ECRONICON OPEN ACCESS

EC PSYCHOLOGY AND PSYCHIATRY
Research Article

The Effectiveness of Psychotherapy Practices in the Management of Substance use Disorders among Affected Persons in Selected Rehabilitation Centres in Wakiso District-Uganda

Kikome R*, Bukirwa and Yiga AP

Nkumba University, J.B.S- Muni University

***Corresponding Author:** Kikome R, Nkumba University and Bukirwa J.B.S- Muni University.

Received: January 03, 2022; **Published:** February 26, 2022

Abstract

This study set out to investigate the psychotherapy practices used and related outcomes among affected SUD persons in selected rehabilitation centres in Wakiso District-Uganda and secondly to establish the effectiveness of psychotherapy practices that are used on persons undergoing rehabilitation in selected centres in Wakiso District-Uganda. A descriptive survey research design was used. Chi square analysis indicated that Meditation Therapy (p = 0.024), Occupational therapy (p = 0.026), Experiential therapy (p = 0.026), Spiritual therapy (0.000) and Aftercare therapy (p=0.000) had significant associations with psychotherapy outcomes. Results of the multinomial logistic regression indicated that sobriety was likely to significantly (p = 0.000) reduce among patients in the 36-45 years compared with those of 16 - 25 years, significantly (p = 0.000) reduce among patients of 46 - 55 years compared to those of 16 - 25 years, significantly (p=0.000) reduce among patients of 56 and more years compared to those of 16-25 years, significantly (p = 0.010) increase by 3.7 times among the patients who thought that Meditational therapy was very influential compared to those who thought that it was not at all influential, significantly (p = 0.043) increase by 2.5 times among the patients who thought that Occupational therapy was extremely influential compared to those who thought that it was not at all influential, significantly (p = 0.027) reduce among the patients who thought that Experiential therapy was extremely influential compared to those who thought that it was not influential at all and significantly (p = 0.000) increase by 7.1 times among the patients who thought that Spiritual therapy was very influential compared to those who thought that it was not at all influential. Sobriety was likely to significantly (p = 0.000) increase by 12.1 times among the patients who thought that After Care therapy was extremely influential compared to those who thought that it was not at all influential. Psychotherapy practices were analyzed and it was realized that Aftercare therapy (45%), experiential therapy (14.3%) and spiritual therapy (13.3%) brought more positive results. Therefore, it is recommended that for an effective psychotherapy outcome, patients should embrace Aftercare therapy whereas counsellors should urgently practice evidence- based relapse prevention strategies. This can be done through comprehensive relapse prevention trainings.

Keywords: *Psychotherapy Practices; Rehabilitation Centres; Wakiso District-Uganda*

Introduction

Psychotherapy has been widely appreciated as a legitimate and beneficial healing practice in many countries around the world [1]. However, while millions of people receive psychotherapy annually [2], marginal evidence of psychotherapeutic outcomes is available in

literature [1]. This study examined the effectiveness of psychotherapy practices in the management of Substance Use Disorders among affected persons in selected rehabilitation centres in Wakiso District-Uganda with a view to develop a model for improved use of psychotherapy practices in drug rehabilitation centres for effective psychotherapy outcomes in Uganda. In this study, Psychotherapy practices constituted the independent variable while Psychotherapy Outcomes constituted the dependent variable.

Globally, psychotherapies have come to play a significant role in the lives of many individuals in the contemporary world since the term's conception in the late 19th century [3]. Estimates made at the turn of the 21st century by the American Psychological Association (APA) suggested over 30 million American Citizens had accessed psychotherapy by 2008 and that there were between 200,000 and 250,000 psychotherapists in the USA, along with 100,000 professional counsellors, and 50,000 marriage and family therapists [4]. By contrast, there were only 41,000 psychiatrists in the country [5]. In Britain, the National Health Service has funded and promoted an initiative for Increasing Access to Psychological Therapies since 2008, largely justified by political arguments about improving national economic performance [6]. Psychotherapy and those who practice it have a stake in contemporary societies, in both the public and private spheres. It is thus imperative that empirical research is carried out to provide a wealth of literature and data on the forms, processes and influence on psychotherapeutic outcomes.

In Africa, the wisdom and knowledge from our African native land were transferred through folklore, storytelling and verbal sharing from one generation to the next [7]. In the same way "psychotherapy" was inherited from one generation to the other. As people grew older, it was expected that they advance in skills of the African traditional counselling [2]. These natural methods of learning seem to have been swallowed up by the advent of western way of therapy making some Africans to perceive their ways as primitive [8]. Therefore, it is believed that the word 'Psychotherapy in Africa' first appeared in literature in 1996 in a book entitled: Psychotherapy in Africa [7]. However, from the beginning of the world and as far back as African continent was in existence, the forefathers have been practicing psychotherapy through giving of advice from the elders and wise ones [8]. Each community identifies among them some of the elders who could be consulted when people have issues that they are not able to resolve on their own either in the communities or within the families [6]. African psychology is a self-motivated expression of combining African principles, values, and traditions that are communal in nature. It reflects within broader Pan-African or transcultural communities [4]. Looking deeper into African Psychotherapy, counselling was offered by uncles, aunts, cousins among other relatives, and gifts were given and received in good faith without dual relationship aspect. In real sense this can be turned as dual relationship from the western psychotherapy point of view [7].

In Uganda, Psychotherapy existed before colonial influence, but was marginalized by the process of colonization and the adoption of western-counseling practices [4]. Researchers, [9] identified that the foundations of professional counseling in Uganda were created by outsider counseling efforts. Many global north funded NGOs as well as privately funded programs entered Uganda and trained Ugandans and cultural leaders to administer counseling interventions using psychotherapy [9]. In order to provide more structure to the field of counseling through psychotherapy, the Uganda Counseling Association (UCA) was established in 2007. The UCA specified guidelines for labeling helping professionals in the community [10]. The results of psychotherapy practices are generally referred to as psychotherapy outcomes. According to [11], descriptions of good outcome clustered around four themes: establishing new ways of relating to others; less symptomatic distress, or changes in behavioural patterns contributing to suffering; better self-understanding and insight; and accepting and valuing oneself. Psychologists traditionally have answered questions about treatment outcome in clinical practice by routinely assessing their patients in an informal manner without the use of outcome measures [9]. These clinicians have often used the patients themselves as the measure of satisfaction, believing that the patients' self-reported progress or termination of therapy was a sufficient measure of therapeutic outcome [11].

