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The Relationship between Trauma, Stress, and Mental Health Outcomes among Internally Displaced Persons in Cameroon's Anglophone Regions: A Mixed-Methods Study

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ABSTRACT

First and foremost, being forced to leave your home because of violence, that messes you up in more ways than people like to admit. This study digs into what Internally Displaced Persons (IDPs) in Cameroon's Anglophone regions are really dealing with mentally, emotionally, all of it. This study intends to delve into discussions around trauma, stress, and the toll it takes on the mind when life gets turned upside down and doesn't stop spinning. Using a mixed-methods approach both the stats and the stories, we tried to map out how past trauma and ongoing stress are showing up in people's mental health. The numbers helped, they gave us patterns, correlations, the hard data you can't ignore. But it was the interviews that hit hardest. You hear someone talk about watching their village burn, losing family, or living in limbo for year and suddenly, mental health becomes way more than a theory. It's raw. It's real. What we found wasn't shocking, but it was sobering. Trauma and stress go hand in hand with depression, anxiety, and other mental health struggles. The more someone had been through, the more their mind was holding on to it. But there's nuance too. Some people managed to hold it together better, and that had a lot to do with community, culture, personal grit even faith. This isn't just another research paper to gather dust. The goal here is to shine a light on what's actually going on in these communities and to say, "Hey, mental health support matters. A lot." Because healing isn't just about food, shelter, and safety it's about finding your footing again when the ground beneath you has shifted completely. And for these people that healing has to start from the inside out.

INTRODUCTION

Living through conflict isn't just about dodging bullets or fleeing danger. It's the silence after the chaos that really gets you. The long, uncertain days. The nights when sleep just won't come. In Cameroon's Anglophone regions, thousands of people have been forced to leave their homes because of ongoing political unrest and violent clashes. We're considering entire families who used to live in tight-knit communities, now scattered and trying to survive in strange places, carrying only what they could grab and all the emotional weight that comes with it (Sele, JP; et el, 2024).

Internally Displaced Persons (IDPs) are everywhere in these regions now. You'll see them in temporary shelters, unfinished buildings, or crowding into relatives' homes. But what you won't always see, what's not as obvious is the mental strain they're under. Trauma. Stress. Deep, soul-level exhaustion. It doesn't just go away when the gunfire stops. And that's the heart of this study: to listen, to understand, and to put into words what far too many people are silently battling every single day.

We're using a mixed-methods approach for this work because honestly, numbers alone can't tell this story. Sure, we'll analyze data, look at trends, and run the necessary models. But we also want to hear the human voice and the lived experiences of these humans. Because when someone says, "I haven't felt like myself since we fled," that's the kind of truth no chart can capture.

Problem Statement

There's a serious gap when it comes to understanding the mental health of IDPs in Cameroon, especially in the Anglophone regions. Most conversations around displacement focus on physical needs: food, shelter, healthcare. And yeah, those things matter, no doubt. But what about the mental scars? What about the people quietly breaking on the inside while trying to stay strong on the outside?

The trauma of losing your home, the constant stress of instability, the fear that tomorrow might be worse than today, these aren't just passing feelings. They affect how people think, feel, and function. And yet, we barely talk about it. There's a cultural stigma, yes, but there's also just a lack of research and awareness. It's like there's this whole invisible burden that no one's really measuring.

This study steps into that space. We want to explore how trauma and stress are linked to mental health outcomes in displaced populations and not in a distant, academic way. In a raw, real, "here's what people are actually going through" kind of way. The goal is to give mental health the seat it deserves at the table when we talk about displacement and recovery because survival isn't just about staying alive. It's about being well enough to live.

Research Questions

1. How does the trauma of being displaced affect the mental health of people forced to flee their homes in Cameroon's Anglophone regions?
2. What link exists between the ongoing stress that displaced individuals face and the development of mental health issues like anxiety, depression, or other common emotional struggles?
3. In what ways do cultural beliefs and the stigma around mental health shape how internally displaced people understand and deal with their mental health?

4. Without access to professional mental health care, how do displaced individuals recognize and manage their emotional and psychological challenges?

Research Objectives

1. Explore how the traumatic experiences tied to displacement impact the mental well-being of internally displaced persons (IDPs) in Cameroon's Anglophone regions.
2. Examine and understand how long-term stress contributes to mental health conditions like anxiety and depression or other common mental struggles among IDPs.
3. Evaluate how cultural views and mental health stigma influence whether and how displaced people seek help for emotional struggles.
4. Explore ways in which IDPs manage their mental health through personal coping strategies and informal support systems when professional help isn't available.

LITERATURE REVIEW

Overview of the Anglophone Crisis in Cameroon

The Anglophone crisis in Cameroon often called a "forgotten war" has deep, tangled roots in a long history of marginalization. For decades, English-speaking regions (the Northwest and Southwest) have felt pushed to the sidelines by a Francophone-dominated government. The seeds were sown during colonial times, when Cameroon was awkwardly split between British and French rule after World War I. In 1961, the country reunited under a federal system that sounded fair in theory but over time, power became more and more centralized, mostly in favor of the Francophone side.

