERVICE PROVISION

With malice toward none; with charity for all;...let us strive to finish the work we are in:...to do all which may achieve and cherish a just and lasting peace (Abraham Lincoln, second inaugural address, 4 March 1865, in R. Basler ed. *Collected Works*, 1953, vol. 8).

Introduction

In times of peace, the gates of Janus' Temple were kept shut. Within the walls and closed gates peace and serenity flourished. There are many analogies with the process of 'recovery' in the Janus story. 'Recovery' represents at the same time a 'beginning' of a new phase of life, and the 'end' of an old one. People are developing new habits, skills and friendships as they leave old ones behind. Treatment settings (whether inpatient or outpatient) were the metaphorical temples which provided sanctuary and respite from the turmoil of *intemperate insanity*. They also provided a place of rest and an environment of peace in which 'recovery' could take place.

Living and *discovering a life* is a social activity, not something one undertakes in isolation. All the 'consumer' participants acknowledge help from an outside source, that most frequently being treatment, therapy or counselling. It is the circumstances under which these are provided that captured the energy and imagination of the staff 'participants' in this study. In this chapter I will focus on the structural configurations from within which 'recovery' can take place, and 'maintenance' be supported.

If one considers the trajectory of coexisting disorders on a continuum from acute illness → wellness, services are provided at the level of acute illness, stabilisation and rehabilitation. The time-frame varies according to individual need, but the 1996 *Ministerial Inquiry into Mental Health Services* (pp. 233-234) proposes a model that agrees the immediate/crisis phase lasts two to seven days, the acute phase seven to ten days, the recovery phase, fourteen to twenty days with a follow up phase of six to twelve months. These first two to seven days and subsequent twelve months are the points in time at which consumers engage with services. Because of the nature of coexisting disorders and the needs of consumers, these services are located within a health context and interventions are aimed at symptom amelioration and early recovery strategies.

Services are offered in several ways in New Zealand. Both mental health and alcohol and drug services were identified in the 1993 *Government Strategic Health Plan* as 'core business'. That is, they were considered to be essential to the health and well-being of New Zealanders and New Zealand society. They continue to be provided at a Government level through the DHBs (District Health Boards). In addition, services have also been contracted out to NGO's (non-government organisations) to provide non-acute services in the community. DHB mental health services offer *ad hoc* intervention for drug and alcohol problems in their own client group. This tends to be staff dependent rather than system oriented ie. in many mental health services, interventions around alcohol and drug issues are dependent on individual staff members with the knowledge, skill and interest. When they resign, the service is discontinued. So concerned were they by this random approach to alcohol and drug input to mental health services, Todd et al. (1999:3) recommended that "all mental health services be required to undertake comprehensive assessment and treatment planning of presenting patients which addresses both mental health and alcohol and drug problems." Likewise, alcohol and drug services may or may not deal with a mental health component of a client's problems. The recommendation to this group of services by the same team (Todd, Sellman & Robertson, 1999:3) for structure and development was that "alcohol and drug services...be...partially integrated into Mental Health Services at a managerial level". In Auckland, this has happened, with the result that alcohol and drugs services now have access to the specialist services of a psychiatrist. This provides for the clients with the most severe mental health symptoms, but does not necessarily serve all those with a need. These services are offered on a continuum of care from inpatient to outpatient and are augmented by specialist dual diagnosis services. NGO (non-government organisation) services such as Odyssey House offer recovery in a therapeutic community and organisations such as Challenge Trust give community support to those living in their own homes or supported accommodation.

The *recovery* phase of *discovering a life* was the point at which the paths of staff and consumer participants intersected.

When I asked the staff participants about working with people with coexisting disorders I had expected them to comment on the intrapsychic and relational aspects of recovery for the clients, and their (staff) input into this recovery. By and large, they had a different way of conceptualising client need in recovery. They felt their 'clients' were best served by attending to some of the meta issues of care. These included structural concerns such as who provides the service,

how it is funded, and the operational issues of staffing (including the skill base required).

At each point in *recovery* staff saw themselves assisting the client in *taking responsibility, sobering up, developing skills* and *incorporating* an understanding of mental illness and substance abuse into their identity as human beings. Although they could not *sober up* on the client's behalf, they were able to provide information, offer strategies and support that made this more likely. Assisting with the transition to *taking responsibility* for one's life and life decisions, and *incorporating* the 'illnesses' into images of self, were the final goals of treatment. This happened in a way that allowed the consumer to achieve a balanced and fulfilling life. It was often seen as an 'end point' at which the client was discharged from the service.

Staff did this through addressing the *model conflict* created by having to work with the disparate treatment models of mental health and substance dependence, and attending to concerns about *integrated* and *cultural dimensions* of care. Finally, in order to support the clients appropriately in *recovery*, they worked to resolve issues of *engagement* practices of services and the *skills and knowledge base* of staff.

By focusing on the structural and operational concerns of service provision, the staff participants felt they best contributed to the *recovery* of the client group they served.

Two of the key issues the staff participants raised (*the model conflict* and *integrated care*) are, to some degree, one and the same but I want to deal with them separately here because they require different responses. The *model conflict* is something that can be addressed on a local level with good will and negotiation on the part of the staff involved. The matter of *integrated care* and the related arguments about the provision of *generic or specialist services* are structural in nature and require a systems response with the attendant funding and resourcing issues.



Key Issues for Staff Participants

Integrated Care

More than ten years ago, Minkoff (1989:1031) wrote of the 'dually diagnosed': "...despite the powerful impact of this population on the service delivery system, advances in treatment and training have been surprisingly slow." He

speculates that one possible contributor to this problem of developing established treatment protocols for dual diagnosis patients is "the conflict that frequently arises when addiction treatment programmes and mental health treatment programmes try to collaborate." Minkoff cites Ridgely et al. (1987) as saying "the fields of mental health and substance abuse have different foci, different philosophies and a history of contentious behaviour toward one another." More than twelve years later and 12,000 miles away, it is still an issue we grapple with in our treatment services today (Warren & Wilson, 1994). There are many ways that treatment for both disorders occurring in the one individual can be provided, and this has led to the development of some 'hybrid' programmes that effectively integrate both mental health and substance abuse treatment (Ridgely, 1991:29). However, before treatment can be integrated, a treatment philosophy that incorporates both mental health and substance abuse into a unified conceptual model needs to be developed. Ridgely (1991:30) has trawled the literature on integrated treatment programmes and advanced a set of principles that need to be reflected in essential service elements, no matter where that service is being offered. Interventions need to:

...engage clients in services, motivate them to seek specific substance abuse treatment, provide comprehensive assessment of alcohol and drug and mental health problems, provide concomitant treatment including a core set of mental health and substance abuse treatment interventions, provide or orchestrate relapse prevention or other after-care interventions, and develop linkages between the alcohol, drug and mental health treatment systems.

In this piece of research, treatment to those with coexisting disorders was being provided out of three distinct health services, each with a different orientation; mental health, alcohol and drugs and a specialist dual diagnosis focus. In addition, some of the services were government owned and controlled through the then Crown Health Enterprise system (now District Health Boards), and the others were NGOs (non-government organisations).

Waveney worked for an NGO supporting consumers in the community:

'Coexisting disorders' is coming to be seen as such a specialty that people get scared of it, yet it is not a great mystery. Whilst it is true that consumers do have a lot of needs, and present with a lot of problems, only part of their problem is with their mental health or their alcohol and drug use. The rest is the way these issues impact on managing their lives. Our problem is

often with trying to meet their needs from inside a service that is not set up to cater for them.

Most of the staff working in a 'single provision service' (mental health or alcohol and drugs) were keen to see the establishment of a specialist service to whom they could refer on. Staff working in a designated 'dual diagnosis' service felt overwhelmed by the enormity of the demands on their time, knowledge and skill, and were keen to see generic workers trained up to offer this comprehensive service in a variety of settings. Ivan found one way of keeping his job manageable was by gate-keeping through the referral system to the 'specialist' dual diagnosis service he worked in:

We've tried out a few systems regarding the referral system. It safeguards us from being inundated with a lot of incoming clients...ideally it would be a good process for case managers to do a lot of the basic assessments.

The *Todd Report* (1999:3) was emphatic that "the development of both the specific role of 'dual diagnosis' workers and 'dual diagnosis' units be discouraged". This could be overcome by each specialist service taking on an advisory role for the other.

Model conflict

A variety of models or theoretical orientations are used to inform treatment and therapy that is offered in both psychiatric and addiction settings (Stuart, 1998:55). According to Stuart (1998:55), each model is "a way of organising a complex body of knowledge" and is used clinically to suggest "reasons for the observed behaviour, therapeutic treatment strategies, [and] appropriate roles for patient and therapist" (Stuart, 1998:55). The predominant models of analysis and care in a psychiatric setting are medical and psycho-social. The medical model sees that "behavioural disruptions result from a biological disease process...and treatment consist[s] of medication and supportive therapy" (Stuart, 1998:56). In this world view, the patient complies with prescribed therapy and reports the effects of therapy to the therapist. The therapist (usually a doctor) undertakes an examination, formulates a diagnosis and prescribes a therapeutic approach. Because in this medical view of the presenting behaviour "an abnormality in the transmission of neural impulses...and neurochemicals" (Stuart, 1998:62) is thought to occur, medication that corrects this chemical imbalance is usually part of the solution. Given this theoretical framework for assessment, it follows that the medical model dominates the intervention in the immediate crisis and acute phase of the illness. According to Stuart (1998:62) "therapy is terminated when the

patient's symptoms have remitted", thus making this period in which the medical model dominates somewhat time limited.

However, the medical model on its own does not account for the recovery period in its entirety, and other branches of research "focus on stressors and the human response to stress" (Stuart, 1998:62). The stress adaptation model developed by Stuart (1998:66-81) takes account of the biological, psychological, sociocultural, environmental and legal-ethical context.

Psychological models focus on "the individual and intrapsychic processes and interpersonal experiences" (Stuart,1998:58), and draw heavily on developmental processes and basic human need. Hildegard Peplau (1952, cited in Stuart, 1998) in her ground breaking work on interpersonal processes in nursing, saw the "two interacting components of health [as] physiological demands and interpersonal conditions".

Addiction treatment services are equally beset by model conflicts of their own. The two competing perspectives are at opposite ends of a continuum; from dependence with a solution based on abstinence from all mood/mind altering drugs (Shaw, 1985:35) at one, to brief interventions aimed at reducing the harm caused by problem drinking (Bien, Miller & Tonigan, 1993:315) at the other. The disease hypothesis of dependence is premised on the centrality of psychobiological alterations to the body, and fits with the "cause, symptom, treatment concept" (Shaw, 1985:39) of the medical model and abstinence based therapy. At the other end of the continuum is the harm minimisation/risk reduction model, and while abstinence is the ultimate harm minimisation outcome, harm minimisation is usually interpreted as the antithesis of dependence. Intervention is based on motivational enhancement and has as its goal, "reduction of harm caused by alcohol/drug consumption rather than abstinence" (Bien, Miller & Tonigan, 1993:315).

The Twelve Step approach has always been a source of conflict within 'professional treatment' services. Some 'professionals' see it as a useful adjunct to more psychological treatment models, others see it as a 'blind leading the blind' self help approach that has never opened itself to rigorous scrutiny or evaluation, and has no proven value. While some authors (Twerski, 1993:44) argue that Twelve Step programmes may not be as effective when there is coexisting emotional or psychiatric disease, others (Segal, Silverman & Temkin, 1995) argue that "these types of programmes often have a higher appeal to individuals who...have a dual diagnosis of mental illness and substance abuse disorder than do traditionally operated programmes." Perhaps the issue is not

self-help/Twelve Step versus 'professional' programmes, but the difference between rehabilitation and recovery, with 'professional' treatment services offering rehabilitation and the Twelve Step programmes, recovery.

The final dimension in the 'model conflict' is the training backgrounds of the staff participants. They came from a variety of disciplines (psychology, nursing, social work and counselling), each with their own theoretical traditions and specialist practices. They operated out of an eclectic model of care that was influenced by their training, the predominant model of their workplace, and also accounted for the way in which the 'clients' made sense of their 'illness'.

It was the competing demands and capacities of the medical, psychosocial and cultural models that provided a challenge to staff to find a way of working in the 'inter-model space'.

Most of the staff participants were working with people in the acute/sub-acute phase of an active episode of mental illness or addiction. Most of their clientele were in the process of detoxification and/or still being medicated and many were still experiencing alterations in perception in one or more of the five sensory modalities (sight, sound, smell, taste, and touch). Staff spent energy in helping to manage 'symptoms' at the same time as trying to re-integrate consumers back into the community from which they had come. This necessitated a flexible and integrative approach using two or more potentially conflicting models. The models of mental health and addiction treatment.

Waveney was working in a community mental health environment that took clients straight from an acute setting:

As health professionals...in relation to dual diagnosis, we're still upgrading out of a medical model, and that actually stands in the way of doing what you need to do to work with this group of people...there are ways around it and we can be creative with it...but I also think as health professionals we need to challenge the medical model...and encourage self-responsibility. It's almost like we've got a bit of a brokering role.

For staff working in an alcohol and drug setting the problems became even greater. From a community alcohol and drug service Toni found that:

...about a third of my client group has a dual diagnosis...long complicated looking stuff...and its difficult because we are a service that's set up to be a brief intervention service...I mean I have a client now who I've been seeing for almost two years, so

this is not brief intervention...I've had to get an okay from the management to go on seeing her.

Whatever the model that informed their clinical practise, Todd et al. (1999:3) argued that "all patients with coexisting disorders [must] have access to mental health and alcohol and drug clinicians who have adequate skills to assess, formulate and implement treatment plans...including their cultural needs."

Meeting Cultural Needs

The socio-cultural model focuses on the importance that culture and social conditions play in both the definition of mental illness and addiction, and the solutions to them. Within the New Zealand context, there are a number of indigenous perspectives that inform mental health (and subsequently alcohol and drug treatment) provision (Durie, 1994:67). The Whare Tapa Wha model forms not only the basis of Maori health provision in Iwi-based treatment services, but it has been adapted in many forms into mainstream services:

...Briefly, the whare tapa wha model compared health to the four walls of a house, all four being necessary to ensure strength and symmetry, though each representing a different dimension: taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whanau (the family). (Durie, 1994:67)

According to Durie (1994:71), these four dimensions of health were originally portrayed as a set of interacting variables, not dissimilar from the holistic view that is familiar to most health professionals in New Zealand. Western health practices have been informed by the World Health Organisation (WHO) cognate holistic definition of health:

...a state of complete physical and social well being, and not merely the absence of disease or infirmity. (Miller & Keane)

However, unlike the WHO understanding of health, the Whare Tapa Wha model is "firmly anchored on a spiritual rather than a somatic base" (Durie, 1994:71).

Todd et al. (1999:3-4) made two recommendations in respect to Maori. Firstly, that Maori "have the responsibility for developing a specific strategic plan for Maori patients with coexisting disorders", and secondly, that they (the project team) support the development of appropriately skilled Maori health workers who have the expertise and knowledge to undertake clinical case management."

Two of the staff participants whilst working in mainstream organisations, principally served Pacific and Maori clients. For Sila and Baley, the cultural component adds another dimension. Sila reflects on his work with his own Pacific Nations clients:

I approach things...basically all my clients from a holistic perspective...the Pacific Island way...it comes naturally to me. I s'pose I tend to lean more on the social side of things. A couple of guys that I'm working with now...it seems to be an induced psychosis...drug and alcohol...all of those symptoms of hallucinations and delusions and all those things that psychiatrists would love to make a diagnosis of...I think that my role is to try and make these people aware and hopefully divert them away from the medical model. But there are those who really need medication...I'm sort of a bit balancing...but we all have our preferences and I prefer them not to be on medication because it's not the culturally appropriate thing...but then you've got to take on board why the medication's there...what sort of illness this person is suffering together with the drug and alcohol use and abuse. Not all Pacific Islanders would agree with what I've just said.

Baley, although Pakeha and traditionally trained in Western psychologies is committed to a kaupapa Maori way of working with people with coexisting disorders:

I've always thought that Maori kaupapa, holistic approach is the best approach for dual diagnosis. You have to look at it that way...it really lines up...you can't just look at the medical...the environment's probably one of the most important things. If a person's in an environment where their family's drinking and their only social activities involve drinking, you can do as much psychotherapy as you wish but...

Here he leaves the interviewer to speculate about the outcome of psychotherapy in such an environment before going on to talk more about the value of the holistic approach:

Treatment based on the Maori kaupapa holistic perspective...and the spiritual dimension...the mental and everything...has become quite productive...it works. The Kaupapa Maori gives a person back his life and identity. Making that person whole. The problem with mental illness is that it eats people up.

None of the Maori participants had been able to get their acute/early recovery needs met in a Maori treatment service and Verity had opted to "take whatever

I can where ever I can get it...I will translate it [the treatment] into my cultural understanding later on".

Skills/Knowledge Base

Whatever the feeling about *generic vs specialist services*, all staff saw a base-line of knowledge and skill for all workers as essential in both mental health and alcohol and drug services that would enable them to both manage and respond to the needs of clients presenting at their agencies.

Victoria, commenting on the recent establishment of a specialist dual diagnosis service in her area, expressed frustration about the lack of skills and knowledge of both disorders in her co-workers in an alcohol and drug setting:

...There's no point in having a specialised dual diagnosis team if the rest of the staff don't recognise or can't identify it [dual diagnosis] or are frightened to ask because they'll be seen as stupid, then its not going to work. There needs to be a broad skill base amongst all the staff to include knowledge and skills in dealing with dual diagnosis, drugs, trauma, sexual abuse and head injury.

According to Minkoff (1996:191):

The most significant predictor of treatment success [in working with coexisting disorders] is the presence of an empathic, hopeful, continuous treatment relationship, in which integrated treatment and coordination of care can take place through multiple treatment episodes.

