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The Impact of Counselling Intervention on the Psycho-Emotional Well-Being of Female Survivors of Conflict-Related Sexual Violence in Anglophone Cameroon

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ABSTRACT

This study examined the impact of counselling intervention on the psycho-emotional well-being of female survivors of conflict-related sexual violence (CRSV) in the crisis-affected North-West and South-West regions of Cameroon. Drawing on a single intervention arm (n = 13) nested within a larger quasi-experimental study, it adopted a mixed-methods embedded design in which a pre-test–post-test comparison carried the primary weight and semi-structured interviews were embedded to explain how and why counselling mattered. Psycho-emotional well-being was measured with Ryff's Psychological Well-Being Scale and the Şimşek Emotional Well-Being Scale. Survivors who received eight weeks of structured, trauma-informed counselling rose from a baseline mean of 4.58 (SD = 0.63) to a follow-up mean of 14.95 (SD = 1.88), with 84.6% thriving at follow-up; a paired-samples t-test confirmed a large and statistically significant gain, t(12) = 20.67, p < .001. The qualitative accounts converged on three themes stress reduction, restored self-esteem, and emotional healing through being heard without judgement giving a human face to the measured recovery. The findings support Adaptive Information Processing theory and the wider empirical literature, and they confirm that counselling is a potent, well-evidenced component of survivor-centered humanitarian response.

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INTRODUCTION

Conflict-related sexual violence (CRSV) remains one of the most devastating and persistent features of contemporary armed conflict, blighting the lives of millions of women and girls across the world. The United Nations Secretary-General's annual report documented a 25% surge in cases in 2024, with more than 4,600 survivors enduring abuses used as weapons of war, torture and political repression across twenty-one countries (United Nations, 2025a); by 2026 the United Nations warned that cases had more than doubled to approximately 10,000, underscoring the escalating magnitude of this global crisis (United Nations, 2026). Women and girls constitute some 92% of documented victims, and these figures represent only a fraction of the true prevalence, since stigma, fear of retaliation and collapsed reporting mechanisms mean that most cases go undocumented.

In Cameroon, the protracted Anglophone crisis that erupted in 2016 has created a context in which sexual and gender-based violence has become pervasive and systematic, with sexual violence weaponised as a tool of punishment and control (Human Rights Watch, 2020, 2026). The psycho-emotional consequences are profound and enduring: survivors experience post-traumatic stress, depression, anxiety, shame, self-blame, social isolation and a shattered sense of self-worth (Campbell et al., 2009; World Health Organization, 2012). It is this psychological dimension of harm what the present study terms psycho-emotional well-being that humanitarian counselling sets out to repair.

Among the interventions delivered to survivors in the Anglophone regions, counselling (psychosocial support and mental-health services) occupies a central place. Yet, despite its widespread provision, it has remained empirically unknown whether, and to what extent, counselling actually improves the psycho-emotional well-being of female CRSV survivors in this specific conflict setting. This article isolates counselling as a single variable and reports the evidence for its impact, drawing on a focused analysis of one intervention arm within a larger quasi-experimental study. It proceeds from background and problem through the conceptual and theoretical literature to the methodology, the summary findings, their discussion, and the conclusions and recommendations that follow.

Background to the Study

Conflict-related sexual violence is neither a new phenomenon nor an incidental by-product of war; it is a deliberate tactic with deep historical roots. From the systematic rape of women during the Second World War to the sexual enslavement of "comfort women", CRSV has recurred across centuries of armed conflict. The international community's recognition of it evolved slowly: although the Nuremberg Trials did not explicitly prosecute sexual violence, the International Criminal Tribunals for the former Yugoslavia and Rwanda in the 1990s prosecuted it as a crime against humanity and genocide, and the Rwandan Tribunal's landmark Akayesu judgement (1998) was the first to recognise rape as a form of genocide. The adoption of United Nations Security Council Resolution 1325 (2000) on Women, Peace and Security marked a further paradigm shift, explicitly linking gender-based violence in conflict to international peace and security. Despite these advances, such violence continues to escalate in contemporary conflicts, and nowhere more visibly than across sub-Saharan Africa.

In Africa, CRSV has reached particularly alarming levels, with the Democratic Republic of the Congo, the Central African Republic, Somalia, South Sudan and Sudan consistently recording the highest numbers of documented cases. The African context is further characterised by chronic under-reporting, limited access to justice and inadequate humanitarian response infrastructure, all of which compound the suffering of survivors. Against this backdrop, Cameroon's Anglophone crisis has produced its own grim record. The crisis erupted in 2016 following grievances over the marginalisation of the English-speaking North-West and South-West regions, and in the years since, armed groups on both sides have perpetrated rape, gang rape, sexual slavery and forced marriage against women and girls. Over 4,000 cases of sexual violence were documented in 2020 alone in the conflict-affected regions, with survivors describing the experience as "worse than death". Human Rights Watch (2026) has documented the government's failure to meet its obligations to address gender-based violence, while observers have highlighted how women in the Anglophone conflict bear a disproportionate burden of violence, displacement and economic deprivation.

Conceptually, the harm that CRSV inflicts is not confined to the body. Survivors carry post-traumatic stress, depression, anxiety, shame and a diminished capacity to cope with daily life, and these psychological wounds are compounded by stigma, rejection by families and communities, economic destitution and persistent insecurity. The present study draws these threads together under the construct of psycho-emotional well-being, which it understands to encompass emotional stability, self-esteem, hope for the future, social connectedness and freedom from traumatic distress. It is precisely these capacities that sexual violence erodes, and precisely these that counselling is designed to restore.

