Efficacy of Counselling Programmes on the Psychosocial Well-Being of Survivors of Child Sexual Abuse in Selected Child Rights Advocacy Centres in Nairobi, Kenya

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Abstract

Child Sexual Abuse (CSA) poses a significant threat to the psychosocial wellbeing of affected children and remains a major public health concern in Kenya. In response to the rising prevalence of child maltreatment, Child Rights Advocacy Centres (CRACs) have been established to offer counselling services tailored to the emotional and psychological needs of CSA survivors. The perpetrators of these heinous acts include family and community members. This study assessed the efficacy of existing counselling programs such as individual, group, family, and telephone counselling in enhancing the psychosocial wellbeing of CSA survivors in selected CRACs within Nairobi County. The objectives of the study were: to determine the efficacy of individual counselling on psychosocial wellbeing of survivors of CSA; to examine the efficacy of group counselling; to establish the efficacy of family counselling; and to determine the efficacy of telephone counselling on the psychosocial wellbeing of survivors of CSA. A descriptive survey research design was adopted. The population of study included survivors of CSA (6-18years old), parents/caregivers, and counselors/social workers. Purposive sampling was used to obtain a sample of 78 child survivors,78 parents or caregivers, and 16 professional counsellors. Data were analyzed using both descriptive and inferential statistics, with simple regression analysis used to test hypotheses at a 0.05 level of significance. Findings revealed statistically significant positive effect of individual counselling, group counselling, family counselling and telephone counselling on the psychosocial wellbeing of CSA survivors: individual counselling ($F(1,146) = 35.660$, $p = .001$), group counselling ($F(1,146) = 26.959$, $p = .001$), family counselling ($F(1,146) = 35.179$, $p = .001$) and telephone counselling ($F(1,146) = 44.494$, $p = .001$). These results led to the rejection of all null hypotheses, affirming the efficacy of counselling interventions across different programmes. It was therefore concluded that individual, group, family, and telephone counselling programmes met the psychosocial needs of CSA survivors. The study recommends enhancing therapist training with a specific focus on mitigating children's fears in counselling settings, increasing parental involvement in therapeutic processes, and building trust and safety in telephone counseling services. The findings are expected to inform practice among counsellors, social workers, caregivers, and policymakers in refining child-focused psychosocial interventions.

Keywords: Child rights advocacy centres, child sexual abuse, counselling programmes, survivors, psychosocial wellbeing

Introduction

Children are highly vulnerable to abuse due to their dependency on adults for physical and emotional well-being. When exposed to Child Sexual Abuse (CSA), they often lack the capacity to articulate their trauma, leading to severe psychological, physical, and social consequences. Article 39 of the UN Convention on the Rights of the Child (UNCRC) recognizes survivors' right

to recovery and restoration of dignity (UNICEF, 2019). Psychotherapy remains a key intervention in addressing the mental health needs of CSA survivors, warranting continuous evaluation for effectiveness (Bows, 2016).

The World Health Organization (2010) defines CSA as sexual activity involving a child who cannot comprehend or consent to it. Perpetrators often include adults or older children with authority over the victim (Mathews et al., 2019). In the United States, 5 percent to 8 percent of adult men and 15 to 20 percent of adult women report CSA in childhood (Hayward & Cheit, 2017). Child Advocacy Centres (CACs) provide forensic, legal, and psychological services that reduce trauma for survivors (Elmquist et al., 2015). Bolivia shows similar efforts through the A Breeze of Hope Foundation (ABH), though many cases remain unreported. For instance, only 30 percent of CSA cases reported in Guyana in 2017 received CAC interventions (Fontes, 2018).

Across Europe, CSA prevalence stands at 13.4 percent for girls and 5.7 percent for boys (WHO, 2018). In England, abuse begins as early as age 12, with girls at greater risk (Webb & Holmes, 2017). Poland has seen a surge in CSA cases involving children under 15, prompting responses like helplines promoted by the Catholic Church (Mandes, 2020). Notably, the Barnahus model in Sweden and Norway offers comprehensive, one-stop psychosocial and legal support for CSA survivors (Langballe & Davik, 2017; Markina et al., 2019).