This lends weight to the argument that there are better outcomes for the client who is treated and managed in the service with which they are familiar, by a person with whom they have built up a relationship of trust, than to be transferred to a 'specialist' service.

Yvonne, in a specialist dual diagnosis service, spends time trying to persuade and support staff in single focus services to continue to work with clients they know well rather than refer on, and speculates why they might not:

I say to them you're the best one to raise the awareness [of the issues] because you're the one with the rapport...I think sometimes it's a way of people getting out of work. And because these clients are usually so complicated on many fronts, instead of being able to say well this is the social aspect and this is the spiritual or whatever, instead of being able to work through each one its just 'why are we burdened with

these really hard ones that are a bit harder than all the others?
They just pass it on to somebody who's meant to be a specialist.

Todd, Sellman and Robertson (1999) advocate that some clinicians should be encouraged to develop a special interest in coexisting disorders within the service they work in, but all clinicians should have a working knowledge and skills in the area.

Engagement

According to the New Hampshire Model (cited in Curtis, 1996), assertive engagement is a necessary strategy for encouraging consumers into treatment and support services. Most alcohol and drug centres are not set up to offer this facility. Appointments are made and if not kept, followed up by a letter offering the client to recontact and make another appointment. With a 'lack of volition' (self motivation) being one of the main features of 'coexisting disorders' in the acute phase, it is unlikely that they will re-contact under these conditions. According to Toni working in an alcohol and drug service, "we have no way of knowing what happens to people who DNA (do not attend) unless they re-present in another crisis."

The *Todd Report* (1999:4) is emphatic that "clinicians practice assertive outreach and follow-up and that patients who miss appointments are enthusiastically followed up." According to Toni "currently this does not happen in my community alcohol and drug treatment setting".

Another component of engagement is that the client must see "you have something to offer, that they will benefit from engaging with your service" (Curtis, 1998). For Victoria, working in an alcohol and drug setting, the operational brief of the service presents problems in engaging people with coexisting disorders:

If you haven't got much to offer other than motivational interviewing and a little bit of drug and alcohol education then that's all you can offer. You don't know whether the client is able to use that information if there's other issues going on...you get clients who use drugs and alcohol to self medicate for mood problems and voices or whatever, and sure they come here and they're encouraged to stop drinking. They stop drinking and do it successfully for three months and they're back to square one. Then they don't have any contact for two years because we weren't useful last time, then the staff change and we get the feedback that it didn't work.

This sentiment had been earlier expressed at an official level. In 1994, the Ministry of Health produced *Guidelines for Managing Co-existing Psychiatric and Substance Use Disorders*. In 1997, the National Centre for Treatment Development (NCTD) in Christchurch was contracted to go beyond this document and "produce guidelines that were useful for clinicians working in both the alcohol and drug sector and the mental health sector" (Todd, Sellman & Robertson, 1999:6). Of the needs they identified as being central to any further work that was done in this area was:

1. The need to find treatments that work for their individual problems [and]
2. The need to offer those treatments to the patient in a way that makes it easy for the patients to accept them.

Clearly, this still remains a need.

Personal values, beliefs and attitudes of the staff, and the way they influenced 'care' were also part of the engagement and treatment concerns for my staff participants. Waveney felt strongly that:

The values, attitudes and beliefs of the staff are important. It doesn't just mean doing an assessment and intervention...its about being aware of their own interpersonal style and their relations with the client because that can present a huge barrier around engaging people in any kind of treatment or treatment plan.

Waveney also expressed concern about the number of people working in NGO community support roles without professional qualifications or training and illustrated this with an example that she felt typified the problem:

I can think of one person who comes from a background as a security officer. He doesn't have a lot of related skills or huge expertise and his behaviour with clients is reflected in his past experience. You know, things like self-determination, accepting responsibility for your own actions...all those really base-line things aren't incorporated into the interactions with the client on a day to day basis.

The final concern was about the way their own alcohol and drug taking habits impacted on the staff's ability to offer professional care:

From a worker's perspective, you're a bit reluctant to talk to the client...especially about their drinking, because if you've fallen below the line on one night or whatever, you think 'shit, maybe I'm over indulging'.

Engagement is a complex and diverse issue. It is influenced by the focus of the service being accessed, the nature of the illness, and the beliefs, skills and training of the staff *engaging* with consumers. It has been identified as an issue in service reviews, and still requires attention if services are to be made more 'customer focused'.



Conclusion

Recovery is the phase of *discovering a life* that is the most public. It is the point in the consumers' lives where they formally engage with treatment services. This involves input from health professionals in the form of 'treatment', advice, therapy and support. The focus for both consumers and service providers is on 'restoring health' but this focus is manifested in different ways for each group.

Although the staff operate from a 'client-centred' model that supports and enhances each step of the *recovery* journey, their (staff) energies centre on structural concerns. Arguments about *integrated* services stand in the way of staff acting in the best interests of the client. This is further complicated by the disparate *engagement* practices of each service. A *model conflict*, or at best a lack of integration of a range of eclectic approaches to coexisting disorders serves to undermine the veracity of each approach. As services expand into the community, and the trend of employing 'untrained' staff escalates, the *skills* and *knowledge base* of staff working with consumers becomes an increasing concern.

Wherever the consumers accessed their treatment and or support, whatever model was employed by the organisation, it was uniformly the presence of an empathic, hopeful, continuous treatment relationship with a named individual, and a readiness for permanent change on the part of the consumer, that were the most significant predictors of a positive outcome of *recovery*.

CHAPTER ELEVEN: LITERATURE REVIEW

Un-dish-cover the fish, or dishcover the riddle (Lewis Carroll,
Through the Looking Glass Ch 9)

Introduction

There are three distinct bodies of literature germane to this piece of research. The first deals with the 'mainstream' view of coexisting disorders within the context of a medical model. It has been addressed in Chapter Five, "The Field". It is literature that researches, records, informs and debates the diagnosis and treatment of coexisting disorders within a medical context.

It has been used in this thesis to provide a background for the issues and to outline the contemporary scholarship about coexisting disorders; to locate the thesis in an established field of knowledge.

The theoretical understandings of this thesis were developed out of the data, and took a different direction. The second body of literature that best informs an analysis of the data grew out of the 'recovery' material. 'Recovery' has its genesis in Jungian psychotherapy and the term has been coined by both the substance abuse and mental health fields. It forms a genre of its own and crosses the disciplinary boundaries of self-help, mental health and alcohol and drug literature. Sources for this literature were more diverse. A search of the academic data bases using the key words *coexisting disorders* and *dual diagnosis* with the addition of *recovery* yielded some one hundred and fourteen articles. Additional sources of literature were located in books, policy documents, and unpublished papers.

Finally, a third body of literature is emerging in the local context, that of service provision in New Zealand.

The results chapters separate the two major bodies of work. The literature that addresses the mainstream concerns of coexisting disorders has been placed before the data in the thesis, in the tradition of a conventional literature review. The latter two bodies of literature, recovery and service provision, arise out of the data and will be reviewed here.

Recovery

Much of the 'recovery' literature found in mainstream mental health and substance abuse publications, (Laudet, Magura, Vogel & Knight, 2000, Kasten, 1998, Miller & Gold 1997, and Goldfarb, Galatnter, McDowell, Lifshutz & Dermatis, 1997) assumes an understanding of 'recovery' that is never explicated. Laudet et al. (2000) interview more than three hundred members of self-help groups "concerning the challenges confronting them in their recovery" and discusses the interrelations of the issues. They focus on the participants' struggle with emotional and socioeconomic issues which then impacts on their ability to manage other aspects of 'recovery'. However, they never define 'recovery', instead relying on an amorphous understanding of the concept by the reader that makes it difficult to comprehend what is being examined, discussed and critiqued.

Failure to define 'recovery' or theorise about it had lead to some conflicting views about its nature and efficacy. Each stake-holder has their own agenda and set of expectations relating to 'recovery'. Whilst it is important that there is flexibility and a range of interpretations that allow the notion of 'recovery' to suit individual needs and differences, there is also the danger that a lack of definition means that the goal posts are always moving and 'recovery' can never be achieved.

According to Curtis (1997) most of the literature on a recovery approach for people with major mental illness comes from the United States and has three main ideological sources:

1. The 'Power of Positive Thinking', Twelve Step groups, co-dependency, self-help and 'new age' philosophies.
2. The mental health service user movement, and its underlying philosophy of human rights and self determination.
3. Psychiatric rehabilitation with its focus on community integration and overcoming functional limitations.

The material in this chapter is organised in two ways. The first uses the schema of diverse ideological sources to define and distinguish between the approaches to 'recovery'. A section has been included that compares the efficacy and effectiveness of different models in the clinical context. The second method of organisation is thematic, according to the elements that are common to recovery across ideological models and examines the 'essence' and tools of

recovery, recovery as a process and the application of recovery principles in the clinical context. However, like much of the material in this thesis, the demarcation between ideas and strategies is an artifice of academic understanding. Most 'recovery' approaches are not theoretically pure with many being a synthesis of models combined to suit the purposes of the user. Neither do all (or many) of the authors declare their theoretical position. The assumptions that inform their analysis are implicit rather than explicit.

The main critique of this body of literature will be found in the 'discussion' chapter. It will be matched against the data generated by the participants of this study and used to advance new ideas about 'recovery' and propose a model of 'discovery'.

Twelve Step, Self-Help and 'New Age' Philosophies

Each of these approaches differs significantly from the more usual treatments in that the fellowship of other recovering persons, rather than professional help, is seen as the crucial intervention. The self-help and new age literature is vast, and I was guided here by the types of material recommended and accessed by the consumer participant group.

Alcoholics Anonymous (AA), an originator of many concepts which characterise recovery in addictions treatment, self-help and peer support, is based on the conviction that recovery requires participatory self-management: an individual must be active in participating in making changes in his/her life about values, beliefs, and ways of living. There is no room for passively waiting to be "cured." The AA philosophy also operates on the basis that this personal commitment to action must be long-term, that the recovery process is ongoing, individual, and non-linear, and that it requires continued support from people with shared experiences (Brown, 1983). Members attend regular self-help meetings based on the twelve steps and twelve traditions of Alcoholics Anonymous (Nuckols, 1993). These have been adapted to meet the needs of people with coexisting disorders. Through this process, they acknowledge they do not have complete power over the problem of coexisting disorders, they seek help from others in coming to terms with this and offer support to those with similar problems. They find a spiritual connection by turning to a higher power "greater than ourselves", face the problem with humility, make amends to those they have harmed by their behaviour and seek to achieve "sobriety and emotional well-being" (Nuckols, 1993:54).

Laudet, Magura, Vogel and Knight (2000) found that people with higher levels of support and greater participation in dual-recovery self-help groups reported

less substance use, less mental health distress and higher levels of well-being than those who did not. My participant group seem to be influenced by this 'life-long', 'do-it-yourself' school of thought, but only half of them actively participated in any Twelve Step programme. Of those who did not currently follow the AA practices, most had been exposed to the Twelve Step approach in addiction treatment settings and remained attached to its philosophy. It is not as widely promoted in mental health settings but can equally be applied legitimately to those with mental illness. It has been applied particularly well to the lives of my participants with coexisting disorders.

Many of the articles sourced for this chapter from the mainstream literature focus on the efficacy of various models used in treatment settings for people with coexisting disorders, and will be analysed later in this chapter. The Twelve Step model is most frequently compared with behavioural and 'case management' approaches. The Twelve Step approach has allowed the participants to step outside of, and at the same time integrate the essence of, the medical model approach into their well-being.

In a qualitative study of mentally-ill adults with co-occurring substance use disorders using self-help groups, Kasten (1998) found that the 'spiritual' component of recovery was important for continued well-being. Defining the human spiritual dimension has been problematic (Ross, 1994:33). Early understandings of spirituality in the nursing literature found that it was equated to or used synonymously with institutionalised religion (Kreidler, 1978). However, later definitions (Renetzky, 1978) capture the essence more comprehensively. Renetzky (1978) defines the spiritual dimension in terms of its three component parts: "the need for meaning, purpose and fulfilment in life, the need for hope and the need for belief and faith in self, others and a power beyond self".

The 'spiritual' beliefs of patients with dual disorders and medical students were assessed (Goldfarb, Galanter, McDowell, Lifshutz & Dermatis, 1997). The patient group place considerably more importance on the place of religion and spirituality in their recovery and Goldfarb et al. (1997) postulated that it might be "clinically relevant to train medical students in the potential importance of spirituality in addiction treatment so that spirituality may be incorporated into addiction treatment".

The *New Age* (1907-1922) was a London-based, left-wing weekly review that carried the work of important radical or new writers (*The Fontana Dictionary of Modern Thought*, 1988). It acted as a literary, cultural and political clearing

house that recorded changing responses to the time. 'New age' now appears to be another of those terms that has acquired a contemporary understanding without definition. It has been applied in this context to a continuum of self-improvement approaches that fall outside the mainstream of psychology and medicine. In spite of being used to describe 'alternative' therapies, 'new age' is neither a new nor homogenous entity. The participants in this study have their own mix and match approach to wellness, but there are some underlying principles that seem to have been the same for all of them. According to Moore (1994:xi) "the great malady of the twentieth century, implicated in all of our troubles and affecting us individually and socially, is 'loss of soul'. When soul is neglected, it doesn't just go away; it appears symptomatically in obsessions, addictions, violence, and loss of meaning." It is this reclamation of 'soul' that binds the intentions of the participants in this study. Like 'new age', 'soul' is a term that has been adopted into the language of recovery without explication. The *Concise Oxford Dictionary*, describes it as the "spiritual or immaterial part of man". The participants, whilst unable to be precise about the nature of 'soul', used the word in relation to the 'spiritual' component of their being, and to distinguish this from mainstream religious practices and protocols.

In addition to the Twelve Step, AA-based literature already mentioned, 'soul reclamation' was achieved with support from the writings of many authors including the mythical works of Joseph Campbell (1989), M. Scott Peck (*The Road Less Travelled*, 1990), James Redfield (*The Celestine Prophecy*, 1993), The *Course in Miracles* (1975) workbook, and Thomas Moore's *Care of the Soul* (1994). One of the participants combined the above 'new age' approach with daily readings from a more traditional book of *Bible Meditations* from the Catholic Book Publishing Company.

According to Moore (1994), soul work adds another dimension to the struggle of release from the troubles and pains of human existence. "Care of the soul touches another dimension, in no way separate from life, but not identical either with the problem solving that occupies much of our consciousness" (Moore, 1994:304). He argues that we care for the soul by "honouring its expressions, by giving it time and opportunity to reveal itself, and by living like in a way that fosters the depth, interiority, and quality in which it flourishes" (Moore, 1994:304).

The Mental Health Service User Movement

The literature of the 'mental health user' is frequently written in the first person or clearly locates the individual at the centre of the narrative. The underlying philosophy of human rights and self-determination that informs the mental

health service user movement grew out of an international trend in the 1980s and 1990s that moved patients out of the public psychiatric institutions into the community. This was influenced by a number of factors:

...the periodic public outcry about deplorable conditions [in psychiatric hospitals]; the recognition that hospitalisation labelled as separate, produced stigma, fostered chronicity, and promoted symptoms and interaction based on the sick role; the introduction of anti-psychotic drugs which alleviated many of the distressing psychotic symptoms; and the civil rights movement [that] questioned whether it is ethically permissible to lock people away for the rest of their lives. (Mason, 1988:135)

Based on this philosophy of human rights and self-determination, Curtis (1998) argues for 'recovery' as "a process, a critical stage of which involves [sic] people moving beyond disability, in fact no longer considering themselves, or being considered primarily disabled, impaired or dysfunctional". Kramer and Cagne (1998) define recovery as "a process by which people with psychiatric disabilities rebuild and further develop personal, social, environmental, and spiritual connections in their lives. It is a process of adjusting one's attitude feelings, perceptions, and goals in life and a process of self-discovery, self-renewal, and transformation". They link the notion of recovery closely to that of empowerment and offer two definitions for the latter. The first defines empowerment as "connecting with a community of peers and caregivers on a mutually respectful level and fully participating in the decisions affecting one's life." The second defines it as "a developmental process through which people become more able to influence those people and organisations that effect [sic] their lives and the lives of those they care about." They also outline some beliefs and requisite steps vital to the empowerment process arguing that people, individually or in groups, must develop a greater sense of self-worth and self-confidence; there must be a change in people's perceptions of their relations with other people and with institutions that define their social world; and implicit in this definition is the belief that individuals know what is best for themselves and their families.

Copeland, Curtis and Palmer (1996) synthesise a definition of recovery that was developed by participants in recovery skills training programmes and includes many of the perspectives articulated in the existing definitions:

Recovery is a process and an attitude, not a place. It is about regaining what may have been lost: rights, roles, responsibilities, decisions, potential, and support. It is not about symptom elimination, but about what an individual wants in his/her life, how he/she can get it, and how others

can help/support the individual to get there. It is about rekindling hope for a productive present and a rewarding future - and believing that one deserves it! Recovery involves people having a personal vision of the life they want to live, seeing and changing patterns, discovering that symptoms can be managed and doing it, finding new ways and reasons for doing it and doing more of what works and less of what doesn't. Recovery is about reclaiming the roles of a 'healthy' person, rather than living life as a 'sick' person. Recovery is about getting there.

Deegan (1997) is an academic who identifies as being a mental health consumer and describes recovery as, in part, *emerging from* an individual, rather than being *imposed upon* an individual. The goal of recovery is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability. The aspiration to live, work, and love in a community in which one makes a significant contribution. For Weisburg (1995), recovery means growing beyond the experience of having (or being labeled with) a mental illness and developing a new meaning and purpose in one's life.

