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**WAR-TRAUMA AND HELP SEEKING BEHAVIOUR AMONG THE DIOCESAN
CLERGY OF KUMBO DIOCESE, ANGLOPHONE CAMEROON**

A dissertation presented to

SCHOOL OF ARTS AND SOCIAL SCIENCES
in partial fulfillment of the requirements for the award of the degree
Master of Mental Health Counselling Psychology

UGANDA MARTYRS UNIVERSITY

Uganda Martyrs University
Making a Difference

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September 2025

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Master's Dissertation

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DEDICATION

I dedicate this research work first to all those clergy who are living the Gospel in the Conflict Zones of Africa. Here, I have in mind in a special way all the clergy who have served and are still serving in the conflict-stricken anglophone regions of Cameroon. These zealous disciples of the Compassionate Lord have submitted their hearts and minds to God's sovereignty even in the most difficult situations, seeing gospel opportunities when the world sees conflict and pain. Their courageous commitment reveals that the gospel can cease conflict by ending the war in human hearts against God. Their commitment to living the Gospel in Conflict zones also testify that only when humans are healed by an encounter with God's love can they lay down their weapons and pick up the cross of love.

This study is also dedicated to my parents for their inspiration and support through challenges, as well as to siblings, mentors, friends, and classmates for their advice and encouragement to complete the study. I also in a special way dedicate this work to God for providing the guidance, strength, and health to make this accomplishment possible.

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In a special way, I praise and thank our Almighty, Merciful and Loving God for giving me life and for protecting me throughout my academic endeavours.

I also thank my dear supervisor, Ddumba M. Pius, who is my mentor, inspirer, role model and guide for supporting me in developing this research proposal. God bless you, Sir!

ABBREVIATIONS/ACRONYMS

ADP	Association of Diocesan Priests
APA	American Psychological Association
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CAR	Central African Republic
CF	Conceptual Framework
CTS	Columbia Theological Seminary
DC	Diocesan Clergy
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5
EAJESS	East African Journal of Education and Social Sciences
G-CARD	Gitoya Centre for Academic Research and Dissemination
IRFR	International Religious Freedom Report
KIIs	Key Informant Interviews
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
PTSD	Post Traumatic Stress Disorders
RCSC	Roman Catholic Secular Clergy
SDG3	Sustainable Development Goal 3
TR	Theoretical Review
USDVA	United State Department of Veterans Affairs
USNIH	United States' National Institutes of Health
WHO	World Health Organization
WOS	Wide Open Spaces
WT	War-Trauma

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ABSTRACT

The ongoing separatist conflict in Anglophone Cameroon has deeply affected multiple sectors of society, including religious institutions. This study investigates the impact of war-related trauma and the patterns of help-seeking behaviour among diocesan clergy in the Diocese of Kumbo, North-West Region of Cameroon. The primary objective was to examine how war trauma is managed among the clergy amidst persistent violence and insecurity. Specifically, the study assessed the effects of stress, anxiety, and depression on clergy mental health, as well as the influence of coping mechanisms on their mental health care-seeking behaviours and trauma resilience.

A qualitative research design was employed, utilizing in-depth interviews with three groups of participants: diocesan clergy, clergy who are victims of kidnapping, and leaders of the association of diocesan priests. Data were analyzed thematically using NVivo 15 software. Findings reveal that war-related stress and anxiety have significantly contributed to psychological distress among the clergy, leading to symptoms such as chronic insomnia, emotional numbness, fear, and spiritual fatigue. Depression was also common, manifesting a reduced pastoral motivation, social withdrawal, and existential crisis.

Despite these challenges, clergy employed a range of coping strategies, notably meaning-focused methods such as prayer, spiritual counseling, peer support, and religious retreats. However, structural barriers—including fear of stigmatization, limited access to mental health services, and ongoing security threats—negatively impacted formal help-seeking behaviours. The findings underscore the importance of integrating psychosocial support into pastoral care structures and highlight the need for faith-based trauma interventions that are culturally and contextually relevant.

This study contributes to the growing body of literature on trauma in conflict settings, offering practical insights for church leadership, mental health practitioners, and policymakers working to support clergy and other vulnerable groups in fragile contexts.

Keywords: *War-trauma, mental health, clergy, stress, anxiety, depression, coping strategies, help-seeking behaviour, Kumbo Diocese, Cameroon.*

CHAPTER ONE

GENERAL INTRODUCTION

1.0. Introduction

War-related trauma is on the increase in Africa with Cameroon listed among the six conflict hot spots (Musisi and Kinyanda, 2020; ISS Africa PSC Report, 2021). This study, therefore, intends to examine trauma management and mental health seeking behaviours among Diocesan Clergy in the Diocese of Kumbo who live and work amidst the Separatist War in Anglophone Cameroon. Presented here in the introductory section is the Background to the study, Statement of the problem, Main and Specific research objectives, Hypotheses, Scope of the study, Justification and Significance of the study, Conceptual framework, and Definition of key concepts/terms.

1.1. Background of the Study

World over, there is recognition of the increasing burden of mental disorders among conflict-affected populations (WHO, 2022). A review of 129 studies in 39 countries by WHO showed that among people who have experienced war or other conflicts in the previous 10 years, one in five people (22%) will have depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia (WHO, 2022). Thus, mental health in times of conflict is a public health issue that cannot be ignored (Lim et al., 2022). This recognition is also embedded in the conceptual background of the study, which is grounded in the understanding that war and violence trigger psychological distress and mental health disorders, shaping the coping mechanisms of both individuals and institutions. Mental health under Sustainable Development Goal 3 (promoting wellbeing for all at all ages) has therefore been recognized as a vital pillar for the achievement of sustainable development (Staglin, 2022).

From a historical background, Africa has endured multiple cycles of war-related distress ranging from ethnic rivalries provoking raids, the slave trade, European colonization, wars for independence, and post-independence political conflicts (Musisi & Kinyanda, 2020). According to Musisi and Kinyanda (2020: p.2), wars of foreign colonization were also characterized by ‘imposed religious wars.’ These colonial systems became the backbone of post-colonial conflicts, including genocides and recurrent wars. To date, Africa continues to experience war-related trauma, as groups—political, religious, and cultural—struggle for resources, power, and control of

boundaries. These conditions have left millions dead, displaced, impoverished, and traumatized (Njenga, Nguithi & Kang'ethe, 2006; Musisi & Kinyanda, 2020).

The global nature of war crises has amplified the risk of war-related trauma among victims. Civilians including women, children, youth, and community leaders—experience extreme stressors such as loss of family members, abduction, sexual violence, forced conscription, and witnessing killings or torture (Suhaiban, Grasser & Javanbakht, 2019; Sabia & Skimmyhorn, 2019). Historical and ongoing examples of such conflicts include the Syrian Civil War (2011–present), which has displaced over 13 million people and exposed civilians to repeated acts of violence; the Rwandan Genocide (1994), which resulted in the systematic killing of approximately 800,000 people and left millions traumatized; the armed conflict in Afghanistan (1979–2021), which subjected civilians to decades of warfare, bombings, and insurgent violence; and the civil war in South Sudan (2013–2018), which led to mass atrocities, famine, and psychosocial trauma among children and adults alike. More recently, the Anglophone crisis in Cameroon (2016–present) has exposed clergy and local populations to armed attacks, kidnappings, and threats to both life and livelihood.

Globally, the impact of conflict is compounded by the dysfunction of healthcare and psychosocial support systems. In many low- and middle-income countries affected by conflict, health infrastructure is either destroyed or inaccessible, leaving victims without formal mental health care (Seguin & Roberts, 2015). This systemic failure forces survivors to rely on personal coping mechanisms, social networks, or religious resources, which may not always be adequate to address the severity of their trauma (Palamarchuk & Vaillancourt, 2021).

Cameroon's Northwest (NW) and Southwest (SW) regions (the Anglophone region) are currently among the six conflict-ridden hotspots in Africa, alongside Libya, South Sudan, the Central African Republic, Northern Mozambique, and Ethiopia (ISS Africa PSC Report, 2021). The conflict began in 2016 after the government cracked down on lawyers' and teachers' peaceful protests. Armed separatists exploited the situation to demand independence for the Anglophone regions (ISS Africa PSC Report, 2021). Since then, the war has displaced over 679,000 people, left more than 600,000 children out of school, and caused over 3,000 deaths (Atemanke & Kahi, 2020).

In this contextual background, the Catholic Church in Cameroon has emerged as both a peacemaker and a victim in the crisis. Officially, the Church has preached peace, justice, and non-violence, while denouncing both separatist brutality and state repression (International Religious Freedom Report, 2019; Slaby, 2021). However, this neutrality has positioned her in the crossfire, with clergymen abducted, detained, and even killed (Finnan, 2018). Despite such dangers, clergy remain on the ground, providing pastoral care, advocating for education, and giving hope to displaced populations (Atemanke & Kahiu, 2020).

