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The Contribution of Psychosocial Intervention Towards Perceived Sobriety: A cross-sectional Survey in the selected Hospital and Rehabilitation Centre, Kampala and Wakiso districts, Uganda.

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Abstract

Background:

Psychosocial intervention, as a core element driving addicts to desire sobriety as a social identity, plays an important role. The study investigated the contribution of psychosocial intervention towards perceived sobriety. The study aimed at examining the influence of psychosocial intervention on perceived sobriety. The research objective was to establish the effect of psychosocial intervention on perceived sobriety in the selected hospital and rehabilitation centre in Kampala and Wakiso districts, Uganda.

Methods:

A cross-sectional design was used, and a mixed method approach with a sequential exploratory and sequential explanatory design, where a combination of quantitative and qualitative data collection and analysis was used to integrate Findings during the interpretation phase. The researcher used a Concurrent triangulation design where only one data collection phase was used; data collection and analysis were conducted separately.

Results:

The results revealed that the majority of the respondents were in the age range of 31-35 years, 95(33.3%), 26-30 years, 71(24.9%), 36-40 years, 64(22.5%), and 20-25 years, 55(19.3%). The majority of the respondents were male, 213(74.7%), and females were 72(25.3%). The result revealed a weak linear positive but significant relationship between psychosocial intervention and perceived sobriety ($r = 0.230$, $p = 0.000$). The findings suggest that psychosocial intervention is likely to lead to perceived sobriety ($r = 0.230$). This implies that psychosocial intervention significantly positively correlates with perceived sobriety at the level of significance.

Conclusion:

Increasing psychosocial intervention would result in feasible recovery, hence achieving sobriety. Therefore, therapists are encouraged to help recovering addicts manage continued vulnerability and develop healthy, productive, and meaningful lives.

Recommendation:

The Ministry of Health, through the Mental Health Desk, should encourage clinical coordinators and treatment providers to train professionals in clinical counseling and psychology to improve the quality of services in the treatment facilities.

Keywords: *Contribution, Psychosocial, Intervention, Perceived Sobriety, Hospital, Rehabilitation-centre.*
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Introduction

Uganda's current population was still experiencing a worrying status of alcohol consumption among African countries, with the highest alcohol intake of an average consumption of 12.21 liters of alcohol per year (World Health Statistics 2023) and 7.1% above the Africa region's 3.7% (Kabwama et al., 2016). Alcohol use has a negative and increasing consequence on the population, resulting in the establishment of treatment facilities, with 90% of alcohol addicts failing to have access to professional treatment facilities (Kabwama et al., 2016). However, the current situation in Butabika National Referral Hospital and Serenity Rehabilitation Centre shows an overwhelming number of addicts, and especially cases of re-admission due to relapse, showing gaps in the application of treatment interventions used in the treatment facilities. Mann et al. (2017) asserted that recovery factors helped the individual to internalize hope and foster relationships with families

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and friends to provide the best alternatives for recovery. Alcoholic Anonymous (2011) involved primary care support, treatment goals, group, individual, the Twelve steps, motivational interviewing, cognitive-behaviour therapy, and brief interventions. All these are aimed at attaining holistic wellness of the recovering alcohol addict, being supported by the AA therapy, which was a self-help programme that does not stand on a solid scientific ground, but is intended to offer a professional treatment for alcohol addicts in addition. According to Klingemann and Klingemann (2017), psychosocial intervention offers the 12–step treatment programme in a professional setting with the philosophy of sense of legitimacy, which could help the individuals to define their own life goals, design unique path(s) towards attainment of goals, and optimize their own autonomy. In line with the Sustainable Development Goal, the study focused on improving the good health and mental well-being of the people as reflected in Goal 3 of the SDG.

Objective

To establish the effect of psychosocial intervention on perceived sobriety in the selected Hospital and Rehabilitation Centre, Kampala and Wakiso districts, Uganda.

Methodology -Study design

A cross-sectional design was used, and a mixed method approach with a sequential exploratory and sequential explanatory design, where a combination of quantitative and qualitative data collection and analysis was used to integrate Findings during the interpretation phase. The researcher used a Concurrent triangulation design where only one data collection phase was used; data collection and analysis were conducted separately.

Study Setting (Unit of analysis)

This focused on the recovering alcohol addicts, and the participants consisted of: Psychological counselors, addiction counselors, psychiatric nurses, occupational therapists, and alcohol addicts. Butabika is located in Nakawa division, Kampala district; it was the only National Referral Mental Health Hospital in Uganda, which accommodates thousands of inpatients and outpatients with mental health challenges and patients of substance use disorder. Serenity is located in Busiro West, Namulanda division, and it is one of the commonly known private rehabilitation centres that accommodates patients of substance use disorders.

Quantitative data collection in Butabika National Referral Hospital was carried out from 2nd to 8th February, 2022, while the one from Serenity rehabilitation centre was from 9th to 11th /February, 2022. Documentary review from Butabika was carried out from 14th to 16th February, 2022, while the documentary review from Serenity was carried out from 14th to 17th February, 2022. Focused Group Discussion from Butabika was carried out on 23rd/02/2022, and Focused Group Discussion from Serenity was carried out on 26th /02/2022; these days were set according to the availability of the respondents. Interviews with the Psychological counsellors, Occupational therapists, and Psychiatric nurses from Butabika were conducted after the statistician had done the quantitative data analysis; it was carried out from 9th to 13th May, 2022, and the one from Serenity was from 17th to 19th May, 2022. Since the study design was a mixed-method approach, the study used a sequential explanatory design, which required the quantitative results to ascertain the qualitative tools for the data collection, where the researcher used a sequential exploratory design. Below are the documentary results from Serenity and Butabika from 2017 to 2021.

Rate of admission

This section presents the documentary review on the rate of admission of perceived sobriety at Serenity Rehabilitation Centre.

Rate of admission on Perceived Sobriety in Serenity Rehabilitation Centre

Table 1: Statistics of Alcohol Use According to Serenity Rehabilitation Centre Records

Items	2017	%	2018	5	2019	%	2020	%	2021	%	Total
Male general list	119	83.8%	99	86.8%	107	85.6%	89	80.2%	68	83.9%	**482**
Female general list	23	16.7%	15	13.2%	18	14.4%	22	19.8%	13	16.1%	**91**
Subtotal	**142**	**100%**	**114**	**100%**	**125**	**100%**	**111**	**100%**	**81**	**100%**	**573**
Male multiple users	72	79.1%	70	85.4%	70	86.4%	73	86.9%	68	79.1%	**353**
Female multiple user	19	20.9%	12	14.6%	11	13.6%	11	13.1%	18	20.9%	**71**
Subtotal	**91**	**100%**	**82**	**100%**	**81**	**100%**	**84**	**100%**	**86**	**100%**	**424**

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Male alcohol user only	47	92.1%	29	90.6%	35	83.3%	16	76.2%	20	86.9%	**147**
Female alcohol users only	04	7.9%	03	9.4%	07	16.7%	05	23.8%	03	13.1%	**22**
Subtotal	**51**	**100%**	**32**	**100%**	**42**	**100%**	**21**	**100%**	**23**	**100%**	**169**
Grant Total	**284**	**24.9%**	**228**	**20.1%**	**248**	**21.8%**	**216**	**18.9%**	**162**	**14.2%**	**1,138**

Source: Primary Data (2022)

Statistical data of alcohol users in Table 1 above on the general list at Serenity rehabilitation centre reveals that 119 (83.8%) in 2017 were males, 2018 they were 99 (86.8%), 107 (85.6%) in 2019, 89 (80.2%) in 2020, and 68 (83.9%) in 2021. Among the females, there were 23 (16.7%) in 2017, 15 (13.2%) in 2018, 18 (14.4%) in 2019, 22 (19.8%) in 2020, and 13 (16.1%) in 2021. As far as male multiple users were concerned, these were 72 (79.1%) in 2017, 70 (85.4%) in 2018, 70 (86.4%) in 2019, 73 (86.9%) in 2020, and 68 (79.1%) in 2021. The male alcohol users only were 47 (92.1%) in 2017, 29 (90.6%) in 2018, 35 (83.3%) in 2019, 16 (76.2%) in 2020, and 20 (86.9%) in 2021. On the side of the females, these were 4 (7.9%) in 2017, 3 (9.4%) in 2018, 7 (16,7%) in 2019, 5 (23.8%) in 2020, and 3 (13.1%) in 2021. The implication of the above statistical data is that, as there are some fluctuations in the percentages, there is a remarkable declining trend, especially among females over the years 2017-2021, which could presumably be due to the availability of some viable recovery interventions.