Carling (1995) moves beyond recovery as a personal ambition and emphasises social action as a core element in the recovery process. "Persons in powerless positions must come to an awareness of their own oppression before they can embrace change. They must understand the nature of that oppression, and then choose to assert their power in order to resist the oppression" (Carling, 1995:109). The rise of consumer advocacy organisations and the peer support movement in many ways is reflective of this view of recovery. Many individuals, both in the literature and this study, comment on how important this movement has been to their own recovery, both in terms of their own empowerment and because of the inspiration, validation, and guidance they receive from finding other people who have "been there" and are "making it."

From Psychiatric Rehabilitation to Recovery

Psychiatric rehabilitation grew out of a need to create opportunities for people diagnosed with severe mental illness to live, learn and work in their own communities (Sundeen, 1998:244). This model proposes that mental illness be perceived as a disability and that people with mental illness need a wide range of services over extended periods of time in the same way as people with physical disabilities (Sundeen, 1998). The focus is on wellness not illness and intervention is based on the person's abilities and functional behaviour. The psychiatric rehabilitation model forms the basis of intervention offered by

mental health services and is seen in the context of the “patient and the social system” (Sundeen, 1998:245). Out of this model, principles and skills-based programmes have been developed. In New Zealand, the Mental Health Commission (MHC) *Blueprint for Mental Health Services in New Zealand – How things need to be done* (1998:16-18), moves away from using ‘rehabilitation’ language and advocates “people working in mental health services must use a recovery approach in their work”. ‘Recovery’ principles are being used to provide a set of guidelines which mental health services must “translate into measurable criteria for service delivery” (MHC, 1998:16), and links the self-help basis of recovery with the service-provision orientation of rehabilitation.

The *Blueprint on Recovery and Discrimination* (1998) talks about recovery as a “journey as much as a destination”. They acknowledge it is different for everyone. “For some with mental illness, recovery is a road they travel on once or twice, to a destination that is relatively easy to find. For others, recovery is more like a maze with an elusive destination, a maze that takes a lifetime to navigate”. “Recovery is happening when people can live well in the presence or absence of their mental illness, and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination”. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.

Lefley (1994) focuses on the artificial distinction between ‘cure’ and ‘care’ in western cultures which influences how clinical and disability services are conceived and delivered. Many treatment and rehabilitation programmes for persons with mental disorders, provide care, symptom management, and assistance in coping with concurrent disabilities, but have frequently given up hope of individuals achieving significant amelioration of the underlying disorder. Additionally many of these programmes choose to ‘treat’ people in compartmentalised programmes, outside of the fabric of their community, social and family lives. By contrast, Sowers and Golden (1999) argue for the necessity of pharmacological interventions as a pre-requisite for recovery from both disorders.

Psycho-education as a way of understanding the ‘addiction’ component of dual disorders is seen as important for patients in a hospital-based mental health setting (Pollack, Steubben & Sobhan, 1997). Pollack and Steubben (1998) develop this earlier work and propose a model of addiction education groups as a resource for clinicians.

Nancy Smyth (1997) presents a motivational model that helps engage and motivate clients to make the changes necessary for recovery from both disorders. Frequently clients recognise either mental illness or substance abuse as a problem, but Smyth (1997) argues they need to accept help for both.

Mead (1997) characterises recovery as a role-reclamation and the shift from seeing oneself primarily as a "patient or sick person" to asserting an identity which fully embraces the roles of other persons of similar age, gender, culture, and background: worker, parent, lover, friend, retiree, tenant, home-owner. She emphasises the need to move beyond perceptions of disability which can perpetuate self-limitations and learned helplessness. Social models of treatment (Weinberg & Koegel, 1996) focus on the process of treatment itself, the formulation of clinical identities, recovery, personal responsibility and authority within the context of the 'therapeutic group process' (Stuart & Laraia, 1998).

Copeland (1994) identifies a number of elements that she sees as being 'core' to recovery. These have formed the basis of service provision in psychiatric rehabilitation settings. 'Hope' is the belief that change and a better life is not only possible but attainable. 'Personal responsibility' means not counting on others to solve one's problems or 'cure' the disorder, but relying on one's self with help from others. 'Self-advocacy' re-establishes control over one's personal life, rights, and responsibilities. 'Education' includes learning about the disorder, one's self, what can be done, and what is available to help. Finally *support* involves assistance from friends, family, and professional health/mental health care givers.

Summary

Whilst there is a plethora of ideas about what constitutes the recovery process, there is no clear-cut consensus at this point. The essence of recovery focuses on the subjective experience of each consumer and each person's approach to recovery is unique. It is therefore important to understand how each individual chooses to define his/her experience with psychiatric symptoms and the meaning he or she gives to this experience in their life (Hatfield, 1994). The complexity and personal richness of recovery will be lost if left to the professionals to define in isolation from consumers (Mowbray & Moxley, 1997).

A Comparison of Models and Model Effectiveness

The relative effectiveness of different models, with different client groups in different treatment settings has been the focus of a number of studies in the last

five years. This literature is located within the mainstream psychological and psychiatric journals. Various combinations of the disease-and-recovery model, the cognitive-behavioural model, the Twelve Step/self-help approach, assertive community treatment (ACT) and intensive case management were compared.

Assertive community treatment is "an intensive community intervention programme, undertaken by case managers with small caseloads and twenty four hour responsibility for their clients, in which a multi-disciplinary team works with patients in their homes, neighbourhoods, and workplaces, providing varying intensities of services, depending on patient need (Stuart & Laraia 1998). This is different from intensive case management which is "aimed at linking the service system to the patient and coordinating the service components so that the patient can achieve successful community living (Stuart & Laraia 1998).

Two approaches to the provision of care to people with a dual diagnosis of substance abuse and personality disorder were compared (Fisher & Bentley, 1996). Using a quasi experimental design, 'patients' from an inpatient and outpatient treatment setting were randomly allocated to groups using either the disease-and-recovery model or the cognitive-behavioural model, and compared to a third group who were given the "usual group therapy". Both inpatient groups responded better to the interventions than the control group, but in the community, cognitive-behavioural group therapy was significantly more effective than the other two approaches across all measures. The outcomes were measured on alcohol use, drug use, social and family relations and psychological functioning. In a 1996 study, J. Jerrell concluded that mental health care augmented by behavioural skills intervention was more effective than case management and modified Twelve Step recovery. However three years later in a subsequent study, Jerrell and Ridgely (1999) took the same behavioural skills training, Twelve Step recovery and intensive case management and factored for 'robustness' of implementation. They concluded that it wasn't the approach *per se* that influenced the success of the treatment, but the robustness with which the planned intervention was managed. The same researchers (Jerrell & Ridgely, 1995) had previously assessed the three intervention models (behavioural skills training, intensive case management and Twelve Step recovery) in relation to gender. Although the women in the sample had more psychiatric symptomatology than the men in the study the outcomes for the women were more positive on psychosocial measures, psychiatric symptomatology, substance use and service utilisation.

Whilst it is good to see comparative studies, it was difficult to find a great range of material. Most of the literature was created by the same authors out of, what appeared to be, the one study. Where clients were randomly assigned using a quasi experimental approach, there was no factoring for individual preference or 'client matching'. The motivational 'readiness for change' was not assessed in the client group and may have affected the efficacy of the approach in individual cases.

Whilst each of the key ideological sources that inform the task we call 'recovery' is important, Mobray and Moxley (1997) argue that:

...rarely is any *one* of these components in isolation of the others, sufficient to kindle and/or foster the recovery process of any individual. Each of these components should be seen as valuable tools to be used by the individual to reach personal growth goals as he/she sees fit. There is some suggestion, however, that consumer service provision/peer support may be an essential feature of any support system devoted to recovery.

Curtis (1997) has developed a model of recovery that simultaneously draws from and transcends at least three bases of knowledge: medical/clinical 'treatment', psychiatric rehabilitation/skill focused coping; and self-help and peer support. She sees each of these as a point on a triangle that embraces recovery.

The Essence of Recovery

Whatever the underlying philosophical orientation of recovery, there are some universal assumptions, principles, elements, tasks, and tools that cross all ideological boundaries. It became impossible to separate these out so they are discussed here in their totality with reference to the underlying philosophical orientation where necessary.

Authors and organisations from a variety of perspectives (Anthony, 1993; Trinity College of Vermont; Alcoholics Anonymous, 1955; Miller & Rollnick, 1996) agree that recovery is a highly individualised, personal and ongoing process, with the "establishment of a sense of control or free-will" critical to its success (Anthony, 1993; Blanch et al., 1995). This includes a responsibility to "Remember your track record...learn from observing your own mental and emotional behaviour...[being prepared to] have core beliefs challenged, staying grounded, and not going into...old behaviour patterns" (Curtis, 1997).

Its path is not linear, but entails personal growth, plateaus, setbacks, relapses, "sidetracks and fast tracks". Some authors (Anthony, 1993; Miller & Rollnick, 1996) argue that recovery can occur without professional intervention, but agree the presence of people who believe in and stand by the person with coexisting disorders is essential. In fact, maintaining or developing connections to valued activities and people is paramount. Social and personal connection is closely linked to the universal constituent of recovery: hope (Yalom & Vinogradov, 1989). Hope is a feeling or expectation that things can and will improve. It is the sense that what has been lost can be regained: "health, self-esteem, sense of place in the world, family, friends, material and emotional security, potential, belief in a positive future, autonomy and control" (Anthony, 1993). Even more than this, Anthony (1993) argues that "recovery would mean returning to 're-recovery.' In other words, it was like how I was before psychosis - combined with all the things I've learned from the process". However, 'recovery' is not just about overcoming illness and the experience of symptoms, it relates to the secondary assaults of stigma, discrimination, and abuse (Anthony, 1993; Blanch et al., 1995), and significant 'anti-discrimination' campaigns have been established to target the staff of health and welfare services as well as the general public (Project to Counter Stigma & Discrimination associated with Mental Illness - formerly Health Funding Authority, now Ministry of Health Public Health Team). Finally, recovery is a process of "finding meaning in your experience".

Tools for Recovery

There is a rich body of knowledge accumulating in the literature and in practical experience about specific tools and strategies which people use to cope on a day-to-day basis with the symptoms of psychiatric disorders. This also transcends the debate about philosophical underpinning, and although some approaches privilege one strategy over another, all tools cross the boundaries and can be found as a component of most treatments (Deegan, 1995; Trinity College of Vermont; and Copeland, 1992; 1994; 1996). Finding other people who have "been there" and learning from them is also consistent with the AA strategy of 'fellowship' and self-help. All the approaches require individuals to have an "awareness and understanding of self, patterns [and] preferences". Self-monitoring of patterns and changes takes many forms, with AA members attending regular 'step' meetings, follow-up appointments with the psychiatrist or key worker in mental health settings, and 'maintenance' groups in addiction treatment facilities. Other tasks, such as identifying triggers and early warning signs, creating and maintaining a personal support network and crisis planning, are also addressed at the same time. This all contributes to

developing a lifestyle that enhances wellness, and fundamental to this healthy lifestyle is good medical care and compliance with medication (particularly the psychotropic drugs that ameliorate the symptoms of psychosis).

Recovery as a Process

Closely linked to the aims and tools of recovery, is the concept recovery as a process. This is to imply some kind of progression between two points. Much of the literature discussed so far assumes that mental illness and substance abuse are life-long problems that require constant attention, not one-off events that can be dealt with by a single hospital admission or course of treatment. Curtis (1998) presents the recovery process as growth in five stages. She also talks about 'incorporat[ing] this new learning into who she is. The five stages are:

1. The wound - all the painful past experiences in her life. It is Being with that inner pain until it is no longer tolerable;
2. Separation - the psychosis cuts me off from friends and family. I am not trusting. There is 'the silence' - a kind of disconnection from the relational world;
3. Healing - Coming out of psychosis. It is being supported. It is being sick and tired and angry with where I am and having a willingness to try new things. In the beginning medications can be helpful, but mostly I need unconditional love and support from people I trust;
4. Execution - my relationships become more mutual. I am more open, more capable of being vulnerable and more willing to make changes that sustain health relationships;
5. Maintenance - means that I strengthen an automatic response to making a commitment to maintaining trusting relationships.

Recovery is Not Rehabilitation

Although many of the goals and principles of rehabilitation are the same as those of recovery (Stuart & Laraia, 1998:345), Curtis (1997:17) argues that they are not the same thing. According to Curtis (1997:17), rehabilitation services offer "help with learning skills, building resources, creating personal networks, accommodation and vocational support, and developing life goals", and "cannot and should not be construed as recovery programmes." If recovery is conceptualised as "the lived experience of rehabilitation" (Deegan, 1998), or "self-directed rehabilitation" then the best a service can become is 'recovery-oriented', and according to Curtis (1997:17) this would take a commitment on the part of the service to "making significant changes in policy, practice and power distribution." Curtis (1997) argues that the challenge for rehabilitation services is to ignite the spark of recovery and foster its process in individuals,

and to “ruthlessly identify” which aspects of their programmes do this and which do not.

Recovery and Service Provision

“Reorienting our vision about the possibilities for those we serve requires a belief, not only that recovery is a possibility, but more emphatically that it may be inevitable” (Curtis, 1998:34). Curtis (1998:34) outlines some “shifts in thinking: implications for mental health systems” that are required to provide recovery focused service. Without these shifts, she argues, we run the risk of “put[ting] old wine in new bottles”.

The first shift is to a belief that ALL (my emphasis) people are able to ‘get better’. ‘Better’ means “having the more difficult symptoms either become minimal or non-existent” (Curtis, 1998:23). It also means that the “previously disabled person moved from a place of feeling like a person with a ‘mental illness’ to just a person with their own unique manifestations of stress and challenges”(Curtis, 1998:23). This self-identification change is fundamental to thinking about the “recovery” experience. Curtis has a message for service providers and insists on a “systemic belief in recovery”, that this belief is fundamental to the way organisations provide support and informs the world view of the staff working in them. “Without this belief, or worse when the belief is ‘you have a chronic condition that will be episodic at best’, where does the impetus for significant personal responsibility and change come from?” (Curtis, 1998:24).

In this thesis, there has already been a debate about language, and whose interests it serves. What we call people with coexisting disorders has not been resolved and tends to reflect the position from which the idea is being debated (see Chapter 5 “The Field”). Curtis (1998) raises a question about the language of ‘safety’ and argues that questions such as “are you safe?” “what would you need to make yourself safe?” and “how will you keep yourself safe?” have a negative impact on the consumer. Risk assessment is a major issue in both mental health and substance abuse treatment settings (Alcohol Advisory Council of New Zealand, 1996). Questions about ‘safety’ are formulated to check suicidal and homicidal potential (Farrow, 2000). In a masters thesis examining the use and effectiveness of ‘no suicide contracts’ (NSCs), Farrow (2000) concludes that there is no clinical evidence for their use (ie. they do not reduce the risk or successful completion of suicide), and at best staff feel that by their use, they have protected themselves and their organisation from potential legal consequences. Consumers in Farrow’s study were divided about their use with half believing that they (NSCs) increased feelings of ‘safety’, reduced the

likelihood of a suicide attempt and strengthened the bond of 'care' between client and key worker. The other half of his sample concurred with Curtis (1998) that they were left feeling fragile and on the edge of disaster, with the implicit message that they could not even manage this simple life task (of keeping themselves safe).

'Mental illness' is the second term Curtis (1998) took issue with arguing that thinking about herself as having a mental illness placed limits and restrictions on her life. "Perhaps if we created a language of adventure, balance with self-care, we would emphasize positive risk-taking that would allow us to stretch beyond our pre-conceived notions of what we are capable of". However, this would require a shift in the socially constructed definition of 'normal' and illness, an acceptance of a more diverse set of responses to stress and the legitimization of analytical paradigms other than the medical one (in relation to coexisting disorders).

A third shift to a more consumer friendly service is structural change. This involves challenges to the idea of prescriptive need and redistribution of power to include meaningful participation by consumers. Curtis (1997:17) argues "it is a question of HOW we go about doing our work as much, if not more, than an analysis of WHAT work should be done." She invites workplaces to reflect on their current practice and be open to ways that can offer a more recovery-oriented approach. This can be achieved through asking how rehabilitation services both help and hinder the recovery process of each individual they serve. It is also important for services to consider how the principles [of recovery] are operationalised in day-to-day policy and practice and how relationships with people can be restructured so that the power is shared equally among professional staff, consumers, and family members.

This would involve 'professionals' seeing themselves differently and finding the humility and confidence to change the way they practice their craft, and the relationships they engage in with the 'clients' they serve. This also brings up the hypothesis that Zohar (1997:152) raises about the difference between eastern and western understandings of 'service'. If our service provision is based on the western understanding, then we are judged by what we 'do' with the emphasis on competition and control. An eastern model of cooperation and trust would be more conducive to the power sharing that Curtis (1997) suggests.

It is not sufficient for staff to 'know' what creates relationships and environments which stimulate and foster recovery. They need to be in

organisations and health care systems that are philosophically set up to sustain it.

The recovery approach requires mental health and substance abuse treatment services to develop and draw on their own resources, but it also requires that they develop and draw on the resources of people with coexisting disorders and their communities:

Recovery happens when people with mental illness take an active role in improving their lives, when communities include people with mental illness, and when mental health services can facilitate people with mental illness and their communities and families to interact with each other...The recovery approach is more compatible with community-based models of service provision than institutionally-based ones, but it is not a model of service delivery. It is an approach which can be applied to any models that draw on the resources of service users, their communities as well as mental health services. (Mental Health Commission website, 2001)



Service Provision in the New Zealand Context

Introduction

Service provision to people with coexisting disorder in Aotearoa New Zealand is informed by three policy documents: *The Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders* (Todd, Sellman & Robertson, 1999), *The Blueprint on Recovery and Discrimination* (Mental Health Commission, 1998) and *Practitioner Competencies for Alcohol and Drug Workers* (ALAC, 2000). The *National Mental Health Standards* have been translated into measurable criteria for service performance by the *Blueprint* document. Using the concept of recovery as a given, this document has some missives for government to provide an environment in which recovery can occur.

