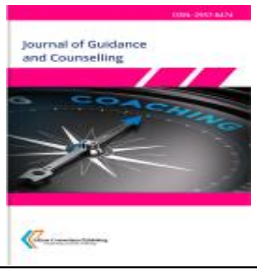

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Efficacy of Family Counselling on the Psychosocial Wellbeing of Child Sexual Abuse Survivors in Selected Child Rights Advocacy Centres in Nairobi, Kenya

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Abstract

This article aims to determine the efficacy of family counselling intervention on the psychosocial wellbeing of survivors of child sexual abuse (CSA) in selected Child Rights Advocacy Centres (CRACs) in Nairobi, Kenya. Although CRACs provide psychosocial support services through counselling to survivors of CSA, empirical evidence regarding the efficacy of family counselling in enhancing survivors' psychosocial wellbeing remains limited. A descriptive survey research design was employed, and purposive sampling was used to select 172 respondents comprising 78 survivors of CSA, 78 parents or caregivers, and 16 counsellors. Data were collected using validated, researcher-developed questionnaires, with internal consistency established via Cronbach's Alpha of 0.767. Simple linear regression analysis revealed that family counselling had a statistically significant positive effect on the psychosocial wellbeing of CSA survivors ($F(1,146) = 35.179$, $p < .001$), accounting for a meaningful proportion of the variance in recovery outcomes ($\beta=0.440$ $p < .001$. Overall, participants reported positive experiences with family counselling, indicating that the intervention effectively addressed the psychosocial needs of survivors. The study concludes that family counselling is an effective intervention for enhancing the psychosocial wellbeing of survivors of child sexual abuse. It is recommended that Child Rights Advocacy Centres strengthen parental engagement and participation in family-based counselling interventions to enhance recovery and psychosocial wellbeing among survivors. This study shifts the focus toward primary service users by providing empirical evidence that family counselling directly improves the psychosocial wellbeing of child sexual abuse (CSA) survivors.

Key terms: Child rights advocacy centres, child sexual abuse, family counselling, psychosocial wellbeing, survivors of child sexual abuse.

1.0 INTRODUCTION

CSA disclosure creates severe disruption across the entire family system, often triggering parental guilt, marital conflict, or secondary traumatic stress (Fong et al., 2020). Despite the widespread implementation of counselling interventions for child sexual abuse (CSA) survivors in Nairobi, child protection practice remains heavily reliant on general supportive protocols rather than empirical, modality-specific outcomes. When non-offending caregivers are not systematically integrated into the therapeutic process through family counselling, the survivor returns to a home environment that may lack the emotional stability and protective capacity needed to sustain long-term recovery (Melville et al., 2010). Although theoretical models such as Bowen's Family Systems Theory emphasise that a child's recovery is deeply interconnected with family dynamics, systemic anxiety, and caregiver support, family-based interventions are often underutilised or implemented without rigorous evaluation of their specific impact. Consequently, there is an urgent need to systematically assess the efficacy of family counselling compared to individual, group, and telephone modalities to determine how best to optimise psychosocial recovery frameworks for CSA survivors.

Children are a vulnerable population due to their exclusive dependency on parents/caregivers for their physical and emotional survival as well as for their protection. Sexual abuse renders children helpless since they have little ability to effectively communicate what they feel and need. The experience of child sexual abuse (CSA) is associated with severe physical, psychological and social harm to the survivors and their families (Sathyamurthi & Nanditha, 2023). Cognizant of this, Article 39 of the UN Convention on the Rights of the Child (UNCRC) states that children have a right to get help if they have been hurt so that they can regain their health and dignity (UNICEF, 2019).

In Kenya, a National Survey on Violence against children found that 32 per cent of girls and 18 per cent of boys were victims of CSA (Bridgewater, 2016; Sumner et al., 2016). Kenya has responded to the issue of CSA by establishing CRACs among other interventions. The CRACs are a multi-agency response to child abuse and Children's Advocacy Centre models whose aim is to provide holistic, child-friendly interventions. However, evaluation of these services tends to rely on procedural metrics such as conviction rates, overlooking the experiences of primary service users. In Kenya, little research has been done to establish the efficacy of counselling programs provided by these CRACs to mitigate the effects of CSA among child survivors.