In addition, the rate of admission of perceived sobriety between 2020 and 2021 was investigated. Table 2 below has the summary of the findings.

Table 2: Rate of Admission on Perceived Sobriety between 2020-2021 in Serenity Rehabilitation Centre

Item category	Frequency	Percentage
Current admitted clients	31	26%
Referred clients	6	5%
Escaped client	1	1%
Discharged clients	83	69%
Total	**121**	**100**

Source: Primary Data (2022)

Results in Table 2 above clearly indicate that between 2020 and 2021, the admitted clients were 31 (26%), the referred clients were 6 (5%), an escaped client was 1 (1%), and the discharged clients were 83 (69%). The above statistical data imply that an increase in discharged clients (69%) could be a result of some recovery interventions.

A documentary review of the rate of admission of perceived sobriety in Butabika was done. Table 3 below has the details.

Rate of Admission on Perceived Sobriety in Butabika National Referral Hospital

Results showed that patients who received pharmacotherapy for alcohol use disorder (AUD) following discharge from a residential facility revealed a delay in alcohol use; Patients often relapse after 3-6 months, although some relapse after 2 to 3 months. This depends on the environment at home that ushers them into a lapse. The inpatient setting provides an opportunity for treating AUD and initiation of sobriety. The majority of the admitted patients were discharged home without continuity of care for their AUD due to limited human resources. However, transitioning from residential or outpatient substance use disorder (SUD) treatment programs after discharge has been shown to significantly reduce readmission rates. Medication affects patients' desire for alcohol use, although this experience was during the time of treatment, but once out of the facility, the desire to use alcohol comes, resulting in relapse. The table below shows the documentary results from Butabika National Referral Hospital. In 2018/19, 1,261,960 people were admitted to hospital where the primary reason or a secondary diagnosis was linked to alcohol, 8% more than the previous year (1,171,250) and 60% more than in 2008/09 (784,650). Almost half of those admitted (47%) were aged between 55 and 74, and just under two-thirds of all admissions were male.

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Table 3: Statistics of Alcohol and Drug Addiction according to the Butabika National Referral Hospital Record report

Item Category	2017	%	2018	%	2019	%	2020	%	2021	%	Total
Male Alc Only	926	83.7%	1,831	86.4%	1,702	87.6%	868	87.4%	835	79.3%	**6,162**
Female Alc Only	180	16.3%	287	13.6%	240	12.4%	125	12.6%	218	20.7%	**1,050**
Subtotal	**1,106**	**100%**	**2,118**	**100%**	**1,942**	**100%**	**993**	**100%**	**1,053**	**100%**	**7,212**
Male Alc & Drug	1,237	92.3%	1,992	92.6%	2,098	89.5%	1,883	92.8%	1,959	87.3%	9,169
Female Alc & Drug	103	7.7%	159	7.4%	245	10.5%	147	7.2%	286	12.7%	940
Subtotal	**1,340**	**100%**	**2,151**	**100%**	**2,343**	**100%**	**2,030**	**100%**	**2,245**	**100%**	10,109
Grant Total	**2,446**	**14.1%**	**4,269**	**24.6%**	**4,285**	**24.7%**	**3,023**	**17.5%**	**3,298**	**19.1%**	**17,321**

Source: Primary Data (2022)

Findings in Table 3 above show that the male alcohol users at Butabika were 926 (83,7%) in 2017, 1,831 (86.4%) in 2018, 1,702 (87.6%) in 2019, 868 (87.6%) in 2020, and 835 (79.3%) in 2021. Among the females, these were 180 (16.3%) in 2017, 287 (13.6%) in 2018, 240 (12.4%) in 2019, 125 (12.6%) in 2020, and 218 (20.7%) in 2021. This implies that the number of both males and females seems to have declined over the period 2019-2021. The male alcohol and drug users were 1,237 (92.3%) in 2017, 1,992 (92.6%) in 2018, 2,098 (89.5%) in 2019, 1,883 (92.8%) in 2020, and 1,959 (87.3%) in 2021. As for the females, they were 103 (7.7%) in 2017, 159 (7.4%) in 2018, 245 (10.5%) in 2019, 147 (7.2%) in 2020, and 286 (12.7%) in 2021. This means that there was an increase in the number of males who used alcohol and drugs in the years 2017-2018 compared to 2020-2021. A similar trend is reflected among the females, an indication of some adoption of recovery interventions, especially for the years 2020-2021. The rate of admission of Alcohol Addicts between 2020 and 2021 was also documented. The summary of the findings is reflected in Table 4.

Table 4: Rate of Admission of Alcohol Addicts between 2020-2021 in Butabika National Referral Hospital

Item category	2020	Percentage	2021	Percentage
Current admitted clients	615	61.9%	510	48.4%
Re-admission	198	19.9%	309	29.3%
Discharged client	180	18.1%	201	19.1%
Total	**993**		**1,020**	

Source: Primary Data (2022)

Study findings in Table 4 above clearly show a decrease among the admitted clients from 615 (61%) to 510 (48.4%) in the years 2020-2021. However, the re-admission cases over the same period increased from 198 (19, 9%) to 309 (29.3%) cases. A similar trend is portrayed for discharged clients, with 180 (18.1%) in 2020 and 201 (19.1%) in 2021. This could presumably imply that there was some inadequate use of recovery interventions.

Participants

The study used simple random sampling and purposive sampling to get the respondents since all the patients, alcohol addicts in Serenity rehabilitation centre and Butabika National referral hospital, were potential respondents, as well as all the psychological counsellors, Occupational therapists, and Psychiatric nurses were potential respondents to the study. So all those selected were eligible to participate in the study. The tools given out were 297questionnires, 50 questionnaires were given to

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respondents in Serenity centre, while 247 questionnaires were administered to respondents in Butabika National Referral Hospital. Tools returned were 47 questionnaires filled out of 50, and 03 questionnaires were not filled out from Serenity rehabilitation centre, while 238 questionnaires were filled, 06 questionnaires were not filled, and 03 questionnaires were not returned from Butabika National Referral Hospital. The participants were randomly selected, 24 participants among alcohol addicts to participate in the focus group discussion, 12 from Serenity and 12 from Butabika, making two groups for the focus group discussion. The participants were purposively selected, and 41 service providers were selected to participate in the study.

Bias

The researcher used a questionnaire survey to reduce bias and stereotypes that might arise from personal experiences of the respondents. The researcher tried to mitigate this by using statistical means based on the population of the study area. The study was also prone to questionable external validity since it had only content validity. Statistical representativeness was needed to understand a phenomenon. In this study, the generalizations made were statistical rather than analytical.