Materials And Methods

The study was carried out in Recovery Solutions treatment and counselling centre and Serenity Centre consisting of a total of 670 clients (patients of SUDs) and 23 Therapists (Counselors). Among the clients, 400 were randomly selected from Serenity Centre and 270 from Recovery Solutions. Similarly 15 counsellors were selected from Serenity Centre and 8 counsellors were from Recovery Solutions respectively.

The study used a descriptive survey research design. The design was preferred so as to gather information about psychotherapy practices, related outcomes and the effectiveness of psychotherapy practices that are used on persons undergoing rehabilitation in selected centres. In order to achieve the stated objectives, self-administered questionnaire (SAQ) was used in order to collect data from large samples because they are cheap to administer, free from bias of the interviewer, provide adequate time for respondents to fill them [12]. In this study, closed ended questions were used on a five pre-coded Likert scale. According to [13], SAQs are less expensive; they offer greater assurance of anonymity allowing respondents to give sensitive information without fear. In addition, interviews using an interview guide was used to collect participants' views on the variables under study. Qualitative research methods focus on discovering and understanding the experiences, perspectives, and thoughts of participants, that is, qualitative research explores meaning, purpose, or reality [14]. Also, four [4] focus group discussions were used to collect data; two from Serenity Centre and two from Recovery Solutions (one for clients and one for counsellors respectively). Focus group discussions were aimed at assessing the levels of psychotherapy outcomes of the clients in the rehabilitation centres. The focus group discussion guide was developed basing on a number of standardized tests, that is; Alcohol, Smoking and Drug Involvement Screening Test (ASSIST); Alcohol Use Disorders Identification Test (AUDIT) and the Addiction Severity Index (ASI). These were designed for interfacing with the clients so as to establish level of psychotherapy outcome.

Lastly, document review was used to gather secondary information regarding the treatment programs in the drug rehabilitation centres in order to investigate psychotherapy practices used in addressing drug abuse in the selected rehabilitation centres. Data collected through the self-administered questionnaire were analyzed using the Statistical Package for Social Scientists (SPSS) and was presented in the tabular form for purposes of identification, analyses and interpretation. Then data collected using interviews and reviews were analyzed using content analysis. The data were then presented in simple, easy to understand statistical representations which included tables and graphs.

Results

This section dwells on the results concerning psychotherapy practices, related outcomes and the effectiveness of psychotherapy practices that are used on persons undergoing rehabilitation in selected centres in Wakiso District-Uganda.

Demographic characteristics

The study used structured self-administered questionnaires (SAQs) to collect data about psychotherapy practices, related outcomes and the effectiveness of psychotherapy practices that are used on persons undergoing rehabilitation in selected centres in Wakiso District-Uganda.

Each of the SAQs had a section for demographic data of the respondents. The importance of collecting and describing the characteristics of respondents has been reiterated by several scholars [15]. At minimum, information needs to be provided about respondents' age, gender, race/ethnicity, social-economic status and educational level. Provision of these characteristics aids in the interpretation of results [15]. Therefore, in this respect, table 1 below presents the demographic characteristics of the patients in the selected rehabilitation centres in Wakiso District.

Variable	Categories	Frequency	%
Gender	Male	276	77.5
	Female	80	22.5
Age-groups	15-25 years	83	23.3
	26-35 years	91	25.6
	36-45 years	83	23.3
	46-55 years	55	15.5
	56 and above	44	12.4
Religion	Anglican	143	40.2
	Catholic	161	45.2
	Muslim	28	7.9
	Others	24	6.7
Marital Status	Married	59	16.6
	Single	262	73.6
	Others	35	9.8
Education Status	None	16	4.5
	Primary	19	5.3
	Low Secondary	38	10.7
	Upper Secondary	72	12.6
	Tertiary	211	65.2

Table 1: *Demographic Data of Client Respondents*

Source: Primary data (2019).

From table 1, 77.5% of the respondents were males while 22.5% of them were females. The client's ages ranged from 15 years and more, where 23.3% were in the '15 - 25' age-group, 25.6% were '26 - 35' age-group, 23.3% were '36 - 45' age-group, 15.5% '46 - 55' age-group and 12.4% were 56 years and above. The results showed that at least 48.9% of the patients were youth of 15 - 35 years. This constitutes the bulk of young people who should be growing up into adulthood. If they are affected by SUDs at such a tender age, the country risks losing its future human resources. More so, 40.2% of the patients were Anglicans, 45.2% were Catholics and 7.9% were Muslims whereas 6.7% were from other religions. This showed that Catholics and Anglicans were affected as compared to the Muslims. Still, 16.6% were married where as 73.6% were single and 9.8% were in other categories. Data in table 1 also indicated that 4.5% of the patients had no formal education while 7.0% had primary education, 10.7% had lower secondary education, 12.6% had upper secondary education and 65.2% had tertiary education. This implies SUDs are more prevalent among the youth in tertiary institutions. This level of education is the terminal level when the country expects to produce the requisite human resource. If the situation is left unabated, Uganda may eventually lose them and suffer inadequacy of human resources.

Psychotherapy practices used and related outcomes among affected sud persons in selected rehabilitation centres in wakiso district-uganda

The first objective of the study sought to investigate the psychotherapy practices used and related outcomes among affected SUD persons in selected rehabilitation centres in Wakiso District-Uganda.

49.7% of the respondents indicated that Individual Therapy was the most extremely used psychotherapy in management of patients with SUDs in the selected rehabilitation centres in Wakiso District. The results further indicated that the other extremely used psychotherapy was Group Therapy (37.1%) which was followed by Experiential Therapy (30.9%). These findings were in agreement with [19] who noted that a wide variety of psychotherapeutic practices for substance abuse and dependence have been adapted for use in a group format.