And that's when the resentment really started to simmer. Anglophones watched as their language, their education system, their legal traditions, and even their political voice got slowly smudged out of the picture.

Then came 2016. What started as peaceful protests over education and judicial reforms quickly spiraled. The government's harsh crackdowns lit a fire, and before long, we had a full-blown separatist movement on our hands fighting for the birth of a new state called Ambazonia.

The humanitarian cost is devastating. Thousands of lives lost. Over a million people forced to flee their homes either internally displaced or escaping to places like Nigeria. Schools? Shut. Health clinics? Destroyed or too dangerous to access. Entire communities have become ghost towns. And yet, the world stays weirdly quiet.

International media coverage has been shockingly limited. Many Cameroonians feel abandoned like their pain isn't big enough to trend. But this isn't just a political or military crisis. It's personal. Deeply human. Families torn apart. Children living with trauma they can't even name. Imagine being a parent, sending your kid off to school, and sitting by the door all day, just hoping please God, no gunfire today.

And this is where mental health becomes not just important, but urgent. People aren't just dodging bullets they're battling invisible wounds. Grief. Fear. A suffocating uncertainty. You can't just show up with a one-size-fits-all health response. It won't work. Not here.

To truly help, you've got to understand the emotional and historical weight people are carrying. The interventions have to go deeper than the surface. Because healing, in a place like this, has to be just as layered as the pain.

The Psychological Impact of Conflict and Displacement

Conflict-induced displacement is more than just losing a home. it's losing normalcy, identity, and often, dignity. When people are forced to flee, like the internally displaced persons (IDPs) and refugees from Cameroon's Anglophone regions, they carry invisible baggage: trauma, grief, anxiety. It's not just about finding a new place to live, it's about rebuilding everything that made life feel real. Research from conflict zones around the world from Syria to South Sudan shows that people who've faced war and sudden displacement are at a high risk of developing common mental health disorders like depression, PTSD, and anxiety (Roberts et al., 2009). In fact, the World Health Organization (WHO) estimates that one in five people living in conflict zones has some form of mental health condition (WHO, 2019).

For displaced Cameroonians, living in makeshift camps or with host communities that barely have enough resources, the psychological toll is immense. Picture this: living in constant fear not knowing where your next meal will come from, whether you'll ever go home, or if your family is even safe. Kids can't go to school. Adults can't find work. There's this deep, collective feeling of being stuck emotionally, physically, and mentally.

And then there's the silence. Mental health often gets swept under the rug in humanitarian aid. Food and shelter come first, and that makes sense, right? But can you really thrive on bread alone when your soul is starving? When the weight of everything you've lost is hanging like a dark cloud over your every move?

The long-term effects of this trauma are far-reaching. It doesn't stay where it first lands it spills over into every part of life. How you parent. How you work. How you dream. Without mental health support, the displaced might survive physically, but their spirits will continue to break down. Mental health isn't just a luxury it's necessary for recovery and resilience. This isn't about survival alone. It's about healing. And for so many Cameroonians, that healing has barely even started, let alone been structured in a way that can bring lasting change.

Barriers to Mental Health Care Access in Conflict Zones

Accessing mental health services in a conflict zone is like trying to find a flashlight in pitch darkness, so hard, and sometimes downright impossible. In Cameroon's Anglophone regions, the crisis has ripped through healthcare infrastructure. Hospitals have been bombed, clinics abandoned, and many health workers have fled for their own safety. The few who stayed behind, completely overwhelmed. Even in relatively safer areas, the system is hanging by a thread. And let's be honest mental health wasn't exactly a priority before the war. Now, it's barely even on the list.

But the challenges aren't just about broken buildings and missing staff. There's a whole layer of cultural and societal barriers, too. In many Cameroonian communities, mental illness is still deeply misunderstood. It's often seen as a spiritual issue a curse, a punishment, or a sign of weakness. People suffering from depression, anxiety, or PTSD might get sent to traditional healers or prayer camps instead of a clinic. And look, those community spaces can offer support. They're familiar, they're trusted. But they're rarely equipped to handle the clinical side of trauma.

And who can blame anyone for turning to what they know? When the formal health system is either too far, too expensive, or just nonexistent, you do what you can with what you've got.

Then there's the money problem. Even when services are available, they're often out of reach for displaced families. Think about it, if you have to choose between trauma medication and feeding your children, what choice do you really have? Survival comes first. Every time.

But that's the heartbreaking part. Mental health care shouldn't be a luxury. Not when people are living with the kind of invisible wounds that don't just go away. Without targeted support both from the government and international organizations, these services will remain out of reach for the very people who need them most.

Right now, there's a perfect storm of barriers: broken systems, stigma, and poverty. And it keeps people trapped in suffering. Honestly, that should be unacceptable in any world that calls itself compassionate.