In Asia, CSA affects between 2.2 and 94 percent of girls and 1.7 and 49.5 percent of boys (Solehati et al., 2021). In the Philippines, 25 percent of children have experienced CSA, with the country ranked among the top producers of child sexual content (UNICEF, 2018). India's response includes nationwide child helpline services in hospitals and clinics to encourage disclosure and access to psychosocial support (Sagar, 2014).

In Africa, CSA affects 30 to 40 percent of children before age 15 (UNICEF, 2018). Prevalence is particularly high in South Africa (36.8% boys, 33.9% girls) and Uganda (33.3% girls, 16.6% boys) (Artz et al., 2018; Badoe, 2017). One-stop centres like Thuthuzela (South Africa), GBV centres in Rwanda, and support centres in Papua Guinea offer integrated services including counselling and legal aid (UNICEF, 2018).

In Kenya, 32 percent of girls and 18 percent of boys report experiencing CSA (Sumner et al., 2016). At the Mombasa GVRC. between 2007 and 2018, 50 percent of the 6575 survivors of sexual violence were children (Temmerman et al., 2019). Teenage pregnancy in Kilifi County is also closely linked to CSA (Kombe, 2019). Interventions include GVRCs in Nairobi and Mombasa offering legal, medical, and psychological support. However, stigma and shame persist, leading to underreporting (Martin & Silverstone, 2013).

Malindi's Child Protection Centre (CPC) model offers a holistic, one-stop response to CSA, providing psychosocial support, legal aid, family counselling, and reunification services (Kombe, 2019; MOLSP Kenya & UNICEF, 2020). In Nairobi, 57.3 percent of sexual abuse cases recorded at Nairobi Women's Hospital between 2015 and 2017 involved children aged 3 to 18 (Juma et al., 2019). Childline Kenya, founded in 2006, offers telephone-based counselling and referrals to legal, medical, and rescue services (Childline Kenya, 2014), contributing significantly to national child protection.

Despite the commendable efforts in establishing CRACs, the efficacy of the existing counselling programmes within these centres is of dire concern. This study aims to investigate whether the current counselling programmes effectively address the psychosocial needs of child survivors of Sexual abuse, and if these programmes sufficiently equip survivors with the coping mechanisms and preventive skills. The gravity of the issue underscores the need for a comprehensive examination of the counselling programmes' impact on the holistic well-being and future resilience of child survivors, thereby informing potential improvements and strategies in combating this distressing societal menace.

Theoretical Framework

This study was guided by Bowen's Family Systems Theory (1966) and Herman's Stages of Recovery from Traumatic Experiences model (Herman, 1998). Both frameworks are crucial in explaining how symptoms affecting the psychosocial well-being of child survivors of sexual abuse (CSA) develop and how such symptoms are best addressed within relational contexts rather than in isolation. Bowen's Family Systems Theory emphasizes that family dynamics significantly influence individual behaviour, asserting that families operate as emotional units in which each member's actions impact the whole. The theory suggests that addressing the family as a unit can support individuals more effectively. Central to Bowen's framework is self-differentiation, which is the capacity to maintain one's identity while engaging in meaningful relationships. Poorly differentiated individuals often become emotionally fused with others, making them vulnerable to psychosocial distress. Emotional triangles form when two stressed family members involve a third party to reduce tension, showing how stress spreads within family relationships. Historical emotional patterns, sibling roles, and generational coping strategies are all central to understanding a child's psychological reaction to CSA.

The theory explains that children's coping mechanisms following CSA are significantly influenced by the family's emotional structure and strategies. Survivors' symptoms are intertwined with the nature of family interactions, especially when the abuse is perpetrated by a family member, leading to severe emotional disruptions, including family breakdowns or divorce (Assink, 2020). Parents' reactions to abuse disclosures also greatly influence a child's recovery process. McElvaney et al. (2020) and Mackay (2012) emphasize that a parent's emotional turmoil—anger, confusion, guilt—can exacerbate the child's psychological distress. Karakurt and Silver (2014) further note that the child's mental well-being hinges on receiving protection, support, and love from the family. When this support is absent, it can result in increased self-blame and mental illness. Conversely, a supportive family environment can foster better mental health outcomes. Haefner (2014) notes that moments of dysfunction offer opportunities to reconfigure emotional systems towards equilibrium. Thus, systems theory enables therapists and caregivers to identify dysfunctional relational patterns and restructure them to support the survivor's recovery and overall psychosocial well-being.