The theoretical background of this study draws on trauma theory and stress-coping models. Trauma theory explains how exposure to overwhelming violence or displacement shatters individuals' sense of security, leading to long-term psychological distress (Carpiniello, 2023). The stress-coping framework further highlights how individuals adopt strategies—spiritual, social, or psychological—to adapt to trauma (Lazarus & Folkman, 1984; Dumke et al., 2021). For clergy, coping may involve prayer, community solidarity, and resilience grounded in religious vocation, however, at risks of burnout and post-traumatic stress.

At the same time, the Catholic Church assumes a dual role in addressing mental health in conflict settings. First, it provides spiritual and social accompaniment to communities struggling with trauma. Second, it advocates for policy changes that ensure equitable access to mental health resources (Slaby, 2021). However, in sub-Saharan Africa, mental health remains poorly prioritized, often managed through traditional and spiritual interventions, with an estimated 70–80% of South Africans consulting traditional healers for psychological ailments (Galvin et al., 2023; Gberie, 2017). War further disrupts the already fragile psychiatric and psychosocial systems by interrupting the supply of essential medicines (Jain et al., 2022). This reinforces the urgent need for faith-based institutions to complement state health systems in providing hope and alternative coping pathways.

Moreover, experiences of war trauma vary across demographics and roles. For instance, Dumke et al. (2021) observed that the impact of trauma differs between men and women, combatants and civilians, or refugees and host populations. For clergy, the uniqueness lies in their dual identity as victims of war trauma and as spiritual caregivers. Lim et al. (2022) argue that while research has documented general war trauma, there remains a critical gap in understanding trauma severity and coping among specific groups such as clergy. Addressing this gap is crucial because clergy play a pivotal role in community healing and resilience.

In sum, this study is situated at the intersection of historical, conceptual, theoretical, and contextual realities of war trauma. Conceptually, it recognizes mental health as a human rights and public health issue. Historically, it acknowledges Africa's long legacy of war-related trauma. Theoretically, it applies trauma and stress-coping frameworks to explore clergy's lived experiences. Contextually, it focuses on the Anglophone crisis in Cameroon, where clergy are both caregivers and victims. This positioning makes the study timely, relevant, and necessary in advancing scholarship on mental health and help-seeking initiatives in conflict-affected populations as in the case of Syria, Israel-Palestine war, Russia-Ukraine war, the Democratic Republic of Congo, Sudan and South Sudan.

1.2. Statement of the Problem

War-trauma is silently affecting the diocesan clergy in Kumbo as unlawful killings, murders, sexual violence, lootings, and kidnappings by the Cameroon defense and security forces, militias, and armed separatists in the Anglophone region of Cameroon have become the norm (Amnesty International's latest report on Cameroon, 2023). Those who speak out about the crisis, including the clergy, are being harassed and sometimes detained by the Cameroonian army and the armed separatists. Catholic institutions and clergy have become among the targeted. Over 15 (23%) clergy men, including, a cardinal, an archbishop, and a bishop have been kidnapped and some tortured. A total of 3 clergies out of 65 (4.6%) have been killed in the arm conflict. A parish church building, and some educational and health facilities belonging to the church have also been burned down in the ecclesiastical province of Bamenda where Kumbo is located (Akana, 2022). The situation is even more traumatizing as the clergy continue to see and bury many people brutally killed, and give hope to multitudes who are victims of the separatist war, yet, they too are undergoing the same war trauma experiences.

Little, however, is known on how war trauma is managed by the Catholic Church or about the clergy's mental health help-seeking initiatives, except for Mazloom's observation that Catholics are generally afraid to deal with mental disorders. He further notes that some catholic clergy mistrust secular psychologists, and many believe that prayer and frequent sacraments is enough to heal them; yet the psyche and soul are different (Mazloom, 2002). This study has also examined mental health help-seeking behaviour of the clergy and its effectiveness. Studies by Murthy & Lakshmi Narayana (2006) contend that 10% of people who experience traumatic events end up with serious mental health problems, and another 10%, develop behaviour that will hinder their

ability to function effectively. This means that an estimated 6% of the clergy will experience serious mental health disorder, and another 6% become dysfunctional out of the 65 who are currently working in Kumbo; if the war trauma is poorly managed. This will be detrimental to the population in Kumbo where an estimated 2500 people are served per priest/clergy (Chenny, 2022).

1.3. Main Objective

To investigate how War-Trauma is managed and mental health help-seeking behaviour among Diocesan Clergy in the Diocese of Kumbo amid the Separatist War.

1.4. Specific Objectives

- i. To find out the effect of stress on mental health among the Clergy in Kumbo Diocese in Cameroon.
- ii. To explain how anxiety affects mental health among the Clergy in Kumbo Diocese in Cameroon.
- iii. To describe how depression affects mental health of the Clergy in Kumbo Diocese in Cameroon.
- iv. To find out how coping mechanisms impact on mental health care-seeking among the Clergy in Kumbo Diocese in Cameroon.
- v. To evaluate the effect of coping strategies on war-trauma and mental health among the Clergy in Kumbo Diocese in Cameroon.

1.4.1. Research Questions

- i. What is the effect of stress on mental health among the Clergy in Kumbo Diocese in Cameroon?
- ii. What is the effect of anxiety on mental health among the Clergy in Kumbo Diocese in Cameroon?
- iii. How does depression impact on mental health of the Clergy in Kumbo Diocese in Cameroon?
- iv. How do coping mechanisms impact on mental health care seeking among the Clergy in Kumbo Diocese in Cameroon?
- v. What is the effect of coping strategies on war-trauma and mental health among the Clergy in Kumbo Diocese in Cameroon?

1.5. Justification

The study intends to establish how diocesan clergy who live and minister in armed conflict areas experience and manage war-trauma despite not being trained as chaplains in war zones; and with no immunity or inclusion as the neutral category in war by the international humanitarian law. According to Andersen (2020) mental health and psychosocial support (MHPSS) is increasingly being recognized as an integral part of humanitarian assistance offered to conflict-affected populations. MHPSS in conflict settings is also a rapidly growing area of research as scholars and practitioners seek to identify predictors of psychological distress and evidence-based approaches to treatment. Thus, information from the study will contribute to literature in the area, and evidence for policy provisions for clergy within the diocesan and government structures for their psychosocial wellbeing. Moreover, the use of the in-depth interviews for data collection gives the study a way of getting entire war-trauma experiences that will bring new insights from the clergy.

1.6. Significance

Hassan (2024) affirms that research significance outlines how the research will contribute to the existing body of knowledge, what gaps it will fill, or what new understanding it brings to a particular field of study. The study, hence, shall improve and bring new understanding on how clergy actually experience and cope with symptoms of war-trauma. It is also a practical guide for the researcher to scientifically learn how to solve problems of human existence and relations, and promote his 'careerism'. The successful completion of the study (thesis) also enables the researcher to obtain a master's degree that can further enhance his 'source of livelihood' in several ways, for instance, for attainment of better jobs (Kothari, 2005: p.7).

1.7. Scope of the Study

As stated by Costello (2023), an academic research is a meticulous process that requires precise planning and clear boundaries. Therefore, the two essential components of scope and delimitations will be applied in this study process to ensure an effective and manageable research, with relevant results. The scope of this research work is seen in the breadth and depth of its investigation, which have been defined, as Hassan (2024) says, by its subject matter, geographical location, time frame, and the issues under exploration, precisely, war trauma management and mental help seeking among clergy.

On the other hand, delimitations which define what the study will not include, have been seen in the researcher's choice of research methodology, his selection of participants, the duration of the study, and more. The researcher, following the advice of Costello (2023), has confined his study to a manageable size as he excludes peripheral elements. He is specific to diocesan clergy who serve amidst the ongoing war in Kumbo.

1.7.1. Content Scope

This study was centered on how management of war-trauma among clergy is being done amidst war. Three theoretical perspectives (Stress and Coping Theory by Lazarus and Folkman, 1984; the constructionist, and socio-ecological theories), guide this study. The Stress and Coping Theory has been instrumental in shaping stress and coping research in recent past (PsycInfo Database Record, 2022 APA). It explains that people respond to stressful events either through the process of appraisal or coping. As a process, coping regulates distress through strategies that are meaning-focused. By drawing on deeply held values and reordering of priorities and goals, the individual creates or renews a sense of purpose that is needed to sustaining coping over the long term (Biggs, Brough & Drummond, 2017). The constructionist psychological theory informs the study as it contends that actual events in the world are constructed by individuals, community, and society. This then determines how people think, feel and behave (McAdams, 2022). Supplemented by the socio-ecological theory, the study is centered on exploring how 'multiple factors', these are, individual, community, and societal affect how the clergy describe and experience war-trauma symptoms, cope and manage it (McCloskey,2015).

1.7.2. Geographical Scope

This research was carried out in the diocese of Kumbo located in the administrative territories of Bui and Donga-Mantung divisions of Anglophone Cameroon. The diocese was created on March 18th. 1982 by Pope Saint John Paul II, with its territory separated from the Archdiocese of Bamenda. Kumbo Diocese, thus, covers two out of the seven administrative divisions that make up the North West Region of the country-Bui and Donga-Mantung divisions with about 8,000 kilometers square as shown on the map below. The seat of the Diocese, Kumbo is about 110 Kilometers from the regional capital, Bamenda and about 70 Kilometers from Nkambe, Donga Mantung Division-the administrative headquarters. The terrain within this surface area is very hilly. The diocese shares national boundaries with Nigeria and local boundaries with the Western

Region, Boyo, Menchum and Ngohketunja Divisions in the North West (Cameroon Today, 2024). It was chosen because of its geographical location where the separatist war is currently taking place. Kumbo is also home to some of the diocesan institutions such as school, colleges (Saint Augustine, Saint Peter, Saint Aloysius, and saint Sylvester), health facilities, and clergy that have been directly/ indirectly targeted.