Study size

Statistical methods (sample size determination formula)

The research focused mainly on alcohol addicts and service providers, Butabika National Referral Hospital in Kampala, and Serenity rehabilitation centre in Wakiso district. The sample size was determined by Dillman 2007), using the Formula for determining sample size as shown below.

NP (P) (1-P)
S=NP-1(B/C) + (P) (1-P)
S= Sample
NP Number of Population
P Population Proposition Magnitude, yielding the maximum Possible Sample Size = 50% =0.5
B= Sampling error = 5% = 0.05
C=Level of Confidence = 1.960

S 2800 (0.5) (1-0.5)
2800 -1(0.005)2+ (0.5) (0.5)
1.960
2800x0.25
S=2799x0.0006507705+0.25
700

S= 2799x0.0006507705+0.25
700
S= 2.0715066295
S=337.9
S=338

Data Analysis:

Quantitative Data Analysis

Quantitative data analysis involved the use of descriptive and inferential statistics, such as mean and standard deviation, that helped the researcher to organize data in a meaningful form and describe the data such that quantitative statements could be made. The study used Pearson's product-moment correlation coefficient to find out whether a relationship existed between variables and determined its magnitude and direction. Multiple regression analysis was used to ascertain how the dependent and mediating effects could be predicted on the independent variables because the main study constructs were disaggregated into their constituent sub-constructs and analyzed separately.

Hypothesis testing

The study result shows a weak linear positive but significant relationship between psychosocial intervention and perceived sobriety ($r = 0.230$, $p = 0.000$). The findings thus suggest that psychosocial intervention is likely to lead to perceived sobriety. The likelihood of perceived sobriety is explained by the positive linear relationship ($r = 0.230$). This implies that psychosocial intervention significantly positively correlates with perceived sobriety at the level of significance. This means that the null hypothesis was retained since there is a positive and significant relationship. H3: There is a statistically significant contribution of psychosocial intervention towards perceived sobriety in Butabika National Referral Hospital, Kampala, and Serenity Rehabilitation Centre, Wakiso District, Uganda. Therefore, the alternative hypothesis of the study was rejected.

Qualitative and Quantitative Data Analysis

Qualitative data analysis involved content analysis. The data was coded and grouped according to similar ideas in the data grouping, and similar information was put together in categories relating different ideas to the content. The researcher further organized the data findings and organized ideas and concepts using content analysis. An interview was used to transcribe verbatim data to support the questionnaire results. Quantitative data analysis involved the use of descriptive and inferential statistics, such as mean and standard deviation, which helped the researcher to organize data in a meaningful form and describe the data such that quantitative statements could be made. The study used Pearson's product-moment correlation coefficient to find out whether a relationship existed between variables and determined its magnitude and direction. Multiple regression analysis was used to ascertain how the dependent and mediating effects could be predicted on the independent variables because the main study constructs were disaggregated into their constituent sub-constructs and analyzed separately.

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Research Ethical Considerations

The study followed the established general principles regarding informed consent, confidentiality, and anonymity. Reading people's case files was a very sensitive issue. Authorities of the selected treatment facilities were informed about the purpose of keeping the secrets of the respondents. To protect the respondents' names, they were not required to write them on the questionnaire. Following principles of autonomy, the study adopted a method to provide adequate information about the research study to the respondents in the consent form given to them, in clear and understandable terms, to enhance their informed consent. The letter of introduction was obtained from the School of Postgraduate Studies and Research of Nkumba University, introducing the researcher to the Clarke International University Research Ethics Committee for approval with UG-REC-015, CIUREC/0216 of the research proposal, and received a letter of approval on 6th /09/2021. The researcher proceeded to submit the protocols to the National Council for Science and Technology (UNCST-SSI026ES) and received the letter of protocol approval on 1st/02/2022. This enabled the researcher to go to the field to carry out the study.

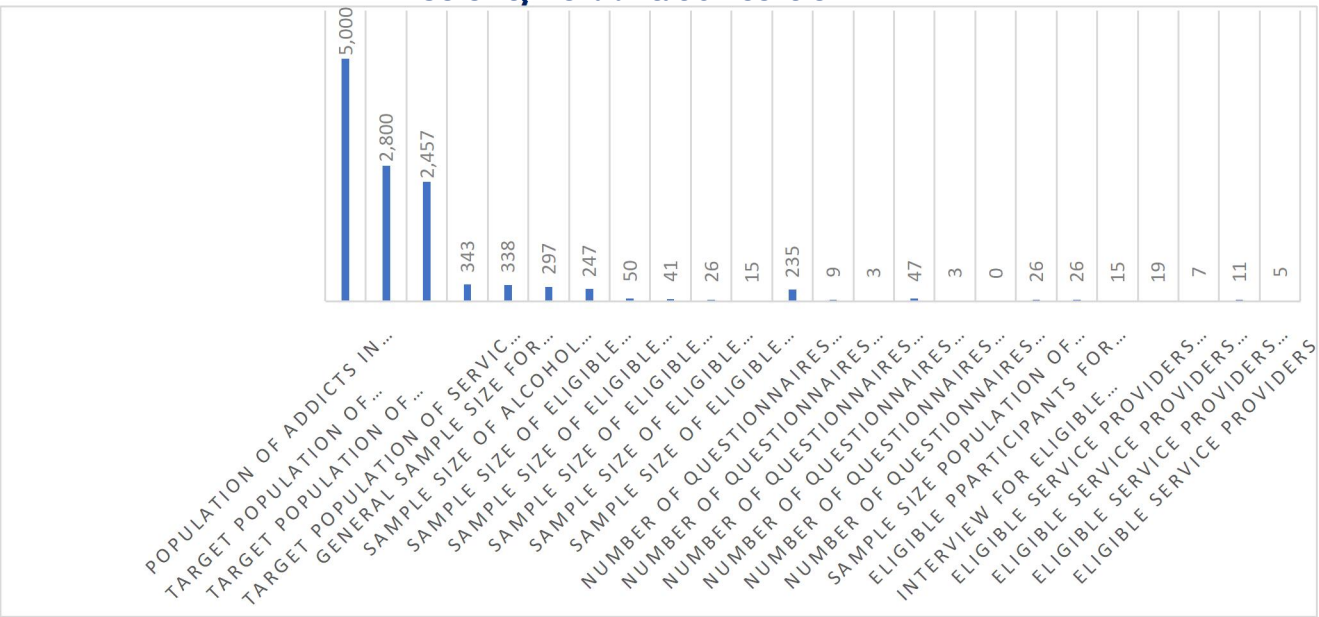
Data Collection

Data was collected using questionnaires survey and interview guide from the large number of respondents 338 respondents participated in the study within the shortest period of time as noted by Tuckman, (1994), that, the result of the questionnaire can quickly be quantified either by use of software package such as SPSS or accordingly, questionnaires were given randomly to sampled respondents to answer with the help of the principal investigator and research assistant. Quantitative data was analyzed using Pearson's product correlation coefficient and hypotheses tested, and Qualitative data was analyzed using content analysis.

An interview guide and a focus group discussion were used for collecting the qualitative data; interview responses were recorded for future reference and in-depth analysis. The interview techniques used enabled data collection. The focus group discussion had two groups of 6 participants from Serenity and Butabika, respectively; this was to give every participant a chance to share their views about the questions of discussion. The identity of the respondents was controlled because they consented to the ethical requirement of keeping confidentiality.

Results of the Findings.