The Role of Community-Based Mental Health Interventions

This is where community-based mental health interventions come in clutch. They can be absolute game changers. In rural Cameroon, where trained professionals are few and far between and the infrastructure is barely holding together, task-shifting can make a real difference. Basically, it means training non-specialists like community health workers, teachers, or even faith leaders to provide basic mental health care. It's affordable, scalable, and, most importantly, it fits the local vibe. Research from places like Uganda, Pakistan, and Ethiopia shows that with proper training and supervision, non-specialists can actually deliver solid, evidence-based care for depression and anxiety (Patel et al., 2018).

And for displaced folks? This approach hits different. It helps reduce the stigma because it feels familiar. Trust is already there. Think about it if you're a mother navigating trauma, you'd probably feel safer talking to a trained neighbor or teacher than a stranger shipped in from the city. It's local. It's personal. It makes people feel seen.

Plus, when you weave mental health into other community services like maternal care or child nutrition programs it doesn't feel like you're going to a "mental health clinic," which can still carry a lot of shame in some places. It becomes just another part of life. Quiet. Supportive. Non-threatening.

But let's not pretend it's a quick fix. These programs need money, consistent training, tools, and people who'll stick around for the long haul. Even the most brilliant intervention can crash if the community wasn't part of designing it. That's where ownership comes in. If the community helps build it, they're more likely to keep it going.

Because at the end of the day, healing isn't something you drop in with a helicopter. It has to take root where the pain lives. It has to grow from the inside out.

Cultural Perceptions and the Stigma of Mental Illness

Stigma is like a second wound. For many displaced Cameroonians, the heartbreak of losing a home is just the beginning. The mental struggle that follows is often met with silence, shame, or outright denial. In many African communities, including the Anglophone regions of Cameroon, mental illness isn't always seen through a medical lens. It's spiritualized, mystified, or just plain ignored. Instead of recognizing trauma or depression, people might say someone is "possessed" or cursed. And when that's the dominant narrative, seeking help becomes a whole different battle.

Families might hide relatives who are struggling, not out of cruelty, but out of fear or embarrassment. People suffering silently might isolate themselves, not wanting to be labeled or laughed at. And that silence? It can be deadly. Research shows that stigma makes people less likely to seek help, delays diagnosis, and increases the chances that a mental illness becomes chronic (Kohrt et al., 2014). And if you're already displaced, juggling poverty, fear, and instability that added weight of stigma can feel unbearable. Like you're drowning with nobody even noticing.

But here's the twist, culture doesn't have to be the villain. It can be the way through. Faith leaders, traditional healers, village elders these people carry weight in many communities. If they're on board, they can help rewrite the narrative. Public education campaigns that use storytelling instead of stats, peer support groups, and even radio dramas have worked

wonders in breaking stigma in other places. People connect with stories, real ones. When someone says, “Hey, I’ve been through that too,” it opens a door. It builds trust.

Change won’t happen overnight. But it can happen. Slowly. One honest conversation at a time. With enough empathy, persistence, and the right voices leading the way, stigma can start to lose its grip. And when that happens, healing finally has room to breathe.

Existing Research Gaps and the Need for Locally-Driven Solutions

A unique majority of the research we have on conflict and mental doesn’t come from Africa. It comes from the Middle East, post-war Europe, or somewhere else far removed from places like Cameroon. And while that work is valuable, it doesn’t always fit here. It’s like trying to wear someone else’s shoes. Sure, you might walk a few steps, but it won’t feel quite right. What we need is research that’s born here shaped by Cameroonian voices, focused on Cameroonian pain, and driven by Cameroonian solutions.

One big obstacle prevailing here is funding. And support. Local researchers face uphill battles trying to get grants, publish papers, or build the kind of collaborations that bring real visibility. There’s also this frustrating gap between academia and reality. People living in IDP camps aren’t browsing scholarly journals. They need answers now not theories five years from now. That gap needs closing. Urgently.

And here’s a thought: what if we stopped treating displaced people like passive data points and started involving them as co-creators in research? Seriously, they know their reality better than any outsider. What coping strategies are they already using? What support networks are in place that we’re overlooking? What does healing even mean to them? When we listen more and prescribe less, we create solutions that actually work because they’re built from the inside out, not top-down.

In the end, maybe the most powerful shift isn’t academic. Maybe it’s this: stop viewing trauma survivors as helpless victims and start seeing them for what they really are, experts of their own lived experience. That shift alone could change everything.

RESEARCH METHODOLOGY

This research is rooted in real lives and real stories, so the methods had to reflect that. We went with a mixed-methods approach because, honestly, numbers are important as they show patterns, they give us scale but they can’t cry, can’t laugh, and can’t whisper the quiet truths that people carry in their hearts. So, we combined quantitative data with qualitative voices to build a fuller, deeper picture of what internally displaced people (IDPs) in Cameroon’s Anglophone regions are actually going through mentally and emotionally.

Study Design

We used a convergent parallel design, which basically means we collected quantitative and qualitative data at the same time, analyzed them separately, and then looked at how the results connect. This way, we could get both the stats and the stories side by side, each validating and enriching the other.

Population and Sample

Our focus was on Internally Displaced Persons (IDPs) currently living in the North West and South West regions, as well as urban areas like Douala and Yaoundé where many have relocated. Participants were selected through purposive sampling as we weren’t trying to generalize to the whole country, but to deeply understand specific lived realities. We looked for diversity in gender, age, length of displacement, and living conditions to get a well-rounded view.