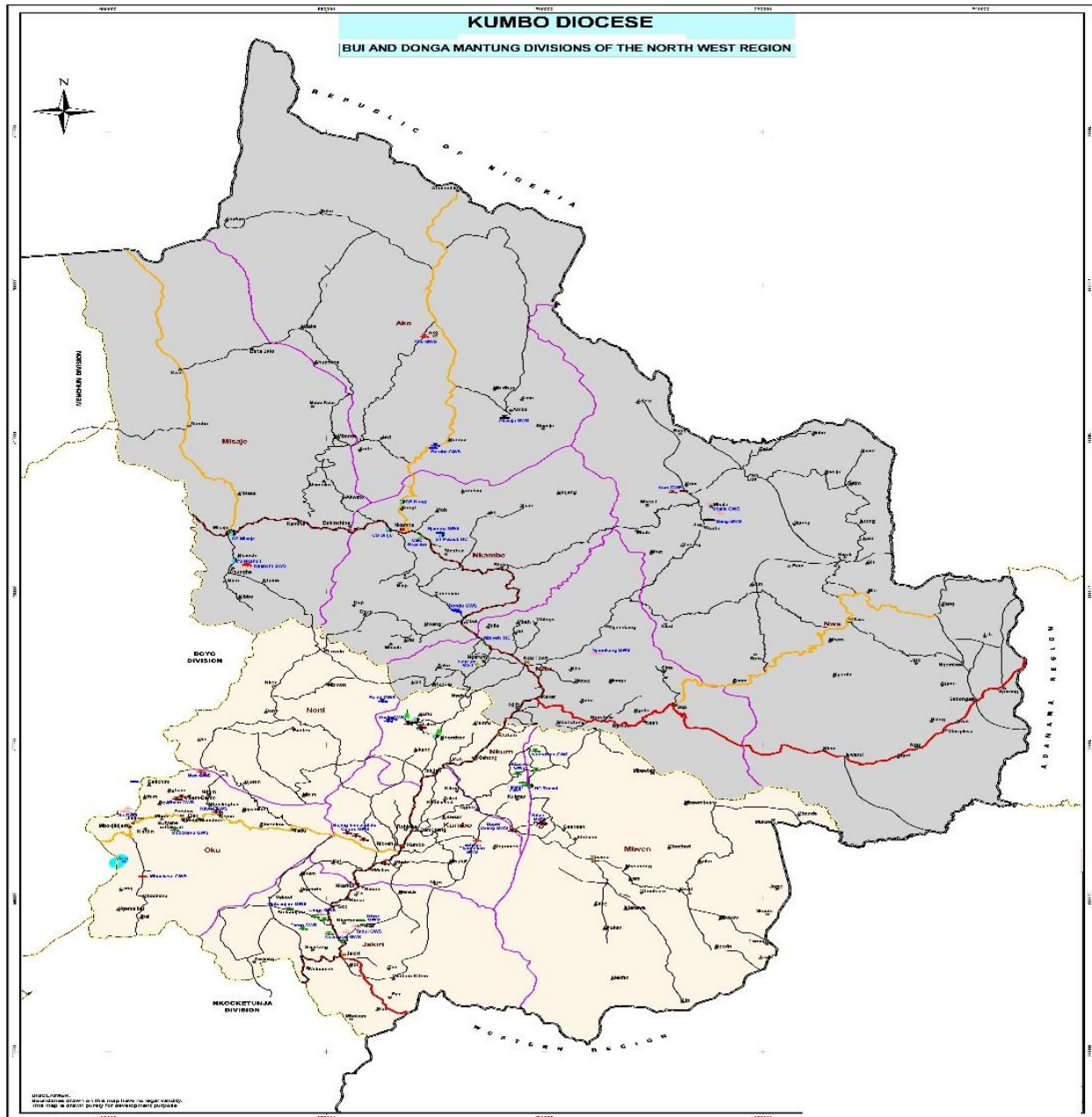


Figure 1: Map of Kumbo Diocese

1.7.3. Time Scope

This study investigated how War-Trauma is managed among Diocesan Clergy in the Diocese of Kumbo amidst the Separatist War within the time-period 2017 to 2024. This is the period within which the war which started at the end of 2016 had clearly established itself as a separatist war. This period of seven years will enable the researcher to identify potential respondents in the study depending on them having lived and worked amidst the war in the past seven years.

1.8. Definition of Key Terms

War-Trauma: War-trauma is a traumatic event which is shocking, scary, or dangerous experience that affects an individual or individuals emotionally (United States' National Institutes of Health, 2019). Traumatic experiences include, but are not limited to, war violence, forced isolation, torture, threats to life (individual and family members), kidnapping, and rape (USNIH, 2019). Traumatic experience that stems from military conflict is considered as war trauma, and all war trauma can lead to mental health disorders like post-traumatic stress disorder (Fielding, 2023).

Mental Health: Mental health includes emotional, psychological, spiritual, and social well-being. It affects how individuals think and feel, and how people understand the experiences of their lives. It is a major factor in an individual's capacity to experience joy in life, work, and relationships (Benjamin & Scherezade, 2020).

Diocesan Priest: A diocesan priest is man ordained to be a minister of the church to serve a specific geographical area called a diocese or an archdiocese (National Association of Vocations & Formation Directors, 2013).

Separatist War: Separatism is the advocacy of cultural, ethnic, tribal, religious, racial, governmental, or gender separation from the larger group (Forrest & Joshua, 2003).

Stress: Stress refers to person-environment transactions in which environmental demands outweigh the individuals' resources, resulting in psychological and/or physiological dysregulation (WHO, 2023; Proulx & Aldwin, 2016).

Depression: WHO (2023) refers to depression as a common mental disorder which can cause difficulties in all aspects of life, including in the community and at home, work and school. It can happen to anyone. Individuals who have lived or are living through abuse, severe losses or other stressful events are more likely to develop depression.

Anxiety: Anxiety is an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure. It is a normal response to possible threats or challenges, which helps to cope with them (American Psychological Association, 2024).

Coping: Coping refers to conscious or unconscious strategies used to reduce unpleasant emotions. The effortful behavioural and cognitive strategies activated in response to actual or anticipated stressful situations that serve to regulate both the stressful context and its negative socio-emotional and physiological consequences (Schwarzer, 2024; Proulx & Aldwin, 2016). To cope is to deal with struggles and difficulties in life.

Coping Mechanisms: Coping mechanisms are psychological strategies or adaptations that individuals use to manage stress and/or trauma and to decrease tension and anxiety. Coping tactics can be cognitions or behaviours and can be individual or social (WHO, 2023; Bailey, 2022; APA, 2024).

1.9. Conceptual Framework

Salawu, et al., (2023) say that the conceptual framework (CF) is an expression either narratively or graphically of the study being embarked upon. It therefore, consists of the study variables: dependent, independent, and at times, intervening or control variables; and the presumed relationships among the variables as illustrated below. Crawford, (2020); Ravitch & Riggan, (2017) state that CF is a depiction of the importance of the study being carried out and the appropriateness or relevance of the ways or methods of accomplishing the study.