Type of Therapy	Not Used At All (%)	Slightly Used (%)	Somewhat Used (%)	Often Used (%)	Extremely Used (%)
Individual Therapy	6 (1.7)	5 (1.4)	53 (14.9)	115 (32.3)	177 (49.7)
Family Therapy	21 (5.9)	59 (16.6)	139 (39.0)	97 (27.3)	40 (11.2)
Group Therapy	16 (4.49)	27 (7.6)	34 (9.6)	147 (41.3)	132 (37.1)
Occupational Therapy	54 (15.2)	68 (19.1)	58 (16.3)	82 (23.0)	94 (26.4)
Cognitive Behavioral Therapy	70 (19.7)	55 (15.5)	50 (14.0)	102 (28.7)	79 (22.2)
Experiential Therapy	34 (9.6)	34 (9.6)	28 (7.9)	150 (42.1)	110 (30.9)
Spiritual Therapy	150 (42.1)	6 (1.7)	120 (33.7)	70 (19.7)	10 (2.81)
After Care Therapy	166 (46.6)	30 (8.4)	19 (5.3)	39 (11.0)	102 (28.7)
Meditation Therapy	207 (58.2)	44 (12.4)	14 (3.9)	43 (12.1)	48 (13.5)

Table 2: *Major Psychotherapy practices Used on Patients in the Rehabilitation Centres*

Source: Primary data (2019).

Source	Partial SS	df	MS	F	Prob>F
Individual Therapy	1.697553	4	0.424388	1.79	0.131
Experiential Therapy	1.105998	4	0.2765	1.17	0.326
Group Therapy	1.125117	4	0.281279	1.19	0.317
Family Therapy	0.151321	4	0.03783	0.16	0.959
Cognitive Therapy	0.606225	4	0.151556	0.64	0.635
Occupational Therapy	1.356869	4	0.339217	1.43	0.224
After-care Therapy	0.678859	4	0.169715	0.72	0.582
Meditational Therapy	2.741494	4	0.685373	2.89	0.023
Spiritual Therapy	1.195126	4	0.298781	1.26	0.286

Table 3: *ANOVA of the difference in the use of psychotherapy practices among patients in Rehabilitation Centres.*

Source: Primary data (2019).

ANOVA results indicated that the practice of individual therapy, experiential therapy, group therapy, family therapy, Cognitive therapy, Occupational therapy, after-care therapy and spiritual therapy were not significantly ($p \geq 0.05$) different between Recovery Solutions and Serenity Centre. However, results indicated that the practice of meditational therapy was significantly ($p = 0.023$) different between Recovery Solutions and Serenity Centre.

Effectiveness of psychotherapy practices that are used on persons undergoing rehabilitation in selected centres in wakiso district-uganda

In presenting the effectiveness of the psychotherapy practices, focus was on the perceived effects and then a consideration of association between perceived effectiveness of psychotherapy. The association between perceived therapy effectiveness and the different therapies used using chi-square analysis were also made.

Perceived effectiveness of psychotherapy practices

Results in table 4, revealed that majority 62.6% of the respondents perceived that overall, the psychotherapy practices used were effective whereas the other 37.4% perceived psychotherapies not to be effective.

Variable	Categories	Frequency	%
Perceived effectiveness of Psychotherapy practices on Psychotherapy outcomes	Not Effective	133	37.36
	Effective	223	62.64

Table 4: *Perceived effectiveness of Psychotherapy practices on Psychotherapy variable.*

Source: Primary data (2019).

Characteristics	Categories	Perceived Effectiveness		X^2	p-value
		Not Effective	Effective		
Gender	Male	109(39.5)	167(60.5)	2.4	0.122
	Female	133(37.4)	223(62.6)		
Rehabilitation Centre	Serenity	68(33.7)	134(66.3)	2.7	0.100
	Recovery solutions	65(42.2)	89(57.8)		
Age group	15-25 years	23(27.7)	60(72.3)	14.7	0.005*
	26-35 years	41(45.1)	50(54.9)		
	36-45 years	41(49.4)	42(50.6)		
	46-55 years	14(25.5)	41(74.6)		
	56+ years	12(31.8)	30(68.2)		
Religion	Anglican	44(31.8)	99(69.2)	9.9	0.020*
	Catholic	73(45.3)	88(54.7)		
	Muslim	11(39.3)	17(60.7)		
	Others	5(20.8)	19(79.2)		
Marital status	Married	18(30.5)	41(69.5)	14.0	0.001*
	Single	111(42.4)	151(57.6)		
	Others	4(11.4)	31(88.6)		
level of education	None	11(68.8)	5(31.3)	9.1	0.058
	Low primary	5(26.3)	14(73.7)		
	Low secondary	12(31.6)	26(68.4)		
	Upper secondary	30(41.7)	42(58.3)		
	Tertiary institution	75(35.6)	136(64.5)		
Abused Drugs	Depressants	25(36.8)	43(63.2)	37.9	0.000*
	Stimulants	43(36.1)	76(63.9)		
	Cannabis	42(39.3)	65(60.8)		
	Inhalants	4(11.1)	32(88.9)		
	Hallucinogens	3(30.0)	7(70.0)		
	Opioids	16(100.0)	0(0.0)		
Used Injectable drugs	No	99(34.3)	190(65.7)	6.3	0.012*
	Yes	34(50.8)	33(49.3)		
Understanding of Psychotherapies	Insufficient	18(27.7)	47(72.3)	3.2	0.075
	Sufficient	115(39.5)	176(60.5)		

Table 5: *Association between perceived effectiveness of psychotherapy practices and respondents' characteristics using chi-square analysis.*

Source: *Primary data (2019).*

The findings indicated that age group, religion, marital status, abused drugs and Injectable drugs were significant ($p > 0.05$) associates of perceived effect of psychotherapies. This indicated that the perception of the effectiveness of these psychotherapies was different in various categories of age group, religion, marital status, abused drugs and Injectable drugs.