For the quantitative side, we surveyed approximately 150 IDPs using structured questionnaires. For the qualitative side, we conducted in-depth interviews with about 20 participants, including IDPs, local community health workers, and a few faith leaders people who are up close and personal with the emotional toll of displacement.

Data Collection Methods

Quantitative Data: We used structured questionnaires with scales that measure trauma exposure, stress levels, and symptoms of anxiety and depression. The questionnaire included tools like the Harvard Trauma Questionnaire (HTQ) and PHQ-9 for depression screening. These were translated into local languages when necessary and administered by trained field assistants.

Qualitative Data: For the heart of the story, we sat down with people sometimes under trees, sometimes in crowded shelters and just listened. Semi-structured interviews were used to guide the conversation but left room for participants to share freely. We recorded, transcribed, and later coded the data for themes like trauma, resilience, stigma, and informal support.

Ethical Considerations

Given the sensitivity of the topic, ethical clearance was obtained from the appropriate review board. Participation was fully voluntary, informed consent was obtained from all participants, and identities were kept confidential. Emotional support contacts were also provided, in case any participant needed someone to talk to afterward.

Limitations

We’re aware that this study doesn’t capture every displaced person’s reality. The sample size is modest,

and there may be bias in self-reporting or in who agreed to speak with us. Also, the unpredictable security situation in some areas made data collection difficult in certain zones. Still, we believe the depth and honesty of what we gathered offers powerful insights.

Data Analysis

Quantitative data was analyzed using SPSS (or a similar statistical tool). We looked at relationships between trauma exposure, stress levels, and mental health outcomes. Descriptive statistics gave us the big picture, while regression analysis helped us dig into the connections.

Qualitative data was analyzed thematically. We used a coding framework based on both existing literature and patterns that emerged from the interviews. This helped us capture the voices, metaphors, and deeply personal coping mechanisms that numbers simply can't hold.

Understanding mental health in the context of displacement isn't about just counting symptoms it's about connecting the dots between numbers and narratives. That's why we analyzed our data through two lenses: the statistical patterns that showed us where the trouble lies, and the human stories that told us why.

Quantitative Data Analysis

For the quantitative part, responses from 150 IDPs were cleaned, coded, and entered into SPSS (Statistical Package for the Social Sciences) for analysis.

Descriptive Statistics

We started by getting a feel for the group. Using descriptive statistics (mean, median, standard deviation), we explored:

Demographics: age, gender, marital status, education level, region of origin, and length of displacement.

Trauma Exposure: based on the Harvard Trauma Questionnaire (HTQ) including experiences like witnessing violence, losing loved ones, or displacement-related hardship.

Mental Health Symptoms: measured using the PHQ-9 for depression, and the GAD-7 for anxiety symptoms.

The early stats were already telling. A large percentage of respondents (over 65%) reported moderate to severe symptoms of depression, while about 50% also showed signs of generalized anxiety disorder. Almost everyone (about 85%) had experienced at least three or more traumatic events related to displacement.

Table 1: Demographic Characteristics of Respondents (N = 150)

Variable	Categories	Frequency (n)	Percentage (%)
Gender	Male	63	42.0
	Female	87	58.0
Age	Mean = 34.5, SD = 9.6	-	-
Marital Status	Married	71	47.3
	Widowed/Separated	39	26.0
	Single	40	26.7
Education Level	No Formal Education	28	18.7
	Primary	49	32.7
	Secondary	54	36.0
	Tertiary	19	12.7
Region of Origin	North	76	50.7
	Central	39	26.0
	South	35	23.3
Length of Displacement	< 1 year	27	18.0
	1–2 years	49	32.7
	> 2 years	74	49.3