Te Tiritiri o Waitangi (*The Treaty of Waitangi*, 1976) forms the basis of a partnership between the Crown and Iwi, and, as the foremost provider of health services in New Zealand, the Crown has a responsibility to encourage “positive Maori participation [in mental health services] and active protection...of Maori interests”. Government is charged with “taking responsibility for Maori health promotion and prevention”. This includes services that are “culturally safe” for Maori and that Maori have “the opportunity to use kaupapa Maori Services.” The alcohol and drug workers *Practitioner Competencies* (2000) also use *Te Tiritiri o Waitangi* as the basis for

values and principles in alcohol and drug treatment for all people in New Zealand. The *Co-existing Disorders* document (Todd, Sellman & Robertson, 1999:3) recommends that "Maori have the responsibility for developing a specific strategic plan for Maori patients with co-existing disorders. However, this does not eliminate the responsibility of all services to develop their ability to be responsive to the needs of Maori".

Length of Treatment

Attention is also given to the length of time consumers are able to access services. On the one hand the *Blueprint* argues "the treatments and supports...should continue for as long as they are needed", but on the other "recovery happens when mental health services can prevent people from using them unnecessarily or staying in them for too long." The narrative in the document frames this argument about time in terms of "early intervention", "risk reduction" and "recovery education" but never actually offers a temporal frame of reference that might guide service providers. This seems to be the domain of purchasing contracts which are much more prescriptive about the periods of time consumers may use a service. Todd, Sellman and Robertson (1999) recommend that "all patients have 24-hour access to community based services [and that] the progress of all patients is reviewed six months after completion of treatment". As with the mental health document, there are no guidelines about what this means in terms of time.

Service Workers

The policy documents of both mental health and substance abuse treatment services express a view about the generic and vocational competencies of the staff who are employed to work in them.

The *Blueprint* describes people wanting to work in mental health services, as "compassionate and competent" who "reflect the cultural backgrounds of people using the service". In addition, these people should have "manageable working conditions and the support to maintain their own wellness". Out of the general recommendations of the *Blueprint*, the Mental Health Commission developed ten competencies which are prerequisites for all mental health workers.

These competencies are recovery based and require a competent mental health worker to understand the recovery principles and experiences in Aotearoa/New Zealand and international context: ie. recognise and support the personal resourcefulness of people with mental illness; understand and accommodate the diverse views on mental illness, treatments, services and

recovery; have the self-awareness and skills to communicate respectfully and develop good relationships with service users; understand and actively protect service users' rights; understand discrimination and social exclusion, its impact on service users and how to reduce it; acknowledge the different cultures of Aotearoa/New Zealand and know how to provide a service in partnership with them; have extensive knowledge of community services and resources and actively support service users to use them; have knowledge of the service user movement and be able to support their participation in services; have knowledge of family/whanau perspectives and be able to support their participation in services.

The *Alcohol and Drug Practitioner Competencies* (2000) refer to the skills and attributes required of staff working in the field. There are guidelines about "relating and communicating" ability with "critical thinking" and "professional" behaviour. The vocational competencies relate to skills of intervention in drug and alcohol related issues and the ability to work with families and communities. Similarly, the coexisting disorders document (Todd, Sellman & Robertson, 1999:3) recommends that "clinicians should have a working knowledge and skills in the area [of coexisting disorders], be able to work with a range of models and be able to include family members and communities."

Linked (somewhat tangentially) to the timeframe of service use, in the Mental Health Commission *Blueprint* is the employment of people with mental illness in mental health services. The *Blueprint* argues that 'recovery happens when mental health services enable people with mental illness to take on competent roles'. This begins with their taking part in their own assessment and decisions about treatment and support, and extends to providing role models to others. Services are encouraged to "support the consumer movement to develop support networks and consumer run services."

The Role of Community in Service Provision

Finally, all the documents acknowledge the importance of 'community' in the recovery of individuals. "Mental health services are there to carry out specialist tasks and roles the rest of the community is unable or unwilling to perform...[and]...should never try to replace natural communities". The biggest barrier to relationship with 'community' is identified by the *Blueprint* as "discrimination". Considerable time and resource is given by the Government to countering stigma and discrimination (Mental Health Foundation, 1999), but it is still framed in terms of individual psychology and responsibility. There is no critique about the nature of 'community'. Ten years ago, a study of

deinstitutionalisation and community care in the mental health sector (Warren, 1997:46) concluded that:

...the notion that community itself is undergoing change has been ignored in the debates about 'community care'. Social attachments are simultaneously more widespread geographically and more privatised within the nuclear family. Contrary to what some policy makers seem to believe, there are not informal social networks 'out there' waiting to be tapped.

Professional Interest in Recovery

According to Anthony (1993), the recovery vision transcends the debate over the causes of severe psychiatric disability and can be adopted by most of the groups concerned with the treatment of those with psychiatric labels. This includes a "professional interest in recovery" (Anthony, 1993), that has been made more possible by new developments in psycho-pharmacology which reduce the distressing symptoms associated with many psychiatric disorders. Alcohol and drug treatment services, whilst not naming recovery as a treatment approach, argue that counsellors must be able to demonstrate "a comprehensive knowledge of a range of interventions including individual, family, group, self-help and community approaches" (*Practitioner Competencies*, 2000). Underlying all of these approaches is a mandate to "convey a belief in the client's ability to achieve their treatment goals" (*Practitioner Competencies*, 2000). This is one of the fundamental principles of 'recovery' (Curtis, 1997:18), and seems to have been unconditionally adopted into mainstream service provision. However, Anthony (1993) is sceptical that the 'professional' interpretation of recovery addresses the "iatrogenic disability and stigma" of mental illness and does not necessarily support the issue of personal and collective empowerment that is so necessary to recovery.

Whilst Curtis (1997) applauds the inclusion of recovery-based strategies and self-help supports into mainstream services, she argues "there is legitimate concern that the concept of recovery, with its deep roots in self-help, self advocacy and empowerment, is being co-opted by professional rehabilitation services and turned into another treatment process or programme."

Barriers to Recovery and Empowerment

Curtis (1998) outlines a number of factors that stand in the way of 'recovery and distinguishes between internal and external barriers. She identifies the internal barriers as "internalised negative beliefs...I am my own worst enemy". These are the kind of belief systems that are addressed in individual 'therapy',

most often by 'cognitive-behavioural' techniques (Verheul, van den Brink, & Ball, 1998; Romach & Doumani, 1998).

The other barriers are external and are either personal (issues related to physical/sexual abuse and trauma and lack of positive role models) or systemic. One set of systemic barriers includes lack of accurate information and access to resources within the health system, medication side-effects and other chronic health conditions and mistreatment and abuse by the service provider (Curtis, 1998). Beyond the immediate concerns is a lack of involvement and participation in treatment planning and policy decisions affecting the lives of people with coexisting disorders. Curtis refers here to the American context, and, in New Zealand, consultation on policy making and treatment planning has been extensive with a third of the project team for countering mental health 'stigma' being consumer representatives.

The final set of external barriers are systemic to society in general. Poverty, isolation, segregation, discrimination in the workplace, financial disincentives in government benefit programmes, and an absence of civil rights. In the New Zealand context Work and Income New Zealand (WINZ) provide supplementary benefits to people with long-term, chronic mental illness (stats.govt.NZ), and the connection between poverty and poor health outcomes has already been identified and discussed (Waldegrave, 1997).

Concomitant with the barriers to recovery and empowerment is the loss of support that comes as consumers 'get better'. According to Curtis (1998):

A common phenomenon reported among survivor ex-patients is the fear of losing all supports as we get better at managing our lives. Often services and support end when they are needed most. All people, including those without disabilities, need support to make the transition to increased independence. These disincentives create a sense of loss and may even feel like punishment: why should I get better if that means I'll be all alone and have no one to help me? These are systemic issues that need to be addressed. Support needs to be flexible and on-going for as long as needed or desired.

Discrimination is probably one of the greatest barriers to recovery. It "erodes people's life chances" (Mental Health Commission *Blueprint*). The *Blueprint* deals with the myriad of ways in which discrimination is expressed on a daily basis. These manifestations of discrimination fall into three categories: undermining respect, rights, and equality for people with mental illness. Conversely, feeding recovery requires attention to each of these dimensions.

Recommendations of the Literature for Service Provision

Curtis (1998) argues that:

...those who have been recipients of lifelong services must be supported in envisioning a future which is characterised primarily by hope for a better, more self-directed life and personal responsibility, rather than by the belief that they are powerless, will require services forever, and that they are, first and foremost, an individual with a disability. They are able to handle stress and/or able to live the life that they perceive non-disabled people can live.

This reflects a deeply held commitment to philosophies and ideals of individualism with "a strong emphasis on human beings as unique individuals each with their own special qualities and idiosyncrasies and responsible for their own actions, and with success, happiness, and fulfilment defined in terms of individual achievement" (Bilton et al., 1996:8). This must not be the justification for managed neglect in this group of people, before the consumer is ready to take on that independence. As humans, we are social beings "so we do not live in shapeless social environments or an undefined social world that we can ignore" (Bilton et al., 1996:8). We need the support and interaction of others in order to function. It is important that service provision takes into account the timeframe it takes to build up a solid and reliable social support network that will allow the individual to live this 'independent' life.

The Mental Health Commission of New Zealand (MHC) offers a critique of the mainly American literature. Their 'recovery competencies' document makes some broad statements in relation to the factors that influence service provision. It argues that:

...the vision of recovery that comes out of the United States is more individualistic and monocultural than many New Zealanders feel comfortable with. The existing recovery literature tends not to focus as much as it could on discrimination, human rights, cultural diversity or even the potential of communities to support recovery.

The MHC has attempted to redefine recovery for the New Zealand context, focusing some of the attention in the mental health sector away from mental health services and towards the community, as a supporter of recovery. "This is a context where we have the *Treaty of Waitangi* and the notion of the indigenous people as 'tangata whenua'." New Zealand has a stronger tradition of state provision for the vulnerable and marginalised than the US, where it tends to be left more to the individual to take responsibility for their own

needs. We also have a weaker heritage, than the US, of the fundamentalist Christian quest for individual salvation “which has been secularised there in the last generation through the growth of the generic recovery movement” (Mental Health Commission, 1998).

Finally, on the matter of discrimination from a service perspective, The Mental Health Commission “advocates zero tolerance of discrimination”. Both the Ministry of Health’s *Looking Forward, Moving Forward* (1994) and *National Mental Health Standards* (June 1997), and the Health and Disability Commissioner’s *Code of Rights* set out the mental health sector’s responsibilities for righting discrimination. According the *Blueprint* (1998:19) “government policy demands that the mental health sector must actively right discrimination against services users”, in accessing services, treatment within services, and “working with other sectors to prevent mental illness for which a contributing cause is discrimination”.



Conclusion

The literature in this review fits with the substantive understandings that were generated out of the data. Because the main concern of the participants was not known beforehand, this aspect of the literature review has been developed, in the ‘grounded’ tradition, subsequent, not prior to the actual research taking place (Glaser, 1998). It is based loosely in the genre called ‘recovery’, but originates out of three main ideological sources; Twelve Step groups and new age philosophies, the mental health service user movement and more mainstream ‘psychiatric rehabilitation’. Included also is a growing body of literature that compares the success of one model over another within this broad ideological framework. A number of features of recovery transcend all the approaches, regardless of origin, and these are discussed thematically. The relationship between the self-help recovery approach and service provision is explored together with some of the barriers that these pose. Finally, recommendations for service provision using the ‘recovery’ approach were found in the literature and have been included here. The literature is predominantly allowed to stand on its own, except where information from the participants’ data or analytical critique expedites the reader’s understanding. Points of clarification, analysis and contention will be raised in the chapter devoted to the ‘discussion’.

CHAPTER TWELVE: DISCUSSION

Introduction

This thesis began with an inquiry into the concerns of people dually diagnosed with a major mental illness and substance use problems, and those providing service to them. The first 'cut' at the data produced an analysis of a 'normal life'. An analysis of 'normal' soon came up against the limits of its internal inconsistencies, and a second analysis produced a matrix of 'discovery'. This chapter has three distinct parts addressing normality, recovery and discovery. Beginning with an examination of the concept of 'a normal life', the part of the chapter focusing on normality goes on to examine lay views, the illness framework of psychiatry, conceptual frameworks of mental abnormality and normality according to psychoanalysis, psychology and sociology and looks finally at cultural prescriptions. The chapter then shifts to focus on recovery beginning with the notion of recovery as a component of normality. The recovery section comprises discussion of the research findings in terms of the limits of recovery itself as a concept, particularly a community concept, and research findings about the limits of role reclamation and integrated care for recovery. An examination of maintenance in terms of recovery for the study's participants leads on to the discovery section of the chapter which goes beyond discovery to discuss the role of myth in discovering a life, discovery as a paradigm shift, discovery as a life-long journey as well as a 'present moment', the dilemma of the health services with regard to discovery, discovery in relation to discrimination and, finally, discovery as a new approach to coexisting disorders offering new possibilities for consumers. It is this matrix of 'discovery' that both enhances, and sometimes replaces, existing 'recovery' approaches which forms the basis for the originality of the thesis.



A Normal Life

Thank God we're normal, normal, normal, / Thank God we're normal, / Yes, this is our finest shower! (John Osborne, *The Entertainer*, 1957).

A 'normal life', 'normality', 'normalisation' are terms that were used frequently both in the interviews and the literature. Notions of 'normality' inform a continuum of behaviours from personal life choices to policy decisions.

However, they have an embedded meaning which is often implied and rarely explicit. Without any clarification, they impact directly on expectations people have of their own relationship to 'normality', the therapies that are offered by treatment services and the social policy that is developed to "care for people who are disabled or dependent" in our "civilised society" (Shannon, 1991:2).

In an attempt to develop a baseline of normal within the research process, I interviewed a further twenty participants from the 'normal' population ie. who did not have coexisting disorders. There was an equal mix of male and female participants aged between twenty seven and fifty one years with an average age of thirty five years. There were as many 'definitions' as participants, but there were two major themes. The first theme raised the issue of there being no 'normal'. Most felt being 'normal' was about conforming, "doing what the majority do" but quickly went on to explain this did not apply to them. They all gave examples that illustrated the ways in which they live outside the 'norms' of society such as not "working nine to five", or not "having a house".

The second theme related to an internal state of 'being'. Typical of the responses were, being "psychologically centred", "in kilter with my own set of norms", "fully authentic" and "not compromising my immortal soul". One thirty five year old male captured the general tenor of responses to the question about 'normal' by saying "I consider it an insult to be called 'normal'. The only people who strive to be 'normal' are the one's who aren't in the eyes of society".

Without proper definition, there is no road map to recovery and change, no benchmark against which to measure progress, success or failure. Attempts have been made in the literature to outline frameworks for "understanding ...normal and abnormal mental life" (Pilgrim & Rogers, 1993:1).

The Lay View

"With or without an expertise in the field of mental abnormality, most people know madness when they see it" (Pilgrim & Rogers, 1993:2). 'Normality' is often defined in the negative, by what it is not rather than what it is. 'Not normal' as a 'lay' understanding is seen in the literature of Janet Frame (*A State of Siege*, 1982) where she writes about the period of her life before admission to a mental hospital, and Sylvia Plath's *The Bell Jar* (1963). The language is personal, autobiographical and domestic. Pilgrim and Rogers (1993:2) argue that if people act in a way others cannot readily understand, they risk being labelled as a "nutter, loony, crazy, mad or even simply mental". One of the

consumer participants, Henry, had a vague 'lay' notion that he might be "insane" or 'not normal':

I was starting to believe that people could read each other's minds and talk to each other telepathy-wise and all that sort of stuff and it's not the case. That's just being insane I guess...which I was for a short time there.

Pilgrim and Rogers (1993:2) contend that the term 'mental distress' has found favour with service users but that it "alludes only to the pain of the patient and it gives no notion that they can be distressing, frustrating or frightening to others at times". For the families I interviewed, this was a preoccupying concern. They described how friends and family had stopped coming to the home because "they never knew how he was going to react or what he would do or if he was actually going to be bizarre or if he was going to be okay". One mother described how frightening it was for the family when her son was in "psychosis". "It was...really...frightening because the whole atmosphere in the house...it was just scary...it was a presence".

There are many 'lay' understandings of madness that are formed out of experience, rumour, hearsay and media images. They may or may not be useful to the individual or the consumer, but they are universal, and we all have them.

Psychiatry

Pilgrim and Rogers (1993:4) describe psychiatry as a "specialty within medicine". It is informed by the medical model and its:

...practitioners...are trained to see their role as identifying sick individuals (diagnosis), predicting the future course of their illness (prognosis), speculating about its cause (aetiology) and prescribing a response to the condition, to cure it or ameliorate its symptoms (treatment).

The diagnosis and treatment of 'coexisting disorders' has been captured by the medical model. This illness framework has a certain logical application, particularly in the 'acute' phase of the illness where 'symptoms' are active and respond well to pharmaceutical intervention.

The same participant, Henry, relates that "the first time it [psychosis] happened to me I was actually admitted to [the local psychiatric hospital], and things were going on...you know...I used to hear voices, but with the medication it subsided a bit and eventually got good again".

However, one of the fundamental problems “with the illness framework in psychiatry is that it deals in the main with symptoms and not signs” (Pilgrim & Rogers, 1993:5). The ‘symptoms’ take on a “great[er] significance to the physician, [in] establishing the identity of the illness” (Miller & Keane, 1978:973), than either objective evidence or the self-report of the consumer.