Chart 1: Response rate for Questionnaires from Butabika National Referral Hospital and Serenity Rehabilitation Centre



Breakdown of participants' eligibility for the study and those eligible but did not participate in the study in Butabika National Referral Hospital and Serenity Rehabilitation Centre. Response rate to the study.
Source: Primary Source Data (2022)

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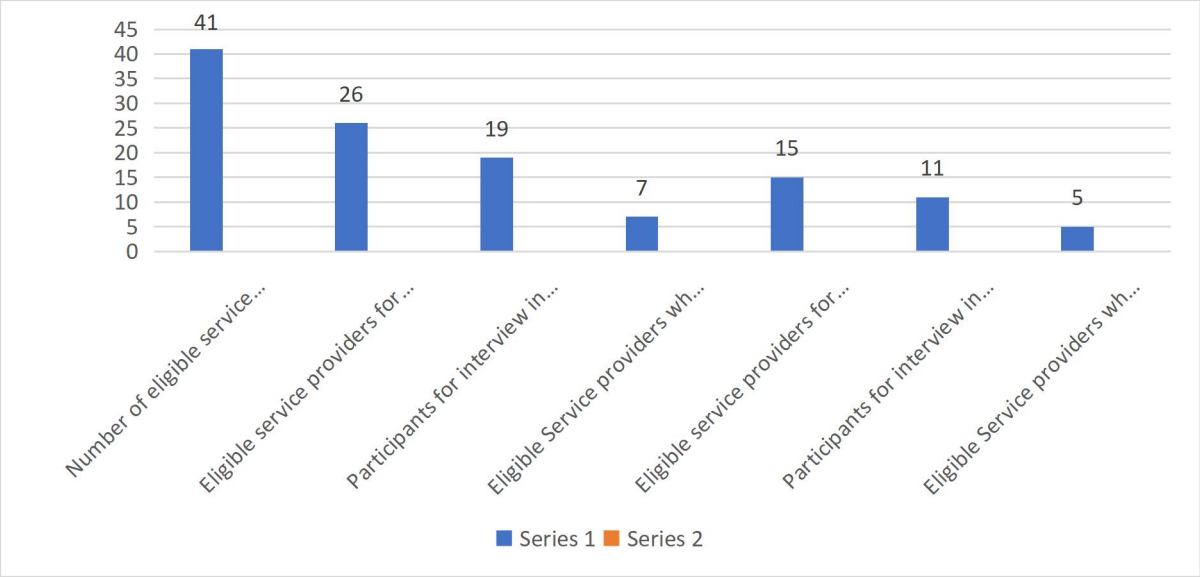
In response to the participants' eligibility, those who were examined were eligible and completed the study, and were analyzed for the final report. Here are the details. Target population of addicts and service providers in Butabika national referral hospitals and Serenity rehabilitation centre was 2,800, while the number of the target population of addicts in Butabika national referral hospital and Serenity rehabilitation centre was 2,457 while the target population of Service providers in both Butabika national referral hospital and Serenity rehabilitation centre was 343 and so using Dillman (2007) sample size determination, the sample size for eligible participants was 338 both Butabika national referral hospital and Serenity rehabilitation centre alcohol addicts and service providers.

Chart 2: Response rate for interviews from Butabika and Serenity.



Breakdown of participants' eligibility for the study and those eligible but did not participate in the study during the interview in Butabika National Referral Hospital and Serenity Rehabilitation Centre. Response rate to the study.
Source: Primary Source Data (2022)

Concerning the participation in the interviews, the study had a sample size of 41 respondents eligible for the interview 26 from Butabika national referral hospital, and 15 from Serenity rehabilitation centre, however, not all participated in the study when the responses reached saturation point so 19 participants were interviewed from Butabika national referral hospital leaving out 07 participants consisting of the different categories identified to participate in the study that is addiction counselors, psychological counselors, occupational Therapists and psychiatric nurses while Serenity rehabilitation centre had 11 out of 15 responses from similar category as potentially identified respondents leaving 05 after reaching point saturation.

Table 5: Descriptive Statistic Results of psychosocial intervention

Psychosocial intervention	Mean	Std. Deviation	Interpretation
My fellow patients are encouraged to participate by the psychologist during group therapy sessions	3.74	1.17	High
I have been helped to identify the problems I face that are related to my drinking of alcohol	3.40	1.05	High
I am always reminded of my commitment towards the change that is desirable	3.67	1.14	High
I think I will become better when I stop drinking alcohol	3.46	1.24	High
I feel I need to change from drinking alcohol to not drinking	3.70	1.18	High
Sub Mean & Standard Deviation	**3.59**	**1.16**	

Legend: 4.20-5.00 Very High, 3.40-4.19 High, 2.60-3.39 Average, 1.80-2.59 Low, 1.00-1.79 Very Low
Source: Primary Data (2022)

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The descriptive statistics in Table 5 above show an aggregate (Mean = 3.59, SD = 1.16), which implies that there is a high level of psychosocial intervention, while the specific results show a high score level of patients encouraged to participate during group therapy sessions with (Mean =3.72, SD=1.01). This means that involvement of patients in recovery, including giving psychosocial support to fellow addicts through peer and group therapy, is a remedy for reducing perceived sobriety since they derive meaning from living life without drinking alcohol, which has a positive influence on recovery, as the overall result shows high levels from the table above.

The interviews and focused group discussions revealed the following results from Butabika National Referral Hospital and Serenity rehabilitation centre on the contribution of psychosocial intervention to perceived sobriety. In relation to psychosocial intervention on perceived sobriety, during an interview, 26/30 respondents said that:

"Psychosocial therapy helps patients learn how to identify and change destructive thought patterns that have a negative influence on their behaviour and emotions. It helps patients develop resistance and face the reality of their behaviour in a more effective manner since most patients are brought to the rehabilitation facility forcefully or against their will, but eventually, some appreciate being in the facility. It helps alcohol addicts learn the danger of associating with excessive use of alcohol; many patients find reason to rehabilitate when psychosocial intervention is well done" **(K.I.I, 2022).**

Positive attitude leads to a change of behaviour, like acknowledgement and acceptance of the program offered at the treatment facility for patients and family, which results in the recovery of the patients. Although some patients recover from the conditions of addiction, others relapse. Therapists provide cognitive behaviour therapy (CBT), sometimes Family therapy, and group therapy as well. This enables patients to interact freely with therapists and colleagues, which motivates them to explore the diverse options for recovery. We encourage them to participate in physical exercise games like volleyball, netball, basketball, ballet, and football in order to occupy their minds and keep alert.

Another key informant said that:

"The process of a patient's recovery is largely dependent on the family support; sensitization is a need for the family to accept the challenge the recovering addicts are having; failure always results in relapse, which can be rated at 5/10 relapse cases. Other factors resulting in relapse were peer influence 80%, stress due to family reactions 15% and other factors take 5%. Furthermore, the overall level of recovery of patients would stand 40/100 (moderate), and this depends on the family support system, the patient's level of insight, both emotional and intellectual, and the reason for admission. Few patients were discharged, and yet more admissions were made as treatment is a continuous process. Sponsors need to be educated about the nature of drug use in the body so that they can help the patients based on their health status. Some of the patients keep escaping from the hospital and come back with sacks of drinks" **(K.I.I, 2022).**

On the contrary, it was observed that as part of psychosocial intervention, the approach counsellors use is not African-based but rather adopted from the Western world. It is important to give information based on the African way of solving problems. The influence of the Western world is just too much; even professionals like counselors give information downloaded from the internet, and even the books are Western-based with Western culture and beliefs, yet African culture and beliefs are different. On the contrary, some of the therapists are harsh towards patients, some counselors make patients avoid coming to share because they do not respect and keep patients' privacy; they share patients' private issues anywhere and make fun of patients' situations. This is a gap in the side of the therapist which needs to be improved following the ethical code of conduct regarding the counselor-client relationship and issues on confidentiality and patients' rights, as well as not harming patients.