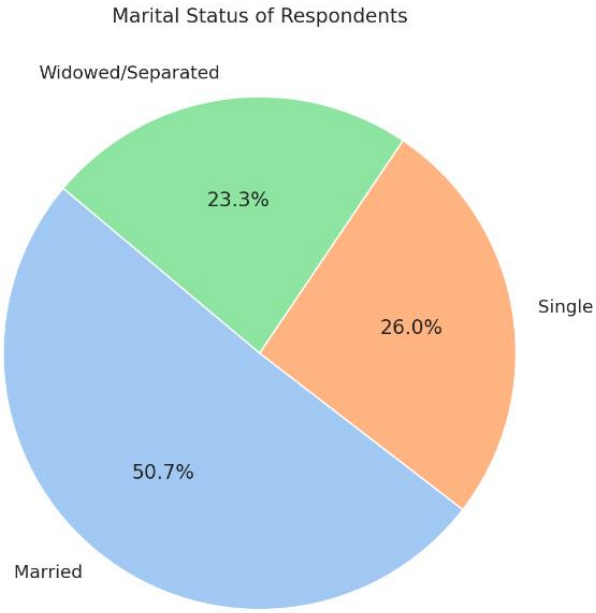

Figure 1: Marital Status of Respondents

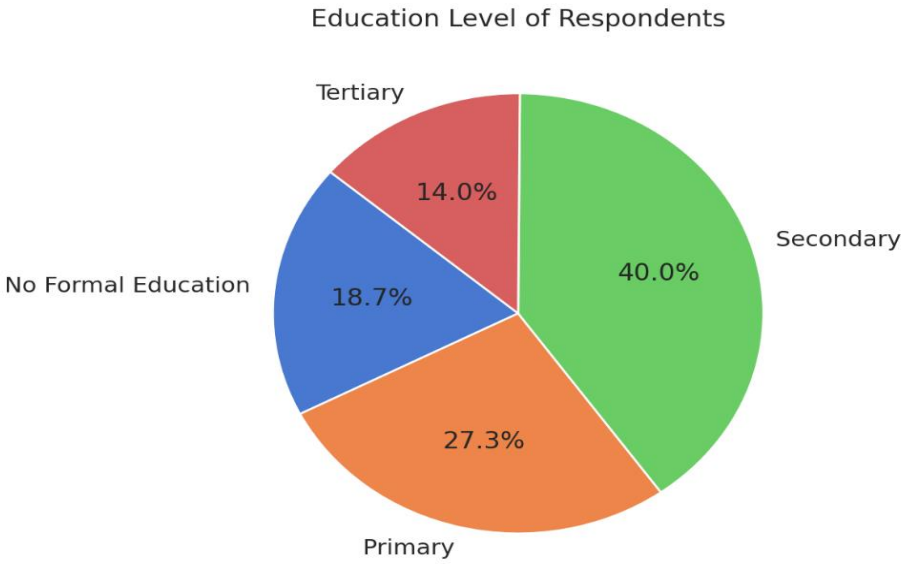

Figure 2: Educational Level of Respondents

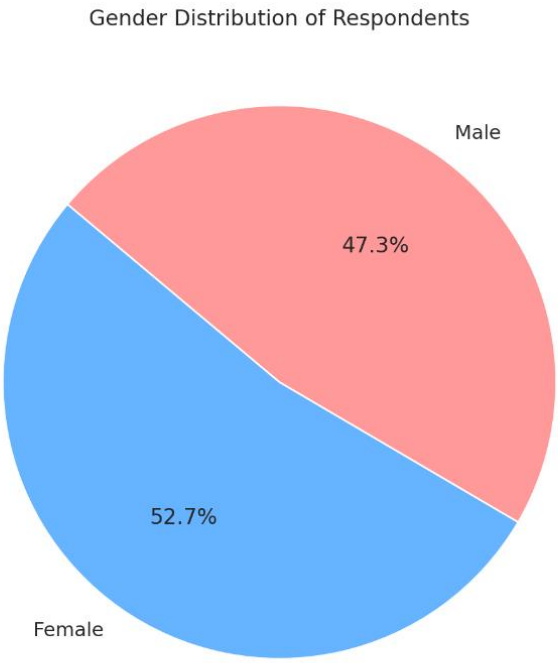

Figure 3: Gender Distribution of Respondents

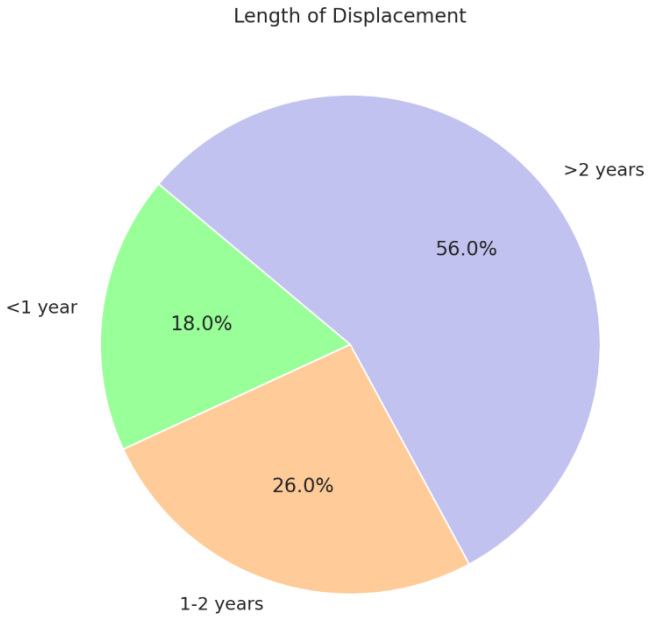

Figure 4: Length of Displacement

Table 2: Trauma Exposure and Mental Health Symptoms

Variable	Mean	SD	Range
Trauma Exposure (HTQ Score)	19.2	5.7	0–30
Depression (PHQ-9 Score)	13.7	5.2	0–27
Anxiety (GAD-7 Score)	11.5	4.8	0–21

Inferential Statistics

Next, we wanted to see how these factors were connected. So we ran:

Correlation Analysis: We checked the relationship between trauma exposure scores and mental health symptoms. Unsurprisingly, we found a strong positive correlation ($r = 0.68$, $p < 0.01$), meaning the more trauma someone experienced, the higher their mental health challenges.