INDEPENDENT VARIABLE

DEPENDENT VARIABLE

War-Trauma

Mental Health Seeking Behavior of Clergy

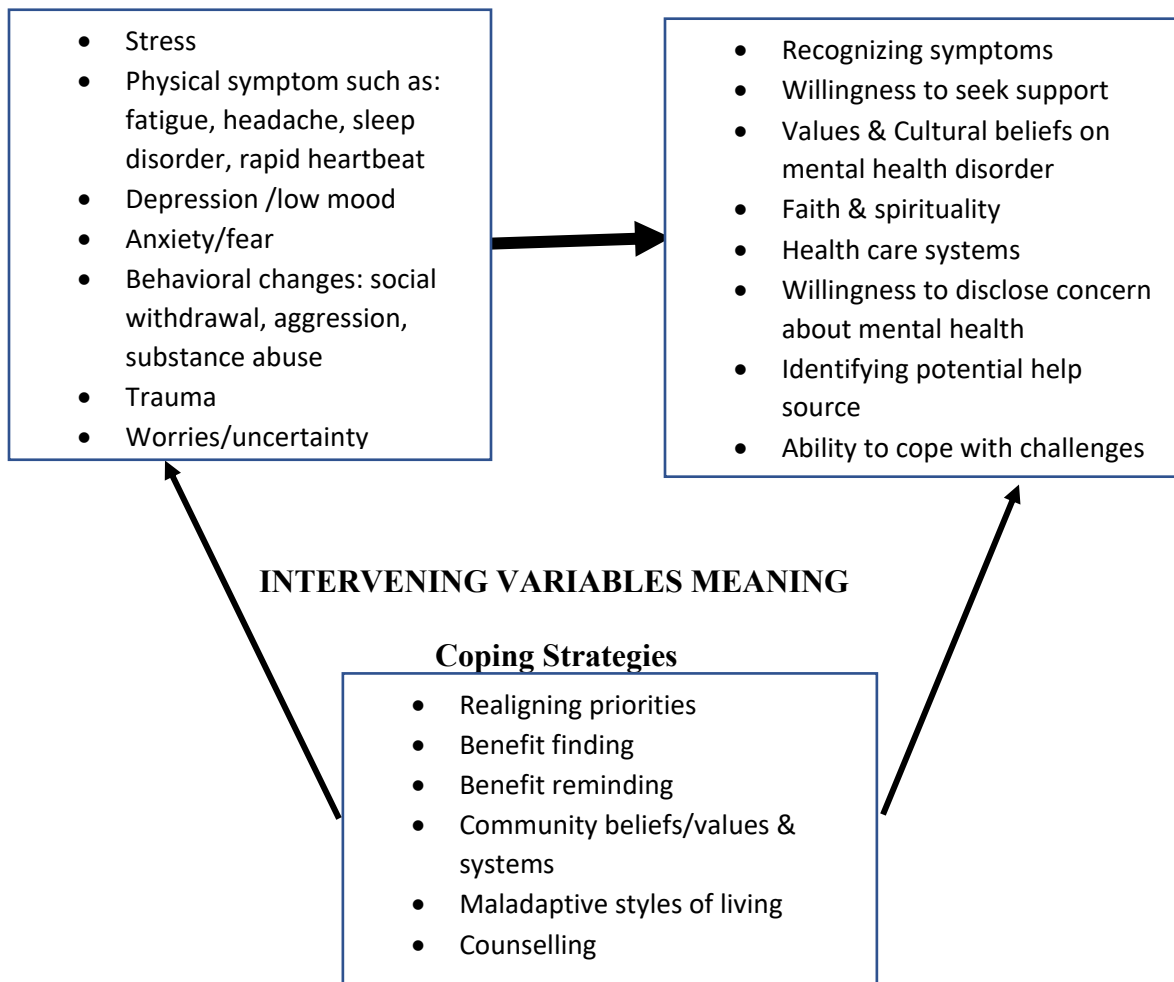


Figure 2: Study conceptual framework

Explanation: According to this conceptual framework, War-trauma is the independent variable and mental health seeking behaviours of clergy are the dependent variable. The intervening variables are the meaning-focused coping strategies. War-trauma affects an individual's entire life (Amoshmash 2016); however, Jain et al, (2022) confirm that war situations disrupt access to trauma treatment. Rocholle et al (2019) give backing to this position by stating that worry, fear, low mood and uncertainty about existing security or anxiety, depression, and symptoms of PTSD are noticeable among individuals exposed to war-trauma. A further research by Rocholle et al (2019) settles that other symptoms of war-trauma stem from cultural rather than global descriptors, including beliefs that symptoms such as hallucinations and paranoid delusions are caused by spirit possessions. The independent variable, explains that those exposed to war-trauma will develop stress, depression,

anxiety, post-traumatic stress disorder, and other mental and emotional symptoms which negatively affect their mental health.

The dependent variable of the frame explains that those exposed to war-trauma are expected to seek mental help, however, their capacity to do depends on factors such their individual values and beliefs, faith and spirituality, cultural descriptor of mental disorder and nature of the available health care systems. The intervening variables have impact both on independent and dependent variables which can either be positive or negation.

CHAPTER TWO

LITERATURE REVIEW

2.0. Introduction

The literature review can serve many functions in the contexts of education and research (Dennis, Elida, & Johnson, 2023). It helps to identify knowledge gaps, inform research methodology, and to develop a theoretical framework throughout the planning stages of a research study or project. Also, in the context of the existing literature, it reports review findings. Literature review is therefore, the process of locating and summarizing studies about a topic and summarizing broad themes in the literature (Creswell, 2009). The review for this study has been done thematically using the guide from Dennis, Elida, & Johnson, (2023); Denney & Tewksbury (2012), and Creswell (2009) who advise that review themes can be formulated from the objective of the study, and must be kept inclusive and open. The themes generated for the review are, the theoretical reviews, symptoms of war trauma, Stress and Mental Health among the Clergy, Anxiety and Mental Health among the Clergy, Depression and Mental Health among the Clergy, Coping Mechanisms and Mental Health Care Seeking, Impact of Coping Strategies on War-trauma and Mental Health among the Clergy.

2.1. Theoretical Review (TR)

Salawu, et al., (2023) maintain that the foundation for conducting research is laid forth in a theoretical review. The TR intends to explain the existing theories that are relevant to the study being conducted and how they are connected. It also emphasizes the theory or theories that form the foundation of the study (Crawford, 2020). Three theoretical perspectives will thus guide this study; the stress and coping theory by Lazarus and Folkman (1984 & 1987), the bio-ecological theory of mass trauma by Bronfenbrenner & Ceci, (1994), and the constructionist psychological theory.

Stress and Coping Theory (Lazarus and Folkman, 1984): explains that people respond to stressful events; through two important processes (appraisal and coping). Coping regulates distress through strategies that are meaning-focused. Meaning-focused coping draws on deeply held values, and leads to a reordering of priorities and goals; creates or renews a sense of purpose that is essential to sustaining coping over the long term (Folkman, 2022). This is done through;

Realigning priorities: When people are faced with a stressful situation, and when they realize that the stressful situation is not going to be resolved in the foreseeable future, then they reorder their priorities in order to deal with the altered reality.

Benefit finding: People find benefit in their stressful experiences. Benefits are personal growth, (growth in wisdom, patience, and competence; greater appreciation of/for life, greater clarity about what matters; strengthened faith or spirituality; and improved quality of social relationships).

Benefit reminding: Closely related to benefit finding is the concept of benefit reminding; as individuals remind themselves of the possible benefits stemming from the stressful experience. They appreciate ordinary events of daily life, such as a kind word offered by a friend, watching a good movie with a friend, seeing something beautiful in nature, such as sunset or sun rise. However, the stress and coping theory does not explain how institutions and communities enable individuals to manage war-trauma. Thus, the need for another theory.

Lazarus and Folkman (1987) updated their 1984 Stress and Coping Theory into what they called the Transactional Theory of Stress and Coping. They explained coping as “a phenomenon that involves both cognitive and behavioral responses that individuals use in an attempt to manage internal and/or external stressors perceived to exceed their personal resources.” According to them, resources can be physical (health, energy), social (social support one can get from family, friends and social network), psychological (beliefs, self-esteem, perceived control, morale), or material (financial, tools). Lazarus and Folkman (1984) affirmed that coping serves two major functions; the regulation of emotions or distresses that come with the stressful situation and management of the problem that is causing the stress by directly changing the elements of the stressful situation (problem-focused coping).

The Stress and Coping Theory asserts that there are five stages of coping with stress. The first stage is the external or internal stressor perceived by the individual to be emerging either from an external source or from internal bodily sensations (Machogu, et al, 2022). The second stage is when the individual appraises his or her capacity to deal with the stressor and he/she then decides whether he or she has the resources to cope. In the third stage, stress responses occur which include behavioral, affective, sensory, imaginary, cognitive, interpersonal, and physiological changes. In the fourth stage, individuals appraise the effectiveness of the coping strategies they have used. The fifth stage relates to the continuing process and long-term consequences. This theory is applicable

to this study which aims at exploring the coping strategies on war-trauma and mental health-seeking behaviours among the Clergy in Kumbo.

The Bio-ecological Theory of Mass Trauma (Bronfenbrenner & Ceci, 1994): This theory is an expansion from Bronfenbrenner's (1979) socio-ecological theory. The theory fits well with the core values of counseling psychology including the promotion of social justice and healthy development. It explains that human experience is woven into a coherent whole whereby each is understood separately and in connection to each other. The theory uses the exosystems which include the more immediate networks or systems that indirectly affect the individual such as neighborhood and community systems (Diocese of Kumbo, Clergy Associations), health care systems, and the mass media; and the macro systems (government systems). It also explains how trauma-focused interventions depends on the degree to which they enhance the person-community relationship (Hoffman & Kruczek, 2011).

The Constructionist Psychological Theory: It informs the study in that actual events in the world are constructed by individuals, community, and society. This, then, determines how people (clergy) think, feel and behave (McAdams, 2022). According to the theory, humans are meaning-makers in their lives and basically construct their own realities. They are active participant in creating and determining their life path. Caddell, (2023) confirms that the theory does not view reality as fixed and to be discovered by humans (clergy), but something that is created. Individuals must make sense of the world and their relationships. Finally, the constructionist psychological theory instead of exploring what is wrong, works to help individuals (clergy ministering in ongoing arm conflict zones) identify their strengths and to use those abilities to create positive changes (Caddell, 2023). It will therefore inform the study in that it helps to explore how individuals, clergy inclusive, create meaning for themselves in a war or conflict and other challenging situations in their live given the fact that trauma often leads to a need for people to find meaning and purpose in their lives.