Counselling, in the humanitarian sense used here, refers to structured, trauma-informed psychological support delivered by trained counsellors, whether individually or in groups, with the aim of easing trauma symptoms,

promoting emotional regulation, rebuilding self-worth and supporting psychological healing. In response to the Anglophone crisis, national and international actors among them UNFPA, UNICEF, the Danish Refugee Council and local civil-society organisations have delivered counselling alongside medical care, protection and economic support. Theory suggests that such counselling should promote recovery by allowing survivors to reprocess traumatic memory and to reframe the beliefs about themselves that the violence installed. Whether it actually does so, in this setting and for these women, is an empirical question that had not previously been answered.

The contextual case for examining counselling in Anglophone Cameroon is compelling. The crisis is now in its ninth year with no political resolution in sight; humanitarian actors will be needed for the foreseeable future; and the state's documented failure on gender-based violence deepens survivors' reliance on them. Humanitarian response, moreover, tends to prioritise physical health and material need while under-prioritising the psychological and emotional dimensions of recovery. In such a setting, evidence on whether counselling restores psycho-emotional well-being is not an academic luxury but a practical necessity, bearing directly on how scarce resources are allocated among some of the most vulnerable women in the region. It is this gap, and this variable, that the study addresses.

Conceptualizing Counselling Intervention on the Psycho-Emotional Well-Being

"Counselling" is not one thing but a family of approaches, each built on different assumptions about how recovery happens and each making different demands on time, training and setting. For survivors of CRSV in a low-resource, displacement-affected context such as Anglophone Cameroon, only some of these approaches are realistic, and the evidence behind them is uneven. Cognitive Processing Therapy (CPT) is a structured, cognitive approach that targets the distorted beliefs trauma leaves behind self-blame, worthlessness, a sense of permanent damage and helps the survivor separate what was done to her from who she is (Resick et al., 2002). It carries particular weight here because Bass et al. (2013) tested a group-based CPT adaptation with sexual-violence survivors in eastern DRC and found substantial reductions in depression and post-traumatic stress, making it the single most directly relevant modality for this population and region. Narrative Exposure Therapy (NET) helps survivors of repeated or continuous trauma construct a coherent account of their whole life, placing the violence within a larger story rather than letting it define them (Schauer et al., 2011). Eye Movement Desensitisation and Reprocessing (EMDR) work directly on how traumatic memories are stored, allowing them to be integrated with less distress (Shapiro, 2018), while Prolonged Exposure and the Common Elements Treatment Approach offer, respectively, a demanding exposure-based protocol and a modular, lay-deliverable option for low-resource settings.

The counselling literature is often read as settled, as though we already knew that trauma-focused therapy heals and only the question of delivery remained. A closer reading tells a more contested story. The deepest fault line runs between the individual and the collective. The dominant models Herman's (1992) stage-based recovery, trauma-focused cognitive and exposure therapies, and EMDR were developed in Western clinical settings and rest on quietly cultural assumptions: that healing happens in a private, one-to-one encounter, that disclosing traumatic memory to a trained stranger is therapeutic, and that the self being repaired is an autonomous, bounded individual. Critics argue that in many African contexts the self is relational rather than individual, that suffering is metabolised communally, and that a therapeutic frame built around individual disclosure may feel alienating.

Against this stands an awkward piece of evidence: the interventions that have produced the strongest results in low-resource, conflict-affected African settings are not indigenous practices but adapted Western models yet, as in the DRC trial (Bass et al., 2013), what was delivered was no longer the Western model in any pure form, being offered in groups, by lay members of the community, in local languages and reworked around local idioms of distress. The position taken here is that adaptation is not dilution: for Anglophone Cameroon, where communal and church-based structures already carry much of the region's emotional life, this points towards group and community-embedded counselling rather than the individual therapy hour not because the individual model fails, but because the collective one is likely to reach further and stigmatise less.

A second, quieter debate concerns the medicalisation of distress. To offer counselling for a diagnosable disorder is to name a survivor's suffering as pathology, and there is a real argument that responses to atrocity grief, rage, fear, numbness are not symptoms of a disorder but sane reactions to an insane situation. This is not an argument against counselling but about how it is framed. The stepped and layered models of psychosocial support in humanitarian settings (Ventevogel, 2014; IASC, 2015) reserve clinical treatment for those whose distress is genuinely disabling while meeting the majority through community and family support that does not require them to be diagnosed at all. The present study therefore treats counselling not as the medical management of a disordered mind but as one layer within a broader ecology of support.

Theoretical Review: The Adaptive Information Processing Model

The Adaptive Information Processing (AIP) model, formulated by Francine Shapiro (1995, 2001, 2018), constitutes the primary counselling-oriented theoretical framework for this study. The AIP model was developed alongside EMDR therapy, but it is important to distinguish the model from the technique: the AIP model is a theory of how the human information-processing system normally functions and how it malfunctions under traumatic stress, while EMDR is one clinical application derived from it. This distinction matters here because the model provides the conceptual rationale for counselling intervention broadly not only for EMDR-specific protocols by explaining why trauma-focused psychological processing is necessary for recovery and why spontaneous resolution of traumatic symptomatology is unlikely without it.