Herman's (1998) model of recovery delineates three stages that survivors of trauma undergo: establishing safety, remembrance and mourning, and reconnection. These stages acknowledge that trauma disintegrates the protective social structures necessary for human well-being, thereby emphasizing that healing must occur within secure relationships. The initial phase focuses on restoring a sense of safety and trust, which trauma has disrupted. According to Hillis et al. (2017), CSA survivors often experience low self-worth, shame, regret, anxiety, and even post-traumatic stress disorder. Herman asserts that before delving into the traumatic experiences, the survivor must first regain control over their physical and environmental surroundings, including food, sleep, health, and living arrangements. The creation of a safe and stable therapeutic setting allows for addressing core emotional and psychological injuries.

The second stage, remembrance and mourning, entails the survivor articulating and processing the traumatic event and the emotional responses from themselves and others. This narrative process helps in forming a new, shame-free interpretation of the traumatic past. Therapists are vital at this point, guiding survivors towards emotional coherence and re-establishing coping skills. Once the survivor has safely processed the trauma, they enter the third stage: reconnection. Here, the survivor begins to reclaim their sense of agency and form or restore healthy relationships. At this juncture, the survivor may seek justice or accountability from the abuser as part of self-empowerment. Reconnection also entails building a new identity, grounded in trust and autonomy. By promoting emotional restoration within relational contexts, Herman's model aligns well with Bowen's theory, reinforcing the notion that healing from CSA is a deeply interpersonal process grounded in secure, functional relationships.

Herman's model recognizes recovery from CSA as an ongoing, transformative process that promotes resilience and personal growth. However, the model overlooks children's developmental needs and dependence on family and community support. By contrast, family systems theory promotes healthy relationships within the family by addressing underlying family structures and emotional processes, supporting sustainable, long-term improvements rather than temporary fixes. However, the theory is limited to the family unit and overlooks broader societal, cultural, and economic contexts that shape family functioning.

Framework of Conceptualization

A conceptual framework illustrates the relationships among key variables in this study. According to Grant and Osanloo (2014), it provides a structured visualization of how the concepts interconnect. In this study, selected counselling programmes are considered the independent variables that influence the dependent variable, psychosocial well-being. These programmes aim to promote emotional resilience, positive mental health outcomes, and improved coping mechanisms among children who are survivors of child sexual abuse (CSA). However, extraneous variables such as the child's age, parental response, and access to medical and legal support may affect the effectiveness of these interventions.

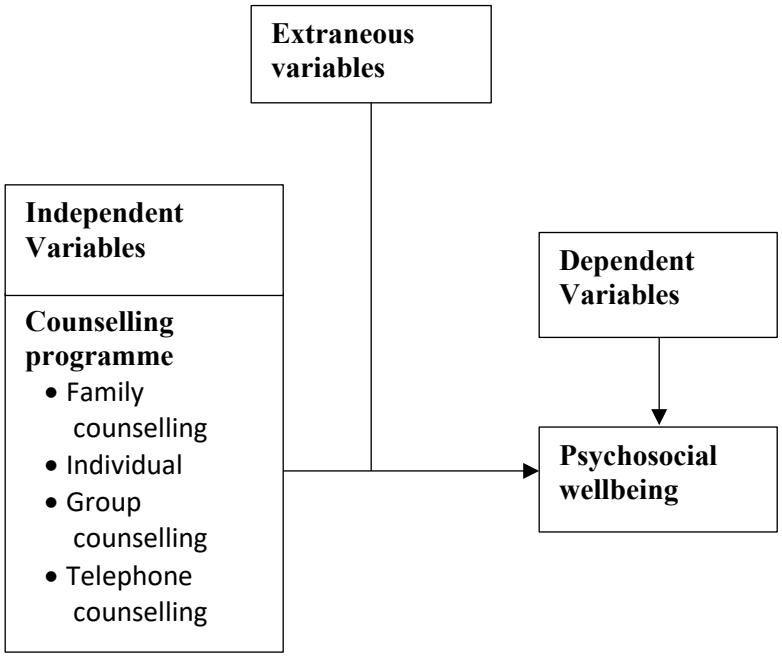


Fig 1: Conceptual Framework

In Figure 1, each counselling approach contributes uniquely to psychosocial wellbeing: individual counselling offers a safe, personalized environment; group counselling fosters shared support and social connection; family counselling enhances relational dynamics within the family; and telephone counselling provides accessible therapeutic communication, especially for those facing barriers to in-person sessions. Together, these methods support psychosocial recovery.