In a nutshell, the current war situation in anglophone Cameroon already suggests a variety of emotional imbalances of stress in the life and ministry of the clergy who are serving there. To this effect, Machogu, et al, (2022) state that coping capacity, for the most part, largely determines where in the five stages the individual finds himself. Thus, if the Clergy is unable to adapt to their challenging experience, they will most likely sink into a dysfunctional level and will be unable to

cope or survive the adversity. They need to act in a constructivist manner by making meaning out of the war and conflict situation.

2.2. Symptoms of War-Trauma

Cross-national and civil wars are a part of daily life for soldiers, clergymen, and civilians worldwide (Charlie Health, 2023). The pain, suffering, and displacement that come alongside a traumatic event is an ever-present aspect of this ongoing violence. The emotions and circumstances connected to this violence are known as “war trauma” and can potentially bring long-term consequences to a person’s mental health and well-being. War atrocities thus, have a powerful negative effect on mental health (Fielding, 2023; O’Brien, 1994), whereas exposure to war related trauma has even more adverse effects on mental health (Munjiza, et al, 2017). Persons who are exposed to war situations often experience symptoms such as persistent fear, helplessness or horror. Some develop persistent avoidance, emotional numbing and arousal (Jones and Cureton, 2014). These experiences increase the risk of developing chronic psychiatric disorders such as posttraumatic stress disorder (PTSD), and major depression (Shannon et al, 2014: p.3). Fielding (2023) simply consider war trauma as a blanket statement covering any traumatic event experienced while preparing for, living through, or serving in a war situation such as is the case in Ukraine and the North West and South West regions of Cameroon.

According to Shannon et al (2014) in a study conducted among Karen refugees in the United States of America, the symptoms of depression were identified to be sadness, irritability or anger, loss of interest, weight change, sleep change, guilt, hopelessness, worthlessness, and suicide ideation/suicide. While bad dreams, over thinking, avoidance, alert and easily frightened, numb or detached, difficulty concentrating, and increased worries or fear, and somatic (headaches, stomachaches, body pain, dizziness, and weakness) were found to be symptoms of posttraumatic stress disorder (PTSD). However, this study was carried out 15 years later after the refugees long experienced the war-trauma.

In a study carried out by Andersen et al (2020) among victims of violence in Burundi, Central African Republic, Democratic Republic of Congo, Mali, Nigeria, and South Sudan, it was found that age is associated with high distress (peaking at 45-54 years). High Anxiety levels and low functioning were also found to be among victims of violence committed by unknown civilians, the military or armed groups. Persons with higher educational levels were also found to experience higher distress among them during war. This is because they tend to be involved in politics thus

become an easy target for the armed groups or military (Andersen et al, 2020). The study also highlights that exposure to violence in the context of armed conflict is associated with high levels of psychological distress and low functioning (Andersen et al, 2020).

Rocholle et al (2019) add that worry, fear, low mood and uncertainty about current security or anxiety, depression, and symptoms of PTSD continue to manifest among persons exposed to war-trauma. Further findings by Rocholle et al (2019) confirm that other symptoms of war trauma among the Rohingya stem from cultural rather than global descriptors, including their beliefs that hallucinations and paranoid delusions are caused by spirit possessions. It is important to note that these studies were carried out in post conflict situations (three months to 15 years outside of the conflict) where victims of war-trauma were either in camps or in asylum countries. Little remains known about those who live in the conflict affected area especially when the people they serve are incognito/camouflaged (are disguised members or supporters of armed groups). Although there is a small but valuable body of research examining the mental health impact of exposure to crisis by clergy, these studies have focused on secondary impact (Rocholle et al, 2019).

A study by Farhood, Fares & Hamady (2018) examined the gender differences experienced in war-trauma in South Lebanon using a cross sectional design. They clustered symptoms of war-trauma as; (i), intrusion and they report that both males and females experienced recurrent thoughts or memories of the most hurtful or terrifying events. (ii), the avoidance symptom where females experienced avoiding thoughts or feelings associated with the traumatic or hurtful experience, while men mostly reported avoiding activities that reminded them of the traumatic or hurtful event. (iii), negative cognitions and mood, where they found that females had difficulty concentrating while males often felt as if they didn't have a future. (iv), alterations in arousal and reactivity; here females reported feeling nervous and easily frightened while the males experienced irritability and anger outbursts (Farhood, Fares & Hamady (2018).

Farhood, Fares & Hamady (2018) recognize that males may display the current symptoms, there may be some Post Traumatic Stress Disorder (PTSD) symptoms that their study has not captured. They recommend that it would perhaps be more efficient to examine how specific vulnerabilities of individuals can propel them to develop PTSD because they believe that PTSD can be prevented let alone be treated. Such gaps are what this study intends to address in examining the specific vulnerabilities of clergy to PTSD through the war-trauma they experience daily.

2.2.1. Summary of the Literature on Symptoms of War-Trauma

Exposure to war situation results in distress. Studies point to the fact that the experiences of symptoms of war-trauma/distress are relative to age, gender, and one's position in the war (either one in combat, as civilian or refugee). However other characteristics like being clergy have been ignored by any studies yet the clergy are often caught up in the middle of war crisis. Little remains known on how clergy actually experience symptoms of war-trauma.

2.3. The Effect of Stress on Mental Health among the Clergy

The militant population is at a higher risk of developing psychiatric symptoms due to heightened combat exposure and first-hand psychological trauma (Hassan, et al., 2024). However, several reports have found that civilians residing in conflict zones are constantly under chronic stress and are particularly susceptible to after-effects just as much as militant personnel. Thus, an accurate estimation of the number of civilians suffering from depression and PTSD, which could influence present and future mental health policies in war-torn areas, is a critical first step in determining the extent of the issue. Stress is a natural feeling of not being able to cope with specific demands and events (Feliman, 2020), there is adequate literature evidence showing that clergy, like other people, are not immune to this emotional state (Ganesan, 2008; Lockwood, 2020). Stressful situations are a common part of daily life, hence, a natural part of the human experience and a normal physiological response. Stress among pastors is a growing problem around the world that affects not only their health and well-being, but also their productivity in the Church (Feliman, 2020; Angetile, 2021). Stressors have a major influence upon mood, our sense of well-being, behavior, and health (López, 2012). Henri Nouwen (1994) observes that because Christian leaders are first of all human beings before being called to serve they are also vulnerable to difficult situation of biopsychosociotechno-spiritual nature.

On the effect of stress on mental health, a study conducted by Frounfelker, et al, (2019) revealed that the burden of mental disorders that results from conflict-neglect, abuse and exploitation is particularly alarming. Their study establishes disparities between the mental health of war-affected children and youth and those in the general population. It attributes the onset and severity of mental disorders among conflict-affected children and youth to their exposure to different types of violence, the duration of the conflict, and the nature of experienced and witnessed traumatic events.

Another study by Charlson, et al, (2019) only highlight that children experiencing arm conflict during childhood and adolescence are in serious danger to developing mental health challenges.

Egunjobi (2019), found stress and burnout to be a common phenomenon with many priests and religious. He considered stress as a psychological perception of pressure, or the body's response to pressure. His research acknowledges that even though Africa unlike America and Europe, is experiencing vocations boom, its volume of pastoral work is, however, not reducing. His research area was Oyo town in Oyo State, Nigeria, and many priests complained of being overwhelmed with too much pastoral engagements. The general conclusion was that despite experiencing vocations boom, priests and religious in Africa still suffer from physical and emotional exhaustions due to ministerial demands and a feeling of financial obligation to their respective families of origin. This negatively impact their ministry as wounded healers.

In his online article in the Catholic Herald, titled "Are priests more prone to stress and mental health?" Lucie-Smith (2014), attributed the stress of priests to when they have to deal with difficult people, to include; lay people, other priests, and clergy who exercise authority. Ezeobi (2016), also found out that female religious also experience stress as a result of a gap in expectations they have of themselves, others, and their religious congregations; poor community relationship, struggles or demands of apostolate, unfaithfulness to commitments, sense of meaninglessness, and crises in values.

These studies do not attempt to address mental health issues among the many secular clergy serving in war and conflict areas of the world. The researchers have focused attention more on the general mental health issues of the clergy both secular and religious resulting the nature of their mission. The plight of the many secular and other clergy who are bound to serve the warring population and live among them as is the case with the secular clergy in anglophone Cameroon, Burkina Faso, Ethiopia, democratic republic of Congo, and Nigeria has been ignored or underrated.

A research conducted in Mexico by Vicente-Galindo, et al, (2017) found that diocesan priests were exposed to difficult situations in areas such as doubts, inner conflicts, tiredness and anxiety. According to them numerous stressors affect clergy daily, including; lack of social support, work overload, interpersonal goals and self-esteem problems. Also, the findings of Machogu, et al

(2022) in the archdiocese of Nairobi indicated higher stress levels among priests with only a bachelor's degree than those with Masters and PhD. The same findings indicated that education level determines stress levels amongst priests. Their study revealed older priests to experiencing more psychological stress due their many responsibilities, more than the younger priests whose minds were still fresh and vibrant. Its conclusion was that a young priest's psychological stress was the product of his personal crises or unrealistic expectations.