Characteristics	Categories	Perceived effect of Psychotherapies		X^2	p-value
		Not Effective	Effective		
Meditational Therapy	Not at all influential	79(38.2)	128(61.8)	8.3	0.082
	Slightly influential	13(29.6)	31(70.5)		
	Somewhat influential	3(21.4)	11(78.6)		
	Very influential	23(53.5)	20(46.5)		
	Extremely influential	15(31.3)	33(68.8)		
Individual Therapy	Not at all influential	1(16.7)	5(83.3)	9.8	0.044*
	Slightly influential	0(0.00)	5(100.0)		
	Somewhat influential	22(41.5)	31(58.5)		
	Very influential	34(29.6)	81(70.4)		
	Extremely influential	76(42.9)	101(57.1)		
Family Therapy	Not at all influential	11(52.4)	10(47.6)	7.3	0.120
	Slightly influential	24(40.7)	35(59.3)		
	Somewhat influential	41(29.5)	98(70.5)		
	Very influential	39(40.2)	58(59.8)		
	Extremely influential	18(45.0)	22(55.0)		
Group Therapy	Not at all influential	10(62.5)	6(37.5)	25.8	0.000*
	Slightly influential	17(63.0)	10(37.1)		
	Somewhat influential	3(8.8)	31(91.2)		
	Very influential	60(40.8)	87(59.2)		
	Extremely influential	43(32.6)	89(67.4)		
Occupational Therapy	Not at all influential	24(44.4)	30(55.6)	9.1	0.060
	Slightly influential	25(36.8)	43(63.2)		
	Somewhat influential	29(50.0)	29(50.0)		
	Very influential	29(35.4)	53(64.6)		
	Extremely influential	26(27.7)	68(72.3)		
Cognitive Behavioral Therapy	Not at all influential	37(52.9)	33(47.1)	22.295	0.000*
	Slightly influential	23(41.8)	32(58.2)		
	Somewhat influential	26(52.0)	24(48.0)		
	Very influential	27(26.5)	75(73.5)		
	Extremely influential	20(25.3)	59(74.7)		
Experiential Therapy	Not at all influential	4(11.8)	30(88.2)	12.924	0.012*
	Slightly influential	13(38.2)	21(61.8)		
	Somewhat influential	15(53.6)	13(46.4)		
	Very influential	58(38.7)	92(61.3)		
	Extremely influential	43(39.1)	67(60.9)		
Spiritual Therapy	Not at all influential	47(31.3)	103(68.7)	7.139	0.129
	Slightly influential	1(16.7)	5(83.3)		
	Somewhat influential	49(40.8)	71(59.2)		
	Very influential	30(42.9)	71(57.1)		
	Extremely influential	6(60.0)	4(40.0)		
After Care Therapy	Not at all influential	58(34.9)	108(65.1)	7.231	0.124
	Slightly influential	16(53.3)	14(46.7)		
	Somewhat influential	5(26.3)	14(73.7)		
	Very influential	19(48.7)	20(51.9)		
	Extremely influential	35(34.3)	67(65.7)		

Table 6: *Association between perceived psychotherapy effectiveness and the different psychotherapy used.*

Source: *Primary data (2019).*

Psychotherapy outcomes

Rather than perceived effect of psychotherapy outcomes, the actual effectiveness of the psychotherapies is illustrated within the psychotherapy outcomes. It is one thing to think that the psychotherapies are effective, yet it is another to demonstrate that they are actually

effective. It was reported that respondents who relapsed were 135 (37.9%) and those who regained sobriety were 221 (62.1%) in both rehabilitation centres.

Psychotherapy Outcomes	Freq.	%
Relapsed	135	37.92
Sober	221	62.08

Table 7: *Psychotherapy Outcomes.*

Source: *Primary data (2019).*

Chi-square analysis was also used to investigate the different associations with psychotherapy outcomes. Age group was the only characteristic of the respondent that was significantly (p = 0.037) associated with psychotherapy outcomes. This indicated differences in the psychotherapy outcomes among the various age groups of respondents. Chi square analysis also indicated that Meditation Therapy (p = 0.024), Occupational therapy (p = 0.026), Experiential therapy (p = 0.026), Spiritual therapy (0.000) and Aftercare therapy (p = 0.000) had significant associations with psychotherapy outcomes. It should be noted that the results from the psychotherapy outcome association investigations are different from the ones of the perceived effect of psychotherapy outcomes. The researcher chose to consider psychotherapy outcomes as a better proxy indicator of effectiveness.

Psychotherapy	Categories	Psychotherapy Outcome		X^2	p-value
		Relapse	Sobriety		
Gender	Male	103(31.3)	62.7	0.189	0.663
	Female	32(40.0)	48(60.0)		
Center	Serenity	76(37.6)	126(62.4)	0.018	0.895
	Recovery Solutions	59(38.3)	95(61.7)		
Age group	15-25 years	32(38.6)	51(61.5)	10.22	0.037*
	26-35 years	29(31.9)	62(68.1)		
	36-45 years	42(50.1)	41(49.4)		
	46-55 years	21(38.2)	34(61.8)		
	56 and above years	11(25.0)	33(75.0)		
Religion	Anglican	55(38.5)	88(61.5)	0.255	0.968
	Catholic	61(37.9)	100(62.1)		
	Muslim	11(39.3)	17(60.7)		
	Others	8(33.3)	16(66.7)		
Marital status	Married	25(42.4)	34(57.6)		
	Single	104(39.7)	158(60.3)		
	Others	6(17.1)	29(82.9)		
Level of education	None	5(31.3)	11(68.8)	2.77	0.597
	Low primary	7(36.8)	12(63.2)		
	Low secondary	15(39.5)	23(60.5)		
	Upper secondary	33(45.8)	39(54.2)		
	Tertiary institution	75(35.6)	136(64.5)		
Abused Drugs	Depressants	24(35.3)	44(64.7)	6.69	0.245
	Stimulants	53(44.5)	66(55.5)		
	Cannabis	40(37.38)	67(62.6)		
	Inhalants	8(22.2)	28(77.8)		
	Hallucinogens	3(30.0)	7(70.0)		
	Opioids	7(43.8)	9(56.3)		
Used Injectable drugs	No	106(36.7)	183(63.3)	1.01	0.315
	Yes	29(43.3)	38(56.7)		
Understanding of Psychotherapies	Insufficient	23(35.4)	42(64.6)	0.22	0.641
	Sufficient	112(38.5)	179(61.5)		
Perception on the effectiveness of Psychotherapies	Not effective	54(40.6)	79(59.4)	0.421	0.641
	Effective	81(36.3)	142(63.7)		