The model posits that the brain possesses an innate information-processing system that ordinarily moves disturbing experiences towards adaptive resolution, integrating them into existing memory networks so that they can be recalled without overwhelming distress. When an event is overwhelmingly threatening particularly where it involves a violation of bodily integrity, helplessness or repeated exposure this system can be disrupted, and the experience is stored in a dysfunctionally encoded, state-specific form that retains the original emotions, sensations, beliefs and imagery, frozen in their original intensity. When a trigger recreates elements of the original state, the survivor does not merely recall the assault but re-experiences its terror and arousal as though it were occurring in the present. This mechanism explains the three cardinal clusters of post-traumatic stress intrusive re-experiencing, avoidance and hyperarousal as interconnected manifestations of a single underlying failure: the inability of the processing system to transform a dysfunctionally stored memory into an adaptively integrated one.

The AIP model further holds that such memories form networks linked by shared thematic content powerlessness, worthlessness, betrayal, contamination so that when a single memory is reprocessed and integrated, the adaptive gains can generalise across the network. This is especially relevant to CRSV survivors, who typically carry not a single traumatic memory but a dense web of related experiences bound together by shared negative cognitions about the self. Counselling, on this account, works by enabling the survivor to reprocess these memories and to replace maladaptive self-beliefs above all the belief that she was to blame with more adaptive ones, thereby restoring affect regulation, self-acceptance and relational capacity. The model thus furnishes a clear, testable expectation: that structured counselling will produce a substantial improvement in psycho-emotional well-being, visible both in measured scores and in the language survivors use to describe their recovery.

Statement of the Problem

Psycho-emotional well-being is foundational to a woman's capacity to function, form relationships, raise children, participate economically and live with dignity. Yet even in peacetime, women's well-being is routinely threatened by gendered harms rooted in patriarchal power, so that women rarely begin from a position of full psycho-emotional security. Armed conflict does not create this vulnerability so much as it radicalises it: what exists as intimate-partner and domestic violence in times of relative normality escalates, under conditions of war, into conflict-related sexual violence inflicted on a mass scale. In Anglophone Cameroon, sexual violence has been deployed systematically as a tool of punishment and control, inflicting trauma, shame and social rupture that strike at the very core of survivors' psycho-emotional well-being.

Crucially, the harm does not end when the assault does. In the protracted aftermath of the crisis, survivors continue to endure the erosion of their well-being through persistent insecurity, displacement, stigma and economic destitution. Women are thus victimised across all three periods before, during and after the crisis yet the psycho-emotional dimension of this continuous harm remains poorly understood and has never been systematically assessed in this context. Humanitarian actors provide counselling to survivors in the Anglophone regions, and prevailing theory suggests it should promote recovery; yet no study has examined whether counselling actually restores psycho-emotional well-being in this specific conflict setting. As a result, humanitarian actors, policymakers and programme designers are left to design and fund counselling services on the basis of assumption rather than evidence. This study therefore investigates the impact of counselling intervention on the psycho-emotional well-being of female survivors of conflict-related sexual violence in Anglophone Cameroon.

Objective of the Study

The general objective of the wider study was to investigate the impact of humanitarian intervention on the psycho-emotional well-being of female survivors of conflict-related sexual violence in Anglophone Cameroon. The specific objective addressed in this article is:

- To examine the impact of counselling intervention on the psycho-emotional well-being of female survivors of conflict-related sexual violence in Anglophone Cameroon.

Research Question

What is the impact of counselling intervention on the psycho-emotional well-being of female survivors of

conflict-related sexual violence in Anglophone Cameroon?

Research Hypothesis

H_{01}: There is no significant relationship between counselling intervention and the psycho-emotional well-being of female survivors of conflict-related sexual violence in Anglophone Cameroon.
H_{a1}: There is a significant positive relationship between counselling intervention and the psycho-emotional well-being of female survivors of conflict-related sexual violence in Anglophone Cameroon.

Justification of the Study

The justification for isolating counselling as a single variable rests on theoretical, empirical, practical and policy grounds. Theoretically, the study tests the applicability of the Adaptive Information Processing model in the under-researched setting of Cameroon's Anglophone crisis, examining whether the mechanisms it predicts the reprocessing and integration of traumatic memory are borne out in survivors' recovery. Empirically, it addresses a critical gap: although CRSV in Cameroon has been documented by journalists and human-rights organisations, and although the psychological consequences of sexual violence have been studied elsewhere, no empirical study had examined the impact of counselling on the psycho-emotional well-being of female CRSV survivors in Anglophone Cameroon. This study provides the first systematic evidence on that question, contributing to the sparse literature on CRSV recovery in sub-Saharan Africa.

Practically and in policy terms, the findings bear directly on how a constrained humanitarian response allocates scarce resources. By establishing whether counselling produces measurable improvement in well-being, the study offers programme designers and policymakers an evidence base for prioritising and optimising psychosocial support, and for moving from assumption-based programming towards interventions demonstrably matched to survivors' needs. The consequences of not knowing are equally telling: without such evidence, counselling would continue to be designed and funded on faith, effective practice might go unrecognised and unscaled, and survivors might continue to receive support that fails to address the psycho-emotional harm at the core of their suffering.

METHODOLOGY

The study adopted a mixed-methods embedded design, in which quantitative enquiry carried the primary weight and a qualitative strand was embedded within it to interpret and give human texture to the numerical findings (Creswell & Plano Clark, 2018). The quantitative core was structured as a quasi-experimental, pre-test–post-test non-equivalent control-group design. Because the participants were female survivors of CRSV living in two regions under volatile crisis conditions, random assignment was neither ethically defensible nor logistically possible; the recognised alternative in such field settings is to work with intact, naturally occurring groups (Campbell & Stanley, 1963; Shadish, Cook & Campbell, 2002). Survivors reached through INTERSOS in the North-West formed the experimental group and those reached through Lukmef in the South-West formed the control group. Following the baseline, the fifty members of the experimental group were allocated, on the basis of their dominant assessed need, to one of four intervention arms; this article reports the counselling arm (n = 13).