The consequences of CSA are not only for the child survivor, as their families and communities are equally affected (UNICEF, 2014). Parenting factors such as child neglect, lack of secure attachment, poor monitoring of the child and role modelling also increase their vulnerability to CSA (Signal et al., 2013). Various interventions are available in Kenya as an attempt to mitigate the effects of CSA. Among these, the child protection centre (CPC) model in Malindi County offers one-stop coordinated services whose provisions include individual assessment of children, child and family counselling, psychosocial support, legal interventions and reunification of separated children (Kombe, 2019).

Family counselling is an intervention that views the child as part of a broader family system, recognising that the psychological recovery of CSA survivors is heavily influenced by familial dynamics, relationships, and support structures (Gow, 2004). Research demonstrates that the inclusion of non-offending caregivers in counselling significantly enhances the psychosocial wellbeing of survivors by reducing anxiety,

depression, and post-traumatic stress while promoting adaptive coping strategies (Melville, 2010). Studies indicate that family counselling significantly enhances the psychosocial outcomes of CSA survivors by strengthening family cohesion and parenting practices; Nwogu et al. (2015) found that children whose caregivers participated actively in counselling programs showed greater reductions in internalising and externalising symptoms than children whose caregivers were minimally involved. In Nairobi, where families may face additional stressors such as poverty, overcrowding, or exposure to violence, systemic interventions that incorporate family therapy are particularly relevant for reducing cumulative risk factors that exacerbate psychosocial vulnerabilities. Nonetheless, as much as family-focused interventions may improve psychosocial outcomes, barriers such as stigma, lack of parental engagement, and socio-economic constraints can hinder participation (Crane, 2019).

Despite the proliferation of counselling services within CRACs, there is limited empirical evidence demonstrating the extent to which these counselling programmes effectively enhance the psychosocial wellbeing of child survivors of sexual abuse. While family counselling interventions are routinely implemented, their relative and overall efficacy in addressing the psychosocial needs of survivors remains insufficiently documented. This study therefore sought to establish whether family counselling intervention has any significant efficacy on the psychosocial wellbeing of survivors of CSA.

2.0 LITERATURE REVIEW

Family counselling is an intervention that views the child as part of a broader family system, recognising that the psychological recovery of CSA survivors is heavily influenced by familial dynamics, relationships, and support structures (Gow, 2004). Family therapy emphasises that parents and caregivers are not only vital for monitoring and protecting children but also for fostering emotional resilience. Research demonstrates that the inclusion of non-offending caregivers in counselling significantly enhances the psychosocial wellbeing of survivors by reducing anxiety, depression, and post-traumatic stress while promoting adaptive coping strategies (Melville, 2010). By engaging families, therapy can address systemic patterns, improve communication, and mitigate conflict, which are often exacerbated by the disclosure of abuse (Fong et al., 2017).

CSA disclosure often destabilises family systems, particularly in cases of intrafamilial abuse, where marital conflict, divorce, or social isolation may ensue. Peratsakis (2017), in "Family Dynamics and Child Sexual Abuse Recovery", argues that unresolved family conflicts during therapy can impede the child's recovery and that family counselling sessions must simultaneously support the non-offending caregivers. By creating a structured environment for dialogue, therapy allows parents to process their emotions, including guilt, anger, and fear, while developing strategies to support their child. In Nairobi, where extended family systems are common, the involvement of guardians, aunts, uncles, or grandparents may be crucial in reinforcing protective behaviours and maintaining therapy continuity.

Studies indicate that family counselling significantly enhances the psychosocial outcomes of CSA survivors by strengthening family cohesion and parenting practices. Nwogu et al. (2015) found that children whose caregivers participated actively in counselling programs showed greater reductions in internalising and externalising symptoms than children whose caregivers were minimally involved. Similarly, Murray et al. (2014) observed that supportive parental involvement correlates strongly with improved self-esteem, social competence, and emotional regulation in survivors. These findings highlight that the family's response is a key determinant of the child's long-term recovery. The evidence base for family counselling also

underscores its ability to mitigate intergenerational transmission of trauma. Bowen's family systems theory (1978) posits that emotional patterns, anxiety, and maladaptive coping mechanisms can pass from parents to children. In the context of CSA, addressing parental anxiety and emotional dysregulation during therapy can prevent these patterns from being internalised by the child.

