Chapter III: Methodology

3.1 Introduction

This study was a quantitative, anonymous retrospective record review. It was based on simplifying interview data into a numerical format and then statistically analysing this information. The records reviewed were in the form of 419 interviews conducted with people being admitted to Houghton House Addiction Recovery Centre. Anonymity was maintained, as the researcher did not know the names of the clients whose histories were being examined. A code was used to replace the client's name on the interview schedule.

3.2 Sample

Houghton House is a private rehabilitation facility situated in the northern suburbs of Johannesburg South Africa. They offer a multidisciplinary and comprehensive approach to treating clients with substance-related disorders (Houghton House, 2005). They follow the Minnesota Model, which is a twelve-step approach to treatment (Weiss, 1999). This process focuses on patient affirmation, intensive counselling and abstinence as the final goal of recovery. This model understands addiction from a disease model, which assumes that willpower plays no part in recovery because the addiction is a disease (Weiss, 1999). Group therapy including peer confrontation and acceptance of the adverse effects of substance abuse are central to this model as part of the process of ameliorating the denial associated with substance use (Weiss, 1999). Each client is seen as an individual and

tailor-made treatment plans are devised for each person. The treatment approach is holistic and includes individual, family and group therapy, exercise (including sports), a healthy diet, psycho-education, occupational therapy and medical treatment (Houghton House, 2005).

As a private facility Houghton House charges R28’500 for an eight-week recovery programme. The first six weeks involve an inpatient stay at the centre. For the last two weeks, the outpatient programme allows the clients to sleep at home, but they have to come in to the centre for the day. This treatment price suggests that the client or client system who seeks treatment from this centre needs to be in a position of relative financial security. This is one of the weaknesses of this sample. The sample consisted of 419 people who were all seeking treatment, supposedly on a voluntary basis, although they may have been coerced to seek treatment by their family members.

3.3 Data Collection

The interview data was collected by a counseling psychologist who has been working in the field of addiction for 10 years. This psychologist is responsible for all the initial intake interviews at Houghton House. The interviews used in this sample were conducted over a three-year period from 2003 to 2006.

Each history taken at Houghton House was conducted after the client had been through the five-day detoxification process. The ultimate aim of the detailed history taking

process was to strategise an intervention plan that will best suit the client. Each interview took about one hour to conduct and the diagnoses were given based on the DSM-IV-TR (APA, 2000).

3.4 Instrument

The instrument used to collect the data does not have a formal name, but is a generic bio-psychosocial interview based on that proposed by Sadock and Sadock (2003). As opposed to a medical interview, the psychiatric diagnosis has no external validating criteria, such as a blood test, to confirm a diagnosis. Sadock and Sadock (2003) therefore argue that the psychiatric interview is only as good the practitioner who uses it. With t10 years experience in the field of addiction, the counselling psychologist who conducted these interviews has had more than adequate experience to make an accurate diagnosis. Please see the attached example of this instrument (Appendix A).

3.5 Data Analysis

In order to answer the research questions, the researcher reviewed the interview schedules and counted the number of people who had or did not have the particular variable being investigated. These findings were then recorded as a “yes” or “no” on an excel spreadsheet. This strategy allowed the retrieved data to be easily coded and entered into the SAS programme, so that statistical analyses could be conducted.

The 19 dichotomous variables investigated were as follows:

1. COD
2. Axis I and axis II disorder
3. The disorder could possibly be induced

Substance-related disorders (abuse or dependence, excluding substance-induced disorders, substance intoxication or substance withdrawal)

4. Alcohol-related disorders
5. Amphetamine or (amphetaminelike)-related disorders
6. Cannabis-related disorders
7. Cocaine-related disorders
8. Hallucinogen-related disorders
9. Opioid-related disorders
10. Sedative-, hypnotic-, or anxiolytic-related disorders
11. Polysubstance dependence
12. Substance-induced disorders (All)

Co-occurring psychiatric disorders

13. ADHD

14. Anxiety disorders (Including panic disorder, agoraphobia, specific phobia, obsessive-compulsive disorder, PTSD, GAD)
15. Conduct disorders
16. Eating disorders (Including anorexia nervosa, bulimia nervosa, eating disorder not otherwise specified)
17. Mood disorders (Including MDD, bipolar disorder, dysthymia, cyclothymia)
18. Other disorders (Including abnormal sexuality, sexual dysfunctions, gender identity disorder, sleep disorders)
19. Schizophrenia

3.5.1 Criteria used to establish the prevalence rates of the various variables

Due to the extent of valuable research information that these interviews could yield, they have been used in a number a research reports. A researcher involved in one of these studies was responsible for recording the majority of the background information of the clients, such as their age and gender. The researcher for this study was responsible for recording the information contained in the client's five axis diagnosis included on the intake history interview form.

The information gathered in other parts of the interview was not used as a source of information regarding the client's diagnosis. For example, for the background history the client may have admitted to throwing up after eating. However, the counselling psychologist may have established that this person did not meet the diagnostic criteria for

bulimia nervosa and therefore not recorded this on axis I. In these cases the researcher only recorded what the counselling psychologist had recorded on the five axes.

When counting the number of people who presented with the various disorders, some problems emerged. Despite his wealth of experience, this practitioner had difficulty establishing whether the psychiatric diagnosis was substance-induced or not. In these cases, the researcher counted this as a 'possibly substance-induced disorder'. As explained in the literature review, it is often difficult to establish whether the psychiatric disorder that was prevalent first or whether the substance-related disorder induced a psychiatric disorder. The psychologist tended to make a diagnosis only if he was completely sure of its accuracy. Tending away from unnecessary labeling, he often questioned his diagnosis stating that further observations would be needed in order to make an accurate diagnosis. In these cases, the researcher has not counted the questionable diagnosis as a "maybe" or a "yes"; instead, a "no" was given. This was in the interests of establishing conservative statistical results.

3.6 Statistical Analysis

The computerised programme Statistical Analysis Software 9.1 ((SAS), SAS Institute, 2002) was used to analyse the collected data. Variables were coded and entered onto SAS. Descriptive data in the form of frequency tables were obtained. This allowed the prevalence rates to be revealed (Howell, 1999).

In order to determine if there was a significant relationship between any of the dichotomous, nominal variables of the COD sample, chi–square tests of association were conducted comparing all the substance-related variables with all the co-occurring psychiatric disorder variables (Howell, 1999). A significance level of 0.05 was used throughout. Only chi-square statistics that met the expected frequency counts for each cell were interpreted for validity purposes.

3.7 Ethical Considerations

The Principles of Beneficence, Autonomy and Non-malificience have been adhered to at all times during the research process, as these are the foundations of all ethical practice according to the South African Code of Professional Conduct (2002). This study is a retrospective record review and therefore the identities of the persons whose histories have been investigated have remained confidential. All names were removed from the case histories and replaced with codes. This ensured anonymity, as the researcher was not able to identify any of the clients whose histories were investigated.

As of June 1 2005, the persons whose histories and case files were used signed consent forms on their admission to Houghton House allowing their information to be used for research purposes. Please see attached consent form (Appendix B). All clients remained anonymous and the information retrieved was purely statistical. This ensured that no ethical dilemmas were posed by this study.