However, one participant acknowledged that:

"Counseling has helped me to appreciate my family members for bringing me here to Serenity Rehabilitation centre because they want to see me keep sober and healthy, not hating me as I thought before, because everyone in the family was hard on me. Now my relationship with my family and myself has changed; since I came here, I have realized great change in my life, and I have come to accept that life without alcohol is actually better. I thank my mother for bringing me here; I think I will try not to disappoint her efforts to spend on me. I have come to understand that recovery starts from me, by accepting that I am an addict and that change is possible. I ask myself what my attitude is about change, since it comes from me. I want to make a difference in my life and to show those who think I cannot change that change is possible. Sister, be prepared to receive my phone calls for your support. This sharing of the group session has touched me deeply. I thank God for being part of this discussion" **(K.I.I, 2022).**

One participant during an interview acknowledged that:

"As part of psychosocial intervention here at the center, we encourage our patients to attend AA group therapy. AA provides a job for the recovering addict; it helps one gain self-confidence. It brings hope and a positive attitude; it brings comfort and helps cope with recovery. It helps a person to learn self-talk. It does not allow an alcohol addict to interact with people who may act as triggers. It helps to break boredom. The information on the 12 steps helped them to acknowledge that they are powerless, which makes them feel that life is possible to live and move on. AA hit right to the point. AA prevents recovering addicts from relapse because the sponsor supports them from relapse, it helps them to examine the negative effects of

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alcohol and substance use, it provides emotional support, and confidentiality is maintained" **(K.I.I, 2022).**

The above findings seem to tally with what is presented in Table 5 above on psychosocial intervention in line with the influence of recovery interventions on perceived sobriety in Butabika hospital and Serenity rehabilitation facilities in Kampala and Wakiso districts, respectively.

Table 6: Correlation of psychosocial intervention and perceived sobriety

Correlations		Perceived Sobriety	Psychosocial Intervention
Perceived Sobriety	Pearson Correlation	1	.230**
	Sig. (2-tailed)		.000
	N	285	285
Psychosocial Intervention	Pearson Correlation	.230**	1
	Sig. (2-tailed)	.000	
	N	285	285

. Correlation is Significant at the 0.01 Level (2-Tailed).

Source: Field Data (2022)

The statistical results in Table 6 above show a weak linear positive but significant relationship between psychosocial intervention and perceived sobriety (r = 0.230, p = 0.000). The findings thus suggest that psychosocial intervention is likely to lead to perceived sobriety. The likelihood of perceived sobriety is explained by the positive linear relationship (r = 0.230). This implies that psychosocial intervention significantly positively correlates with perceived sobriety at the level of significance. This means that the null hypothesis was retained since there is a positive and significant relationship. H3: There is a statistically significant contribution of psychosocial intervention towards perceived sobriety in Butabika National Referral Hospital, Kampala, and Serenity Rehabilitation Centre, Wakiso District, Uganda. Therefore, the alternative hypothesis of the study was rejected.

Results of Hypothesis

The null hypothesis was tested against the directional, and the result revealed that psychosocial intervention has a statistically significant contribution to perceived sobriety, meaning that the null hypothesis was retained.

Contribution to Knowledge (ISCAR Model)

As a contribution to knowledge, the study came up with a model to address the challenges of perceived sobriety in Butabika National Referral Hospital and Serenity Rehabilitation Centre in order to improve the quality of services offered for the recovering addicts, where psychosocial intervention as a recovery intervention was investigated together with the mediating factors. The Psychosocial Model focusing on the general consistency in viewing alcohol as largely from numerous states of the mind, this provokes conflict as a result of emotional dysfunctionality with an individual who chose of using alcohol to provide symptomatic relief including some aspect of psychodynamic pattern, where the individual experiences emotional distress as a result of learned behaviour viewed as appropriate, respective modality for treatment (McLellan, Woody and O'Brien, 1979; Khantzian, 1985). However, the Integrated Self and Community Awareness Recovery (ISCAR) Model attempts to integrate or merge the viable aspects of the existing models in a bid to attain a diversified recovery intervention approach that can address perceived sobriety challenges.

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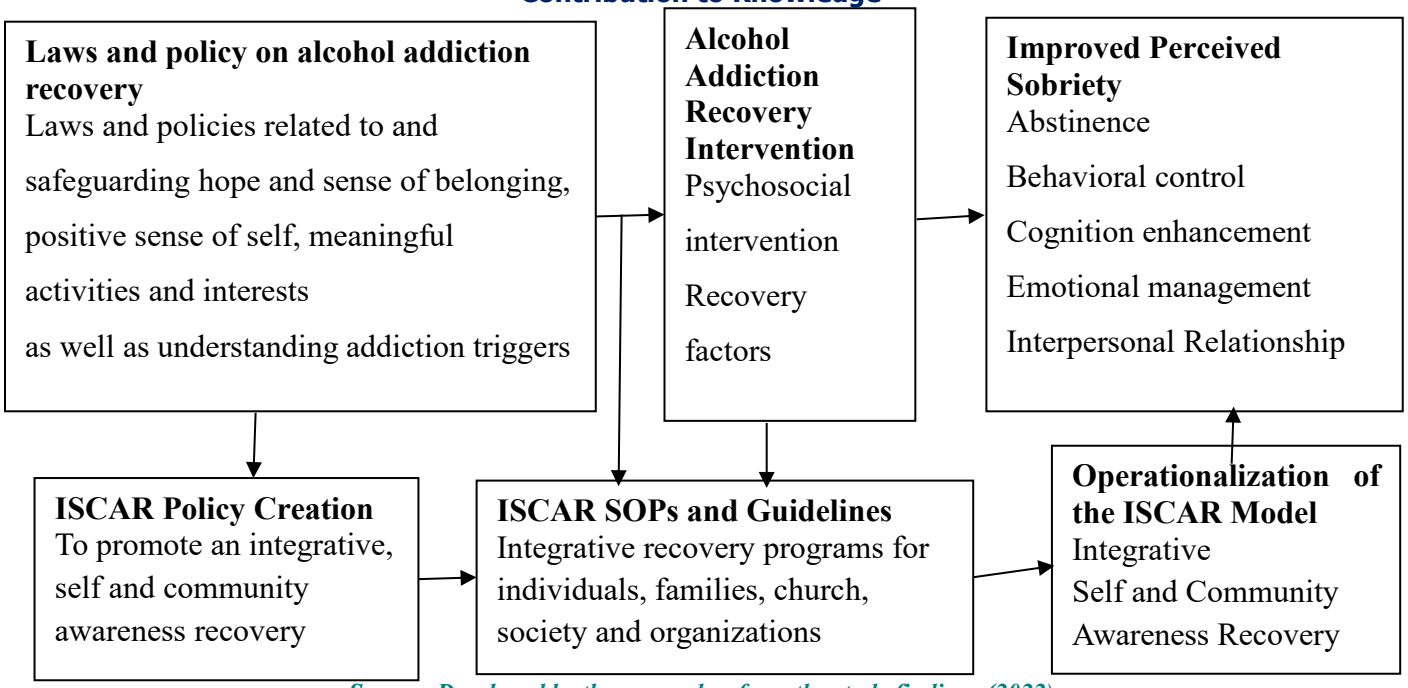
Figure 1: Integrated Self and Community Awareness Recovery (ISCAR) Model ISCAR Model Contribution to Knowledge



Source: Developed by the researcher from the study findings (2022)

The ISCAR model supports the recovering addict to maintain sobriety. The interaction channel flows from laws and policy on alcohol addiction recovery, together with alcohol addiction recovery interventions that are psychosocial interventions to improve perceived sobriety, resulting in abstinence, behavioural control, cognition enhancement, emotional management, and interpersonal relationships. Based on laws and policies related to and safeguarding hope and sense of belonging, positive sense of self, meaningful activities and interests, as well as understanding addiction triggers.