Methodology

This study employed a descriptive survey research design to investigate the effectiveness of counselling programmes on the psychosocial wellbeing of sexually abused children (CSA) within selected Child Rights Advocacy Centres (CRACs) in Nairobi County. Nairobi was purposively selected due to its high prevalence of CSA cases and the concentration of CRACs offering counselling interventions. The population of study comprised sexually abused children aged 6 to

18 years, their parents/caregivers, and counsellors/social workers involved in the counselling programmes. Purposive sampling was used to select the three CRACs providing relevant counselling services, and all eligible children who had completed counselling sessions prior to the study were included. Table 1 shows the sampling frame.

Table 1: Sample Frame

CRAC	County	Children	Parents	Counsellors
CRADLE	Nairobi	33	33	3
JM	Nairobi	25	25	5
CHILDLINE	Nairobi	20	20	8
Total		78	78	16

Data collection was conducted using structured questionnaires tailored for the different respondent groups: children, parents/caregivers, and counsellors. The questionnaires captured demographic data and measured key variables such as psychosocial wellbeing and counselling effectiveness through symptom severity scales. To ensure validity, the tools were aligned with established theoretical constructs and reviewed by experts. Reliability was confirmed via a pilot study using the test-retest method and Cronbach's Alpha coefficients, which ranged from 0.767 to 0.787, indicating high internal consistency for all counselling intervention programs.

The researcher obtained all necessary ethical approvals before data collection, ensuring confidentiality and voluntary participation. Data were analysed using SPSS version 26, employing both descriptive statistics (frequencies, means, standard deviations) and inferential statistics (simple regression analysis) to examine the relationship between counselling programs and psychosocial wellbeing. The hypotheses tested the significance of individual, group, family, and telephone counselling on the psychosocial outcomes of CSA survivors, providing a comprehensive framework to assess the efficacy of counselling programmes at the selected CRACs.

Findings

This study presents the empirical findings, derived from the investigation into the efficacy of various counselling interventions such as individual, group, family, and telephone counselling in enhancing the psychosocial wellbeing of child sexual abuse (CSA) survivors in selected child rights advocacy centres in Nairobi, Kenya.

The analysis integrates both descriptive and inferential statistical approaches to assess the relationship between each counselling modality and psychosocial outcomes. The findings are organized thematically in alignment with the study's specific objectives and hypotheses. They are interpreted within the context of existing literature on trauma-informed care, child protection, and psychological recovery, thus offering a nuanced understanding of how structured counselling programmes contribute to the holistic rehabilitation of CSA survivors. Each subsection presents detailed statistical results and corresponding interpretations to highlight the therapeutic impact of each intervention strategy.

Response Rate and Sample Size

The study's sample size consisted of 16 counsellors/social workers, 78 parents/caregivers, and 78 children who had experienced sexual abuse. All expected participants received questionnaires. The questionnaires were satisfactorily completed and returned by 69 (88%) of the parents/caregivers and 63 (81%) of the children who had experienced sexual abuse. 16 counsellors and social workers (100%) completed the questionnaire and sent it back. Table 2 shows the response rate. Mugenda (2019) states that a response rate of 50 percent or higher is sufficient for data analysis. The researcher began examining the gathered data based on this response rate.

Table 2: Response Rate

Target Group	Sampled No. of respondents	No. of Questionnaires Returned	Response Rate (%)
Sexually abused children	78	63	81
Parents/Caregivers	78	69	88
Counsellors/Social Workers	16	16	100
Total	**172**	**148**	**86**

Construct validity for the study was attained by ensuring that the measurement tools accurately reflect the theoretical concept of 'psychosocial wellbeing' and its relationship with the different counselling interventions. Content validity was ensured by developing or selecting instruments that comprehensively cover all relevant aspects of psychosocial wellbeing and the specific counselling interventions being studied.

Types of Counselling Received

The researcher asked the sexually abused children to specify the kinds of counselling that they were given. Figures 3 and 4 show the results.