The study was conducted in the two Anglophone regions of Cameroon the North-West and the South-West which have borne the weight of the socio-political crisis that escalated into armed conflict from 2016. From a study population of 8,000 female survivors, a target population of 2,500 and an accessible population of 140, a sample of 100 survivors was drawn using Slovin's formula (Slovin, 1960), with purposive and stratified sampling: purposive selection ensured that participants had actually experienced sexual violence and received intervention services, while stratification by region separated the experimental and control groups and, within the experimental group, allocated participants to the four intervention arms by dominant need. Five survivors from each group were purposively selected for qualitative interviews.

Psycho-emotional well-being was measured with two standardised instruments: Ryff's Psychological Well-Being Scale, a 42-item five-point Likert measure organised into six subscales (autonomy, environmental mastery, personal growth, purpose in life, positive relations with others, and self-acceptance; Ryff, 1989), and the Şimşek Emotional Well-Being Scale, a 14-item measure of positive and negative emotional well-being. The instruments were validated for face and content validity, the latter using the Content Validity Index, and reliability was confirmed through a pilot study using the test–retest method, with an overall Cronbach's alpha of 0.702 indicating good internal consistency. A semi-structured interview guide, aligned with the research objective and supported by probes, gathered the qualitative data.

Survivors in the counselling arm received structured, trauma-informed psychological support delivered through individual and group counselling sessions by trained counsellors over eight weeks. The sessions drew on the Direct Delivery Technique and on cognitive-behavioural and supportive-counselling principles to address trauma symptoms, promote emotional regulation, rebuild self-worth and support psychological healing, with careful attention to confidentiality and

emotional safety throughout. This arm was theoretically grounded in the Adaptive Information Processing model (Shapiro, 2001). Both groups completed the two scales at baseline and again after the eight-week programme, while the control group received only the standard services routinely available to them.

Quantitative data were analysed with SPSS (version 26) using descriptive statistics (frequencies, percentages, means and standard deviations) and inferential statistics, with paired-samples t-tests comparing pre-test and post-test scores within groups at the 0.05 level of significance and Cohen's d estimating effect size. The qualitative data were analysed thematically following Braun and Clarke's (2006) six-phase approach. Throughout, the study upheld rigorous ethical commitments: ethical clearance was obtained from the University of Buea and administrative authorisation from the participating organisations; written informed consent (and, for minors, assent alongside guardian consent) was secured; participation was voluntary; confidentiality and anonymity were protected; and a survivor-centred, do-no-harm approach, with referral pathways to further support, was maintained at every stage.

Summary of Findings

The thirteen women who formed the counselling arm spanned the full range of adult ages, with the largest shares at the two ends of the spectrum four (30.8%) aged 15–20 years and four (30.8%) aged 30 years and above so that the sub-group was not dominated by any single generation. This breadth matters, for it means that any benefit observed cannot be attributed to the particular resilience of one age group alone.

Quantitative Findings

At baseline, the counselling sub-group was in a state of pronounced and uniform distress. Of the thirteen women, seven (53.8%) fell into the impaired or distressed category and the remaining six (46.2%) were languishing; not one was thriving. Their baseline scores clustered tightly at the bottom of the scale, with a mean of 4.58 (SD = 0.63) and a range of just 4 to 6. At follow-up, after the eight-week counselling programme, the picture had changed almost beyond recognition: eleven of the thirteen women (84.6%) had moved into the thriving category, and the remaining two (15.4%) were in mild distress, while the impaired and languishing categories which together had accounted for the entire sub-group were completely empty. The mean score had risen to 14.95 (SD = 1.88), with scores ranging from 10 to 16, so that even the lowest-scoring woman at follow-up was functioning well above the highest-scoring woman at baseline.

A paired-samples t-test confirmed that this improvement was both large and statistically significant. The mean difference between follow-up and baseline scores was 10.372 points (SD of the differences = 1.809; SE = 0.502), with a 95% confidence interval running from 9.278 to 11.465, so that even on the most conservative reading the women gained, on average, more than nine points. The test returned $t(12) = 20.67$, $p < .001$, representing a large effect. The narrowness of the confidence interval and the modest standard deviation of the differences show that the gain was shared consistently across the sub-group rather than driven by a handful of exceptional cases: the women improved together, and reliably. Set against the control group, whose scores scarcely moved over the same period, this gain cannot plausibly be attributed to the passage of time, to repeated testing, or to spontaneous recovery.

Qualitative Findings

The interviews gave voice to the women behind the numbers, and their accounts organised themselves around three themes. The first was stress reduction. For several, relief came simply from being able to speak: "I felt at ease after talking to someone," said one, while another explained that "the counselling has helped me reduce my stress and I feel calmer than before." For others the easing of stress was bound up with a lessening of fear "I am no longer too scared after talking to someone here" and a fourth reflected that "I now feel a bit relieved to move on with life."

The second theme was positive self-esteem. One participant explained that the sessions had freed her voice: "I feel much better because I can now express my feelings without fear or shame." For another, the turning point lay in reframing the experience itself: "I now understand that what happened to me is not my fault, and this has improved my self-esteem." A third spoke of a renewed orientation towards the future: "I feel emotionally stronger and more hopeful about meeting my dreams." The third theme was emotional healing through being heard. One woman described the beginnings of rest after a long sleeplessness "before, I could not sleep; after the sessions I am learning to quiet my mind" while another located her healing in the relationship itself: "having someone who listens without judging me has helped me accept myself again." Taken together, the qualitative evidence reveals that counselling gave these women back three things that violence had taken: a voice, a sense of innocence and a future. On this evidence the first null hypothesis is rejected and the alternative upheld.