In Nairobi, where families may face additional stressors such as poverty, overcrowding, or exposure to violence, systemic interventions that incorporate family therapy are particularly relevant for reducing cumulative risk factors that exacerbate psychosocial vulnerabilities. Empirical studies demonstrate measurable outcomes of family therapy on psychological symptoms. Hubel et al. (2014) reported that children participating in programs with parental involvement exhibited significant decreases in depression, anxiety, loneliness, and post-traumatic stress symptoms. Importantly, improvements were sustained over a six-month follow-up period, highlighting the durability of family-based interventions. Such findings suggest that adapting similar approaches within Kenyan CACs could enhance therapeutic outcomes, particularly if sessions are designed to accommodate local cultural practices. Family counselling also addresses the secondary trauma experienced by caregivers. Fong et al. (2017) observed that parents often experience depression, anger, guilt, and social isolation following disclosure.

By incorporating caregivers into therapy, interventions can provide emotional support to these adults, enhance coping strategies, and foster consistent caregiving. In Nairobi's informal settlements, where caregiver mental health resources are limited, integrating caregiver support within family counselling is vital to ensure the survivor's wellbeing is reinforced at home. Furthermore, culturally adapted family therapy improves engagement and retention. Karakurt and Silver (2014) demonstrated that family involvement in therapy improves trust, communication, and behavioural monitoring within the household, reducing the likelihood of secondary victimisation. In the Kenyan context, incorporating culturally appropriate approaches, such as acknowledging extended family structures, communal decision-making, and traditional caregiving roles, can enhance the acceptability and effectiveness of counselling interventions. Research in Kenya demonstrates the potential and challenges of family counselling for CSA survivors. Crane (2019) observed that family-focused interventions may improve psychosocial outcomes, yet barriers such as stigma, lack of parental engagement, and socio-economic constraints can hinder participation.

Programs that address these barriers by providing flexible scheduling, caregiver education, and community sensitisation are more likely to succeed. Overall, family counselling emerges as a critical intervention that not only addresses the psychological sequelae of abuse but also strengthens the family unit to support long-term resilience. The literature presents both converging and diverging findings on the effectiveness of family counselling. While Hubel et al. (2014) and Fong et al. (2017) emphasise measurable reductions in PTSD and depressive symptoms, other studies such as Nwogu et al. (2015) caution that family engagement alone is insufficient if socio-economic and cultural barriers are unaddressed. In Kenya, poverty, stigma, and patriarchal family structures can limit caregiver participation, meaning that interventions proven effective in Western contexts may require adaptation to local realities. The synthesis suggests that the efficacy of family counselling is contingent on the integration of culturally sensitive approaches, caregiver mental health support, and community-level awareness.

Furthermore, studies converge on the point that family counselling is most effective when combined with other modalities, such as individual and group therapy. The intersection of these interventions creates a

holistic support system that addresses the survivor's psychological needs across multiple contexts. For example, children participating in both family and individual counselling demonstrate better emotional regulation and reduced behavioural problems than those in single-modality interventions (Melville, 2010). This supports the argument for multi-modal treatment programs in Kenyan CACs.

Finally, in Nairobi, family counselling must contend with urban-specific challenges. High population density, limited access to trained mental health professionals, and diverse cultural beliefs about CSA complicate therapy implementation. Adapting Western-based family therapy models, such as SAFE (Hubel et al., 2014), to Nairobi requires integrating local cultural norms, extended family involvement, and practical measures to enhance engagement. These considerations underscore the necessity of critically contextualising evidence to ensure that family counselling not only replicates observed successes but is responsive to the unique psychosocial and structural realities of Kenyan CSA survivors.