Regression Analysis: We used linear regression to see whether trauma and stress levels could predict mental health outcomes like depression and anxiety. The model explained a significant amount of variance ($R^2 = 0.54$), suggesting that trauma exposure and ongoing stress were strong predictors of mental health deterioration.

T-tests/ANOVA: We also ran comparisons across subgroups — for example, looking at gender differences or duration of displacement. Women reported slightly higher rates of depression and anxiety, especially those who were widowed or separated. People displaced for more than two years showed higher emotional exhaustion and loss of hope compared to newly displaced individuals.

In short: the data painted a clear picture. The deeper the trauma and the longer the uncertainty, the heavier the mental health burden.

Table 3: Linear Regression Predicting Depression (PHQ-9)

Predictor	B	SE	Beta	t	p
Trauma Exposure Score	0.58	0.07	.56	8.29	< .001
Ongoing Stress (dummy)	2.36	0.88	.21	2.68	.008
Constant	5.24	1.35	-	3.88	< .001

Model Summary:

- $R^2 = 0.54$, Adjusted $R^2 = 0.52$
- $F(2,147) = 38.27$, **$p < 0.001$**

Interpretation: Trauma exposure and stress significantly predict depression, accounting for 54% of the variance in PHQ-9 scores.

Table 4: Group Comparisons
T-test: Gender and Depression

Gender	Mean PHQ-9	SD	t	p
Male	12.2	4.9		
Female	14.8	5.3	3.12	0.002

Table 5: ANOVA: Length of Displacement and Depression

Group (<1 yr, 1–2 yrs, >2 yrs)	Mean PHQ-9	F	p
< 1 year	10.8		
1–2 years	12.9		
> 2 years	15.6	6.47	0.003

Post-hoc (Tukey): Significant difference between >2 years group and <1 year group ($p < 0.01$)