DISCUSSION

The quantitative and qualitative strands converge on a single, coherent finding: counselling exerted a large, significant and humanly meaningful positive influence on the psycho-emotional well-being of female survivors of CRSV. The movement from a baseline mean of 4.58 to a follow-up mean of 14.95, confirmed by a paired-samples test ($t(12) = 20.67$, $p < .001$) with a large effect,

was not merely a statistical event but a transformation in the women's emotional lives, and the survivors' own words supplied its meaning. What the counselling gave them, their accounts suggest, was not simply a reduction in symptoms but the recovery of self-worth, speech and hope.

Interpreted through the Adaptive Information Processing model (Shapiro, 2018), these findings are consistent with the proposition that traumatic memories, when left unprocessed, remain isolated and continue to trigger distress, but that a structured, supportive therapeutic encounter allows the survivor to process and integrate them. In the woman who said "I now understand that what happened to me is not my fault," one sees the theory at work in its most human form: a maladaptive belief about the self being reprocessed and replaced by a more adaptive one. In the woman who "felt at ease after talking to someone," the memory of the assault is no longer firing in isolation but has been linked to the safe, present relationship of the counsellor and has begun to lose its power to overwhelm. The reduction in stress and the renewal of self-esteem the survivors reported are therefore not incidental; they are precisely the psychological signatures of reprocessing that the model predicts.

The finding is strongly supported by the wider empirical literature. In a widely cited systematic review of mental-health and psychosocial support interventions for survivors of sexual and gender-based violence in armed conflict, Tol et al. (2013) found consistent evidence that structured psychological and psychosocial support improves survivors' well-being, particularly for symptoms of distress and trauma. Lomax et al. (2022) similarly concluded that psychosocial interventions produce significant improvements in the well-being of survivors of sexual assault and rape, with the strongest and most reliable gains recorded for counselling-based models, while Burdeu et al. (2026) reported that even brief therapeutic interventions can significantly reduce mental-health symptoms, and Bangpan et al. (2017) found in a major review of emergency settings that psychosocial support yields moderate but positive benefits for functioning and coping. The relatively large effect observed here (t(12) = 20.67) is consistent with the pattern in these reviews, in which counselling repeatedly emerges as one of the most effective modalities available to survivors of CRSV.

Honesty requires that the limitations of the evidence be acknowledged. Some reviews caution that the quality of the evidence base in conflict settings remains constrained by small samples, short follow-up periods and the difficulty of isolating a single intervention from the other support survivors receive. The present study is not immune to these constraints: the counselling arm was small (n = 13), the data relied on self-report, outcomes were captured at only two points in time, and the design, though strengthened by a control group, was not fully randomised. A minority of survivors, moreover, benefit less than others, and the two women who remained in mild distress at follow-up are a reminder that recovery is uneven. The counselling result should therefore be read as strong supporting evidence within a field that is still building its evidence base, rather than as an isolated or conclusive demonstration. With that caveat, the convergence of a large measured gain, a coherent theoretical mechanism and consistent qualitative testimony lends the finding real authenticity.

Implications of the Study

The findings of this study have significant implications for psychological theory, counselling practice, humanitarian intervention, mental health policy, community-based psychosocial support, and future research on conflict-related sexual violence (CRSV). The substantial improvement in psycho-emotional well-being recorded among female survivors following eight weeks of structured counselling provides encouraging empirical evidence of the potential contribution of psychological interventions to trauma recovery in conflict-affected communities. Specifically, the increase in mean psycho-emotional well-being scores from 4.58 (SD = 0.63) at baseline to 14.95 (SD = 1.88) at follow-up, with a statistically significant difference, $t(12) = 20.67$, $p < .001$, suggests that structured counselling can contribute meaningfully to psychological adjustment and emotional recovery. The qualitative findings, which revealed reductions in stress, improvements in self-esteem, and emotional healing through supportive therapeutic relationships, further demonstrate that recovery extends beyond the reduction of psychological distress to include the restoration of personal dignity, self-acceptance, emotional stability, and hope for the future. These findings have important implications for understanding and responding to the complex psychological consequences of sexual violence within the sociocultural and humanitarian realities of Anglophone Cameroon.

Theoretical Implications

Theoretically, the findings provide contextual support for the relevance of the Adaptive Information Processing (AIP) model developed by Shapiro (2001, 2018), which proposes that psychological distress following traumatic experiences may persist when disturbing memories are inadequately processed and integrated into adaptive memory networks. According to this perspective, traumatic experiences can become associated with dysfunctional beliefs, negative emotions, and maladaptive interpretations of personal identity. The improvement in survivors' psycho-emotional well-being following counselling is consistent with the proposition that structured psychological support may facilitate emotional processing, cognitive restructuring, and the development of more adaptive interpretations of traumatic experiences. Particularly significant is the qualitative finding that some survivors developed a

renewed understanding that the violence perpetrated against them was not their fault. Such cognitive transformation suggests that counselling may contribute to challenging internalised blame, shame, and negative self-perceptions associated with sexual victimisation. Nevertheless, because the study did not directly measure traumatic memory processing, the findings should be interpreted as consistent with the AIP model rather than as definitive evidence of its underlying mechanisms.