Gitoya Centre for Academic Research and Dissemination (G-CARD) in the East African Journal of Education and Social Sciences (EAJESS) October – December 2021 explained that clergy in Tanzania, were susceptible to stress coming from their struggle to balance the frequently conflicting expectations of their congregations, denominational demands and family issues while attempting to stay true to their religious calling. This research finding was based on the clergy of the Moravian Church of Tanzania. The conclusion was that clergy suffered from stress resulting from their disagreement with church members. The same study also found stress to have short- and long-term consequences to clergy. These include deterioration of their physical health, lack of self-care; the appearance of abnormal or bad behaviour such as being cruel; change in daily messages or sermons to Christians becoming less meaningful. The study furthermore, affirmed that stress could ignite frustration and anxiety as well as physiological and psychological relational problems in the clergy, their families and communities.

Bonsu (2016), in separate research in Ghana revealed that the responsibility of clergy to provide; counseling services, social amenities, moral, and financial support to their congregations, communities, and families contributed greatly to work-related stress affecting their work and family life. Bonsu asserted that the workplace stress among the clergy increases as their role in church increases. Rossetti and Rhoades (2013) had associated priests' psychological well-being in Nigeria with job satisfaction, inner peace, relationship to God, and good friends. For Catholic priests, strong psychological and spiritual support systems was the most important in preventing burnout, especially for those engaged in the demanding positions of caring for others.

Some of the impacts of stress include lack of performance at work, decrease of productivity, and confusion among Christians. Clergy suffer from stress as they not only get to be with the people

in their wonderful moments of life. There are many issues which can make their ministry really tough since they have a lot of direct exposure to the sufferings of the people and to personal pain and suffering. Clergy thus, like all humans need healthy coping strategies in overcoming stress in extreme situations. The extent of their direct exposure to suffering; difficult losses, deaths, existential crises, coupled with the unpredictability their mission and ministry has very much been underrated. The situation is even worse for clergy serving in ongoing conflict or war zones. This is evidenced by the little or no research addressing the effects of stressors and war trauma on their mental health as is the case with children, women, refugees, and soldiers.

2.3.1. Summary of Literature the Effect of Stress on Mental Health among the Clergy

Reviewed literature all point to the fact that mental health challenges are real among clergy (Fekadu, 2022). It acknowledges the high levels of stress and other mental disorders among persons living in conflict and war zones than in general population. Deliberating on stress levels and its impact on those living in warring areas, literature majorly focus on children, youths, women, soldiers and ex-combatants. The mental health risk of clergy serving and ministering to the population in this area is underrated or to say the least, ignored. Even so, reviewed literature identify mental health risk factors among clergy to include, work overload, socio-cultural setups that distrust the clergy, lack of sufficient support (especially from the Church authorities), and excessive demands from their families of origin versus vocational needs. Researchers have not yet seen plight of clergy living and ministering in conflict-affected regions as a risk factor to their mental health and well-being. The findings underscore the urgent need for comprehensive mental health interventions tailored to the unique needs of clergy in conflict-affected regions.

2.4. How Anxiety Affects Mental Health among the Clergy

Natasha, (2012) states that, it is not uncommon for clergy to feel anxious when and when not exercising their priestly or religious duties. Life experiences such as traumatic events that an individual experienced or is experiencing (living and serving in warring and conflict situation) can trigger anxiety disorders in people who are already prone to anxiety by nature or nurture (Drevitch, 2024). The most common signs and symptoms of anxiety including; nervousness, restlessness, feeling impending danger, increased heart rate, rapid breathing and sweating, trembling, difficulties concentrating or thinking about anything other than the current worry.

As Boateng, et al. (2024) underscore, clergy play a crucial role in supporting the mental health of their congregants. They are prone to the signs and symptoms of anxiety. Dias (2019) confirms that these signs and symptoms appear especially when the clergy feels inadequate or lacks preparation in carrying out particular religious/spiritual tasks, when faced with the bishop or superior, or when they are ministering in conflict affected regions. Sielaff et al. (2021) categorize the primary stressors on clergy as chronic and traumatic stress. Clergy experience chronic stress due to intrusive demands on their emotional energy and time. Criticism and congregational conflict are two sources of intrusive demands. Chronic stress may also arise from the overwhelming demands of clerics' roles. Garner (2013) reported that clergy experienced criticism and negative feedback in varying degrees and that these experiences had an adverse impact on the clergy member. Further, Shaw et al. (2021) reported on the adverse impact of criticism on clergy, and also revealed the stressors of congregational demands and loneliness. In a study by Poon (2019) of Chinese pastors in Canada, the top areas of concern reported were in categories of challenging church relationships, physical health, emotional health, and family and/or marital satisfaction. A study by Knox, Virginia, and Lombardo (2002) examined the level of depression and anxiety amongst Roman Catholic clergy. The rate of depression and anxiety from work stress was found to be more common among Roman Catholic secular clergy than among clergy who live in community. The same study also reveals that healthy relationships with superiors and peers would reduce depression and anxiety among clergy.

Another study by Duke Divinity School (2022) found high stress and anxiety rates among the United Methodist clergy in North Carolina. More than 7 percent of clergy simultaneously experienced depression and anxiety. The predictors of depression and anxiety were, job stress as clergy were found to engage in many stressful activities, including grief counseling, navigating the competing demands of congregants, and delivering a weekly sermon that opens them up to criticism. Moreover, the study identified the top predictor of depression among clergy to their sense of guilt about not doing enough at work. However, doubt of their call to ministry was identified as a top predictor of anxiety.

Societies/communities marked by armed conflict face huge challenges in mental health care provision. This is due to lowered resources and destruction of infrastructure along with an increased need for care (Østergaard, 2023). This especially affects the vulnerable groups already

facing bigger challenges in terms of higher disease burden and limited access to care. It is unfortunate that little or no reliable published data or literature exist on the mental health and psychosocial well-being of clergy serving in ongoing armed conflict areas especially in Africa. This reveals that there is no reliable intervention with regard to their psychological well-being nor any evaluation of the efficacy of such interventions if any, or of whether the clergy feel that such interventions are useful and helpful to them. This calls loudly for a study that will examine impact of anxiety on the mental health of clergy living and serving in ongoing armed conflict areas of the world, especially, in sub-Saharan Africa.

2.4.1. Summary of Literature on How Anxiety Affects Mental Health among the Clergy

The available data only give general insights on clergy's emotional health and coping skills for enhancement of their psycho-social wellbeing. It thus neglects anxiety issues among clergy serving in ongoing conflict and war areas of world. The focus has been more on the rates of anxiety and depression between Catholic secular clergy and those who live in community (religious clergy). It has attributed mental health issues among clergy mostly to ministerial demands and their lack of personal material needs (National Institute of Mental Health, 2019). But the impact of clergy roles on their own well-being is understudied. Even so, the additional challenges of living in armed conflict area have been underrated or ignored by most studies.

2.5. How Depression Affects Mental Health among the Clergy

As the clergy's role in supporting mental health continues to evolve (Boateng et al., 2024), there is a growing emphasis on various aspects of their work, including providing spiritual and emotional support, promoting mental health awareness, offering counseling services to community members, and facilitating access to necessary mental health resources (Heseltine-Carp & Hoskins, 2020; Iheanacho et al., 2021). However, there is a limited understanding of how these increasing demands might affect clergy members' happiness and life satisfaction, and the specific activities they engage in to navigate the challenges (Terry & Cunningham, 2020) for which they may be untrained. The nature of the work of clergy places them at an increasing risk of depression and burnout. They are often stressed and at times lonely and tarnished (France-Pressé, 2012). Machogu, et al (2022) affirms that their work is challenging and exhaustive as explains by its interpersonal nature, multiple responsibilities, and emotional content. This routine places them in a situation where they have little or no time for self-care, slipping into burnout (Clarke et al., 2023).

Antony Raj (2005) examined burnout and depression among Catholic clergy in southern India. His finding showed secular clergy to greatly experience more burnout and depression than clergy in the religious order, an indication that parish structural and administrative systems can significantly lead to burnout and depression.

Antony Raj (2005) stresses that even though, Roman Catholic clergy all share the same ordination and priesthood, they do not live and practice their ministerial life in the same manner. Boateng, Britt & Hayoung (2024) add that this makes the secular clergy more likely to experience greater depression. Their finding revealed the following information; secular clergy experienced a greater degree of depression (72%) than both religious order and monastic clergy (40.8% and 39.5%, respectively). They also found the secular clergy to receive less support system than both monastic and religious clergies.

Among the clergy of the Catholic Diocese of Minna in Nigeria, findings confirmed a majority of the clergy to have experienced and were experiencing burnout (Idogbo-Noba, 2017). The diocesan clergy was noted to experience more burn out than the religious, a situation which reduced their work productivity, and left them helpless, hopeless, distrustful and resentful.