3.0 METHODOLOGY

This study utilised a descriptive survey research design. This research design was preferred because, rather than merely observing outward behaviour, a descriptive survey design is uniquely suited for systematically gathering detailed qualitative and quantitative data on human perceptions, attitudes and subjective experiences (Mugenda & Mugenda, 1999; Creswell & Creswell, 2018). This research design was chosen because investigating the perceived efficacy of family counselling requires directly capturing the multi-dimensional perspectives of survivors, caregivers, and service providers. Through this design, the researcher could systematically evaluate and articulate participants' experiences regarding counselling outcomes and the impact on psychosocial wellbeing of CSA survivors within the operational context of Child Rights Advocacy Centres (CRACs). The research was conducted across selected CRACs in Nairobi County, which were purposively selected due to their high reported prevalence of CSA and their high concentration of operational advocacy centres. The specific CRACs were purposively selected because they possessed the key structural and programmatic characteristics central to the study's focus, providing an ideal setting to examine how family counselling interventions are experienced and valued in practice (Juma et al., 2019; The National Council for Children's Services, 2015).

The study's target population included CSA survivors aged 6–18 years, parents or caregivers of survivors aged 6–18 years, and counsellors/social workers as key informants. Given the small accessible population size, a census approach was adopted, selecting all 172 individuals who completed family counselling sessions at the designated CRACs. The resulting sample comprised 78 children, 78 parents/caregivers, and 16 practitioners. Purposive sampling was used to obtain children and caregivers who had completed family counselling sessions and counsellors working with the children. Data were collected using three researcher-developed questionnaires completed by children, parents/caregivers, and counsellors. Construct and content validity of the instruments was enhanced through operationalisation of constructs in line with theory and literature, comprehensive coverage of study dimensions, and expert opinion from supervisors and the School of Education, while reliability was established through a pilot study in Nakuru County, obtaining a reliability coefficient of 0.767 using Cronbach's Alpha.

Data collection followed ethical approval from LU-ISERC, research authorisation from NACOSTI, and permission from the Children Department and selected CRACs. Data were coded and analysed using SPSS version 26 through descriptive statistics and simple regression analysis. The hypothesis, *There is no statistically significant efficacy of family counselling on psychosocial wellbeing of sexually abused children*

in child advocacy centres in Nairobi, Kenya, was tested using simple regression analysis, with family counselling as the independent variable and psychosocial wellbeing as the dependent variable. Ethical considerations included informed consent, confidentiality, voluntary participation, impartiality, independence, and referral for counselling where necessary.

4.0 FINDINGS AND DISCUSSION

This section presents complementary evidence supporting the efficacy of family counselling.

The hypothesis held the assumption that family counselling offered to survivors of CSA in selected child rights advocacy centres in Nairobi, Kenya, has no significant effect on the psychosocial well-being of survivors. The truth regarding the statement was ascertained through simple regression analysis. The results of these effects are discussed in Table 1, which shows a correlation between family counselling and the psychosocial well-being of survivors of child sexual abuse.

Model Summary

Table 1: Pearson's Correlation Coefficient between Family Counseling and Psychosocial Wellbeing of Survivors

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F Change	df1	df2	Sig. F Change
1	.441[a]	.194	.180	.3376	35.179	1	146	p < .001[b]

a**.** Predictors: (Constant), Family Counselling
b**.** Dependent Variable: Psychosocial Well-being (adjust if different)
Source: Research Data (2024)

The results shown in Table 1 revealed that the relationship between Family counselling and psychosocial well-being is a moderate, statistically significant positive linear relationship (r=.441, p < .001). The R-squared value was 0.194, indicating that family counselling intervention explains 19.4 per cent of the variation in psychosocial well-being of survivors of child sexual abuse. That reveals that 80.6 per cent of the variance in psychosocial well-being could not be explained by Family counselling alone. The findings match with Fong et al. (2017), who concluded that family counselling helps improve communication within the family, allowing members to express their feelings and concerns in a safe environment. The process can help rebuild trust between the survivor and other family members, which is often eroded by the abuse. The results of simple regression analysis are shown in Table 2.