The findings also contribute to the broader conceptual understanding of psychological well-being advanced by Ryff (1989), who conceptualised well-being as a multidimensional construct encompassing self-acceptance, positive relationships, autonomy, environmental mastery, personal growth, and purpose in life. The survivors' accounts of improved self-esteem, emotional strength, reduced fear, and renewed aspirations suggest that counselling interventions may support several interconnected dimensions of psychological functioning. This implies that the effectiveness of trauma counselling should not be evaluated exclusively through the reduction of psychopathological symptoms such as anxiety, depression, and post-traumatic stress. Rather, assessments should incorporate positive indicators of psychological functioning, including self-worth, resilience, social connectedness, personal agency, and future orientation. The study therefore reinforces the importance of adopting a holistic understanding of psycho-emotional recovery in which healing involves not merely the absence of distress but also the progressive restoration of psychological resources necessary for meaningful participation in everyday life.

Furthermore, the findings contribute to debates concerning the applicability of Western-derived psychological theories and counselling approaches within African conflict settings. Although the intervention was informed by established trauma-focused and cognitive-behavioural principles, its implementation occurred within a sociocultural environment characterised by communal relationships, religious affiliations, collective coping mechanisms, and culturally embedded interpretations of suffering. The positive outcomes suggest that established psychological approaches may have practical relevance in African humanitarian contexts when implemented sensitively and adapted to survivors' circumstances. This interpretation is consistent with Bass et al. (2013), who demonstrated the effectiveness of an adapted cognitive processing therapy intervention among survivors of sexual violence in the Democratic Republic of the Congo. Consequently, the study highlights the importance of developing culturally responsive counselling frameworks that integrate evidence-informed psychological principles with African understandings of personhood, social relationships, collective resilience, and community support.

Implications for Counselling Psychology and Professional Practice

The findings have direct implications for counselling psychologists, guidance counsellors, clinical psychologists, social workers, and other mental health professionals involved in supporting survivors of sexual violence. The significant improvement observed following the eight-week intervention suggests that structured, trauma-informed counselling deserves consideration as an important component of professional psychological support in conflict-affected settings. Counselling practitioners should therefore move beyond exclusively crisis-oriented responses towards systematic interventions that address emotional regulation, traumatic stress, negative self-beliefs, psychological adjustment, and the restoration of personal agency. This position is consistent with Herman's (1992) conceptualisation of trauma recovery as a process involving the establishment of safety, the processing of traumatic experiences, and the restoration of meaningful connections with oneself and others. Counselling programmes should consequently be designed to provide survivors with psychologically safe environments in which they can progressively regain emotional stability and rebuild their sense of personal identity.

An equally important implication concerns the therapeutic relationship and the interpersonal qualities of effective counselling. The qualitative findings demonstrated that survivors attached considerable importance to being listened to without judgement, expressing their emotions freely, and receiving reassurance within a confidential and supportive environment. These experiences suggest that the effectiveness of counselling cannot be understood solely in terms of the techniques employed; the quality of the therapeutic relationship may also contribute substantially to survivors' perceived recovery. For women who have experienced sexual violence, particularly within communities where stigma, victim-blaming, and social rejection remain prevalent, the opportunity to communicate traumatic experiences without fear of condemnation may represent an important step towards rebuilding trust and self-acceptance. Counsellors should therefore prioritise empathy, unconditional respect, confidentiality, cultural sensitivity, informed consent, and emotional safety throughout the therapeutic process. These principles are particularly important because inappropriate questioning, judgemental attitudes, or breaches of confidentiality may expose survivors to additional psychological distress and social vulnerability (Campbell et al., 2009).

The findings further imply a need to strengthen professional preparation and continuing education for practitioners working with survivors of CRSV. Counselling professionals operating in conflict-affected communities require specialised competencies in trauma

assessment, psychological first aid, crisis intervention, cognitive restructuring, emotional regulation, safeguarding, and referral management. The positive outcomes associated with structured counselling underscore the potential value of equipping practitioners with evidence-informed intervention skills, including elements of cognitive processing therapy and other trauma-focused approaches appropriate to their professional qualifications and the resources available. Resick et al. (2002) demonstrated the effectiveness of cognitive processing therapy in addressing trauma-related psychological difficulties among female survivors of rape, while Bass et al. (2013) provided evidence of the potential benefits of adapted psychological treatment in an African conflict setting. Training institutions in Cameroon should consequently consider strengthening trauma-informed counselling content within programmes in counselling psychology, educational psychology, social work, and related disciplines. Such preparation should include supervised clinical practice, ethical decision-making, cultural competence, and procedures for recognising survivors who require specialised psychiatric or medical intervention.

Implications for Humanitarian Intervention and Psychosocial Support

The study has important implications for humanitarian organisations providing assistance to women and girls affected by armed conflict in the North-West and South-West regions of Cameroon. The findings suggest that psychosocial recovery should be recognised as a fundamental dimension of humanitarian assistance rather than a supplementary service provided only after immediate physical needs have been addressed. Although emergency medical treatment, shelter, food assistance, legal protection, and livelihood support remain essential, the psychological consequences of sexual violence may continue to undermine survivors' functioning long after the immediate incident. The improvements observed following counselling indicate that psychological support may contribute to restoring survivors' emotional stability, self-confidence, and capacity to cope with adversity. Humanitarian organisations should therefore consider integrating structured counselling into comprehensive survivor-centred response programmes that simultaneously address physical, psychological, social, protection, and economic needs.