This was the problem for Peta during a psychiatric assessment following her admission to an ‘acute’ unit:

He [the psychiatrist] was only seeing me as one dimensional...really only seeing what was on the surface... he was very aloof and just totally blank and he wrote things about me like...they asked me to spell the months of the year backwards and I freaked out and ran back to my room and they put “Caucasian woman in her early thirties...runs down the hallway in her pyjamas”...they were just very clinical about the way they perceived me.

Peta’s behaviour was taken as a ‘sign’ of madness and, in this instance, judgements about whether she was mentally ill focused mainly on the immediate communication and not the context. In other circumstances, Peta’s behaviour could have been seen as a normal response to an unreasonable request, or a bizarre situation. She may have been adjudged sane to ensure her safety by running away from a man asking ‘mad’ questions.

Forensic psychiatry combines attempts to understand, diagnose and manage disorders of the mind with the set of rules governing socially important aspects of human behaviour, enforced by society for the welfare and protection of its members (Wily & Stallworthy, 1962:v). It is perhaps this requirement for legalistic precision that has led Wily and Stallworthy to define ‘the normal man’. Whilst referring to many judgements describing the impossibility of the task, this psychiatrist and lawyer outline “a number of general attributes of normality” (Wily & Stallworthy, 1962:38). In essence, these include:

- an adequate appreciation of reality (an ability to see things as they really are, not a fabrication of personal fears, hopes or prejudices)
- thinking and reasoning (according to reality and logic)
- an ability to experience a range of emotions (without being controlled by them) that are consistent with those around him/her
- an acceptance of personal capacities and limitations
- aspirations within the ‘customs and ethics’ of society
- to live life ‘easily’ within the dictates of the society lived in
- good judgement

- volition (making conscious and deliberate decisions to act).

The legal framework does not provide a definition of 'normal' or 'abnormal'. Normality is explicated in the negative (by what it is not) and relies heavily on psychiatric opinion to determine those who are sufficiently mentally ill to require compulsory treatment. The definition of mental disorder is crucial as it sets the threshold for treatment under the *Compulsory Assessment and Treatment Act* (CATA, 1992). For compulsory treatment to be permissible an individual must be in an "abnormal state of mind whether of a continuous or intermittent nature which is characterised by delusions or by disorders of mood volition, cognition or perception. In addition, their 'abnormal state of mind' must be of such a degree that it "poses a serious danger to the health and safety of the person or of others; or seriously diminishes the capacity of the person to take care of him or herself" ('Mental Health', CATA, 1992). Under this Act, substance abuse does not constitute a reason to subject a person to compulsory mental health treatment. Because the definition of 'mental illness' is so narrow in this context, by implication the parameters of 'normal' are wide, and individuals do not come up against their limits until their behaviour is extreme and well outside the 'cultural' norms.

Psychoanalysis, Psychology and Sociological Concepts of Normality

According to Pilgrim and Rogers (1993:6) psychoanalysis had its origins with Sigmund Freud and although his pioneering ideas have been developed and refined, psychoanalysis still "works on a continuum principle [of] abnormality and normality...[and] is saturated with...the terminology of pathology". Although psychoanalysis offers a conceptual framework of 'mental abnormality', it does not seem to be measured against its corollary 'normal'. Pathology has become the 'norm'.

Psychologists, for their part, have developed three concepts of 'normality'/'abnormality': "statistical, ideal, and the presence of specific behaviours" (Buss, 1966:1). The 'statistical' notion argues that "frequently occurring behaviours in a population are normal" (Pilgrim & Rogers, 1993:7). This is somewhat akin to the Durkheimian analysis of 'social fact', (the conventions of behaviour and standards of value which exist independently of individuals and which exercise a coercive influence), although it is important to draw the distinction between social norms - what people think ought to happen, and statistical norms - what actually happens.

The 'ideal' notion of normality takes two forms. The first developed within the psychoanalytical tradition, and was defined as "a predominance of conscious

over unconscious characteristics in the person" (Kubie, 1954:167). The second arose out of the work of Marie Jahoda (1958) whose humanistic psychology drew together six criteria for mental health;

1) the balance of psychic forces; 2) self-actualisation; 3) resistance to stress; 4) autonomy; 5) competence and 6) perception of reality.

A focus on 'specific behaviours' grew out of the psychology of behaviourism that "tried to limit the purview of psychology to behaviour and eliminate the subjective experience as data" (Pilgrim & Rogers, 1993:9). Subsequent behaviourist discourses have been broadened to include the socially negotiated aspects of normality in a way that "reflects both the power relationships and the value system operating in a culture at a point in time" (Pilgrim & Rogers, 1993:10).

As with the other paradigms, there is no consistency or agreement within the discipline of sociology about 'normal'.

In his *Histoire de la Folie*, Foucault (1976), dealt with the effect on thinking about the treatment of the insane of the eighteenth century's concern with devising a form of social citizenship appropriate to a bourgeois political and economic culture. "It was one of the eighteenth century's constant endeavours", Foucault writes "to adjust with the old juridical notion of the "subject of law" the contemporary experience of social man...Nineteenth-century positivist medicine is the heir to this effort of Enlightenment." Our modern conception of 'normal man' is a construct dating from this era; "its conceptual space lies not within the space of nature, but in a system which identifies the *socius* with the subject of law." The abnormal person with mental illness, as a "slowly constituted product representing the mythical union of the juridically incompetent subject with the man who is perceived as perturber of a group", emerges in conjunction with a new style of public sensibility towards the socially irregular.

Wolf Wolfensberger (1972) developed his ground breaking model of 'normalisation' in the context of 'human management' of the mentally retarded. 'Normalisation' was first defined by Bank-Mikkelsen (cited in Wolfensberger, 1972:27) as "letting the mentally retarded obtain an existence as close to the normal as possible". Wolfensberger (1972:28) reformulated the definition in accordance with his human management principles to include "utilisation of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible". These definitions of 'normal' were

formulated against an understanding of 'deviancy' that labelled a person deviant if they were seen to be "significantly different from others in some aspect that is considered of relative importance, and if this difference is negatively valued" (Wolfensberger, 1972:13).

Cultural Norms

"Living in a social world...is an action-constraining experience" (Bilton, Bonnett, Jones, Skinner, Stanworth, & Webster, 1996:10). These constraints are either applied externally by the world in which we live, and/or internally as an individual takes on awareness of the social rules of that world. "People work out their lives individually and collectively by drawing on shared ideas about what is desirable and undesirable, appropriate and inappropriate, good and bad, right and wrong" (Bilton et al., 1996:10). The foundation of social propriety is made up of **norms** and **values**. **Norms** are "socially accepted 'correct' or 'proper' forms of behaviour...that either prescribe given types of behaviour or forbid them"(Bilton et al., 1996:10). **Values** are a "consensus of morals, principles, and standards of behaviour" (Bilton et al., 1996:10), which incur graded sanctions when not adhered to.

It has been difficult to locate a directory of norms and values that guide our behaviour in Aotearoa, New Zealand to use as a baseline for analysis in this thesis. The very nature of norms and values mean they are not openly visible or prescribed in law. The power they have to influence, constrain and shape individuals' lives cannot be underestimated. "If and when...[norms and values] are profoundly absorbed and internalised and become powerfully ingrained in actors' consciousnesses, they may take on an *objective* reality for us..."(Bilton et al., 1996:11).

The **norms** that can be quantified are the statistical ones that describe households, marriage, income, and employment. These seemed to be significant for all my subject groups, and in many cases, attainment of the statistical norm formed an integral part of treatment goals. In addition, the 'consumer' group used them as a yard stick for the measurement of 'wellness' and 'success'.

In the 1996 census, 'one family' households were predominant (63%), with "one person households...easily the next most common type, comprising 20.1 percent of all private households". The one person households are becoming more common with eighteen percent in 1986, rising to twenty percent in 1991 (Statistics New Zealand, 2001). With the exception of one subject, all my participants lived successfully on their own, yet saw this as some kind of

failure, inspite of the fact that this type of household was the second most common and on the increase.

With only one of the 'consumer' subjects in full-time, permanent employment, this group were over represented in the unemployment figures (about 90%) compared with the national average of 5.2% (*Household Labour Force Survey*, September 2001). This left them overwhelmingly dependent on the sickness benefit for financial support, providing them with less than one third of the average wage of \$34,000 (Statistics New Zealand, 2001).

Summary

There have been a number of attempts in the literature to define 'normal' but they have rarely been applied to the lives of consumers in a clinical setting. Many of the definitions are narrow in focus and rely heavily on recognising behaviours that deviate from the 'norm'. Heidegger (1962) notes that the traditional interpretations of human existence have been one-sided to the extent that they concentrate on our ways of existing when we are engaged in theorising and detached reflection. It is this narrow focus on the 'spectator attitude' that has lead to an increasingly restrictive understanding of 'normal'. In the absence of a 'gold standard', all the participants (consumer, service and family) have created an individualised, mix-and-match awareness of 'normal' that has been applied with varying degrees of beneficence to their lives.

For the purposes of this discussion, a more philosophical view of normal will be used as a yardstick against which success is judged. Heidegger's description of *Dasein's* "average everydayness," our ordinary, pre-reflective agency when we are caught up in the midst of practical affairs, allows the participants to construct a definition of normal that can be applied in a personalised way to their daily lives. The "phenomenology of everydayness" leads us to see the totality of human existence, including our moods, our capacity of authentic individuality, and our full range of involvements with the world and with others. Heidegger (1962) holds that there is no pre-given human essence. Instead, humans, as self-interpreting human beings, just are what they make of themselves in the course of their active lives. Thus, as everyday agency, *Dasein* is not an object with properties, but is rather the "happening" of a life course "stretched out between birth and death" (Heidegger, 1962). Whilst lacking in detail, this notion of 'normal' bypasses statistical and culturally constraining definitions of normality and allows the participants to create and live by their own unfettered 'norms'.

Recovery

Recovery as a Component of 'Normal'

Recovery, in its narrowest sense, is a return to 'normal' (Copeland, Curtis & Palmer, 1996). It is a concept and a tool that has formed the basis of 'treatment' in both mental health and alcohol and drug settings over time. It has developed out of a diversity of traditions and theoretical orientations. It has been useful for the participants of this study, in that it has offered them a wide range of options and approaches to the management and expression of their lives with coexisting disorders. It has given them access to a grab-bag of tools including cognitive behavioural re-framing, learning from others who have 'been there', psycho-education, personal techniques for reducing symptoms and crisis prevention and planning. Many of these strategies have been used in conjunction with the more traditional medical interventions, the most universal being psychotropic medication. In combination, these tools and strategies have had a powerful influence on the lives of the participants, and allowed them to achieve a degree of 'wellness' that would not have been possible through one approach alone. Using their own standards of 'normal' each participant in this study went beyond 'recovery' to achieve a life greater than they would have otherwise expected, 'hyper-normal'. They lived, studied, worked and explored aspects of their 'being' in ways they would have never contemplated under more 'ideal' circumstances. At the same time, they were constrained by the 'statistical' norms and expectations of relationship, employment and housing. In addition, many were trapped by the 'normative' component of psychiatric rehabilitation that had been useful in the period following acute illness. Rehabilitation begins with an assumption of 'disability' and carries with it an imperative of 'overcoming'. Whilst the participants had significant 'dis-ability' in medical terms, it did not prevent them from living full and productive lives. They did not strive to 'overcome', but simply re-oriented their lives to fit with the abilities they had. They used these various abilities to explore new horizons and expand their lives in ways they would not otherwise have considered. Recovery and rehabilitation are terms that are often used interchangeably in the literature and cause confusion for consumers, families, and services.

The Usefulness of a Twelve Step Approach in Coexisting Disorders Recovery

My 'consumer' participants, no matter what their 'recovery' path, have unanimously agreed, that the maintenance of wellness is a life long endeavour, with daily tasks that require attention and commitment. To this end, the Twelve Step approach is ideally suited to their needs. It accepts that their

struggle will be 'life-long', has a programme that supports them uncritically over a life-time and they can join or leave as their needs dictate without fear of being labelled no longer suitable for that particular treatment modality.

Recovery in the AA custom has 'members' attend regular meetings based on the Twelve Steps and Twelve Traditions of Alcoholics Anonymous (Mosby, 1995:105). It offers a daily programme of recovery that begins with the acknowledgment that one doesn't have complete power over the problem, seeks help from others in coming to terms with this and offers support to similarly afflicted people. Strength is found by turning to a power greater than one's self-will, and facing the problem with humility. It is important to make amends to people one has harmed without making excuses or minimising or rationalising the damage. It is a 'life long' programme that sees to approach an imperfect world with serenity. This is a useful and legitimate approach to 'recovery' for people with coexisting disorders. In relation to helping alcoholics maintain abstinence and good recovery, the AA 'Big Book' makes the claim that "rarely will a person fail who thoroughly follows this path to recovery" (Mosby, 1009:105). So what aspect of the 'programme' is critical to success? Each person 'works' the programme according to their need, but from a therapeutic perspective, Twelve Step programmes contain all the elements critical for the success of both mental health and substance abuse treatment. According to Bourne (1990:90-92) these are: a social support system; a sober social circle; role models; they accept and don't judge others; they reach out to new members; they rebuild self-esteem; practical suggestions for sobriety and accessibility twenty four hours a day and at no cost.

Nace (1992) cites the critical element of AA's success as the group process. Offered at meetings is: hope through association; universality and acceptance through sharing stories and experiences; information sharing; imitation through role models; learning about alcoholism and that recovery is possible; catharsis through getting up at meetings to talk and sober social support.

For about four percent of the population (ALAC, 2001) there is a physiological basis to substance dependence. This means that they cannot consistently choose how much they will drink or how many drugs they will take. The only choice they have is the decision to take that first drug or drink. It is a life-long response for this group of people and does not change with age, circumstance, training or therapy. Given that, in the population of the mentally ill, the percentage of people with a substance dependence is even greater than for the general population (Minkoff, 1996), it is necessary to build into treatment, a component that is 'life long'. To use an analogy in the physical world of

medicine, substance dependence and major mental illness are analogous to diabetes. They are there for life but can be managed, and the individual needs to do something every day to 'manage' it. Coexisting disorders cannot be treated like the common cold (that one catches from time to time but doesn't need to give a thought to in between), or appendicitis (that only occurs once and you have the appendix cut out). According to Weingarten (1989):

A...doctor once compared my mental illness to diabetes. "You have a chronic illness...you will have to take medication for it, probably all the rest of your life. But it will keep your illness manageable and under control". It took me several years and three more hospitalisations before I heeded that doctor's advice. But when I did, I discovered that medication alone was not the only factor that made me feel well, nor was it therapy either. I had to create a life that gave me the structure, support, and meaning I needed to resume normal living.

The role of prayer and spiritual development were paramount to the well-being of the participants in this study. It was practiced in a number of ways with about half the group accessing their 'spiritual' dimension through the Twelve Step programme. Others felt uncomfortable disclosing their mental illness in case they were discouraged from taking their psychotropic medication, and chose to use alternative approaches. The one certainty they were all agreed on was the necessity of a 'spiritual' component to recovery and wellness.

Limits of Recovery as a Concept

Whilst recovery has been interpreted and applied in a general way to people with coexisting disorders, emerging literature (Nuckols, 1993) and this study suggest there are limits to this approach. Recovery needs to be interpreted and applied in a way that is more specific to the needs of the population of people living with coexisting disorders, and, at the same time, more generally applicable to life. It is not sufficient to adopt a style or way of thinking that has been developed for an alcohol and drug treatment setting or a mental health environment, unmodified into the management of coexisting disorders. In addition, 'dual' diagnosis implies two identified diseases. This is somewhat misleading given that many of the people I see as a clinician also have a head injury (often more than one) and an undiagnosed 'post traumatic stress disorder'. People are often coping with a multiplicity of issues and challenges that require careful support and intervention on a number of levels, if they are going to live richly textured lives.

The originality of the thesis can be further asserted here, as the lives and information of my participant group challenge a number of areas of recovery.

These include recovery as community concept, recovery as role reclamation and recovery in terms of integrated care.

Recovery as a Community Concept.

Bridgman, Dyall, Bidois, Gurney, Hawira, Tangitu, Huata, Webster, and Heron (2000) in trying to transform the 'recovery' approach into an outcome measure for mental health, adapt American philosopher Ken Wilber's 'wellness holon' - an integrated theory of consciousness and behaviour. They super-impose the quadrants of the 'holon' over the four elements of Durie and Kingi's (1997) Te Whare Tapa Wha model of wellness for Maori. Bridgman et al.'s (2000) research found that "service users have a distinct and internally consistent view of their illness which differed from those of caregivers and service providers". The service users "had a stripped-down view of wellness that lacked a collective context and reflected the low expectations of that group" (Bridgman et al., 2000). The participants of this study, on the other hand, referenced their 'wellness' to the collective norm and, in many domains, found themselves wanting. Rather than resolving the dissonance created by the "stripped-down view of wellness" offered by the service providers, the 'collective norm' pitted the participants against the statistical norms that are frequently taken as the "desirable and appropriate" goals of social behaviour.

In spite of the laudable effort by the Mental Health Commission to make recovery a more 'community' concept, my participant population still saw it as a very individual responsibility. The Maori participants (who were more receptive to community intervention) felt their communities were part of the problem. Until they addressed some of their own community issues around drugs and alcohol, in particular, they would not be in a position to support and nurture individuals.

Role Reclamation

In the literature review, Mead (1934) developed a model of role reclamation. Roles are a set of socially expected behaviours associated with an individual's function in various social groups. Roles provide for a means of social participation and "a way to test identities for consensual validation by significant others" (Stuart & Laraia, 1908:865). Role reclamation, for the participants of this study, was, at the same time problematic and irrelevant. For many of them, roles once held were no longer available. Many will never have meaningful paid employment (that is not to say that they are not meaningfully employing their time). They had been alienated from family members and no longer filled those family related roles of brother/sister, mother, grandmother.