Table 2: Regression Analysis of Family Counselling on Psychosocial Wellbeing of Survivors

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	8.654	1	8.654	35.179	p < .001[b]
	Residual	35.954	146	.246		
	Total	44.608	147			

a. Predictors: (Constant), Family Counseling
b. Dependent Variable: Psychosocial Wellbeing of Survivors of Child Sexual Abuse

From Table 2, the simple regression analysis of family counselling on Psychosocial wellbeing was found to be statistically significant F (1,146) =35.179, P< .001). The results therefore led to the rejection of the null hypothesis (H03), which stated that family counselling has no statistically significant effect on the psychosocial wellbeing of survivors of CSA in selected child rights advocacy centres in Nairobi, Kenya and concluded that family counselling enhances psychosocial wellbeing of survivors of CSA in selected child rights advocacy centres in Nairobi, Kenya. These findings align with existing scholarship on the critical role of family dynamics in the recovery process of children who have experienced sexual trauma. According to Deblinger, Mannarino, and Cohen (2006), the family environment can either facilitate or hinder psychological healing, depending on the level of emotional support, stability, and communication within the household.

Both the Pearson correlation (r=.441, p < .001) and ANOVA test (F = 35.179, p < .001) confirm that family counselling has a statistically significant positive effect on a survivor's psychosocial recovery. The empirical agreement confirms that when non-offending caregivers are engaged in therapy, the family transitions from a potential source of secondary trauma or anxiety into an active protective barrier, thereby improving the survivor's psychosocial wellbeing (karakurt &silver, 2014). However, whilePearson correlation (r=.441, p < .001)represents a moderately strong association between variables, R-squared0.194reveals that 80.6 per cent of the variance in a survivor's psychosocial wellbeing is explained by external factors other than by family counselling alone. CRACs must therefore combine family therapy with other modalities when working with survivors of CSA.

All the same, when counselling programs successfully engage caregivers and provide structured support, they can enhance the child's sense of safety, attachment, and emotional regulation core components of psychosocial 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. As highlighted by Wekerle and Wolfe (2003), CSA often destabilises familial relationships, erodes trust, and induces guilt or denial among caregivers. 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. This

suggests that family counselling may serve 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. The findings also agree with Peratsakis (2017), who concluded that family counselling helps create a supportive network by involving family members in the healing process. It encourages the family to understand the survivor's experiences and needs, fostering a supportive environment that can significantly aid the survivor's recovery. When family members are educated about the effects of trauma and the importance of support, they can provide more effective emotional and practical support.

By working together in a therapeutic setting, family members can repair and enhance their relationships, which supports the survivor's emotional healing. Furthermore, the findings agree with Gow (2004 who argues that engaging in family counselling can promote healing and resilience within the family unit. By working together to address the effects of the abuse, family members can develop a stronger, more resilient family bond. This collective healing process helps create a nurturing environment that supports the survivor's recovery and fosters overall family well-being. 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. It is therefore imperative that such programs include psychoeducation components, trust-building activities, and ongoing follow-up mechanisms to reinforce the gains made during formal sessions.

In summary, the study establishes that family counselling is a robust and statistically significant contributor to the psychosocial wellbeing of CSA survivors. It enhances emotional security, promotes healing within the family system, and equips caregivers with the tools necessary to provide continued support. These findings underscore the necessity of integrating family-based interventions within holistic counselling frameworks for child survivors of sexual abuse in Kenya and similar socio-cultural contexts.

Caregivers' Perspective on Efficacy of Family Therapy

The study sought to assess the efficacy of family therapy on the psychosocial wellbeing of survivors of CSA. The statement in Table 3 describes the counselling experience of children on a scale of 1=Never, 2=Sometimes, 3=Often, 4=almost always, 5=always.

Table 3: Parents/Care Givers Perspective on Efficacy of Family Therapy

Statement	5 (%)	4 (%)	3 (%)	2 (%)	1 (%)
Mother and child had shared sessions	35	45	3	10	7
Father and child had shared sessions	29	41	12	10	8
My child and her/his siblings had shared sessions	39	43	2	9	7
My child felt understood, accepted and respected	34	46	2	18	0
My child felt confident in the therapist's ability to help	54	30	6	10	0
My child was afraid of parents	32	58	4	6	0
The counselling room was friendly	33	57	2	8	0
My child was able to talk about my issues and got help	26	47	17	10	0
The counselling program made my child feel good about himself/herself	37	45	13	5	0
My child was happy to see his parents in the counselling room	55	42	3	0	0
My child was given adequate time to talk about his/her problem	57	37	6	0	0
My child would love to use this service again in future	54	30	6	10	0