Fig. 3: Types of Counselling Offered to Sexually Abused Children between the ages of 11 to 18 Years

As indicated in Figure 3, 17 percent of the sexually abused children received individual counselling, 54 percent received group counselling, 22 percent received family counselling while 7 percent received phone call counselling. This implies that the majority of the sexually abused children received group counselling in comparison to the other types of counselling. The researcher asked parents to indicate the types of counselling offered to their children aged 6 to 11 years. Figure 4 presents the findings.

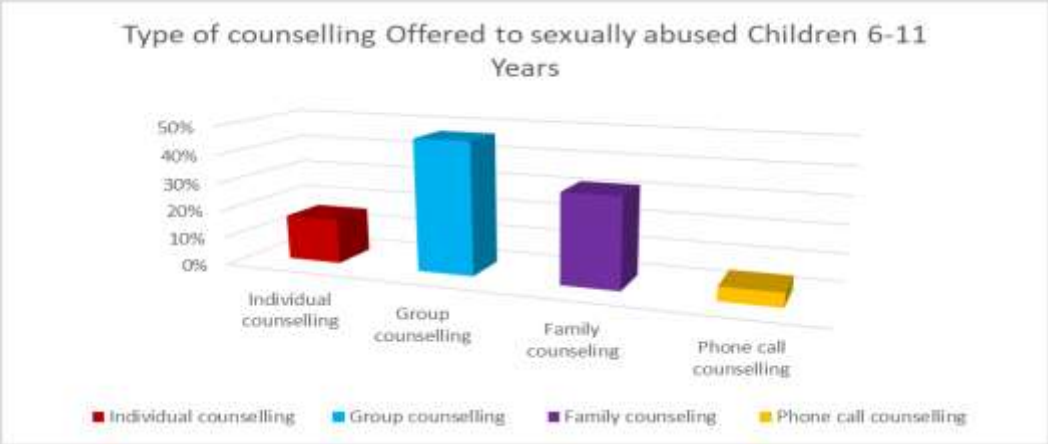


Fig 4: Type of Counselling Offered to Sexually Abused Children between the ages of 6 to 11 Years

Figure 4 indicates that 16 percent of the children aged 6 to 11 years received individual counselling, 47 percent indicated that their children received group counselling, 32 percent indicated that their children received family counselling while 5 percent indicated that their children received telephone counselling. This implies that the majority of the children received group counselling.

The next section presents a synthesized analysis of the study's findings on the efficacy of four distinct counselling modalities—individual, group, family, and telephone counselling—in enhancing the psychosocial wellbeing of survivors of child sexual abuse (CSA) in selected child rights advocacy centres within Nairobi, Kenya. The study employed descriptive and inferential statistical methods to rigorously evaluate the relationship between these therapeutic interventions and the psychological and emotional outcomes observed among child survivors.

Efficacy of Individual Counselling Programmes

The investigation into the impact of individual counselling sought to determine the extent to which this one-on-one therapeutic engagement contributed to the psychosocial rehabilitation of CSA survivors. Guided by the null hypothesis that posited no statistically significant effect of individual counselling on psychosocial wellbeing, the study employed Pearson correlation analysis and regression modelling to test the hypothesis empirically.

The results demonstrated a moderately strong and statistically significant positive correlation between individual counselling and psychosocial wellbeing ($r = .443$, $p < .001$), indicating that improvements in counselling delivery were associated with measurable enhancements in children's emotional and psychological states. Furthermore, the regression analysis revealed that individual counselling accounted for approximately 19.6 percent of the variance in psychosocial wellbeing outcomes among the study participants. This was supported by a statistically significant F-value ($F(1,146) = 35.660$, $p < .001$), confirming the model's robustness.

Based on these findings, the study concluded that individual counselling exerts a demonstrable and meaningful impact on the psychosocial wellbeing of CSA survivors. Surbakti and Harahap (2024) highlight the importance of sustained, professional and individualized therapeutic support, which offers survivors the safety, confidentiality, and emotional validation necessary for psychosocial healing.

Efficacy of Group Counselling Programmes

Contrary to the null hypothesis, empirical evidence revealed a statistically significant positive relationship between group counselling and psychosocial wellbeing. A Pearson correlation

coefficient of $r = .395$ ($p < .001$) indicated a moderate yet meaningful positive association, suggesting that children who participated in group counselling sessions generally experienced improved emotional, behavioural, and interpersonal functioning. The regression analysis further affirmed the strength of this relationship, showing that group counselling accounted for 15.6 percent of the variance in psychosocial wellbeing, with the model yielding a statistically significant F-statistic ($F(1,146) = 26.959$, $p < .001$). Based on these outcomes, the null hypothesis was decisively rejected at the 0.05 level of significance.