Friendships were lost, or re-negotiated, but mostly made anew. Many of the participants, such as Xanthie, were dependent on the friendship of health professionals whilst they made the transition from 'patient' to 'person':

I'm friends with my psychologist. She's done her masters in psychology and a lot of her friends have done their masters in psychology and I have become friends with them.

Some friendships survived beyond this period and most of the participants I spoke to claimed support from a health professional that went further than their original role. This blurs professional boundaries and, on the surface, flies in the face of conventional wisdom and ethical conduct. However, both staff and consumers were cognisant of the pitfalls and had been careful to terminate the professional relationship before beginning the personal one. It could be argued that this is the ultimate expression of integration back into the community. Why should friendships be restricted by the presence of mental illness or substance abuse?

At the same time, this participant group found their lives and perceptions of themselves severely restricted as they struggled to achieve the statistical norms of society. To live successfully with others was not a realistic option, neither was the taking on of debt that went with the purchase of a house and car. Those who did not already have children weighed up the benefits of this against the risks of destabilisation in their mental condition and the effects of psychotropic medication on the unborn child.

To redefine oneself in terms of a role is, itself, a limiting exercise. My participants seem to have moved beyond this and are finding a definition of self that includes the fullness of who they are - unique individuals with a life-long mental illness and substance dependence - which has meaningful implications for their lives. The mental illness and substance dependence is part of who they are. This limits their life options at one level, and, on another, offers them opportunities they would not otherwise have had - for instance, personal growth and an opportunity to revisit family of origin issues. Like all of us, they are offered turning points at various times in their lives, and must make decisions about which direction to take next. Seeing mental illness and substance dependence as part of who they are flies in the face of the received wisdom of recovery, and makes another original contribution to conceptualising life with coexisting disorders.

Integrated Care

It is now more than ten years since Kenneth Minkoff (1989) proposed a structure of integrated care, and two years since similar recommendations were made locally (Todd, Sellman & Robertson, 1999:3). Although some specialist services (Regional Alcohol and Drug Services' Auckland Dual Diagnosis Service, Odyssey House Inpatient Dual Diagnosis Service and Challenge Trust Dual Diagnosis Services) have been established, they cater for a limited number of people. Although mental health and alcohol and drug services have moved to address both issues, they are still a long way from the 'one stop shop' approach implicit in Minkoff's (1989) model or "compatible models and a conceptual framework that can integrate them...into a coherent treatment package" (Todd, Sellman & Robertson, 1999:2). Consumers and families still struggle to access services that meet their needs and battle a *Privacy Act* that does not always serve the best interests of consumers, families or communities. In a move to meet one of the key recommendations of the *Todd Report*, the Auckland District Health Board has taken steps to partially integrate alcohol and drug services "into Mental Health Services at a managerial level above that of the service manager, while maintaining the identity of alcohol and drug services" (Todd, Sellman & Robertson, 1999:3). However, at a practice level, liaison occurs between individual workers in a way that is *ad hoc* and not always sanctioned by the service they work for. Priority needs to be given to formalising these informal arrangements of cooperation, knowledge sharing and clinical support.

Other systemic arrangements also need to be reviewed. Workers in my study experienced difficulties in helping families get their needs met. Neither service addresses the concerns of staff who are actively working with family/whanau in a system that is not funded to care for families. They do not deal with the difficulties staff experience in constantly having to re-interpret what they do to meet funding concerns and the attached 'outputs'. If the worker is being paid to see x no. of clients in a day/week or month, how do they account for the time they are spending with families? There is a gap between the rhetoric and reality of service provision and individual competencies and achievements.

Information from the provider participants indicated that recovery was a concept that they valued. However, their time was so taken up with trying to manage the intricacies of the systems they were operating in that this (operational problems with service provision) became the focus of their energies.

The Maintenance of Discovery

The 'maintenance' phase of *discovering a life* is present-continuing. It not only supports the participants in maintaining the changes they have made to their lives to date, but sets them up to deal with the constantly changing world they now live in. There is almost no material on this phase of *discovering a life* in the health literature, and yet, at the same time, this is the area of life about which most is written in a broader context. There is a whole industry that has grown up around self-help, spiritual development and personal improvement. By the time people reach the maintenance phase, they have had exposure to a variety of 'treatment' strategies and wellness theories. Most alcohol and drug treatment services have an eclectic range of strategies with which to support individuals in changing, and most attempt to 'match' client to approach. Likewise, mental health services draw on the composite dimensions of the bio/psycho/social model that allows people to find equilibrium in the present. All approaches lay the foundation for future management and ongoing change. Each approach has within it the seeds of its own development and its ability to contribute in an ongoing way to the life of the individual who chooses to engage with it. All my participants had chosen a number of paths dependent on what was right for that issue or moment in time, a path that reflected their development and growth to that point. By this stage, most of the participants have been discharged from both mental health and alcohol and drug services. Their psychotropic medication is being prescribed by their general practitioner and, no longer meeting the criteria for Government funded health services, they have been left to their own devices to get on with their lives as best they can. My criticism is not that this is happening, but that there has been so little support for their transition or adventure back into community. When health resources are scarce it is understandable that they would be directed to those who are acutely ill. However, it seems to make no sense that this group of people, who are high users of services (having had an average of four acute admissions to inpatient services each), would not be better supported in their efforts to stay well. The key to their wellness is their sobriety and daily commitment to 'wellness' activities. These endeavours could be supported in a number of low-level, low-cost ways:

1. The acceptance and inclusion of Twelve Step approaches as legitimate strategies for the treatment of co-existing disorders.
2. The inclusion of families and whanau in treatment from the outset, not simply as a discharge destination.

3. Continuing low-level input from health services until new support structures and strategies are not only in place, but well established as lifestyle behaviours. It is not that these participants lack skills for healthy living, but they need ongoing support in changing long established destructive lifestyle practices and replacing them with new ones.



Discovery

Beyond the Maintenance Phase of Recovery

Discovery - the action of uncovering or fact of becoming uncovered. The finding out or bringing to light of that which was previously unknown; making known (*Oxford English Dictionary*)

The entity discovery: is closely linked in the dictionary to exploration - to go into or range over for the purpose of discovery; to conduct operations in search for (*Oxford English Dictionary*). The manifestation 'discovery' fits the trajectory of my participant group from 'intemperate insanity' to 'maintenance' and puts them in the role of explorer and path-finder in the journey of their own lives. It captures the constant movement and growth that takes them beyond the 'maintenance' phase of 'recovery'. Recovery relationships are defined either in relation or opposition to health professionals. 'Discovery' brings with it a completely new set of relationships based on a completely different set of assumptions and understandings. It also brings to the field of 'coexisting disorders' a new way of conceptualising, what has until now been seen as, the exclusive domain of medicine and psychiatry.

This is a thesis about 'discovery' in a context that straddles the divide between health and 'life'. There are a number of elements that constitute 'discovery' as it applies to the participants who are dually diagnosed with a major mental illness and substance use problems. The concept of 'discovery' brings with it a new dimension that integrates coexisting disorders seamlessly into the lives of the people affected by them. It takes coexisting disorders out of the realm of 'illness' and into the business of 'being' human.

The Role of Myth in Discovering a Life

A myth is one story in a mythology or system of hereditary stories which were once believed to be true. Myths served to explain why the world is as it is and things happen as they do, as well as to establish the rationale for social customs and observances and the sanctions by which people conduct their lives (Abrams, 1981:111).

In his study of *Becoming Alcoholic*, Bigus (1996) has a category whereby his participants try 'to get out' of the alcoholic career and return to 'normal' social networks. The success of the consumer participants in this study depends on their not trying to 'get out' of their state of being, but embracing it. It is this ability to embrace coexisting disorders that takes them out of the realm of 'patient' and redefines what it is to be human:

'Embrace your monster', Frankenstein. The Being continued...
"let him live with me in the interchange of kindness; and instead of injury, I would bestow every benefit on him with tears of gratitude at his acceptance. But that cannot be; the human senses are insurmountable barriers to our union. Yet mine shall not be the submission of abject slavery. I will revenge my injuries: if I cannot inspire love, I will cause fear; and chiefly towards you my arch enemy, because my creator, do I swear inextinguishable hatred. Have a care: I will work at your destruction, not finish until I desolate your heart, so that you shall curse the hour of your birth." (Shelley, *Frankenstein*, 1969:145)

The coexisting disorders were analogous to Frankenstein's monster, that, depending on the response of the individual, had the potential to enhance or destroy their lives. The act of 'embracing', 'accepting with affection' (rather than denying, rejecting or trying to rid themselves of) the mental illness and substance abuse has been critical to the success of the lives of the participants. The inner turmoil had stopped, and they were able to apply their full concentration and talents to making the most of the life they had been given. Unable to do this in the story, Dr Frankenstein was ultimately destroyed by his own monster, and whilst it is true that he did manage to kill it, he also brought about his own demise in the process.

Stories about the demi-god Prometheus are told differently in different texts and it is not my intention to explore his 'life' here. However, there are two aspects of his being that have metaphorical significance for this piece of research. The first is his role as the bringer of fire to earth, fire whose "beam dispel[s] the dread of darkness and...warmth remove[s] the chill of winter" (Murray, 1988:206). Fire was seen as an "emblem of the life of man" with the possibility of both illuminating and extinguishing life. Alcohol is often called 'fire water' - with the same possibilities. Abstinence was the single most important strategy in the 'wellness' plan of the participants. Illumination came in the form of an understanding of the impact alcohol and drugs had on their lives. The understanding was that drugs and alcohol would extinguish their lives if they were not able to remain abstinent from them. The strategies of

'risk reduction' and 'harm minimisation' were no longer available to my participants as long-term, realistic life-choices. They had already experienced *intemperate insanity* and all had tried at least once to take their own life. 'Recovery' is the bringer of light to the soul, and relapse brings with it the possibility of extinction.

The second significant contribution of Prometheus to this metaphor is the state of torment in which he lives as a consequence of 'stealing' fire from the God Zeus - being chained to a rock on Mount Caucasus, where a vulture preyed on his liver, which regenerated as fast as it was devoured:

This state of torment might have been brought to an end at any time by Prometheus, if he had been willing to submit to his oppressor...but that he disdained to do...[and he became] the symbol of magnanimous endurance of unmerited suffering, and strength of will resisting oppression. (Holme, 1981:42)

One of the certain consequences of drug and alcohol abuse is damage to the liver (which is an organ that has regenerative powers) and mental illness that brings with it 'unmerited suffering'. Many people with co-existing disorders live in a 'state of torment' that has the potential to be brought to an end by a process of 'surrender' to the oppressor (addiction and mental illness). This is the basis of the Twelve Step approach (Step One only) of Alcoholics Anonymous - "...admitted we were powerless over alcohol that our lives had become unmanageable". Participants in this study surrendered, not in a passive, submissive manner, but in a way that is life-enhancing and life-affirming. This not only ensured their continued existence, but gave them a framework of understanding for their 'condition' and a setting in which to claim their lives. This 'client centred' approach gives new meaning to a concept which is frequently claimed, and seldom practiced, by health services. It is the way in which consumers think about and claim their own lives that adds to the body of knowledge of coexisting disorders and contributes to the originality of the thinking in the thesis.

The success of my participants was due in part to their ability to do as Janus did - to look forward from the past. They were able to look backwards and forwards and to successfully manage their 'endings' and new 'beginnings'. They understood the destruction of their addictions, they had lived in a state of torment, and knew what it was to have a damaged liver. Most had experienced the 'illumination' and near 'extinction' of life. They were now able to move forward in their lives remembering the mistakes made and the lessons learned from the past. They did not wallow in morbid regret but used the past as a

reminder about what they would be if they didn't stay in 'recovery' mode on a daily basis. They submitted to a power greater than themselves and used their individual experiences cumulatively to live in a richer present.

Discovery as a Paradigm Shift

One of the key features of this basic social process of *Discovery* is a paradigm shift from depending on external forces ('health professionals' to tell you how to 'be well', or taking the medication that was prescribed, and accepting the 'medical model' analysis of your illness) **to** internal processes of taking responsibility for one's own recovery and well-being. Responsibility may include taking medicines and accepting that one has is a 'disease', but it is only part of a broad band of intervention and life-management strategies. This integrated approach - one that has successfully combined the wisdom of medicine with the intelligence of 'self', again, lends originality to the thinking in this thesis.

Anthony (1993) argues recovery is about *regaining* (my emphasis) what has been lost: health, self-esteem, sense of place in world, family and friends, material and emotional security, potential, belief in a positive future, autonomy and control. Anthony implies that people had these things to start with. My data says that this was not necessarily so. The notion of recovering what has been lost does not take account of that which is gained, learned/developed anew. Developing that which has not been there before, exploring potential, testing limits, seeing how far one can go. The section *pushing the boundaries* in Chapter Nine, *Living Without the Armour - Maintaining*, introduces a new dimension to recovery, and another dimension of originality to the thinking put forward by the arguments in this thesis.

Discovery as a Life-Long Journey

In this section, I contest the idea of recovery as a destination and a return to 'full health', and argue for 'discovery' as a life journey. For the participants of this study, there is no destination, they are where they need to be at this moment, and what they are living with in the moment is full health. It might not have been what they had before, but it is their full capacity and they are learning to enjoy the richness of life, and to explore where it might take them.

Ultimately, what the consumer participants described was more than recovery. They went beyond the mandate to recover what is, to *discover* what could be, and to live their lives with a greater abundance than might otherwise have been possible had they been content with recovery. It is this new way of thinking

about 'recovery' from coexisting disorders that lends excitement to 'treatment' possibilities and challenges existing 'knowing' in staff and consumers alike.

Discovery as a 'Present Moment'

Discovery focuses on living 'in the moment', and whilst 'recovery' shares some of the same immediacy, there is an aspect of 'recovery' that involves putting life on hold in the 'hope' for a better future, 'hope' of a cure, or 'hope' that the 'community' will give them the respect and support they want. The 'discovering' participants were able to do as Janus did, look backwards and forwards whilst living fully in the present. They did not spend time, as they had in the past, regretting the actions and behaviours that had not served them or others well. They did not sit around in a state of inaction dreaming about a future that may or may not materialise. They did not live in 'hope' of a cure, but made the most of the skills and abilities they had. They did this by accepting that mental illness and substance use problems were part of their make up. They did not see coexisting disorders as pathological entities to be excised in the same way as a diseased appendix might be removed. They successfully found a way of acknowledging coexisting disorders as a small part (but not the totality), of who they are. This allowed them to live life to the full, each day.

Discovery and the Dilemma of the Health Services

Since our focus within mental health systems continues to be on those individuals who presumably will be lifelong recipients of mental health systems, minimal research has been conducted which identified those individuals who are at the stage of recovery in which they are no longer conspicuously mentally ill. (Curtis, 1998)

This thesis researches just such a group who are no longer 'conspicuously mentally ill' but nonetheless require ongoing acknowledgment of the existence of mental illness and substance abuse in their lives and that these things will always be a part of them. This is the first study of its kind that researches consumers in this group who are no longer acutely mentally ill or actively using substances. Rather than anticipating or hypothesising about what 'might be', or examining aspects of treatment that have been developed for an acute setting, this thesis has done what Janus did - looked back from the future with the wisdom of the past to understand and inform the present.

The participants sit on the margins of 'illness' and 'wellness'. When they are 'well' they do not need the input of health services. However, they need the input of health services (albeit at a very low level), in order to stay 'well'. This

is also the dilemma of the health services. They are contracted to provide support to people who are unwell. Once they are 'well' they are obligated to discharge them from the books. Some services have managed to negotiate a longer period of contact with their clients than others, but none has a mandate to go on caring over the life span of the client.

Discovery and the Irrelevance of Discrimination

Discrimination - "treats people as objects without full human status" (*Blueprint on Recovery and Discrimination*). What interests me about discrimination is that none of my consumer participants talked about it. One could argue that this is because they are so incapacitated by it that they do not have the energy to either recognise or fight it. Whilst I am not arguing with the sentiment of the anti-discrimination campaign, it is asinine to expect individual consumers to have any control over the behaviour of others. Nor is it reasonable to expect that it is the role of the 'oppressed' to educate the 'oppressor'.

Another possible explanation for the failure of the participants to mention discrimination is, not that it does not happen, but it reflects the lack of relevance it has for their lives. Either they are so focused on their own 'discovery' that they do not have the time or energy to be politicised about the behaviour of others, or does it mean that they have taken on the teachings of their discovery programme to "change what they can, accept what they can't and have the wisdom to know the difference"?

This leads to a second and connected idea about 'discrimination'. All the discrimination literature comes out of mental health. It is not located in the alcohol and drug literature, and there is little from the literature about coexisting disorders. Whilst it is acknowledged (Minkoff, 1996) that people with coexisting disorders fare worse on every measure (than those with either mental illness or substance abuse alone), and that their symptoms are worse and treatment outcomes poorer, there may also be an 'up' side. Having more than one disorder gives consumers the opportunity to access more than one treatment option. They can take advantage of the best that mental health and alcohol and drug services have to offer. The Twelve Step approach puts the individual at the centre of their own recovery. This shifts the focus from the 'other' to 'self', and allows individuals to take control of their lives in a way that is profound and meaningful for them. If consumers can treat themselves as "equally human", it makes it more difficult for others to treat them "as objects without human status" (*Blueprint*, 1998:19). If they value and accept themselves it makes it difficult for others to "punish people with mental illness for something they did not choose" (*Blueprint*, 1998:19). It is hard to

discriminate against someone who values and accepts who they are. The lack of relevance of discrimination in the consumer participants' lives was a surprising find and establishes another point of originality in this piece of work. The *discovery* paradigm meant they did not identify themselves within the frame of reference of discrimination as is popularly imagined.