Feasibility of the Integrative Self

ISCAR model supports the psychological world of the recovering addict to address the internal locus of control as one of the aspects that leads the person to desire excessive use of alcohol. This helps the individuals to manage continued vulnerability and develop a healthy, productive, and meaningful life. As noted by White (2007), recovery was the process of resolving addiction issues with the development of cognitive, emotional, physical, educational, relational, occupational, and ontological health, while Hansen, Ganley, and Carlucci (2008) revealed that recovering individuals experience commitment to serve, positive outlook, and attitude about life and established relationships. The analysis was done on the comparable preference and feasibility of all the recovery intervention models used in the study with respect to perceived sobriety, as shown below. First, the question raised to the respondents was: Do you prefer the Integrated Self and Community Awareness Recovery Model to the recovery pathways approach as shown in Table 7.

Table 7: ISCAR Model versus Psychosocial Model

Response	Frequency	Percentage
ISCAR Model	14	56%
Psychosocial Model	11	44%
Total	**25**	**100%**

Source: Primary Data (2022)

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Statistical data revealed in Table 7 above indicate that the majority of the respondents (56%) support the ISCAR model, and only 44% of the respondents were in support of the Psychosocial Model of recovery intervention. Finally, the ISCAR model was also pilot-tested in relation to the AA Model of Intervention. Having examined both models, the respondents were asked to give their points of view on their feasibility.

Community Awareness Recovery (ISCAR) Model

In using the ISCAR model at the initial phase, therapists need to establish a relationship and secure environment for the recovering addict to get in touch with their problems. The client is supported by the ISCAR model; therapists express empathy and understanding to the recovering. A good working relationship is established and constitutes the basis for specific interventions. The methodological phase of counselling is characterized by the application of specific interventions according to the individual's presenting problems and needs. The goal was to encourage the recovering addict to face the reality of being an addict and to be able to deal with life and its difficulties constructively and creatively. Accepting that one is an alcoholic was the first step and paramount. Personal growth is facilitated through self-awareness that offers new and unusual experiences.

The ISCAR model encourages therapists to help the recovering addict get in touch with the inner conflicts and learn to recognize them more consciously.

ISCAR model supports the recovering addicts to do a SWOT analysis as a way of helping the client face the reality of the addictive behaviour and desire change as a transformation process.

The ISCAR model aimed at encouraging therapists to be able to offer the recovering addict a framework that can keep in mind and easily structure the narrative, as well as generate possible directions that the client can base their decisions on. This framework was to enable the client to conceptualize issues easily and keep focus on the dimensions that seem to be important for their recovery.

ISCAR model encourages therapists to encourage recovering addicts to develop self-efficacy, which is an individual's belief in his or her ability to perform certain behaviour to achieve a desired outcome. At the initial stage of building a relationship with the client, an ISCAR therapist can start with any dimension, although establishing a working counsellor–client relationship would be the first step most of the time, when a supportive attitude of the counsellor is of great importance to stabilize the client.

Therapists are to encourage recovering addicts to explore their dysfunctional / belief system, so that the client recognizes its inconsistencies and the dysfunctional aspects. The client was helped to develop a new set of beliefs, which were questioned again, so that the client had to defend them; the realization that there are no inconsistencies, or find a better way of dealing with the challenge.

Discussion for the objective to be published

Results from the findings revealed that there is a weak linear positive but significant relationship between psychosocial intervention and perceived sobriety ($r = 0.230$, $p = 0.000$). The findings thus suggest that psychosocial intervention is likely to lead to perceived sobriety. The likelihood of perceived sobriety is explained by the positive linear relationship ($r = 0.230$). This implies that psychosocial intervention significantly positively correlates with perceived sobriety at the level of significance. This means that the alternative hypothesis is retained because the findings are in accordance with hypothesis 3. Therefore, in conformity with the result, psychosocial intervention helps to improve physical health and reduce perceived sobriety; Mann et al. (2013) affirmed that residential treatments seem beneficial in patients with moderate-to-severe alcohol dependence and patients with psychiatric or medical comorbidity or both.

In relation to Magill and Ray (2009), there is an improved outcome from the combination of AA, CBT, and medications for relapse prevention in alcohol dependence, as psychosocial intervention represents the social identity transition in recovery, and then the social processes are identified as critical in the recovery process from addiction. In this regard, psychosocial intervention provides the most widely available community support programmes for problem drinkers (Kelly and Yeterian, 2008). Furthermore, AA is one of the psychosocial interventions that provide a mutual aid organization for peers to support each other to overcome addiction to alcohol, based on 12 steps and 12 traditions that members work through over time. More so, AA was used as a mutual aid to recovery group with the largest membership and the strongest empirical evidence base among recovery groups and services. This is very true; however, the AA group in Uganda was not strong enough to support its members. As a result, many addicts relapse after some time due to family challenges, meaning that they do not get enough skills to resist the challenges out there.

However, apart from AA, model, recovering addicts were not prepared to face the challenges out there during the treatment process, which is a gap within the treatment facility. ISCAR model was set to prepare patients face the reality of the community to prevent relapse after discharge such that patients leave treatment facilities well equipped to embrace the family, community with all its challenges and are prepared to face them and be positive without becoming overwhelmed; ISCAR model programme calls for stakeholders participation in advocating for alcohol free program in family, community, churches, society and

organizations and together with law and policy makers to support the campaign for healthy body healthy mind.

Buckingham et al. (2013) say that alcoholics cultivate recovery-based intervention through social identity involvement in psychosocial activities and internalization of AA values, so the social identity associated with using the group was diminished. Alcohol addicts who form new social networks with non-substance-using peers are more likely to sustain sobriety (Best et al., 2012; Kelly, Hoeppner, Stout, and Pagano, 2012). Furthermore, the influence of psychosocial involvement in social networks results in a change, together with an increase in sobriety to recovery from perceived sobriety (Kelly and colleagues, 2012). The researcher agrees with the above scholar's views; however, there was a need to strongly emphasize the interventions as a core element driving the alcoholics to desire sobriety, much as social identity plays an important role. The Integrated Self and Community Awareness (ISCAR) will help the addict to explore the facts surrounding the temptation to relapse because of social interactions. This would help the individual to be aware and prepared to face the reality after discharge. This would help to reduce the level of perceived sobriety, resulting in recovery.

The Integrative Self Community and Awareness Recovery (ISCAR) model focuses on helping recovering alcohol addicts face the reality of being powerless over their use of alcohol. ISCAR model therapists are encouraged to support patients to share their own stories. As the structure of the sponsor, the system serves to generate active involvement and membership, thus binding addicts to group therapy that is an ongoing process of psychosocial intervention for recovery (Kelly, 2013). The findings on psychosocial intervention revealed a significantly negative direct effect on perceived sobriety with (β= -.034, P= 0.540 > 0.05). This means that increasing psychosocial intervention would lead to feasible recovery from perceived sobriety. Furthermore, the principle of keeping AA intervention as part of the recovery process within and outside the rehabilitation gives members freedom to share experiences and have the power to protect their own ongoing recovery by helping others around them achieve sobriety as well. Frings and Albery (2014) added that AA offers a positive recovery-based social identity that is accessible for members to use as a basis for self-definition and sustainability of a recovery-based social identity.