The findings highlight the therapeutic utility of group counselling as a space where survivors can find mutual understanding and validation through shared narratives. These findings align with the findings of Amin et al. (2018), where group counselling was shown to be one of the most popular therapies for children and adolescents who had experienced sexual abuse. Group treatment, according to Amin et al., goes above and beyond individual therapy for CSA survivors, leading to greater psychological health and empowerment. This is because children in the same age group can build trust and self-disclose more easily.

In the Kenyan socio-cultural context, where stigma, victim-blaming, and silence around CSA persist, group counselling also serves as a culturally sensitive avenue for deconstructing harmful narratives and building resilience. According to Mutiso and Musyoka (2021), collective healing spaces are particularly valuable in African settings because the communal nature of psychosocial support emphasizes relational rather than individualistic modes of recovery.

Despite its benefits, the findings also suggest that group counselling was somewhat less impactful than other modalities such as telephone or individual counselling, based on the proportion of explained variance. This discrepancy may be attributed to challenges related to group dynamics, including unequal participation, re-traumatization through vicarious experiences, or lack of confidentiality—factors that have been noted by Matafwali et al. (2020) as potential drawbacks in group therapy for trauma survivors. While group counselling demonstrated clear benefits, its relative effectiveness was modest compared to other formats, necessitating further emphasis on optimizing group composition, session facilitation, and trauma-informed practices. Enhancing facilitator training in group process management and incorporating regular participant feedback could significantly improve therapeutic outcomes.

The study therefore affirms that group counselling is a statistically and clinically effective modality for improving the psychosocial wellbeing of CSA survivors. It provides critical peer-based emotional support and fosters collective coping strategies. However, its full potential hinges on creating safe, inclusive, and structured environments that accommodate individual differences within collective healing. Yusop et al. (2020) reiterate that what makes group counselling effective is the fact that the members are able to transfer learned behaviours to real life.

Efficacy of Family Counselling Programmes

Empirical findings from the study indicated a significant positive correlation between family counselling and psychosocial wellbeing, with a Pearson correlation coefficient of $r = .441$, statistically significant at $p < .001$. Regression analysis further revealed that family counselling accounted for 19.4 percent of the observed variance in psychosocial wellbeing outcomes. The F-statistic ($F(1,146) = 35.179$, $p < .001$) underscored the strength and reliability of this relationship. These results led to the rejection of the null hypothesis at the 0.05 level of significance, affirming that family counselling exerts a meaningful and statistically significant positive effect on the psychosocial wellbeing of CSA survivors.

According to Karakurt and Silver (2014), non-offending caregivers' involvement in treatment programmes may reduce their negative emotional response to CSA and, in turn, have a positive impact on the abused children's wellbeing. Furthermore, family counselling is particularly effective when it addresses not only the survivor’s individual trauma but also the relational disruptions that typically accompany CSA cases. Peratsakis (2017) observed that CSA disrupts

family functioning; hence, during the counselling period, such conflict and other obstacles that may impede family cooperation must be remedied. Therefore, therapeutic approaches that involve the family unit can help rebuild communication pathways, resolve interpersonal conflicts, and empower parents or caregivers with skills to support the child's long-term recovery.

In the Kenyan context, where extended family systems and cultural norms heavily influence child-rearing practices, the integration of family counselling into CSA recovery frameworks is especially pertinent. Research by Aloka and Nyang'ara (2017) demonstrates that active parental involvement in therapeutic interventions is a strong predictor of successful psychosocial outcomes among children facing trauma. Varghese (2020) suggests that family counselling serves not only as a therapeutic modality but also as a conduit for broader community healing and awareness, particularly in societies where sexual abuse remains a taboo subject and survivors face significant stigma.

Despite its efficacy, the implementation of family counselling is not without challenges. Issues such as inconsistent parental attendance, emotional detachment, and intergenerational trauma may limit the depth of therapeutic engagement. Therefore, such programs should include psychoeducation components, trust-building activities, and ongoing follow-up mechanisms to reinforce gains made during formal sessions.