Summary of key original findings

1. A New Approach

Discovery does not require consumers or health care providers to abandon their existing knowledge and practice. There is still a necessary place for medication, inpatient care and 'expert' learning. However, if services to people with coexisting disorders are to be truly 'client-centred' there is a requirement to engage in a new paradigm of thinking – a paradigm that challenges current beliefs about the nature of coexisting disorders and the people who live with them. There is a need for a paradigm that has room for the place of myth, not the myths of 'madness' and 'addiction', but the more constructive myths of acceptance and integration. It will involve simultaneously understanding and letting go of the limitations placed upon people with coexisting disorders and replacing them with the vision of new possibility. 'Discovery' is, at the same time, a 'present moment' and a 'life long journey'. This new paradigm of thinking invites us to consider ideas we have previously believed to be mutually exclusive, to bring together positions that have existed only as polemics in our minds.

2. New Possibilities

To let go of the old paradigm about coexisting disorders opens the way for exciting new possibilities. The possibility for existing services to truly collaborate with self-help and Twelve Step programmes in a partnership of equals. An opportunity to put the 'client' at the centre of their own world, not just the rhetoric of the service. Most exciting of all, there is also the possibility of **discovering a life** based on an inclusion and acceptance that gives way to the potentiality of human existence.



Conclusion

Considerable confusion has been generated by the adoption of the self-help terminology of 'recovery' into the service provision language of 'rehabilitation'.

Rehabilitation programmes have been refocused to encourage 'recovery' in consumers. 'Recovery' traditionally belongs with the individual and not with the services, but has been adopted by services to encourage individuals to take responsibility for their own well-being. In this context, 'recovery' has been seen as a time-limited intervention offered by 'treatment' services to assist people to 'normalise', or reach their full potential. Time limits on 'recovery' in a treatment environment vary from service to service and model to model, but it generally ranges from anywhere between six weeks and two years.

It may be that services are only 'purchased' to work with a client for a period of six weeks to two years, but this should not stop them from taking a long-term view. This raises the spectre of the argument as to when coexisting disorders cease to become a health issue and therefore cease to be funded from Vote Health. Management of the maintenance phase of the process seems to be a key factor in the ongoing wellness of the consumer.

According to 'Howie the Harp' (cited in Curtis, 1997:4):

The problem that we're facing is that, similar to people with physical or developmental disabilities, the mental health system, and a large part of the general public, believe that we are not capable of living independently, and believe that we must live and work in situations which give us care and treatment for the rest of our lives. That's the myth we have to debunk.

This sentiment of other's attitudes to recovery seems to typify and form the essence of recovery-related thinking and the programmes that are developed out of it. It is an amorphous mental health system and an even more obscure public whose minds and attitudes need to be changed before the 'mentally ill' can embark on a rich and meaningful life. Whilst I am not letting the mental health services or the public off the anti-discrimination hook, nor laying the responsibility for wellness at the feet of the individual consumer, I am wondering about the balance. The data generated by my consumer participants would seem to indicate a group of people who believe they are capable of living independently, and need to make a life-long commitment to their mental health needs. Perhaps a first step in the recovery tapestry is to accept that, for many consumers, living independently and holding a life-long commitment to recovery is not an oxymoron. How can others be convinced of the possibility of a rich and fruitful existence for people with coexisting disorders if the consumers cannot be first convinced of this themselves.

The 'recovery' debate takes place within the parameters of the very paradigm it criticises: "Recovery is a very individual process by which people actively reject the status quo or belief that they have an incurable illness from which they can only hope, at best, to find temporary relief" (Curtis, 1998). What Curtis is arguing for here is a way of 'getting well' that involves the excision of mental illness (and in the case of co-existing disorders) substance dependence. "When we maintain the assumption of permanent psychiatric disability, even if we focus heavily on quality of life, we reinforce an identity of fragility, unpredictability, and negative difference, along with an assumption that ongoing success is inevitably linked to the reliability of skilled professional help over time, a tenuous proposition at best" (Curtis, 1998). It is my contention, however, that the participants who are 'getting well' best, are those who do acknowledge that mental illness and substance dependence are life-long, but not necessarily permanently disabling, and have found a way of integrating them into their 'being' and personhood. This perspective contributes to the originality of this piece of research and provides a direct challenge to current health practices for people with coexisting disorders.

The success of the consumer participants is that they have learned to live successfully with and manage ambiguity. The same cannot be said for the health professionals or the families. They continue to struggle with the dissonance created by a range of theoretical models that inform the understanding and treatment of co-existing disorders. They are drawn to the polemic that preferences one approach over another. Therapists defend the validity of their model of choice to the exclusion of all others and families seek out therapists who most closely match their own worldview. Whilst some models are more useful than others at particular points in treatment, medication is always appropriate in reducing the distress of psychosis during the early onset of symptoms, and a medicated detoxification is essential for the safety of dependent users. However, as the acute symptoms abate it is limiting to continue to work with a medical model exclusively. The participants in this study successfully integrated the knowledge and strategies of Twelve Step groups, self-help and 'new age' philosophies, the mental health user movement, community rehabilitation and medicine. They were able to 'pick and mix' to their best individual advantage and change as their needs demanded.

'New age' approaches have traditionally been regarded in a derogatory way by mainstream psychologies and psychiatry. The originality of this study would suggest that no matter how they are regarded, 'new age' self-improvement approaches form an important part of the wellness armoury of

those people who are dually diagnosed with mental health and substance use disorders.

Whilst 'soul work' and self-improvement programmes may not be the concern of mainstream health care (although some authors suggest it should be) this research found it would advantage the consumer participants to have it introduced as part of a menu of options for their journey of *discovery*. As consumers make the transition from acute care to community and independent living, they are well placed to make informed choices about their ongoing well-being.

The consumers are the experts on their own lives. Out of their wisdom and knowledge has come a paradigm shift that moves the possibilities for people with coexisting disorders beyond recovery and into a realm of *discovery*. What has historically been seen as a life-depriving illness compounded by the use of drugs and alcohol, has been seized by the participants of this study as an opportunity. They have developed a mind-set of thinking and framework for action that enriches their lives in ways that may never have been possible without coexisting disorders.

In the next chapter, the "Conclusion", recommendations that have emerged from the data for service providers and policy makers, will be considered along with suggestions for further research in this complex and diverse arena of coexisting mental health and substance use disorders.

CONCLUSION

From the earliest history of Alcoholics Anonymous, a relationship has existed between psychiatry, psychology and AA. The AA term "spiritual conversion" - that is, the point where grandiosity and defiance give way to an inner sense of harmony and connectedness - first appeared in a letter Bill W. received from the famous psychoanalyst Carl Jung. Discussing an individual with alcoholism who, in spite of the greatest effort, could not seem to recover, Jung credited the person's eventual recovery to a conversion of the spiritual kind. This letter first documented the potential for a successful marriage between medicine, psychiatry, and what would eventually become the self-help movement. (Nukols, 1993:x)

It is this successful marriage of medicine, psychiatry and self-help that forms the basis of *discovering a life* for people with coexisting disorders. But *discovering a life* is more than a "conversion of the spiritual kind." This thesis tracks the journey of a snowball sample of people who are living successfully with coexisting disorders, and the multiple pathways to *discovery*.



Findings

Like any relationship, in order to understand the whole, it is important to understand the parts and the connection between them. In the introduction to *Love for all Seasons* (Innes-Kent,1998:15), New Zealand relationship commentator Suzanne Innes-Kent outlines some basic premises behind her book (and the nature of relationships). These premises are based on "challenge", "change" and "occasional crises". Innes-Kent (1998:15) argues that "we can learn to be open to and enjoy change. This requires a more flexible basis to our relationships than previous generations have needed". And so it is with the crisis and change that occurred in the lives of the participants of this study. Not only were they able to embrace challenge, crisis and change in their own lives, they did it by successfully facilitating a relationship, or marriage even, of medicine, psychiatry and self-help strategies to their best advantage.



This study began as a general inquiry into the lives of people living and working with coexisting mental health and substance use disorders. The topic arose out of a clinical interest held by the researcher, and a desire to research coexisting disorders in a new and exciting way. The thesis is prefaced by a copy of a self-portrait of one of the consumer participants. It establishes, from the outset, the participants as the focus of the study and helps to orientate the reader to the inner world of coexisting disorders. The picture is one of distress and fragmentation that is often representative of the experiences of people with coexisting disorders and the services who are trying to support them.



Contemporary research and literature (Chapter 2) is informed by a 'medical model' that clearly locates coexisting disorders within the disease construct. It covers matters of prevalence (of the disease) within the general population and in the sub-populations of psychiatry and addictions. Diagnosis, treatment and prognosis are prescriptively determined by the guidelines of the *Diagnostic and Statistical Manual of Psychiatric Disorders* (IV, 1996).

Coexisting disorders are life long and occur on a continuum of illness to wellness. Consumers first come into contact with the health system at the onset of acute symptomatology of major mental illness and/or substance abuse. They remain in the hospital system from the moment of first contact until their symptoms are deemed to have settled. This may be anything from a few days to a few weeks. Outpatient contact is maintained as the consumer undergoes a period of rehabilitation and integrates back into the community. This may take up to two years, at which point the consumer is discharged from the service. It is this epoch in the chronology of the consumers lives that is captured by the literature. Their signs and symptoms are examined, analysed and recorded. Treatment modalities are advanced and their efficacy debated. A burgeoning number of researchers participate in these studies and academic arguments, but little is known of the lives of consumers after they are discharged from the 'system'.



In a bid to shift the emphasis of investigation from instruments of measurement and service provision, to the lives of the participants and their perceptions, the qualitative methods of 'grounded theory' were used. The study allowed participants to identify the issues that were significant to them and focussed on the way they lived successfully with coexisting disorders. 'Slices of data' were gathered from consumers, family members, staff, and policy documents and

analysed using the constant comparative method (see Chapter 4 "The Audit Trail").

A matrix of participant experiences was systematised and aggregated to create a second level 'theory' (see Chapter 2 "Theory") of *discovering a life* with coexisting disorders. The Roman God Janus (of endings and new beginnings) who is portrayed with two faces, one looking backwards and the other forwards, was used as a metaphor to enhance the understanding of the nature of the strategies participants adopted to '*discover*' their lives.



They began by remembering two aspects of the past. First, the *intemperate insanity* that involved a lifestyle of unrestrained drinking and/or drug taking, and episodes of mental illness that went unrecognised, untreated or poorly managed. From the participants' point of view, this lifestyle was not all negative. In the beginning, the drinking and drug taking were a way of *connecting* with others. It was a vehicle for socialising and celebration in congenial circumstances. At other times it was a way of *coping* with problems. It provided temporary respite from the vicissitudes of daily living and momentarily left the participants feeling confident about the future. The second important element of remembering the past was the inevitable *crisis* that brought the participants to a point of change. The *crisis* was not a one-off, random, unanticipated event. There was a period of *build-up* (sometimes over many years) that often included multiple smaller events. Each on their own was not sufficient to cause distress, but, when combined, left the individual feeling *overwhelmed*. The usual coping strategies failed under the complexity of events leading to what the participants described as a *breakdown*. They had all visited this point many times before and it led inevitably to an *intervention* from forces outside of themselves. This memory of the past was an important element of the present. It was recalled not with judgment or shame, but as a salutary reminder of possibilities for the future.



Recovery is a concept that has been well documented in both the mental health and addictions literature. This is the point at which the participants *recognised* their problems and began to *understand* the connection between these, their mental illness and substance use, and began to make changes. They had passed this way many times before, but the critical juncture on this occasion was achieving and maintaining *sobriety*. Some literature (Minkoff, 1998) acknowledges that people with mental illness prefer to focus on the problems

of substance abuse rather than take on the identity of 'mental patient'. Contrary to popular opinion, the participants in my group were happy to acknowledge their mental illness as long as no one looked too closely at their drinking and drug-taking. Some of the male participants had struggled with fluctuating mental wellness for twenty years until their drinking and drug-taking behaviour had become so untenable that they were forced to consider abstinence (albeit temporarily in the first instance). As they nurtured their sobriety, their mental health began to improve. They had less hospitalisations, were able to reduce medication and finally were able to make the connection between their substance use and episodes of mental illness. A lifetime commitment to sobriety did not come instantly. Most remained sober 'one day at a time'. The days added up to weeks and the weeks to months. Most of the participants in this study had achieved at least two years of sobriety and now saw it as a way of life. All talk of returning to substance use ceased as the benefits of abstinence grew. Having made a life-long commitment to sobriety and having seen its benefits, the participants were now in a position to *discover* their lives.



Discovering a life took them beyond the traditional limits of 'recovery' with an emphasis on regaining what they had lost and returning to 'normal'. One participant called this period *living without the armour*, and was able to enhance the lessons of 'recovery' to '*discover a life*' that was different from, and may not have been possible without the understandings that came from learning to live with coexisting disorders.

There were four elements important to *living without the armour*. The first were the *daily reminders* of the past. Participants did this in a number of ways, by attending 'meetings', supporting others in need, setting aside time each day to reflect on the past in relation to the progress of the present, or through symbolic items. One participant bought a "park bench" for his garden to remind him of his days of "living rough".

Making new and meaningful *human connection*, bringing people into their lives who are supportive of their changes and new ways of living was the second element.

The third involved *expanding* their minds, skills and repertoire of behaviours, in a way that allowed them to live more richly satisfying lives.

The fourth and final element involves a modification of the Twelve Step concept of 'giving back'. This is the stage at which participants make a contribution to the lives of others in both practical and existential ways. It is a form of 'thank you' for the help and compassion they have received from others on their journey with coexisting disorders. For a variety of reasons it was not always possible directly to repay those particular individuals who had provided support, and participants found a diversity of ways of 'giving back'. This included being a 'sponsor' to others in 'recovery', working with health professionals to help them 'understand', or training to be health professionals themselves. Others 'gave back' in more indirect ways, such as teaching English as a second language.



The preponderance of coexisting disorders literature is focussed on mental health and addictions services, and the people who staff them. In spite of this, service provision represented only a small time-fragment in the lives of people with coexisting disorders. In terms of the 'process' of the illness, health services were significant in helping to manage the crisis, stabilisation and early recovery periods. In a temporal timeframe, this may have been anywhere from six weeks to two years. The staff participants only thought about the consumers in the context of acute unwellness, stabilisation of their 'condition' and early recovery. Their data reflected concerns about the *model conflict* that was created by different institutional approaches, staff training and preferences and service focus. The prevailing medical model was often seen to be at odds with the psychological and social interventions, with staff perceiving each as mutually exclusive. Each model informed not only the 'treatment' approach, but the way coexisting disorders were interpreted and understood. This *model conflict* was further compounded by the arguments about *engagement strategies*, the *skills and knowledge-base* of the staff and *parallel vs integrated care*. Services to people with coexisting disorders in New Zealand have grown separately out of mental health and substance abuse facilities, with each trying to adapt their own particular philosophies and approaches to meet the needs of people with coexisting disorders. It has been the failure to successfully accomplish integration of services and models that has formed the basis of much discussion in the literature, and led ultimately to the current study.



Meeting cultural needs is the focus of much emerging literature (Durie, 1994), but did not emanate as a significant concern for the participants. Only

mainstream services were investigated. All staff (regardless of their own ethnic origin) had a level of understanding of Treaty issues as they affected health, and some integrated Whare Tapa Wha principles of understanding into their clinical practice for all consumers. The Maori participants could not get their acute illness needs met in iwi-based services and accepted medical-model treatment from mainstream providers.



There are a number of significant aspects of *discovery* that contribute to the originality of this thesis. *Discovery* challenges some fundamental elements of *recovery* in a way that leaves room for a new paradigm of change in the lives of people with coexisting disorders.

My participants are able to reconcile the paradoxes of mental illness and substance dependence in an abundance of creative ways:

1. They are simultaneously able to accept their coexisting disorders as life-long (not time limited) and transient. They are able to separate the periods of acute unwellness from the continuing but unobtrusive presence of mental illness and substance use problems in their lives.
2. They are able to experience coexisting mental health and substance use disorders at the same time as both a problem full of negative and destructive consequences and an opportunity for growth, change and discovery.
3. One of the strategies that gives rise to the successful inclusion of coexisting disorders in their lives is their acceptance of such disorders as an integral part of who they are, not as a disease to be managed, treated or overcome.
4. The participants found a way of cultivating their strengths and inner resources, not looking for flaws of personality that had to be modified, suppressed or excised.
5. Finally, they were able to resolve the dissonance created by the use of a multiplicity of treatment models in a way that allowed them to benefit from each approach. Unlike the staff participants, consumers were unconcerned by the model, strategy or theoretical purity of each 'treatment' intervention. They took a more pragmatic view and judged the success or failure of the therapy according to the impact it had on their own lives. They did not allow the boundaries and distinctions between the paradigms to interfere with their need for wellness, and took what they needed from each approach in order to achieve that.

6. In a world of apparent confusion, the participants had mastery over their lives. They steadfastly resisted other people's judgements of who they are and the meaning of coexisting disorders to them.



Recommendations

There are a number of insights and recommendations that treatment services can take from the material provided by the consumer participants. Some are direct, others are implied and extrapolated.