As indicated in Table 3, 35 per cent of the participants indicated that they always had shared sessions with their mother, while 45 per cent stated almost always. Additionally, 3 per cent reported often having shared sessions, with 10 per cent sometimes and 7 per cent never having shared sessions with their mother. This suggests a varied experience regarding involvement of mothers in the therapy sessions, with room for improvement in ensuring consistent participation. Examining the percentages, 29 per cent of the participants mentioned that they always had shared sessions with their father, while 41 per cent stated almost always. Additionally, 12 per cent reported often having shared sessions, with 10 per cent sometimes and 8 per cent never having shared sessions with their father. This indicates a similar trend as with mothers, highlighting potential challenges in engaging fathers consistently in the therapy process. Considering the data, 39 per cent of the participants reported always having shared sessions with their siblings, while 43 per cent stated almost always. Additionally, 2 per cent reported often having shared sessions, with 9 per cent sometimes and 7 per cent never having shared sessions with their siblings. This suggests a relatively positive trend in involving siblings in the therapy process, with a majority of participants having shared sessions with their siblings.

From the caregiver's perspective, 34 per cent of the participants indicated that they always felt understood, accepted, and respected, while 46 per cent stated almost always. Additionally, 2 per cent reported often feeling understood, accepted, and respected, with 18 per cent sometimes and none never feeling this way. This suggests a generally positive therapeutic environment where participants feel validated and respected by the therapist. The study findings are in line with the findings of Crane (2014), who revealed that family involvement significantly contributed to the success of therapy interventions, particularly in promoting long-term recovery and emotional well-being. Families provided crucial support networks and served as primary sources of encouragement and motivation for individuals undergoing therapy. Moreover, family participation in therapy sessions helped to address cultural and contextual factors influencing mental health outcomes, enhancing the relevance and effectiveness of therapeutic interventions.

As indicated in Table 3, 54 per cent of the participants mentioned that they always felt confident in the therapist's ability to help, while 30 per cent stated almost always. Additionally, 6 per cent reported often

feeling confident, with 10 per cent sometimes and none never feeling confident in the therapist's ability to help. This indicates a high level of trust and confidence in the therapist among the majority of participants. Considering the percentages, 32 per cent of the participants reported always being afraid of their parents, while 58 per cent stated almost always. Additionally, 4 per cent reported often being afraid, with 6 per cent sometimes and none never being afraid of their parents. This suggests a prevalent sense of fear among a considerable portion of participants in relation to their parents, highlighting potential familial challenges that may need addressing in therapy. Examining the data, 33 per cent of the participants mentioned that the counselling room was always friendly, while 57 per cent stated almost always. Additionally, 2 per cent reported often finding the counselling room friendly, with 8 per cent sometimes and none never finding the counselling room friendly. This suggests a generally welcoming and supportive environment within the counselling room, contributing to participants' comfort and engagement in therapy.

The findings also reveal that 26 per cent of the participants indicated that they always were able to talk about their issues and got help, while 47 per cent stated almost always. Additionally, 17 per cent reported often being able to talk about their issues and get help, with 10per cent sometimes and none never being able to talk about their issues and get help. This indicates a mixed experience regarding the effectiveness of communication and support in addressing participants' concerns. The study findings are in tandem with those of Pearson and Wilson (2012), who indicated a generally positive perception of the counselling room's atmosphere, with a majority of participants finding it welcoming and supportive. Participants emphasised the importance of feeling comfortable and respected within the counselling space, highlighting the role of the physical environment and therapist demeanour in promoting trust and openness during therapy sessions.

In terms of feelings about themselves, 37per cent of the participants reported always feeling good about themselves as a result of the counselling program, while 45per cent stated almost always. Additionally, 13per cent reported often feeling good about themselves, with 5per cent sometimes and none never feeling good about themselves. This suggests a generally positive impact of the counselling program on participants' self-esteem and self-perception. Looking at the percentages, 55per cent of the participants indicated that they always were happy to see their parents in the counselling room, while 42per cent stated almost always. Additionally, 3per cent reported often being happy to see their parents in the counselling room, with none sometimes and none never being happy to see their parents in the counselling room. This indicates a positive attitude towards parental involvement in therapy among the majority of participants. Considering the data, 57per cent of the participants mentioned that they always were given adequate time to talk about their problem, while 37per cent stated almost always.