Table 8: *Association between psychotherapy outcomes and respondents' characteristics using chi-square analysis.*

Source: *Primary data (2019).*

Psychotherapy	Categories	Psychotherapy Outcome		X^2	p-value
		Relapse	Sobriety		
Meditational Therapy	Not at all influential	81(39.1)	126(60.9)	11.2	0.024*
	Slightly influential	21(47.7)	23(52.3)		
	Somewhat influential	9(64.3)	5(35.7)		
	Very influential	11(25.6)	32(35.71)		
	Extremely influential	13(27.1)	35(72.9)		
Individual Therapy	Not at all influential	3(50.0)	3(50.0)	2.4	0.672
	Slightly influential	2(40.0)	3(60.0)		
	Somewhat influential	18(34.0)	35(66.0)		
	Very influential	39(33.9)	76(66.1)		
	Extremely influential	73(41.2)	104(58.8)		
Family Therapy	Not at all influential	8(38.1)	13(61.9)	5.3	0.261
	Slightly influential	26(44.1)	33(55.9)		
	Somewhat influential	45(32.4)	94(67.6)		
	Very influential	36(37.1)	61(62.9)		
	Extremely influential	20(50.0)	20(50.0)		
Group Therapy	Not at all influential	8(50.0)	8(50.0)	1.5	0.818
	Slightly influential	11(40.7)	16(59.3)		
	Somewhat influential	11(32.4)	23(67.7)		
	Very influential	55(37.4)	92(62.6)		
	Extremely influential	50(37.9)	82(62.1)		
Occupational Therapy	Not at all influential	25(46.3)	29(53.7)	11.1	0.026*
	Slightly influential	28(41.2)	40(58.8)		
	Somewhat influential	28(48.3)	30(51.7)		
	Very influential	20(24.4)	62(75.6)		
	Extremely influential	34(36.2)	60(63.8)		
Cognitive Behavioral Therapy	Not at all influential	27(38.6)	43(61.4)	4.0	0.403
	Slightly influential	27(49.1)	28(50.9)		
	Somewhat influential	16(32.0)	34(68.0)		
	Very influential	36(35.3)	66(64.7)		
	Extremely influential	29(36.7)	50(63.3)		
Experiential Therapy	Not at all influential	8(23.5)	26(76.5)	11.1	0.026*
	Slightly influential	9(26.5)	25(73.5)		
	Somewhat influential	6(21.4)	22(78.6)		
	Very influential	64(42.7)	86(57.3)		
	Extremely influential	48(43.6)	62(56.4)		
Spiritual Therapy	Not at all influential	70(46.7)	80(53.3)	23.7	0.000*
	Slightly influential	4(66.7)	2(33.3)		
	Somewhat influential	47(39.2)	73(60.8)		
	Very influential	10(14.3)	60(85.7)		
	Extremely influential	4(40.0)	6(60.0)		
After Care Therapy	Not at all influential	66(398)	100(60.2)	40.9	0.000*
	Slightly influential	23(76.7)	7(23.3)		
	Somewhat influential	11(57.9)	8(42.1)		
	Very influential	17(43.6)	8(42.11)		
	Extremely influential	18(17.7)	84(82.4)		

Table 9: *Association between psychotherapy practices and psychotherapy outcomes using chi-square analysis.*

Source: *Primary data (2019).*

Psychotherapy Outcomes	AOR	95% Confidence Interval	P-value
Relapsed	(base outcome)		
Sober			
Age group			
16-25 years			
26-35 years	1.076	[0.464–2.498]	0.864
36-45 years	0.076	[0.019–0.295]	0.000*
46-55 years	0.045	[0.010–0.199]	0.000*
56 and above	0.162	[0.032–0.807]	0.026*
Meditational Therapy			
Not at all Influential	*Reference*		
Slightly influential	0.666	[0.274–1.619]	0.370
Somewhat influential	0.405	[0.088–1.872]	0.247
Very influential	3.698	[1.360–10.053]	0.010*
Extremely influential	2.003	[0.859–4.674]	0.108
Occupational Therapy			
Not at all Influential	*Reference*		
Slightly influential	1.279	[0.532–3.074]	0.583
Somewhat influential	1.009	[0.395–2.579]	0.985
Very influential	2.294	[0.919–5.722]	0.075
Extremely influential	2.504	[1.029–6.099]	0.043*
Experiential Therapy			
Not at all Influential	*Reference*		
Slightly influential	0.396	[0.083–1.903]	0.248
Somewhat influential	0.358	[0.060–2.125]	0.258
Very influential	0.275	[0.063–1.208]	0.087
Extremely influential	0.198	[0.047–0.828]	0.027*
Spiritual Therapy			
Not at all Influential	*Reference*		
Slightly influential	0.885	[0.096–8.162]	0.914
Somewhat influential	2.016	[0.874–4.645]	0.100
Very influential	7.065	[2.738–18.230]	0.000*
Extremely influential	4.486	[0.755–26.638]	0.099
After Care Therapy			
Not at all Influential	*Reference*		
Slightly influential	0.612	[0.159–2.359]	0.475
Somewhat influential	0.794	[0.216–2.919]	0.728
Very influential	1.724	[0.547–5.436]	0.353
Extremely influential	12.104	[3.837–38.183]	0.000*
**significant at 0.05*			

Table 10: *Predictors of psychotherapy outcomes using multinomial Logistic regression.*