Efficacy of Telephone Counselling Programmes

Quantitative analysis revealed that telephone counselling had the strongest positive correlation with psychosocial wellbeing among all the modalities evaluated, with a Pearson correlation coefficient of $r = .484$, which was statistically significant at $p < .001$. Furthermore, the regression analysis indicated that telephone counselling accounted for 23.4 percent of the variance in psychosocial wellbeing scores. The F-statistic for this model ($F(1,146) = 44.494$, $p < .001$) confirmed the robustness of this relationship. Consequently, the null hypothesis was rejected at the 0.05 significance level, affirming the significant positive effect of telephone counselling on the psychosocial wellbeing of CSA survivors.

These findings resonate with broader research that positions remote counselling as a viable and impactful therapeutic modality, particularly in contexts where physical access to professional support is constrained. For instance, studies by Brockes et al. (2017) and Gibson et al. (2021) underscore the growing evidence that teletherapy, including telephone-based interventions, can yield comparable outcomes to traditional in-person counselling, especially when conducted by trained professionals using structured therapeutic protocols. The anonymity and accessibility afforded by telephone counselling may also enhance its acceptability among survivors of sexual trauma, who often struggle with shame, stigma, or fear of disclosure in face-to-face settings (McGee et al., 2011).

Moreover, telephone counselling provides a flexible, low-cost intervention that bridges service gaps in resource-constrained or emergency contexts, such as during pandemics, conflict, or natural disasters—conditions that often exacerbate the vulnerabilities of CSA survivors (Lustgarten & Colbow, 2017). Within the Kenyan context, where logistical, economic, and socio-cultural barriers frequently impede access to psychosocial care, telephone counselling represents an especially pragmatic and inclusive approach. Its utility is further underscored by its potential to support survivors in rural or underserved areas who might otherwise remain without consistent mental health support.

Conclusions and Recommendations

The study concludes that individual counselling is central to the recovery and psychological growth of CSA survivors. Its personalised approach enables children to express emotions, process traumatic experiences and rebuild their self-concept. Group counselling also contributes significantly to healing by providing opportunities for shared experiences, peer support and

structured therapeutic activities. This collective environment helps normalise trauma, reduce isolation and strengthen social connectedness. However, fear and discomfort in some therapeutic relationships indicate gaps in trust and therapeutic rapport. Effective counselling therefore requires consistent, child-sensitive and trauma-informed approaches that strengthen the therapeutic alliance and promote emotional safety.

Further, family counselling is particularly beneficial when caregivers are actively involved. Meaningful caregiver participation strengthens communication, emotional bonds and stability within the home, thereby reinforcing therapeutic gains and reducing the risk of re-traumatisation. However, inconsistent participation, emotional unavailability, and denial or minimisation of abuse can undermine these outcomes. Sustaining these benefits requires caregiver engagement through psychoeducation, motivational interviewing and long-term family support.

Telephone counselling also has considerable potential to improve the psychosocial wellbeing of CSA survivors. Its accessibility, flexibility, convenience, and relative anonymity can facilitate disclosure and emotional expression, particularly where logistical, economic, or safety barriers limit face-to-face services. Nevertheless, the absence of face-to-face interaction can constrain rapport-building and the assessment of non-verbal cues. Effective telephone counselling therefore requires specialised training in remote therapeutic presence, active listening and emotional containment, supported by protocols that address trust and emotional distance.

The study recommends continuous professional development for therapists, with emphasis on trauma-informed care and child-centred communication. Improvements in counselling environments and the introduction of real-time feedback systems would enhance the monitoring of therapeutic rapport and effectiveness. Group cohesion can be strengthened through trust-building activities and peer-support models. Regular assessments are necessary to ensure emotional safety and sustained engagement among group members. Group content also needs to reflect individual needs within collective therapeutic settings.

Parental involvement requires greater attention through structured engagement programmes and family education workshops. Follow-up services would help monitor familial progress and address intergenerational trauma dynamics. Remote counselling would benefit from standardised therapeutic protocols that promote emotional safety and therapeutic rapport. Therapists need appropriate training in active listening and crisis intervention for telephone-based counselling. Supplementary services, including digital resource packages, referrals and follow-up support, can further strengthen remote therapeutic interventions.

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