However, Riper et al. (2014) argued that psychosocial therapies are important components of the treatment for AUDs; the range of psychosocial therapy was substantial and heterogeneous, which makes it difficult to compare scientifically; psychosocial interventions were difficult despite different countries using them as an intervention. For this reason, more evidence from Riper et al. (2014) was needed to assess the effectiveness of psychosocial interventions on the treatment of AUDs, where treatment options should be offered to patients based on their individual needs and preferences. The newly established model, whose target was to strengthen the level of interventions used in the treatment facilities, encourages therapists to consider the use of other psychological interventions besides pharmacological interventions to reduce perceived sobriety to experience recovery; therapists need to consider individual differences in attending to patients, since different people respond differently in the process of recovery.

The study found that psychosocial intervention has a significantly positive, indirect effect on perceived sobriety through meaningful activities (β=.340, P=0.030**> 0.05). This means that the more the psychosocial intervention, the more meaningful activities improve towards a feasible recovery level. Recovery was reflected by experiences of fruitful existence in addition to the remediation (BFI Consensus panel, 2007), as the current study findings named it recovery interventions, such as socio-cultural, pharmacotherapy, and psychosocial interventions to address the internal locus of control as one of the aspects to address the desire for excessive use of alcohol. This helps the individuals to manage continued vulnerability and develop healthy, productive, and meaningful lives ElGuebaly, 2012; White, 2007). While Hansen, Ganley, and Carlucci (2008) revealed that recovering participants experienced commitment to serve, positive outlook, and attitude about life, and established relationships, the ISCAR model, being integrative in nature, would strengthen the interventions used in the treatment facility and promote recovery.

According to Borkman, Stunz, and Kakutas (2016), individuals' failure to perceive the quality of life, such as moral changes that maintain relationships, is not explored; therapists need time to listen to the stories of patients before discharge. While (Kelly, Stout, Magill, Tonigan and Pagano, 2011; Lyons, Deane and Kelly, 2010; Witbrodt, Kaskutas, and Grella, 2015), viewed recovery in terms of spiritual transformation in a clinical sample, Kaskutas, Kaskutas, Bond and Weisner, (2003) revealed that treatment seekers were three to four times more likely to abstinent if they had a spiritual awakening. According to Mental Health Public Administration, proper prevention planning requires knowledge of the individual abusing alcohol and the interaction between the factors negatively affecting the individual drinking alcohol and the environment. Prevention in public health was an evolutionary field that is constantly growing from individuals' experiences. The current study focused on addressing the influence of recovery intervention and recovery factors on perceived sobriety, leading to recovery and living a meaningful life.

However, alcohol abuse treatment services in Uganda are facing a wide range of challenges (Kalema et al., 2015): the Minnesota model was criticized for focusing too much on addiction as an incurable disease and for ignoring other significant elements of recovery such as clients' wellbeing

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Kalema and Vanderplasschen, (2015), argued that, a lot of people drop out of treatment due to the strict approach and long duration of the programme. Huebner and Kantor (2011), cited in Kalema and Vanderplasschen (2015), found that many health professionals lack the skills to treat patients with AUDs (Kalema et al., 2015). There was a limited variation in intervention techniques (Kalema and Vanderplasschen, 2015). In conformity with the study, the findings revealed that the treatment facilities have limited human resource especially in psychology department leading to an increase in perceived sobriety meaning no recovery but increases the rate of admission due to relapse which was the reason for the establishment of the ISCAR model whose target was to empower therapists journeying with the addicts to explore internal locus of control to reduce perceived sobriety and maintain recovery.

Riper et al. (2014) argued that psychosocial therapies are important components of the treatment for AUDs; the range of psychosocial therapy was substantial and heterogeneous, which makes it difficult to compare scientifically; psychosocial interventions are difficult despite different countries using them as an intervention. For this reason, more evidence from Riper et al. (2014) was needed to assess the effectiveness of psychosocial interventions on the treatment of AUDs, where treatment options should be offered to patients based on their individual needs and preferences. The newly established model, whose target was to strengthen the level of interventions used in the treatment facilities, encourages therapists to consider the use of other psychological interventions besides pharmacological interventions to reduce perceived sobriety to experience recovery; therapists need to consider individual differences in attending to patients, since different people respond differently in the process of recovery.

The study further found that Psychosocial: the application of psychosocial intervention has a positive, significant indirect effect on perceived sobriety through hope and a sense of belonging (β=.080, P=0.515 greater than 0.05). This implies that the more the psychosocial intervention, the more the recovery to a feasible level. However, according to K4health, (2007), specialized treatment centres are scarce in Uganda and mainly concentrated in urban areas such as Kampala and are hardly accessible and available for the majority of Ugandans due to relatively high costs and Uganda has only one public alcohol and drug unit in the Butabika National Psychiatric Referral Hospital, which was often avoided by alcohol addicts due to the stigma associated with mental disorder Sullivan and (Fleming, 1997) cited in (Kalema and Vanderplasschen, (2015). Because of the challenges the alcohol treatment services face, alcohol treatment in Uganda was severely hindered, and the needs of the majority of the people with AUDs are neglected (Kullgren, Alibusa, and Birabwa-Oketcho, 2009). Most of the treatment facilities are business-oriented but do not focus on the reduction of perceived sobriety, which is why aftercare was not taken seriously. T

The ISCAR model was established to bridge the gap identified by the above scholars to strengthen the level of use of the existing interventions and focus on the reduction of perceived sobriety. The ISCAR model encourages the therapist to explore issues leading to relapse and discuss positive alternatives to maintain sobriety after discharge.

Generalizability

The study used a sample of 338 respondents (drawn from the population of 2,800 in Butabika National Referral Hospital and Serenity rehabilitation center), results from which could not be generalized to the entire population of addicts in central Uganda, which is about 5,000 addicts, including service providers in the country (UYDL, 2018/2019).

Conclusions

There is a significant relationship between psychosocial intervention and perceived sobriety. Therefore, increasing psychosocial intervention would result in feasible recovery, hence having perceived sobriety. Increasing psychosocial intervention could lead to feasible recovery from perceived sobriety, since recovery was reflected by experiences of sober or fruitful existence in addition to the remediation. Therapists are to help individuals manage continued vulnerability and develop healthy, productive, and meaningful lives. Individuals' failure to perceive the quality of life, such as moral change that maintains relationships that are not exploitative.

Study Limitation

Looking at the weakness of the qualitative approach, the researcher used interviews and focused group discussions; the researcher obtained extensive oral information during the survey interview. Interpretation was a challenge, while the quantitative approach was limited to highly structured data, which required a scientific method of analysis. Silverman (2016) noted that the techniques chosen to describe the process of data analysis and how the conclusions were formulated may differ. To avoid the weakness of each method, the researcher adopted a triangulation approach of combining the qualitative and quantitative approaches. Patton (1990) and Vulliamy, Lewin, and Steven (1990) argued that the available evidence of data was supportive of qualitative and quantitative research methodologies as complementary rather than conflicting paradigms.

Recommendations

The Ministry of Health should set up a Mental Health Desk to encourage clinical coordinators and treatment providers to train more professionals in clinical counseling and psychology to improve the quality of services in the

treatment facilities; to address the challenge of limited human resources in Butabika National Referral Hospital, since the hospital was overwhelmed with the challenge of mental health.

Community teams need to be trained and empowered from time to time as part of psychosocial intervention through seminars and workshops to address the negative effects of alcohol and how to support addicts after discharge from the treatment facilities.

Therapists in the treatment facilities identify the potential and resourceful recovering patients and have them trained to support the recovery process, since they have the experience of the dangers of alcohol, which may inspire others in the rehabilitation facilities to accept that change.