Notably, none of the respondents reported often having adequate time, with none sometimes and none never having adequate time to talk about their problem. This suggests a generally satisfactory level of attention to participants' concerns and experiences during therapy sessions. The findings align with those of Malero et al. (2021), who, while examining the effectiveness of group counselling interventions in improving participants' self-esteem and well-being, suggested that participants who were engaged in group counselling reported positive changes in their self-perception and emotional well-being. Group counselling sessions provided opportunities for participants to explore their feelings, receive support from peers, and develop coping strategies, ultimately leading to improvements in self-esteem and confidence. These findings suggest that counselling programs can have a positive impact on participants' self-esteem and self-perception in African contexts.

Similarly, 54per cent of the participants indicated that they would always love to use this service again in the future, while 30per cent stated almost always. Additionally, 6per cent reported often wanting to use this service again, with 10per cent sometimes and none never wanting to use this service again in the future. This indicates a positive inclination towards utilising family therapy services again among the majority of participants, reflecting satisfaction with the experience. The study findings are in tandem with the findings of Karakurt and Silver (2014), who revealed that individuals who perceived mental health services as culturally relevant, accessible, and respectful of their values and beliefs were more likely to express intentions to utilise these services again in the future. Conversely, individuals who perceived mental health services as stigmatising or culturally insensitive were less inclined to seek help again, even if they had positive experiences during their initial engagement with services. These findings underscore the importance of culturally sensitive approaches to mental health service delivery in promoting service utilisation and satisfaction among individuals.

Counsellors' Perspective on Efficacy of Family Therapy

The study sought to assess the efficacy of family therapy on the psychosocial well-being of survivors of CSA. The statement in Table 4 describes the counselling experience of children on a scale of 1=Never, 2=Sometimes, 3=Often, 4=Almost always, 5=Always.

Table 4: Counselors Perspective on Efficacy of Family Therapy

Statement	5 (%)	4 (%)	3 (%)	2 (%)	1 (%)
Children enjoyed sessions with their mothers alone	68	23	2	4	3
Children enjoyed sessions with their fathers alone	69	21	0	5	5
Children enjoyed joint sessions with both parents/caregivers	40	55	0	2	3
Children resisted sessions with parents/caregivers	49	33	12	3	3
Siblings participated in counselling sessions	55	40	0	5	0
Children were afraid to open up in the presence of their parents	32	41	8	8	11
Children had adequate time to talk about their problem	40	48	2	6	4
Children were able to talk about their issues and were satisfied with the support they got	38	52	2	8	0
The involvement of family members made children feel good about themselves	49	41	2	8	0
I would love to use this service again in future	35	45	3	10	7
Children would always love to use this service again in future	29	41	12	10	8

Source: Research Data (2024)

The percentages in the table represent the responses of counsellors regarding various aspects of family therapy as experienced by children, ranging from enjoying sessions with specific family members to their level of satisfaction and willingness to utilise the service again. Starting with sessions involving mothers alone, the data shows that 68 per cent of children always enjoyed these sessions, with an additional 23 per cent almost always enjoying them. However, 2 per cent often, 4 per cent sometimes, and 3 per cent never enjoyed these sessions, indicating a generally positive but somewhat varied experience among the children.

Similarly, sessions involving fathers alone also received positive responses, with 69 per cent of children always enjoying them and 21 per cent almost always enjoying them. However, 5 per cent sometimes and

5per cent never enjoyed these sessions, suggesting some variability in children's experiences with paternal involvement in therapy. Regarding joint sessions with both parents and caregivers, 40 per cent of children always enjoyed these sessions, while 55 per cent almost always did. However, 2 per cent sometimes and 3 per cent never enjoyed them, indicating a generally positive but not universally consistent experience with joint family therapy sessions. The study findings are in line with those of Klein et al. (2023), who examined children's experiences in family therapy sessions involving fathers. Their findings aligned with the presented data, indicating positive responses from children towards sessions with their fathers. However, similar to the findings, there were also instances of variability in children's experiences, with a small percentage reporting less enjoyment of these sessions. These findings highlight the importance of considering individual differences and preferences in paternal involvement in therapy to enhance overall engagement and satisfaction among children.