Predictors of psychotherapy outcomes using multinomial Logistic regression

Age group, Meditation Therapy, Occupational therapy, experiential therapy, Spiritual therapy and After Care therapy would be used to predict psychotherapy outcomes. Further investigations with multivariate logistic regression were to be used to determine the actual predictors of psychotherapy outcomes. Results of the multinomial logistic regression indicated that sobriety was likely to significantly ($p = 0.000$) reduce among patients in the 36 - 45 years compared with those of 16 - 25 years. Sobriety was likely to significantly ($p = 0.000$) reduce among patients of 46 - 55 years compared to those of 16 - 25 years. Sobriety was likely to significantly ($p = 0.000$) reduce among patients of 56 and more years compared to those of 16 - 25 years. Sobriety was likely to significantly ($p = 0.010$) increase by 3.7 times among the patients who thought that Meditational therapy was very influential compared to those who thought that it was not at all influential. Sobriety was likely to significantly ($p = 0.043$) increase by 2.5 times among the patients who thought that Occupational therapy was extremely influential compared to those who thought that it was not at all influential. Sobriety was likely significantly ($p = 0.027$) reduce among the patients who thought that Experiential therapy was extremely influential compared to those who thought that it was not influential at all. Sobriety was likely to significantly ($p = 0.000$) increase by 7.1 times among the patients who thought that Spiritual therapy was very influential compared to those who thought that it was not at all influential. Sobriety was likely to significantly ($p = 0.000$) increase by 12.1 times among the patients who thought that After Care therapy was extremely influential compared to those who thought that it was not at all influential.

Therefore, age group, meditational therapy, Occupational therapy, experiential therapy, Spiritual therapy and After Care therapy were likely to influence psychotherapy outcomes.

Discussion of Findings

Psychotherapy practices used and related outcomes among affected SUD persons in selected rehabilitation centres in Wakiso District-Uganda

The sample size of the study was 384 but the number of respondents who actually participated in the study was 356. Therefore, the overall response rate was 356 divided by 384 multiplied by 100 giving 92.7%. This response rate indicates a quality survey because according to [16] higher response rates provide more accurate survey results. An overall rate of return of 92.7% implies that the survey quality was good [17]. However, the variation in the response rate among different categories of respondents was due to different reasons depending on the category of respondents. For instance, some respondents (counsellors) were either quite busy or out of station at the time of data collection; so, it was difficult to access them.

Nonetheless, most of them were found in their centres and were easily accessed. 56.7% (202) patients who responded to the study were from Serenity Centre, while 154 (43.3%) were patients from Recovery Solutions. This indicates a ratio of approximately 1:3.5 of female to male respondents in both rehabilitation centres. In other words, the proportion of males was three and a half times that of females in the sample. This ratio was a true reflection of the proportion of male to female patients in the rehabilitation centres under study. This implies that most of the patients are males and this confirms statistics from Kiswa Primary Health Centre in Kampala which indicate that 10% out of 17% of adult male patients aged between 35 to 44 years screened for alcohol-related problems had a higher possibility of being diagnosed to alcohol dependence [18]. Meanwhile 49.7% of the respondents indicated that Individual Therapy was the most extremely used psychotherapy in management of patients with SUDs in the selected rehabilitation centres in Wakiso District. The results further indicated that the other extremely used psychotherapy was Group Therapy (37.1%) which was followed by Experiential Therapy (30.9%). These findings were in agreement with [19] who noted that a wide variety of psychotherapeutic practices for substance abuse and dependence have been adapted for use in a group format.

The results also revealed that Experiential Therapy (42.1%) and Group Therapy were the ones that were more often used in management of patients with SUDs in the rehabilitation centres in Wakiso District. Two other therapies that were also often used were the Individual Therapy (32.3%) and the Cognitive Behavioural Therapy (28.7%). Data in table 1 further showed that Family Therapy (39.0%) and Spiritual Therapy (33.7%) were somewhat used in the management of patients with SUDs in the rehabilitation centres in Wakiso District. Furthermore, Occupational Therapy (19.1%) and Family Therapy (16.6%) were found to be only slightly used in the management of patients in the rehabilitation centres in Wakiso District.

The results finally indicated that Meditation Therapy (58.2%) and After-Care Therapy (46.6%) were the ones that were not often used. These findings were in agreement with [20] who noted that psychotherapies are quite diverse, and it is debatable whether all are equally helpful. Moreover, numerous family psychotherapies merge a variety of techniques. It is important to identify which technique works best in addressing of drug abuse. More so, the symptoms of the identified addict do not mean necessarily that the whole family is sick and it is also debatable whether the entire family has to be worked on before the addicted client can improve. In addition, [21] noted that individual therapy sessions help both the addicted client and the therapist identify and explore the reasons as to why the individual abuses drugs. This is also backed up by other studies which show that individual, group and couple or family psychotherapy are helpful for disorders; Drug abuse and its related problems with children, adolescents, adults, and older adults [22- 24]. Accordingly [25] noted also that, Family therapy regards the family as a whole, as the unit of treatment, and emphasizes such factors as relationships and communication patterns rather than traits or symptoms in individual members. It is important to note that, regardless of the origin of the problem, and regardless of whether the patients consider it an 'individual' or 'family' issue, involving families in solutions often benefits patients [26]. The study concludes that, different psychotherapy practices wok differently on different people thus the binary outcomes (sobriety or relapse).

[27] believe that comparable rates of psychotherapeutic effectiveness between group and individual therapy translate into better cost-effectiveness for group therapy. However, a recent meta-analysis based on a limited number of studies suggested that at least one type of group therapy for SUDs, CBT, might not be more cost-effective than individual therapy, because higher costs were associated with group CBT even though both group and individual therapy were found to be equally efficacious. Findings from Focus Group Discussions show that both rehabilitation centres engage their patients with recreational activities such as indoor games, experiential therapy and all these work hand in hand with pharmacotherapy. All therapies were reported to be influential to the patients in one way or the other. However, Meditational Therapy, Individual Therapy, Occupational Therapy and Group Therapy proved to be the most influential psychotherapy practices in both rehabilitation centers. [26] noted that, at the focus of every meditative practice is a search for detachment or inner calm. In this sense meditation fits satisfactorily with recovering alcoholics' central goals of establishing distance between themselves and their desire to drink or abuse drugs. On this note therefore, there is no doubt that meditation therapy emerged the first. Meditation offers increased self-awareness, a renewed spiritual religious connection, increased creativity, and a decrease in negative emotional responses to the stresses in life in connection to drug abuse.