The Ministry of Health needs to follow up on all the rehabilitation facilities for quality work done, and should increase Human Resources for follow-up of patients after discharge in the communities. It is imperative to have in place strict community and government alcohol policies to avoid excessive use of alcohol. Schools should also be involved in the alcohol prevention measures so that they can do something to prevent children from using alcohol and drugs, since many alcohol addicts and drug users learn from schools.

Acknowledgment

I thank God for His immeasurable support, protection, and guidance. I wish to extend my sincere thanks and gratitude to my supervisors, Associate Prof. Kiyingi Pio Frank and Dr. Nyende Paul, whose untiring positive criticisms led to the actualization of this work. I also acknowledge Dr. Mposa John Baptist for committing their precious time to proofreading and editing this work. Special appreciation goes to the superiors of the Missionary Sisters of Mary Mother of the Church (MSMMC) for allowing me to carry out my studies. I equally extend my heartiest appreciation to Msgr. Fr. Louis Ajusi for the moral and spiritual support. Profound thanks to the late Rev. Sr. Cecilia Nibyobyonka for her tireless effort to initiate the Counseling program in the University of Kisubi (Unik) and Uganda Martyrs University (UMU), where I am working. Special thanks to friends Sr. Teresa Namataka, Sr. Rose Miria Kareo, Sr. Premina Draru, Mr. Odendi Robert Gordion, and Dr. Ceaser Sikia, whose support has been vital to me for the completion of the PhD programme. I am greatly indebted to my entire family, especially uncle Zira Lali William, my sister Ms. Asitolo Joyce, and my brother Fr. Emmanuel Drici for their mutual moral and spiritual support, which has been indispensable in my doctoral journey.

List of abbreviations

AA	Alcohol Addicts
AA	Alcoholics Anonymous
APPS	Alcohol Policy and Perceived Sobriety
AUDs	Alcohol Use Disorders
BC	Behavioural Control
BNRH	Butabika National Referral Hospital
CIU	Clarke International University
CIU/REC	Clarke International University Research Ethics Committee
CIURE	Clarke International University Research Ethics
D.V	Dependent Variables
DHO	District Health Officer
FGD	Focused Group Discussion
GOU	Government of Uganda
HT	Hypothesis Testing
I.V.	Independent Variables
ISCAR	Integrative Self and Community Awareness Recovery
MoH	Ministry of Health
NCA	National Council on Alcoholism
NCST	National Council for Science and Technology
NGO	Non-Governmental Organization
NH	Null Hypothesis
NHP	National Health Policy
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NSDUH	National Survey on Drug Use and Health
NTASM	National Treatment Agency for Substance Misuse
NU	Nkumba University
PS	Perceived Sobriety
PsI	Psychosocial Intervention
QDA	Qualitative Data Analysis
QDA	Quantitative Data Analysis
REC	Research Ethics Committee
RF	Recovery Factors
SDGs	Sustainable Development Goals
SPSRNU	School of Postgraduate Studies and Research, Nkumba University
SRC	Serenity Rehabilitation Centre
SUD	Substance Use Disorders
TEDS	Treatment Episode Data Set
TEDS-A	Treatment Episode Data Set: Admissions
UAPA	Uganda Alcohol Policy Alliance
UAS	Uganda Alcohol Status
UG-REC	Uganda Research Ethics Committee
UNCST	National Council of Science and Technology
VHT	Village Health Team
WHO	World Health Organization

Conflict of interest

Based on the reality of the findings from the study, the author has a conflict of interest in establishing a rehabilitation service for the local communities in the rural area to facilitate services to those who are not able to come to Serenity and Butabika for rehabilitation. Addressing the challenge of mental health through awareness creation is the desire of the author.

The external validity of the study results

The recovery model was pilot-tested in the non-study areas of St. Mary's Recovery Home, Nsambya, and Mental Health Care and Rehabilitation Centre, Bwebajja, to ascertain its feasibility. To achieve this, the study purposively selected 25 participants. Participants in all the respondents' categories were requested to give their opinions on the feasibility or applicability of this new recovery model vis-à-vis the previous models. The respondents were exposed to the various viable elements or aspects of the three previous models and asked to compare them with those of the new proposed one, as regards recovery from alcohol addiction. All the responses gathered were summarized and tabulated to indicate the degree of preference and feasibility of the new proposed recovery model shown in Figure 1, and the testability result is in Table 7 above.

Author's Contribution

Dr. Lindrio Celestine is a psychologist with research experience in qualitative and quantitative research and a research supervisor of graduate students' dissertations. She is the Administrator of the School of Graduate Studies and Research and Innovations. She supervises graduate students in research. She mentors counselling students in Practicum/supervision and on one counselling service, as well as group therapy and experiential therapy at the University of Kisubi. As the administrator for graduate school, Dr. Lindrio organizes workshops, seminars, meetings, and conferences at the graduate level for all the lecturers and graduate students, as well as the entire university staff and students of the University of Kisubi. She is also the coordinator for the university innovations. Dr. Lindrio organizes the University of Kisubi innovators to participate in the exhibitions organized by the National Council for Higher Education and organizations that invite the University to participate in and innovation exercise where they have won in the past 5 years. She represents the staff in the Senate Committee of the University of Kisubi, she is a member of the University Examinations Committee, and the patroness of the three (03) student associations at the University of Kisubi.

Outside the university responsibilities, Dr. Lindrio Celestine served as the mistress for Junior Sisters of the Missionary Sisters of Mary Mother of the Church (MSMMC) 2017-2020, lecturer, Supervisor, and Mentor for Master Students of Mental Health Counseling Psychology of Uganda Martyrs University (UMU) 2019—2023. She also served as the a Board Member of Uganda Counselors Association (UCA) 2016—2017, she was the Assistant Country Coordinator for All Africa Conference Sister to Sister (AACSS) 2017-2019 and then served as the National Coordinator for All Africa Conference Sister to Sister (AACSS) 2019 –2024 and now a committee member for the Mission Sustainability for AACSS 2022 -to-date and a board member for Uganda Counsellors Sisters network and now a member of Network for Education Multidisciplinary Research Africa (NEMRA). As a young, growing academician, Dr. Lindrio Celestine has two publications from her PhD thesis**. She** is very enthusiastic to venture into research and publication amidst her busy schedule. She has two publications, looking toward publishing more. She has also graduated 10 master's students in research supervision from different facilities. She still has more to support in their academic career, research supervision, and mentorship.

Author's Biography

Dr. Lindrio Celestine is a Clinical Psychologist, a Religious Missionary Sister of Mary Mother of the Church, a lecturer in the faculty of Social Sciences and Psychology, and an administrator in the School of Graduate Studies and Research (SGSR), University of Kisubi. She holds a Certificate in Child Protection and Safeguarding from Makerere University. A Diploma in Counseling Psychology from Kisubi Brothers University College of Uganda Martyrs University, Nkonzi, Uganda. A Bachelor's Degree in Counseling Psychology from Kisubi Brothers University College of Uganda Martyrs University, Nkozi, Uganda. A Master of Arts in Counseling Psychology with Bishop Magambo Counselor Training Institute branch of Uganda Martyrs University, Nkonzi, Uganda, focusing *on "Alcohol abuse by parents and child neglect in Families" and* a PhD in Psychology (Clinical Psychology), *focusing on Alcohol Addiction Recovery Interventions and Perceived Sobriety in selected Hospital and Rehabilitation Centres.* Now desire and aspire to become a researcher and a publisher in the field of academia.

Philosophy of life

Each individual has the potential to make their personal choice and live a meaningful life if not interfered with, and everyone is responsible for his / her own decision in life.

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