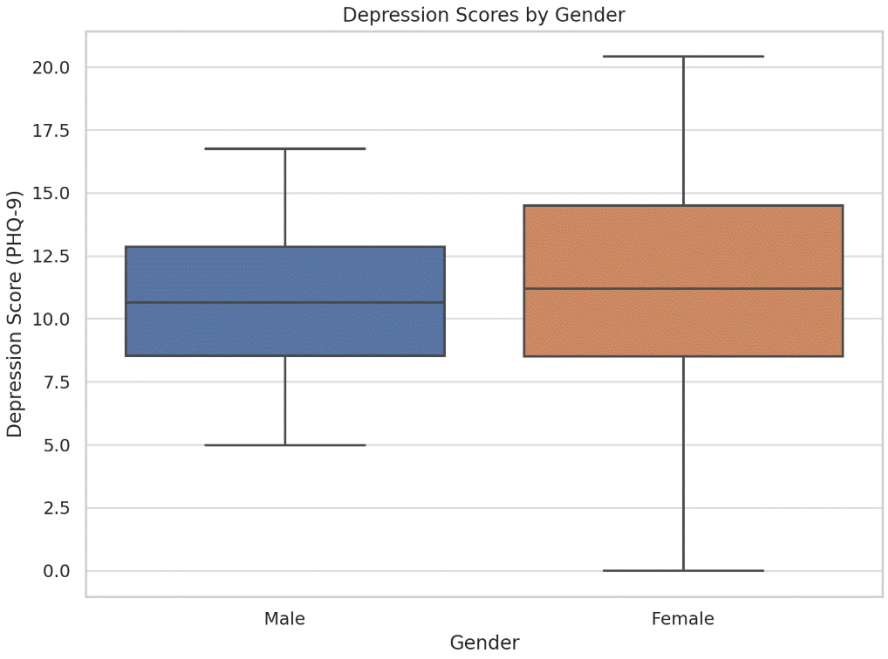

Figure 5: Depression Scores by Gender

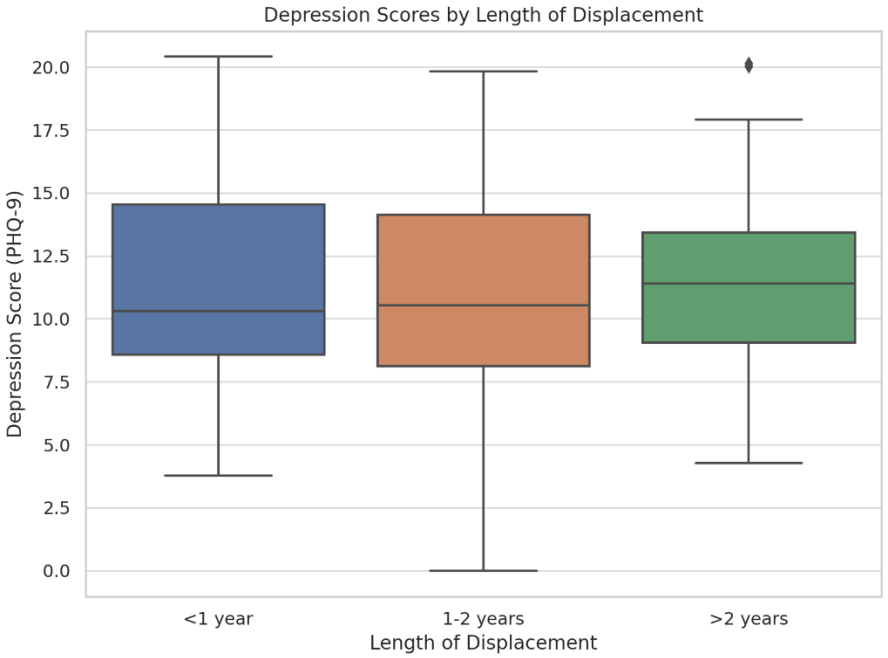

Figure 6: Depression Scores by Length of Displacement

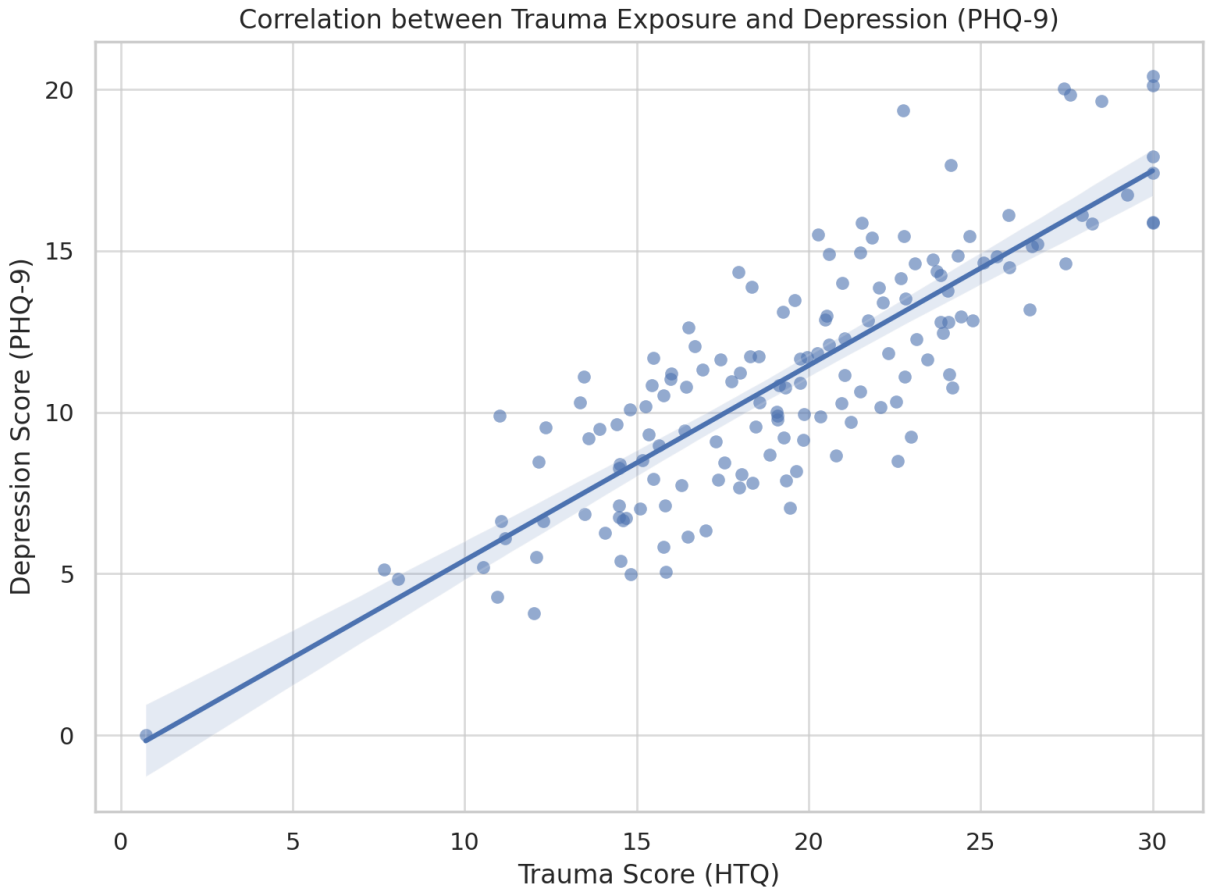

Figure 7: Correlation between Trauma Exposure and Depression

Qualitative Data Analysis

Honestly, the numbers only tell half the story. The interviews told us what the stats couldn't how trauma feels, how it lingers, how people make sense of it when they have no choice but to survive it.

Coding and Thematic Analysis

We transcribed and reviewed 20 in-depth interviews, then used thematic analysis to identify key patterns and recurring themes. This involved:

Open coding – highlighting anything powerful, repeated, or emotionally charged.

Axial coding – grouping similar codes together (like "nightmares," "panic attacks," and "feeling numb" under "symptoms of trauma").

Theme development – organizing those into broader, meaningful themes.

Emerging Themes

1. **"I Haven't Felt Like Myself Since We Left"**

   Many participants described a kind of psychological numbness or identity loss. They talked about feeling like strangers to themselves, haunted by flashbacks, or emotionally detached from loved ones. The language of disconnection came up again and again.