In the United States, a study has shown that approximately 1500 pastors leaving the ministry monthly due to burnout, moral failure, and church conflict. More so, 75% of the clergy here often experience a notable stress- related crisis (Kayler, 2011). Ehusani (2021) stated that the vow to keep the confessional seal unbroken in whatever circumstance has exposed the Catholic clergy in California to mental disaster. While in Germany, Baumann, Jacobs & Frick, (2017) emphasized that majority of Catholic clergy perceive the vow of celibacy as a burden. They would not choose celibate life again. Others however believe that the celibate life has helped and is helping them to minister more effectively.

Dias (2019) publicized in his research work that Catholic clergy in Brazil experience frequent stressors in their pastoral work. They face countless demands and unrealistic expectations, always under constant scrutiny, and are surrounded by a culture that is increasingly diocesan or secular and seemingly less supportive. This is exposes them to significant levels of burnout.

Similarly in Belgian, higher levels of depressive disorders and post-traumatic stress disorder were confirmed among religious leaders than in the general population (Ruffing, Bell and Sandage, 2020). The clergy in this country showed low degrees of well-being, high degrees of burnout, experienced work/family conflict and little job satisfaction. Also, in Australia, 25% of clergy were experiencing burnout as a severe or significant problem and 50% were at risk of developing burnout (Kaldor and Bullpitt, 2011).

A number of authors (Grosch & Olson, 2000; Machogu, et al., 2022) associated depression and burnout among clergy to systemic factors like; bureaucracy, poor administrative support, and difficult work conditions. They also brought out intrapersonal-related factors to include religious idealism and perfectionism (Machogu, et al., 2022).

Clergy with less mental health training may feel pressured to provide help that they are not qualified to give. They may also feel overwhelmed by the number of people seeking their support which may compound existing feelings of stress and even depression Stephen (2020).

Mental health issues are very challenging to every human being. Most authors have attributed clergy's mental health issues to work-related stress and burnout. The observed correlation between the demands of clergy roles and adverse mental health outcomes only mirrors what has been documented in the general population. For instance, a study by Holleman and Eagle (2023) revealed that mental health outcomes among clergy were similar to those in the general population. Benjamin & Scherezade (2020), noted that their mental health issues are often accompanied by an existential and spiritual crisis making them unable to perceive the real meaning and purpose of life. Clergy are thus prime targets for experiencing stress, depression, and burnout (Columbia Theological Seminary, 2022).

2.5.1. Summary of How Depression Affects Mental Health among the Clergy

Literature review portray higher levels of occupational distress and depression among clergy than in the general population. In fact, clergy with less mental health training, less social support, and a feeling of social isolation are found to be at a higher risk for depression (CTS, 2022). This revelation has raised a general concern about the mental health of clergy and support for them. However, the even worse situations of clergy serving and living in ongoing armed conflict or war-torn regions of the world especially in sub-Saharan Africa, have been very much neglected. The

current study also seeks to examine the mental health challenges and levels among this class of clergy who are not necessarily military chaplains.

2.6. How Coping Mechanisms Impact on Help Seeking among the Clergy

There is an established fact that war-trauma affects a person's entire life (Amoshmash 2016); yet war situations disrupt access to trauma treatment (Jain et al, 2022). This then leaves victims of war-trauma with no option but to cope with it especially where war is ongoing. Coping with war-trauma requires cognitive and behavioral resources that enables a person to solve a problem, reduce or eliminate it (Ubillos-Landa et al, 2019). According to Ubillos-Landa et al (2019) emotions are responsible regulating strategies used for coping with war-trauma. Individuals therefore react to war-trauma through feelings (Gross, 2015). People exposed to war atrocities experience and respond to trauma differently depending on the various internal and external factors (Almoshmosh, 2016). Internal factors are those related to emotions while external are those related to socio-cultural factors. This means that people have different coping mechanisms towards war-trauma.

According to Ubillos-Landa et al (2019) emotion regulation for coping with war-trauma comprises five phases explained by Gross (2015) as: (a) situation selection, (b) situation modification; in both these phases, individuals choose or avoid certain activities, people, or places in accordance with their expected emotional impact; (c) attentional deployment; is where persons focus on one specific aspect of the emotion triggered by a situation; (d) cognitive change, where persons select one of the possible meanings ascribed to the chosen situation; and (e) emotional response modulation; where persons alter one or more of these response tendencies once they have been triggered.

Each phase has a different coping strategy for instance, problem-directed action and psychological abandonment are often strategies for situation modification; rumination, religion, and positive reappraisal are strategies for attentional deployment and cognitive change, while emotional response modulation strategies include regulated expression, confrontation, venting, and inhibition (Gross, 2015). Female victims of the Columbian armed conflict were found to use suppression or coping strategies based on avoidance and/or silence (Ubillos-Landa et al (2019). This study will therefore establish which strategies are most used by the clergy in similar war circumstances.

A study carried out among the Rohingya following the August 2017 crisis by Rochelle et al (2019: p, 95) found that religiosity acts as a 'protective factor and source of resilience' among adult

Rohingya. Another study by Pietkiewicz & Bachryj (2016) on help seeking attitudes and coping strategies among Roman Catholic Secular Clergy in Ireland also reports religious coping for maintenance of emotional balance when faced with stressors. However, Ubillos-Landa et al (2019) report that the religion just calms down the emotional reactions to war- trauma and later increases anxiety and depression. McGregor et al. (2010); cited in Ubillos-Landa et al (2019) warn that using religion as a coping strategy may lead to idealist extremism that also contributes to anxiety and depression.

This affirms what Slaby (2021) said, that the psyche is different from the soul. This means that war-trauma related symptoms must be addressed through appropriate psychological means rather than through means fit for the soul. It is thus advisable for persons faced with war-trauma to use coping strategies which aim to alter the situation, such as active coping (problem solving) and cognitive change (positive reappraisal). These help to decrease the presence of anxiety and depression because these strategies enable individuals to learn from the difficulties, they face by identifying the positive aspects of the problem (Ubillos-Landa et al, 2019).

A related study by Cherewick et al (2015); which used a similar method (qualitative approach through purposive sampling) established how affected youth (10-15 years) are coping with war-trauma in Eastern Democratic Republic of Congo. Dumciene & Pozeriene (2022) maintain that war trauma affected youth employed more than one coping strategy including trying to forget and praying (cognitive strategies) and seeking social support and engaging in risk taking behaviour (using more alcohol and drugs) with most deteriorating in mental health.

A research conducted by Saxon, L. et al. (2017) among conflict-affected persons in Georgia found out that coping strategies such as use of humour, emotional support, active coping, acceptance and religion are significantly associated with better mental health outcomes. The study found the coping strategies of behavioural and mental disengagement, denial, venting emotions, substance abuse and gambling to be associated with poorer mental health outcomes among this population. There was significant variation in the use of coping strategies between men and women among conflict-affected persons in Georgia. This current study therefore seeks to examine specific coping strategies often adopted by clergy in conflict-affected zones or areas with ongoing arm-conflict and terrorism to support their mental health.

In another study by the United State Department of Veterans Affairs (2012) spirituality was found to be a resource connected with resilience and recovery for those experiencing war-trauma or trauma survivors. This finding also confirmed what Currier, et al (2023) assert that in some circumstances of trauma the importance of spirituality and the beliefs that previously sustained victims may be questioned, leading to spiritual struggle or even loss of faith.

A study in the Archdiocese of Nairobi in Kenya, by Machogu, et al (2022) revealed many cases of clergy with maladaptive patterns of living like alcoholism, depressive sicknesses and addiction due to psychological stress. It found out that the affected were either recommended to take spiritual retreats, or taken on transfers, sabbatical/ study leaves, but a few others were recommended for rehab and specialized professional therapy. It also informed that due to their reverential status of ordination and vows, most of the Clergy in the diocese hardly share what is happens deep in their personal lives, so, they hardly seek help unless they are forced to. Even though spiritual direction is part of the priestly training and religious formation, a majority of them do not make use of it after their ordination or religious profession. This is explained by few spiritual directors, no time, unconcern, and spiritual pride or feelings of self-righteousness.

Coping mechanisms among the clergy in the archdiocese of Nairobi are in-servicing of priests, and the use of different professionals during retreats and clergy workshops. the lay Christians in the diocese are empowered to be able to communicate effectively with their clergy such as advising them in ways can improve and promote their psycho-social wellbeing instead of critiquing them (Machogu, et al, 2022).

Another study of the same nature by Joseph Kelly (2012), established most priests and religious with psychological challenges not interested in professional counseling. This situation is associated to ignorant of the benefits of counseling and in others fear of stigma associated with counseling. Its conclusion is that a physician may not be able to heal himself, thus, clergy cannot adequately handle all their own biological, emotional, sociocultural, technological, and spiritual challenges but need external assistance.

Egunjobi (2019) on mental health seeking-behaviour of clergy revealed that compared to those in Europe and America, Africans and African clergy are not likely to seek professional help. Egunjobi (2019) only confirms White (2016) and then adds that African Americans are far less likely to seek mental health treatment than Caucasian Americans.

Other findings by Alton (2020); Besterman-Dahan et al., (2012) indicate a rise in the use of religious counseling services as an alternative to professional secular psychological counseling services. These studies, however, failed to clearly bring out the relative psychological benefits of religious over secular counseling. They only emphasized that the level of social stigma involved in seeking religious counseling services is lower than in professional psychological counseling services. The credit of the studies is its improvement on prior literature as they use the setting of modern war to explore the causal impact of combat-induced traumatic health shocks on veterans' religiosity. Military chaplains are only mentioned as those whose preaching may affect religiosity in environments where competition from secular counselors is relatively limited.