The data also highlight that 49 per cent of children always resisted sessions with parents or caregivers, with an additional 33 per cent almost always resisting them. However, 12 per cent often, 3 per cent sometimes, and 3 per cent never resisted these sessions, indicating a significant proportion of children experiencing resistance or discomfort during therapy. Regarding sibling participation in counselling sessions, 55 per cent of children always had siblings participate, while 40 per cent almost always did. However, 5 per cent sometimes and 0 per cent never had siblings participate, suggesting a generally positive practice of involving siblings in therapy sessions. Moreover, the data reveals that 32 per cent of children always felt afraid to open up in the presence of their parents during therapy sessions, while 41 per cent almost always felt this way. Additionally, 8 per cent often, 8 per cent sometimes, and 11 per cent never felt afraid to open up, indicating varying levels of comfort and fear among children during therapy.

In terms of having adequate time to talk about their problems, 40 per cent of children always felt they did, while 48 per cent almost always felt this way. However, 2 per cent often, 6per cent sometimes, and 4 per cent never felt they had adequate time to talk about their problems, suggesting a generally positive but somewhat varied experience with time allocation during therapy sessions. Research by Charest et al. (2019) suggests that children may react to trauma by engaging in social withdrawal and fearfulness of adults based on how they were treated or supported by attachment figures. Failure to get reliable care would impact receptivity to counsellors. Factors such as parental expectations, perceived judgment, and communication barriers may contribute to children's feelings of fear and discomfort in therapy settings.

Furthermore, 38 per cent of children always felt able to talk about their issues and were satisfied with the support they received, while 52 per cent almost always felt this way. However, 2 per cent often, 8 per cent sometimes, and none of the respondents never felt satisfied with the support they received, indicating overall satisfaction but some room for improvement in certain cases. The involvement of family members in therapy made 49 per cent of children always feel good about themselves, with an additional 41 per cent almost always feeling this way. However, 2 per cent often, 8 per cent sometimes and none of the respondents never felt good about themselves due to family involvement, indicating overall positive effects on self-esteem and well-being.

Lastly, regarding future service utilisation, 35 per cent of counsellors expressed a desire to use the service again in the future, while 45 per cent almost always felt this way. However, 3 per cent often, 10 per cent sometimes, and 7 per cent never expressed a desire to use the service again, indicating varying levels of intention among counsellors. Murage (2020) found similar trends to the data presented, indicating varying

levels of intention among counsellors to use the service again in the future. Factors such as workload, professional satisfaction, and perceived effectiveness of therapy interventions influenced counsellors' intentions for future service utilisation. These findings underscore the importance of addressing organisational factors and providing ongoing support and training to counsellors to enhance service engagement and retention.

5.0 CONCLUSION AND RECOMMENDATIONS

Conclusion: The study concluded that family therapy showed positive experiences among participants, particularly regarding parental involvement. While siblings were generally involved positively, challenges were noted in engaging parents consistently. There was a prevalent sense of fear among participants in relation to their parents, suggesting familial challenges that need addressing. Despite mixed experiences regarding communication and support effectiveness, the counselling program had a generally positive impact on participants' self-esteem and self-perception. Participants generally expressed a positive inclination towards utilising family therapy services again.

Recommendations: The study recommended that the child rights advocacy centres should develop targeted interventions to increase parental engagement and address familial challenges identified during family therapy sessions. This may involve offering parenting workshops or support groups to help parents better understand and respond to the needs of their children. Additionally, providing additional support and resources to enhance communication and support effectiveness within family therapy sessions will be crucial for promoting positive outcomes. Conducting regular follow-up sessions will also be important to monitor the long-term impact of family therapy interventions on participants' psychosocial wellbeing and identify any ongoing needs or concerns that may require further attention.

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