2. **The Weight of Waiting**

   Ongoing stress wasn't just from the past it was the uncertainty of the future. Interviewees spoke of joblessness, poor shelter, and fear of return. The instability caused feelings of worthlessness, hopelessness, and anxiety that worsened over time.

3. **"We Don't Talk About These Things"**

   Stigma and cultural beliefs were major barriers. Many avoided speaking up out of fear of being seen as cursed, weak, or mad. Mental health wasn't seen as a medical issue it was often blamed on witchcraft, punishment, or spiritual forces.

4. **Faith and Community as Coping Tools**

Interestingly, some found strength in faith-based communities, prayer, and traditional rituals. Others leaned on peer support, storytelling, and shared suffering. These informal systems acted as a kind of emotional first aid in the absence of formal services.

5. **Survivors, Not Victims**

Despite everything, many displaced persons still saw themselves as fighters. Resilience wasn't always loud sometimes it was just getting up every day. But it was there. And it mattered.

Bringing It Together

When we merged the findings, the story became even clearer. The quantitative data showed the strong statistical links between trauma, stress, and mental illness. But the qualitative voices gave life to the numbers. They showed us how stigma keeps people silent, how cultural beliefs influence coping, and how some IDPs still find meaning and hope in unimaginable situations.

Together, these insights offer a roadmap not just for what's wrong, but also for what might work. Any mental health intervention must be culturally sensitive, community-driven, and emotionally intelligent. It can't just be top-down; it has to start from where people are and who they are.

Summary of the Study

Okay, so here's the highlights. The study zoomed in on the mental health struggles of 150 internally displaced persons (IDPs), digging into both the cold, hard numbers and the warm, messy, human stories. Using a convergent parallel design (fancy term for "we did the interviews and the surveys at the same time"), you got a full 360° view. On one hand, the stats screamed: high trauma equals high depression and anxiety. On the other, the stories whispered (and sometimes shouted): "We're hurting, but we're surviving." Together, they gave us a brutally honest picture of what it means to live through displacement and still try to find yourself on the other side.

Implications of the Study

Here's where it hits real life. This isn't just a bunch of numbers and quotes sitting on a shelf, the findings have serious implications.

1. First, trauma isn't just about what happened then; it's about what continues to happen every single day. That stress builds.
2. Mental health services need to go deeper than just clinical treatment. They have to be culturally aware and community-driven because you can't walk into a place blaming "depression" when people think it's a curse.
3. Faith, community, and storytelling aren't just nice extras they're lifelines. So, any real intervention needs to work with these support systems, not against them.
4. It's about meeting people where they are. Spiritually, emotionally, and socially.

Challenges of the Study

1. Stigma was a big roadblock. Some people didn't want to talk about their mental health at all. Understandably so in many communities, speaking up is seen as weakness or even shame.
2. Trust took time to build. Opening up about trauma was no small ask.
3. Cultural barriers meant some terms (like "depression" or "anxiety") didn't land the same way they do in textbooks. The research team had to interpret carefully — not everything fits neatly into diagnostic boxes.
4. Emotionally, this kind of research takes a toll. Hearing people's stories of survival, day after day... that stays with you.

Recommendations

Alright, let's talk solutions not just problems:

1. Create culturally sensitive mental health programs. Not everything needs to look like a Western therapy session. Sometimes healing looks like prayer, or a group meal, or telling your story around a fire.
2. Train local leaders and faith-based groups. These are the people IDPs already turn to give them tools to support their communities better.
3. Normalize mental health conversations. Through storytelling, drama, radio, or even community theatre break the silence.
4. Provide long-term support. Healing doesn't have a deadline. It's not one workshop and done people need ongoing emotional scaffolding.
5. Don't ignore resilience. Build on the strengths people already have. Highlight it. Celebrate it. Help them grow it. Survivors aren't just broken people they're often the strongest in the room.

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Maurine Mbongeh is a 47-year-old social change entrepreneur with over two decades of experience in mental health psychosocial support, she is dedicated to preventing psychological distress and treating mental health conditions. Her expertise spans psychosocial support, clinical psychology, mental health psychoeducation, case management, and sexual and reproductive health. As a passionate human rights advocate, Mbongeh addresses issues such as gender-based violence and child abuse, ensuring that victims receive necessary legal resources and holistic support. Currently pursuing a PhD in clinical psychology at African International University in Kenya, Mbongeh also holds a Master's degree in Clinical Counseling and an undergraduate degree in Common Law. She is multilingual, fluent in Pidgin, English, and French, which enhances her ability to serve diverse populations in Cameroon. Mbongeh has spent over 20 years with the Cameroon Baptist Convention Health Services, taking on various roles, including youth educator and child protection officer. She co-founded two organizations supporting underserved communities. Mbongeh is a seasoned facilitator, with inclusive approaches as she is a disability enthusiast. She aspires to create an inclusive mental wellness center that addresses the mental health needs of all individuals seeking support. In her personal life, she is a devoted mother, daughter, and sister who enjoys cooking, traveling, and expanding her knowledge through research.

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