This implication is consistent with the Inter-Agency Standing Committee (IASC, 2015) guidelines, which emphasise coordinated, multisectoral responses to gender-based violence in humanitarian emergencies. It is also supported by Tol et al. (2013), whose systematic review highlighted the potential contribution of mental health and psychosocial interventions to addressing the consequences of sexual and gender-based violence in armed conflict. In practical terms, humanitarian organisations operating in Anglophone Cameroon should strengthen collaboration among counselling professionals, healthcare providers, social workers, community protection structures, and organisations providing legal and economic assistance. Such collaboration would facilitate timely identification of psychological difficulties, appropriate referral, continuity of care, and coordinated responses to survivors' multidimensional needs. Importantly, counselling should remain voluntary and survivor-directed, with careful attention to confidentiality, informed consent, and the avoidance of further harm.

The findings also have implications for the design, duration, and evaluation of humanitarian psychosocial programmes. The positive changes observed over eight weeks suggest that relatively time-limited, structured interventions may offer meaningful psychological benefits in resource-constrained environments. However, this should not be interpreted as evidence that eight weeks of counselling will be sufficient for every survivor. Trauma recovery is influenced by the severity and duration of victimisation, previous psychological vulnerabilities, ongoing insecurity, displacement, family relationships, and access to social support. The fact that two participants remained in mild distress after the intervention further demonstrates that psychological recovery is not uniform. Humanitarian programmes should therefore adopt flexible and needs-responsive approaches that combine initial psychological assessment, structured intervention, periodic monitoring, and additional support for survivors experiencing persistent distress. Such an approach is consistent with the layered provision of mental health and psychosocial support advocated within humanitarian practice (IASC, 2015; Ventevogel, 2014).

Implications for Mental Health Policy and Institutional Development

At the policy level, the findings highlight the importance of strengthening mental health and psychosocial support within national and regional responses to conflict-related sexual violence in Cameroon. The measurable improvements in survivors' psycho-emotional well-being suggest that psychological services can make a meaningful contribution to recovery and should therefore receive explicit consideration in humanitarian planning, gender-based violence response strategies, and public health programming. Policymakers should recognise that the consequences of sexual violence extend beyond immediate physical injury to include persistent emotional distress, impaired social functioning, diminished self-worth, and difficulties in rebuilding personal and family relationships. Consequently, policies addressing sexual violence should incorporate provisions for accessible, confidential, affordable, and professionally supervised psychological support.

The study further suggests the need for institutional collaboration among government ministries responsible for public health, women's empowerment, social affairs, education, and humanitarian response. Such collaboration could facilitate the development of coordinated referral pathways, professional training standards, community-based mental health services, and mechanisms for monitoring the quality of psychosocial interventions. The World Health Organization (2012) emphasises that violence against women has serious psychological and physical health consequences, requiring comprehensive and appropriately coordinated responses. Within Anglophone Cameroon, where armed conflict has disrupted access to essential services, institutional efforts should particularly prioritise displaced women, adolescent survivors, rural communities, and individuals facing financial or geographical barriers to mental health care. However, decisions concerning the large-scale expansion of particular counselling models should be supported by further evaluation of effectiveness, feasibility, acceptability, and sustainability.

Sociocultural and Community Implications

The findings have significant sociocultural implications, particularly regarding the relationship between psychological recovery, community attitudes, and the social reintegration of survivors. The qualitative evidence indicates that survivors experienced improvements in self-esteem and emotional well-being when they were able to express their feelings without fear or shame and when they received reassurance that they were not responsible for the violence committed against them. These experiences suggest that psychological recovery may be constrained by social environments in which sexual violence is associated with stigma, silence, victim-blaming, or rejection. Campbell et al. (2009) demonstrated that the psychological consequences of sexual assault are influenced not only by the traumatic experience itself but also by survivors' interactions with their social environments. The present findings therefore imply that individual counselling should be complemented by broader community sensitisation aimed at challenging harmful attitudes, promoting survivor dignity, and strengthening supportive social relationships.

Within the African sociocultural context, family networks, religious institutions, traditional community structures, and women's associations may provide important sources of emotional reassurance and social belonging. These structures could support survivor recovery through appropriately designed awareness programmes, voluntary peer-support initiatives, and community-based psychosocial activities. Nevertheless, community participation must be approached cautiously because the same social structures that provide support may also reproduce stigma or compromise confidentiality. Survivor-centred practice therefore requires that community involvement be guided by the preferences, safety, and informed consent of individual survivors. The findings support further exploration of culturally adapted individual and group counselling approaches that acknowledge communal forms of coping without assuming that all survivors prefer collective disclosure or community-based intervention. This position is consistent with the evidence from Bass et al. (2013), which demonstrated the potential effectiveness of culturally adapted group psychological interventions among survivors of sexual violence in an African conflict environment.

Implications for Women's Empowerment and Social Reintegration

The improvements in self-esteem, emotional strength, and hope reported by participants also have implications for women's empowerment and social reintegration following conflict-related sexual violence. Sexual victimisation can undermine survivors' confidence, personal autonomy, interpersonal relationships, and expectations concerning their future. The qualitative accounts suggest that counselling may help some survivors reconstruct more positive perceptions of themselves and regain confidence in their capacity to pursue meaningful personal goals. These outcomes are consistent with Ryff's (1989) conceptualisation of psychological well-being, particularly the dimensions of self-acceptance, personal growth, autonomy, and purpose in life. The findings therefore suggest that psychosocial interventions may provide an important foundation for broader processes of personal recovery and social participation.