The effectiveness of psychotherapy practices that are used on persons undergoing rehabilitation in selected centres in Wakiso District-Uganda

Results in table 3.4, revealed that majority 62.6% of the respondents perceived that overall, the psychotherapy practices used were effective whereas the other 37.4% perceived psychotherapies not to be effective. The findings were in agreement with [28] who empirically evaluated the effectiveness of body-orientated psychotherapy in the treatment of mental disorders. He found that body-oriented psychotherapy has generally good effects on subjectively experienced depressive and anxiety symptoms, somatization, psychosomatic disorders and social insecurity, as well as improved psychomotor behavior and social and emotional interaction in people living with schizophrenia. These findings were also in agreement with [29] who reviewed 857 records from a combined search and found that non-drug therapies such as psychotherapy, bodywork (without high-energy manipulations), mind-body medicine, body-psychotherapy, sexology, clinical ho-

listic medicine, and complementary and alternative medicine had no significant negative side effects (NNH (number needed to harm) > 18,000). The authors concluded that the likelihood of significant effectiveness of body-oriented psychotherapy interventions is insignificantly small, compared to the likelihood of having significant effectiveness of psychopharmacologic drugs (NNH = 2) [30].

[31] are other researchers who investigated the adverse effectiveness of Gerda Boyesen's type of body psychotherapy. They reviewed 13,500 patients who were treated during 1985 and 2005. The review found that at least one in two individuals was helped to improve their quality of life, or physical, psychological, sexual, psychiatric and existential issues. No patient committed suicide or attempted to commit suicide during the treatment. These reviews indicate that body-oriented psychotherapy interventions provide safe and effective help for patients with physical, mental, sexual, quality of life-related psychological and existential problems as well as suicide prevention [31]. The interventions appear to offer promising additional psychotherapeutic tools in areas where traditional talking psychotherapies seem to fail, such as somatoform disorders, medically unexplained syndromes, Posttraumatic Stress Disorder (PTSD), anorexia nervosa and chronic schizophrenia [28].

The findings were also in agreement with several other researchers who carried out trials and reviews based on the Dejian Mind-Body Intervention (DMBI). For instance [32] carried out three randomized controlled trials comparing the efficacy of a Chinese Chan-based Dejian Mind-Body Intervention (DMBI) on improving depressive mood in an adult community sample with Cognitive Behavioral Therapy (CBT). In two of the studies a waitlist group was also included. Both the DMBI and CBT groups demonstrated significant reduction in depressive mood according to the Beck Depression Inventory. However, only the DMBI group demonstrated a significant increase in prefrontal activation asymmetry which suggested an increase in positive effect. To further discover the effectiveness of the psychotherapies, it was prudent to find out the association between perceived effect and the psychotherapy outcomes. To do this a Chi-square analysis was used to further investigate the associates of perceived effect of psychotherapy outcomes.

The findings indicated that age group, religion, marital status, abused drugs and Injectable drugs were significant ($p > 0.05$) associates of perceived effect of psychotherapies. This indicated that the perception of the effectiveness of these psychotherapies was different in various categories of age group, religion, marital status, abused drugs and Injectable drugs. The findings were in agreement with [33] who explored the effectiveness of Dohsa-hou relaxation on body awareness and psychological distress. The results indicated significant differences between the Dohsa-hou relaxation and control groups in walking and standing awareness, bodily distress, awareness of bodily feeling, and psychological distress. Functional relaxation is an effective treatment for somatization [34].

The study also tested the association between perceived therapy effectiveness and the different therapies used using chi-square analysis. The Chi square analysis indicated that there was significant ($p > 0.05$) association between the perceived effectiveness of psychotherapies and Individual Therapy, Group therapy, Cognitive Behavioral Therapy and Experiential Therapy.

The findings revealed that there were significant ($p = 0.044$) differences in the perceived effectiveness of psychotherapies at the different levels of Individual therapy. There was significant ($p = 0.000$) differences in the perceived effectiveness of psychotherapies at the different levels of Group therapy and Cognitive Behavioral Therapy. Analysis also indicated significant (0.000) differences in the perceived effectiveness of psychotherapies at the different levels of individual therapy. It was also noted that there was significant ($p = 0.012$) differences in the perceived effectiveness of psychotherapies at the different levels Experiential Therapy. This indicated that to be able to predict the perceived effectiveness of psychotherapy practices, there was need to further study the age group, religion, marital status, abused drugs, Injectable drugs, Individual, Group, Cognitive Behavioral and Experiential Therapy.

Conclusion

The findings indicated that several psychotherapy practices are used and these fall under individual therapy, family therapy, group therapy, occupational therapy, cognitive behavioural therapy, experiential therapy, spiritual therapy, aftercare therapy and meditation

therapy. However, occupational therapy, experiential therapy, spiritual therapy, and meditation therapy were found to be more effective. The next chapter presents findings on the effectiveness of the psychotherapy practices used in management of Substance-Use-Disorders on psychotherapy outcomes among affected persons in selected rehabilitation centres in Wakiso District.

Presently there is a disagreement about whether, or when, psychotherapy effectiveness is best evaluated. Another issue is the attempt to normalize psychotherapies and link them to specific symptomatic groups, making them more responsive to examination. Some claim that this may reduce effectiveness over individual needs. Many psychotherapists believe that the effectiveness of psychotherapy cannot be apprehended by questionnaire-style observation, and prefer to rely on their own clinical experiences and conceptual arguments to support the type of treatment they practice. Suffice to note that, extensive international reviews of scientific studies have concluded that psychotherapy is effective for numerous conditions. According to [35] 'Meta-analyses of psychotherapy, studies have consistently demonstrated that there are no substantial differences in outcomes among treatments'. The handbook states that there is "little evidence to suggest that any one psychological therapy consistently outperforms any other for any specific psychological disorders. In other words psychotherapy outcomes should not solely be identified with the type of psychotherapy. Other factors like family and social support, environment, individual physiology to mention but a few should be put in consideration. Additionally psychotherapy outcomes depend on the category of the drug of abuse and the damage of the substance to the physical, psychological, social, mental and spiritual aspects of the person.