1. Information gathering and assessment enables the health professional "to make sound clinical judgements and plan appropriate interventions with the client" (Stuart, 1998:176). Although the language and rhetoric is of 'client-centredness', the focus is on meeting the needs of the health professional and systems of accountability of the service they work in. Many of the consumer participants felt outside of, and irrelevant to, the process of information gathering. They experienced it as a prelude to 'treatment', not part of it. As I reflect on the positive feedback I received from consumer participants about the way they were able to tell their story instead of answering my questions, I can see the possibility for the assessment phase of intervention to be more therapeutic and healing than it currently is. Much of the information the participants gave me (of their own volition and in their own way) could easily have been adapted to fit the information gathering format of the health system. It is not that the 'facts' were different or irrelevant, they were merely conveyed in a different way. It was a way that did not compound the stress and trauma of admission to hospital, and began the healing process for the participants. A trial of 'narrative-style' information gathering would soon reveal the practicalities and pitfalls of approaching consumers' interface with the health system in a more humane and healing way.
2. Interpretation of the *Privacy Act* was problematic for the family and staff participants of this study. It was a source of constant vexation for staff participants who were trying to juggle the interests of their clients with the needs of family and other health, social and justice services. It was a cause of frustration and anguish for family members who remained at the centre of the caregiving system, but struggled to give or receive what they determined to be information essential to the safety and well-being of the identified patient, the family and often the wider community. They were driven by fears for the safety of the lives of those affected by their mentally-ill family member. Every time a killing by someone with coexisting disorders made

the headlines, they saw the very real possibilities for their own family member to do the same, and wanted to use the intimate knowledge they had of that person to avert another potential crisis, or to ensure the safety of themselves and those around them. A *Privacy Act* that is less rule-bound and allows for more individual interpretation would protect and support family members. A more free exchange of information between services would also contribute to greater understanding and more integrated care.

3. The theoretical models (medical, psychiatric, psycho-social, behavioural or rehabilitation) used to inform the understanding and subsequent intervention of coexisting disorders were not necessarily the frameworks consumers used to make sense of their changing world. Consumers need to be allowed to understand their problems, their way. This may not be in a medical model framework. From the consumers' perspective, it would be helpful if staff could be more flexible in the range of possible interpretations they place on what they see before them. It would be even more helpful if they could find a way of understanding the frame of reference the consumer uses to make sense of their world, and to incorporate that into negotiations around treatment and therapy.
4. As a natural progression from point three (above), 'treatment' needs to include a marriage of models from those used by health professionals to consumer-initiated Twelve Step and self-help. None of these approaches is mutually exclusive and the consumers in this study found a pragmatic way of taking what they needed from each to enhance the discovery path they had set for themselves.
5. Whichever 'treatment' approach is adopted, one clear imperative from the study is that both staff and consumers need to be willing to work with a goal of 'normal' that is not an idealised or statistical 'norm'. Struggling to meet the 'norms' and expectations of self, health services and society was a source of consternation for all the participants of this study. They struggled to achieve states that were not only unrealistic for themselves (given their various abilities), but also did not enhance their lives in a meaningful way or actively undermined their attempts to make lasting and healthful changes. 'Normal' was different for each participant. By adopting a more benign and elastic approach to 'normal', participants were able to achieve a greater richness and diversity in their lives than they would have had they adhered rigidly to the statistical and idealised 'norms' of our society.

6. Closely linked to the theoretical interpretations of coexisting disorders is the fundamental paradigm shift from a model of excision/adjustment of 'pathological' symptoms, to integration/acceptance of coexisting disorders as part of the totality of each individual. Where this acceptance and integration had taken place, the consumer was able to shift the focus of their lives away from illness and dys-function to health and wellness in every domain of their existence.
7. Care in and by the health system needs to be seen as part of a continuum of care that does not finish for the consumer when they reach the limits of mainstream treatment. Attention to the detail of their lives is ongoing and permanent. It may fluctuate in intensity and particularity but there never comes a point at which the journey of *discovery* is over. The transition between hospital and community is a long and protracted one that requires recognition and ongoing support. Rather than being seen as a sign of 'failure' to fully recover, the present-continuing approach to their lives is an indication that they are likely to remain out of the health system and in the community.
8. 'Significant others' are an integral part of the process of *discovery* for the consumer. They are an integral part of the 'problem' and the solution (both positive and negative) and health services need to find a way of legitimising their 'expert' input. They need to be able to impart information as well as receive it. What they have to say can make an important contribution to the overall outcome of 'treatment'. At the moment, they are not the 'identified' patient and as such, are not entitled to 'help' in their own right. Many family members are damaged as part of a trans-generational pattern of addiction and mental illness. Others are stressed by trying to live with, and support, a family member they do not understand. They are often overwhelmed by the complexities of their family member's needs and demands. Help and support needs to be offered in two domains:
 - They require assistance to understand the nature of coexisting disorders, what they might expect to see in their relative, and develop strategies to support them.
 - Even more importantly, significant others need education, help and support in their own right, that does not require the identified patient to be at the centre of the intervention. Family members have issues of their own that are often created, but more usually compounded by a parent, sibling or child with coexisting disorders.

'Helping' agencies need to be able to broaden the scope of support they can offer.



This is a unique piece of research in several respects.

1. The 'grounded theory' method of investigation has, to the knowledge of the investigator, never been applied to the study of coexisting disorders. Most studies are located resolutely in the mainstream literature of medicine, psychiatry, psychology and addictions. A 'grounded' approach allowed the investigation to advance with no pre-conceived ideas or hypotheses to be tested and either proven or refuted. It began with the concerns of the participant group (not the researcher or the 'field of knowledge') and left open the possibility for original discovery. The participants have provided many insights, from which recommendations can be drawn, which can be linked back to improving traditional treatment methods and services. The data has created another level of understanding of coexisting disorders and the people with them.
2. The study has exposed the reader to the possibility of the value of taking a risk with therapy and being willing to look beyond the traditional psychological and rehabilitation models and experiment with narrative and other inclusive forms of therapy for people with coexisting disorders.



Recommended areas for future study are as follows:

1. A snowball sample of participants who are successfully managing their lives with coexisting disorders was generated for this investigation. There may be others who are not so fortunate in their quest for wellness and integration. A study of 'resiliency' may help to distinguish between them and identify the factors that make a difference.
2. Although there are many comparative studies of therapeutic modalities, an exploration of a wider range of therapies and their usefulness at different phases of the illness-wellness continuum might be advantageous. In particular, this should include an understanding of the ways in which treatment modalities are combined and integrated in the consumer's best interest.

3. A trial of 'narrative' methods of collecting data from consumers would prove valuable. At the moment 'information gathering' systems are set up to suit service organisations and their funders. The process of therapy and healing may begin at an earlier point if consumers are able to tell their story their way. It may also satisfy the needs and accountability of the institutions.
4. There is currently little research into coexisting disorders in the New Zealand context and none from an indigenous or Pacific perspective. Tangata whenua and Pacific Nations researchers need to be supported and funded to conduct research into, and for the benefit of, their own people.



In Conclusion

'Coexisting disorders' covers more than the occurrence of mental illness and substance abuse in the one individual. It is the culmination of genetic vulnerability, social factors, behavioural elements and timeliness that aggregate in this particular presentation. Relationships between the elements are convoluted, and solutions are as complex as the 'problems' and the individuals in whom they manifest.

The thesis began with reference to the Roman God Janus, his looking backwards and forwards, the God of endings and new beginnings, the gates of his temple being shut in times of peace and open in times of war. I would like to conclude with a reference by Thomas Moore (1994:19-21) to an even earlier civilisation's mythology - that of the ancient Greeks. Ancient Greek philosophy influenced much of the thinking of civilisations which developed later including the period of Roman intellectual ascendancy in which Janus was one of the Gods that reigned and our own intellectual era in which the medical model reigns, albeit shakily, over the lives of those with coexisting disorders:

Care of the soul, looking back with a special regard to ancient psychologies for insight and guidance, goes beyond the secular mythology of the self and recovers a sense of the sacredness of each individual life. This sacred quality is not just value - all lives are important. It is the unfathomable mystery that is the very seed and heart of every individual. Shallow therapeutic manipulations aimed at restoring normality or tuning a life according to standards reduces - shrinks - that profound mystery to the pale dimensions of a social common denominator referred to as the adjusted personality. Care of the soul sees another reality altogether. It appreciates the mystery of human suffering and does not offer the illusion of a problem-free life. It sees every fall into ignorance and confusion

as an opportunity to discover that the beast residing at the centre of the labyrinth is also an angel...The Greeks told the story of the minotaur, the bull-headed flesh-eating man who lived at the centre of the labyrinth. He was a threatening beast, and yet his name was Asterion - Star. I often think of this paradox as I sit with someone with tears in her eyes, searching for some way to deal with a death, a divorce, or a depression. It is a beast, this thing that stirs in the core of her being, but it is also the star of her innermost nature. We have to care for this suffering with extreme reverence so that, in our fear and anger at the beast, we do not overlook the star.

EPILOGUE

Subsequent to the submission and examination of this thesis, the Mental Health Commission, (Lapsley et al., 2002) has published '*Kia Mauri Tau: narratives of recovery from disabling mental health problems*'. The project, out of which the publication arose, was developed, in part, as a response to the concerns of the Mental Health Commissioner that:

...the questions mental health research sought to answer were of little relevance to people with mental health problems. The research agenda has been set by academics and professionals who value...objective evidence over subjective experience (Lapsley et al., 2002:V11).

A bicultural research team at the University of Waikato, asked the question of mental health service users "what keeps people well?" (Lapsley et al., 2002:V11). The Waikato team developed a framework of "pathways to wellness" that contains many elements similar to my own map of *discovering a life*. Three key journeys or themes are explored beginning with 'journeys into mental ill health' (Lapsley et al., 2002:17-42). Within each 'journey' are a series of stages akin to the codes and categories generated by my own research. The journeys into mental ill health describe the origins, onset, experience and consequences of mental ill health, (Lapsley et al., 2002:15). 'Journeys towards recovery' outline two recovery frameworks (RECOVER and HEART) which are acronyms for the elements which comprise each ie. Hope, Esteem, Agency, Relationship and Transitions, go to make up the acronym HEART, (Lapsley et al., 2002:71-75).

The final 'onward journey' deals with life after mental ill health, and relates most closely to my *living without the armour*:

Coming out the other side of mental ill health and recovery, participants had changed profoundly. They had become more resilient, yet accepted their limitations as well as understanding their strengths, (Lapsley et al., 2002:100).

Along with my own, this study affirms the importance of investigating the concerns of the participant community rather than embarking on a research agenda set by academics and health professionals. However, a key point of

difference remains - the ongoing nature of recovery/discovery. Lapsley et al. (2002:100) talk about all the participants having "recovered" (past tense). This difference between 'recovery' and *discovery* may be semantic rather than substantive in nature, but the participants in my study are very clear that *discovery* is a present-continuing undertaking. Perhaps it is the additional element of substance dependence and the ever-present threat of a relapse that keeps them vigilant in the present. The closest description I can find of *discovery*, in the mental illness literature is the post script by Julie Leibrich in her investigation of 'recovery' (1999:181):

Right now, the best way I can describe dealing with mental illness is making our way along an ever-widening spiral of discovery in which we uncover problems, discover the best way to deal with them, recover ground that has been lost, discover new things about ourselves, then uncover deeper problems, discover the best ways...and so on in an intricate process of growth.

It is my privilege to have been part of the lives of the participants of my PhD study, and my hope that I can continue to contribute to the debate on recovery and *discovery*.

APPENDICIES

Appendix One: Participant Information Sheet

DUAL DIAGNOSIS STUDY

PARTICIPANT INFORMATION SHEET

My name is Helen Warren. I am a Phd student researching Sociology at Massey University. I am also a Registered Nurse who had been working in the Mental Health and Alcohol and Drug fields since 1982.

I am asking people who have a 'dual diagnosis' of mental health and substance use to help me with this study. I am trying to get information about these issues. If you agree to take part, we would have a talk in your own home or wherever it suited you. If you would like to have a friend or family member, patient advocate or your Case Support Worker present, this can easily be arranged. The interview might last for about 1-1½ hours. A second interview may be arranged if there is more you want to say. Your information will give a better idea of how life is for you and others in your position.

The results will be used for a University study. I will provide you with the important findings once I have finished. No one will be able to identify you from the information you have given me.

If you decide to take part and then change your mind, you are free to withdraw from the study at any time without having to give a reason. If you still want to be part of the study, but would like to have some of the information taken out, you are also able to do that. The support or treatment you are currently receiving from your Case Support Worker or Doctor will continue no matter what you decide.

If there is anything else you need to know in order to help you make up your mind please contact me through your keyworker or the Department of Sociology, Massey University, Albany Campus Ph. 4439660. Leave your name and number and I will get back to you within 24hrs. My supervisors, Professor Paul Spoonley and Dr Grant Duncan are available at the same address and phone number if you have any complaints or concerns.

Thank you for taking time out to consider my request.

Helen Warren

Appendix Two: Consent Form

DUAL DIAGNOSIS STUDY

CONSENT FORM

English:	I wish to have an interpreter		Yes	No
Maori:	E hiahia ana koe ki tetahi tangata hei korero Maori ka koe	Ae	Kao	
Samoan:	Oute mana'o e iai se fa'amatala upu		Ioe	Leai
Tongan:	'Oku fiema'u ha fakatonnulea		Io	Ikai
Cook Is:	Ka inangaro au I tetai tangata uri reo		Ae	Kare
Niuean:	Fia manako au ke fakaaoga e tagata fakahokohoko vagahau	E		Nakai

I have read the Information Sheet and have understood what is being asked of me. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may ask further questions at any time.

I agree to participate and I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that I will not be able to be identified.

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I wish/do not wish to see a copy of what I have said at my interview.

I have given consent freely and with understanding.

Signed:

Name:

Support Person (if applicable)

Date:

DUAL DIAGNOSIS STUDY

PARTICIPANT INFORMATION SHEET FOR HEALTH WORKERS

My name is Helen Warren. I am an PhD student researching Sociology at Massey University (Albany Campus). I have also been employed as a Nurse, Counsellor and Manager in Mental Health and Alcohol and Drugs since 1981.

My thesis involves a study of patients' experience, policy development and service provision for the group of people who are dually diagnosed with a substance use disorder and a mental health disorder.

I understand some of the issues that service providers face in catering for the needs of the dually diagnosed, and as part of my PhD thesis I am wanting to interview staff working in this field. I am trying to get some sense of the satisfaction and limits involved in providing a service to this group of people.

I am using **grounded theory methods** to generate a theory that accounts for a rationale of service provision which is relevant for those involved. From the information provided by health professionals, I will create analytic codes and categories, and from there develop middle-range theories that will give me an opportunity to reflect on service provision for the dually diagnosed in a new way.

If you agree to participate (or allow your staff to participate), the interview would take about one hour, and would be held at a time and place of your convenience.

Individuals and organisations will not be identified by name, and the data collected will be presented in aggregate form (anonymous quotes may be used to illustrate a point).

If you decide to take part and then change your mind, you are free to withdraw yourself and your information (or part of your information) from the study at any time. The interview will be audio-taped and you will be given an opportunity to edit the information you have given me.

The results will be used primarily for my PhD thesis, but significant data will be presented to policy advisers in a form useful to them in policy formation. You will also be furnished with a report of the results at the completion of the study.

If you require further information, or have any queries that I have not been able to answer to your satisfaction, my supervisors are Professor Paul Spoonley, Associate Dean, Faculty of Social Sciences, Massey University, Albany Campus Ph. 443 9704, and Dr. Grant Duncan, Social Policy Department, Massey University, Albany Campus (on the same number).

Thank you for considering my request.

Helen Warren (Ph. 846 0504)

A. AS A PATIENT I HAVE THE RIGHT:

- ▶ to be treated with dignity, cultural sensitivity and respect.
- ▶ to receive my consultation, examination and treatment in privacy.
- ▶ to have the support person of my choice present for most examinations, treatments and procedures. There may be times when this is not possible, as it may affect my care or wellbeing. This will be discussed with the support person.
- ▶ to have a trained interpreter if I do not understand.
- ▶ to have access to my health care records.
- ▶ to have a patient advocate to assist me.
- ▶ to leave at any time against medical advice. This right may be limited by the law in some cases.
- ▶ to have all written and verbal information about me treated confidentially and accordingly to provisions of the Privacy Act, 1993. (Waitemata Health may, in some circumstances be legally obliged to pass on information about me to Government departments without my consent).
- ▶ to have adequate information to make an informed choice (see Part B).

Problem Solving: I have the right to question, seek advice or complain about the service I am getting by:

- Discussing the issue with the person caring for me.
- Contacting their immediate superior.
- Contacting the Customer Services Officer based at North Shore Hospital (tel. 486-1491) or Waitakere Hospital (tel. 837-2777).
- Writing to the Chief Executive, Waitemata Health, Private Bag 93-503, Takapuna, Auckland 9.
- Asking to see a representative from Patient Advocacy Services (Auckland) Ltd (tel. 638-9638).
- Mental health clients can also contact a District Inspector or Official Visitor.

B. INFORMED CONSENT

As a patient I have the right:

- ▶ to know the name, position and role of any staff treating me.
- ▶ to be given information in words I understand.
- ▶ to take part in decisions about my care and treatment. I realise this may be difficult or impossible in emergencies.
- ▶ to know about the choices of treatment open to me.
- ▶ to refuse treatment. This right may be limited by the law in some cases.
- ▶ to know that my written or verbal consent must be given before any treatment/procedure/surgery; verbal consent is acceptable for minor procedures where I am conscious and able to call a halt to the procedure. Written consent is required for all circumstances where oral consent is not acceptable. It is necessary where either party request it.
- ▶ to know that I will not be involved in any research unless I have given prior written consent.
- ▶ to give my prior consent to involvement in teaching sessions.
- ▶ to withdraw from teaching sessions at any time without affecting my care in anyway.
- ▶ Special procedures apply for children under 16. In general, treatment or investigation will not take place without the informed consent of the parent or guardian. Wherever possible the child will be involved in decision-making and his/her wishes followed.

As a patient I am aware that I also have responsibilities to:

- ▶ be sensitive to the rights of other people.
- ▶ co-operate with health staff in my treatment.

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