However, improvements in psychological well-being should not be equated automatically with economic empowerment, educational reintegration, or improved livelihood outcomes, since these dimensions were not directly measured in the present study. Rather, the findings point towards the potential value of linking counselling services with complementary interventions in education, vocational training, livelihood development, legal assistance, and social protection. Such integrated programmes could address the structural conditions that continue to expose survivors to vulnerability, including displacement, poverty, insecurity, and limited access to essential services. This broader approach is consistent with Herman's (1992) emphasis on reconnection as an important dimension of trauma recovery and with the IASC (2015) framework for integrated humanitarian responses.

Methodological and Research Implications

Methodologically, the study demonstrates the value of combining quantitative and qualitative approaches when examining psychological interventions among survivors of conflict-related sexual violence. The quantitative findings established a statistically significant

improvement in psycho-emotional well-being following counselling, while the qualitative accounts provided insight into the subjective experiences associated with this improvement. This convergence illustrates the contribution of mixed-methods research to understanding both measurable psychological change and the meanings survivors attach to their recovery experiences. Creswell and Plano Clark (2018) argue that integrating quantitative and qualitative evidence can provide a more comprehensive understanding of complex social and psychological phenomena than either approach alone. Future investigations of trauma counselling in conflict-affected settings may therefore benefit from incorporating standardised psychological assessments alongside in-depth interviews, observational evidence, and longitudinal accounts of recovery.

Notwithstanding the encouraging results, the findings also highlight important directions for further investigation. The counselling intervention arm comprised only 13 participants, and the outcomes were assessed over a relatively short period. Moreover, the absence of random assignment within the wider quasi-experimental design limits the strength of causal conclusions that can be drawn from the observed improvements. Future studies should therefore employ larger and more diverse samples, include clearly specified comparison groups, and assess psychological outcomes at multiple follow-up points to determine whether the benefits of counselling are sustained over time. Where ethically and practically feasible, stronger experimental or quasi-experimental designs should be considered to distinguish intervention-related improvements from other influences on recovery (Shadish et al., 2002). Further research should also investigate the relative effectiveness of individual counselling, group counselling, culturally adapted cognitive-behavioural interventions, and community-based psychosocial support.

Additional research is required to establish whether counselling outcomes vary according to survivors' age, educational background, displacement experiences, severity of traumatic exposure, social support, and access to complementary humanitarian services. Particular attention should be given to adolescent survivors, women with disabilities, and individuals living in remote or highly insecure communities, whose counselling needs and barriers to accessing services may differ considerably. Future investigations should also examine the mechanisms through which counselling contributes to psychological recovery, including changes in trauma-related beliefs, emotional regulation, perceived social support, and therapeutic alliance. Such studies would help clarify the extent to which the theoretical processes proposed by Shapiro (2018) explain improvements in psycho-emotional well-being within African conflict settings.

Overall, the implications of this study extend beyond demonstrating improvements in psychological well-being following counselling. They underscore the importance of recognising psycho-emotional recovery as an essential component of survivor-centred humanitarian intervention and highlight the potential contribution of structured, culturally responsive counselling to restoring emotional stability, self-worth, and hope among female survivors of conflict-related sexual violence. While the small sample and methodological limitations require cautious interpretation, the convergence of statistically significant improvements and survivors' positive accounts provides a compelling basis for strengthening trauma-informed counselling services, professional capacity development, integrated psychosocial programming, and contextually grounded research in Anglophone Cameroon.

CONCLUSION

This study set out to examine the impact of counselling intervention on the psycho-emotional well-being of female survivors of conflict-related sexual violence in Anglophone Cameroon. On the evidence presented, it concludes that counselling exerts a significant positive influence on survivors' psycho-emotional well-being: survivors who received eight weeks of structured, trauma-informed counselling moved from pronounced and uniform distress to a state in which more than four in five were thriving, a change that was statistically significant, substantial in effect, and corroborated by the survivors' own accounts of reduced stress, restored self-esteem and emotional healing. The finding was consistent with Adaptive Information Processing theory and with the international empirical literature, and the convergence of theory, measurement and lived experience strengthens confidence in the conclusion. Counselling, in short, is not merely helpful but is one of the most potent and well-evidenced forms of support available to survivors of CRSV most powerful, this study suggests, when delivered with respect, confidentiality and a survivor-centred spirit, and when understood as one layer within a broader, holistic response rather than as a stand-alone remedy.

Recommendations

On the basis of the findings and conclusions, the following recommendations are made with specific reference to counselling.

- To humanitarian organisations and service providers: sustain and expand structured, trauma-informed counselling for survivors of CRSV, and deliver it as part of an integrated package of support rather than as an isolated activity, so that psychological, medical, protection and economic needs are addressed together.

- To counsellors and frontline staff: deliver counselling in a respectful, non-judgemental and survivor-centred manner, since the survivors in this study linked their recovery as much to the experience of being heard without judgement as to any specific technique; confidentiality and emotional safety should be safeguarded at every stage.
- To programme designers: favour group and community-embedded counselling models adapted to the Anglophone-Cameroonian context, where communal and church-based structures already carry much of the region's emotional life, as these are likely to reach further and stigmatise less than the individual therapy hour, while retaining the core mechanism of reprocessing and reframing.
- To policymakers: allocate dedicated funding for mental-health and psychosocial support within humanitarian response budgets, and ensure that it reaches women-led and community-based organisations closest to survivors.
- To training institutions and supervisors: incorporate trauma theory and the Adaptive Information Processing model into the training of counsellors and health workers, so that frontline staff understand not only what to do but why trauma-focused processing matters.
- To future researchers: follow survivors over longer periods to test the durability of the gains observed, use larger and, where ethical, randomised samples to strengthen causal claims, and give particular attention to the experiences of adolescent girls and survivors with disabilities.

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