Bibliography

1. Angermeyer K., *et al*. "Novel models for delivering mental health services and reducing the burdens of mental illness". *Clinical Psychological Science* 27.1 (2017): 42-51.
2. Olfson P and Marcus W. "Lay health worker led intervention for depressive and anxiety disorders in India: impact on clinical and disability outcomes over 12 months". *British Journal of Psychiatry* 199.6 (2010): 459-466.
3. Howe B. "Negative effects from psychological treatments: a perspective". *American Psychologist* 65 (2008): 13-20.
4. Hayward NT. "Negative treatment by family as a predictor of depressive symptoms, life satisfaction, suicidality, and tobacco/alcohol use in Vietnamese sexual minority women". *LGBT Health* 3 (2014): 357.
5. DeLeon S., *et al*. "Psychotherapies should be assessed for both benefit and harm". *British Journal of Psychiatry* 208 (2011): 208-209.
6. Marks MJ. "Patient experience of negative effects of psychological treatment: results of a national survey". *British Journal of Psychiatry* 208 (2012): 260-265.
7. Okpalaenwe PD. "What's SWOT in strategic analysis?" *Strateg Change* 7 (2015): 1.
8. Ofer PGD. "Iatrogenic harm from psychological therapies - time to move on". *British Journal of Psychiatry* 208 (2014): 210-212.
9. Senyonyi RM., *et al*. "The Development of Professional Counseling in Uganda: Current Status and Future Trends". *Journal of Counselling and Development, JCD* 90.4 (2012).
10. Uganda Counselling Association. Situation Analysis on Substance-Use-Disorders. Kampala, Uganda (2010).
11. Sexton TL Sexton and Whiston MAL. "Levels of evidence for the models and mechanisms of therapeutic change in family and couple therapy". In M.J. Lambert, (Edition.). Bergin and Garfield's handbook of psychotherapy and behaviour change (5th Edition.) (2014): 590-646.
12. Kothari CR. "Research methodology". New Age International Publishers Limited India (2006).

13. Amin ME. "Social Science Research: Conception, Methodology and Analysis. Makerere University Printery, Kampala (2005).

14. Saunders M., *et al*. "Research Methods for Business Students", 4th edition, Prentice Hall (2007).

15. Ellis K. "Computer-based brief motivational intervention for perinatal drug use". *Journal of Substance Abuse Treatment* 28.4 (2009): 305-312.

16. Babbie E. "The Practice of Social Research (9th Edition.). Belmont, CA: Wadsworth Thomson (1990).

17. Rea F and Parker H. "Investors' perceptions of earnings quality, auditor independence, and the usefulness of audited financial information". *Accounting Horizons* 17 (1997): 37-48.

18. Kullgren L., *et al*. "Predicting Frequency of Treatment Visits in Community-Based Youth Psychotherapy". *Psychological Services* 5.2 (2018): 126-138.

19. Khantzian C., *et al*. "Chronic illness beliefs and role of social networks among Chinese, Italian and Angloceltic Canadian". *Journal of Cross-Cultural Psychology* (2004).

20. Sholevar CD. "Therapist-client five-factor personality similarity: A brief report". *Bulletin of the Menninger Clinic* (2003).

21. Hough CA. "Are Mindfulness-Based Interventions Effective for Drugs Use Disorders? A Systematic Review of the Evidence". Drugs Use Misuse (2006).

22. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th edition., text rev.). Arlington, VA: Author (2016).

23. Carr A. "The effectiveness of family therapy and systemic interventions for child-focused problems". *Journey of Family Therapy* 31 (2011): 3-45.

24. Norcross G and Lambert M. "Correlates of cannabis use among high school students in Shamva District, Zimbabwe: A descriptive cross-sectional study". *Malawi Medical Journal* 28.2 (2011): 53-56.

25. Ankwasiize EG. "Family Rights Synergies, Inter- Intra Family Linkages and the Counselling Implications". Entebbe Uganda: Marianum Press (2013).

26. Goldenberg C and Goldenberg P. "Humanistic approach/ client centred therapy (2008).

27. Tucker PT and Oei W. "Integrated family and cognitive-behavior therapy for adolescent substance abusers: A stage I efficacy study". *Drugand Alcohol Dependence* 71.3 (2007): 303-317.

28. Röhricht Papadopoulos Suzuki and Priebe. "Multisystemic therapy and neighborhood partnerships: Reducing adolescent violence and substance abuse". New York, NY: Guilford Press (2009).

29. Ventegodt SG and Merrick J. "The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-Analyses*". Cognitive Therapy and Research* 36.5 (2009): 427-440.

30. Adams KH., *et al*. "The Effect of Adding Psychodynamic Therapy to Antidepressants in Patients with Major Depressive Disorder. A Systematic Review of Randomized Clinical Trials with Meta-Analyses and Trial Sequential Analyses". *Journal of Affective Disorders* 137.1 (2007): 4-14.

31. Allmer Ventergodt Kandel and Merrick. "Use of brief interventions in a middle and high school setting". *Journal of School Health* 77.4 (2009): 196-206.

32. Chan Cheung., *et al*. "Long-term outcome of substance dependent youth following 12-step treatment". *Journal of Substance Abuse Treatment* 33.1 (2011): 61-69.

33. Fujino KC. "Current advances in the treatment of adolescent substance use". *Adolescent Health, Medicine and Therapeutics* 5 (2012): 199-210.

34. Lahmann Loew., *et al*. "Usual Care' for Major Depression in the 1990s: Characteristics and Expert-Estimated Outcomes". *American Journal of Psychiatry* 160.4 (2008): 720-726.

35. Eckshtian D., *et al*. "Meta analysis: 13-year- follow up of psychotherapy effects on youth depression". *Journal of the American Academy of Child and Adolescent Psychiatry* 59.1 (2020): 45-63.

Volume 11 Issue 3 March 2022