Suhaiban, Grasser & Javanbakht (2019) hold that severe stress exposure is a key predictor of mental health. In their view, civilian war trauma, torture, and forced migration rank among the most traumatic life experiences. These experiences, they maintain, are unescapable in nations undergoing both internal and external conflicts. On their part, Sabia & Skimmyhorn (2019); considered war to be a life-and-death struggle that generates substantial health trauma to those experiencing it and their families. These authors, however, focus their research on servicemen who are deployed, and the imminent-threat of physical injury and death they face or witness or may participate in the deaths of enemy combatants, civilians, and comrades-in-arms.

Clergy are wounded in the same manner as those entrusted to their care, and should not display any maladaptive behaviour just because of their vocation (Naab, 2014). Mental illness is more serious and challenging than physical sickness. Clergy can only be of better service if they first take care of their own challenges. Coping with challenges and adversity effectively there does not solely dependence on the individual's capacities but is also facilitated by both his personal and social resources. The clergy's perceived self-efficacy serves as his personal resource, empowering him to navigate hardships, while social support, his crucial social resource, can play a key role in offering a network that alleviate the impact of his stressors (Schwarzer, 2024).

Given the distinct role clergy play in supporting their congregants, even minor mental health challenges may influence their ability to fully support different aspects of their ministry. Jacobi et al., (2022) have said that besides the inherent challenges of supporting congregants with mental health concerns, clergy members may encounter additional obstacles, such as stigma and cultural barriers within their religious communities. It must be clear that psychological issues require

psychological interventions, and spiritual issues require spiritual interventions, while psycho-spiritual issues also require a psycho-spiritual intervention. If this is ignored the clergy may never seek proper mental health care, a situation which Machogu, et al., (2022) say can turn a priest or religious into a deviant, an abuser, or a wounded wounder.

2.6.1. Summary of How Coping Mechanisms Impact on Help Seeking among the Clergy

There are five recognized emotional phases established in the literature review that individuals who face war trauma can undergo in order to cope with war-trauma. They include situation selection, situation modification, attentional deployment, cognitive change, and emotional response regulation. Characteristics such as being male or female, youth; or persons who are faced with war trauma such being male or female, and youth influence a person to adopt certain coping strategies that belong to one or more of the phases above (Snoubar & MuSAH (2017). Studies revealed how youth, children and women are synonymous to certain strategies but not the catholic clergy (USDVA, 2012). The traumatic experiences and other mental health challenges of clergy living and ministering in ongoing arm-conflict and war environment in addition to their daily work-related stress has been neglected. Pietkiewicz & Bachryj (2016) already highlighted that there is still limited empirical evidence about how Roman Catholic secular clergy cope with stressors. Thus, this study will identify such coping strategies among older youth who are clergy and will further inform literature in this area to improve better coping strategies.

2.7. How War-Trauma is managed among the Clergy

War-trauma can be managed if the conditions under it are known and can be established. The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) describes trauma as the exposure to actual or threatened death, serious injury or sexual violence. It occurs when one: (a) directly experiences the event; (b) witnesses, in person, the event occurring to others; (c) learns that such an event happened to a close family member or friend; and (d) experiences repeated or extreme exposure to aversive details of such events (Jones and Cureton, 2014). Thereafter, the victim experiences induced fear, helplessness or horror. A person can therefore be confirmed to be traumatized if he/she has one symptom of persistent re-experiencing of fear, helplessness; if a person experiences three symptoms of avoidance of or emotional numbing; and if a person experiences two symptoms of increased arousal for at least one 1 month (Jones and Cureton, 2014).

Managing war-trauma can be in the form of encouraging and enabling ‘survivors themselves and the community’ to play their role (Rochelle et al, 2019: p, 95). However, their role is often ‘disregarded, ignored and trivialized by all concerned’ (Rochelle et al, 2019: p, 55). The management of war related trauma should therefore be in form of enabling victims to fight fear-based responses. Andersen (2020) uses theory of Bandura to encourage self-management for victims of trauma through self-reappraisal of one’s own situation and sharing the fear.

Another study by Shannon et al (2015) on torture, war trauma, and mental health symptoms on Karen refugees recommend an early education about mental health issues for those exposed to war situations so as to equip victims to self-manage war trauma. This is because access to proper screening may not be possible in war situations. This early psychoeducation can help avert future mental health disorders and enforce preventive care (Shannon et al., 2015); while O’Donnell (2020) encourages church leaders read about trauma to develop trauma literacy so as to be alert to trauma symptoms.

The clergy, just like doctors are trained to be independent, confident with some special skills to offer counsel and some form of therapy to Christians. However, just like Hudzik (2019) notes, they tend to sometimes overlook and down play their health problems. Slaby (2021) categorically says that Catholics generally believe that participating in sacraments and using sacramental/prayer is enough to heal their psyche which is not true. Hudzik (2019) emphasizes the need for all humans to be listened to, reassured, hospitalized and feel safe.

Pietkiewicz & Bachryj (2016) also note that clergy generally underutilize the existing resources for social support or professional help due to various personal and cultural factors. Their study maintains that Irish clergy preferred to keep a positive image of themselves and the church and to comply with group norms than to disclose their personal problems to lay people. Even so, when they seek professional help, it is done with a lot of reluctance and as a last resort. This behaviour is attributed to the self-stigma they perceive to be involved in seeking help.

Past and present researchers have shown concern for the welfare of all those exposed to violence due to war (Lim et al, 2022). They all acknowledge the psychological effects on all human beings who experience war trauma irrespective of who they are. Ashley Olivine, (2024) advises anyone experiencing symptoms of trauma which affect his daily life to seek help from a psychiatrist, psychologist, or other mental health professional. Most of the researchers agree that experiences

and management of war trauma are unique to individuals, and settings/cultures. Several studies have investigated war trauma among civilian populations (children, women, prisoners of war, and combat) in war zone areas like Croatia, Kosovo, Lebanon, Afghanistan, Vietnam, among many others. Needs of war victims in post conflict humanitarian settings have always been recognized and addressed.

Yet, there is scarcity of literature relating war trauma and its management especially among catholic clergy. Most of the trauma related literature about the clergy is related to vicarious trauma (trauma experiences felt after listening to and observing needs of parishioners), and other occupational stressors (Case et al., 2020; CTS, 2022; Clarke et al., 2023).

2.7.1. Summary of How War-Trauma is managed among the Clergy

Literature points to self-management of war-trauma as the most efficient way for prevention, and early diagnosis of adverse effects of war-trauma on mental health of victims. Humanitarian relief for survivors of Trauma is also the norm in war crisis especially for Post-Traumatic Stress Disorder (PTSD). However, little is known about how institutions like the church integrate nonspiritual (secular) mechanisms for war trauma and mental health management especially in the African context.

2.8. The Effect of Coping Strategies on War-Trauma and Help Seeking among Clergy

Research show that armed conflicts continue to occur in the world, leaving the population severely affected and health care systems dysfunctional, unable to cover the needs of either people with severe general mental health conditions or victims and combatants traumatized by conflict-related events (Østergaard, et al., 2023). Humans have thus become generally vulnerable to physical, psychological, social, technological, and spiritual challenges (Nouwen, 1994). A situation which if not adequately addressed and responded to, as Nouwen asserts will result into serious physical, psychological, social, technological and spiritual consequences. The best approach to these victims is to seek the help of a physician, psychologist, psychiatrist, community elder, and spiritual leader. But professional helpers are themselves not immune from the consequences of the same challenges (WOS, 2019). It is rather unfortunate that online search for the possible psychological challenges of clergy and religious only provides the numerous articles focusing largely on sexual abuse of the clergy (WOS, 2019).

Palamarchuk & Vaillancourt (2021); Luszczynska, Benight & Cieslak (2009) acknowledge that to effectively cope with challenges and adversity is not exclusively dependent on one's capacities, but, is also the product of both his personal and social resources. Thus, perceived self-efficacy serves as a personal resource, whereas, social support is a key social resource, both, offering a network that can alleviate the impact of stressors. They argued that when faced with traumatic events such as those associated with military conflict, individuals with greater self-efficacy will likely employ more adaptive coping mechanisms. They will easily seek social support, utilize problem-solving skills, and maintain a positive outlook, despite the adversity. Nancy Kingwood (2019) maintains that those with lower self-efficacy may struggle to effectively manage the emotional and psychological aftermath of trauma putting them at higher risk of developing Post Traumatic Stress Disorder or other mental health issues.

According to Ralf Schwarzer (2024) psychosocial challenges are the most formidable obstacles faced by populations experiencing war, terrorism, and forced migration. Palamarchuk & Vaillancourt (2021) thus, add that individuals caught up in arm-conflict zones grapple with compromised psychological well-being. They also endure intense distress, which render them vulnerable to various adversities, as well as violence, suicidal tendencies, and compromised physical health. The situation can further be aggravated by harmful health practices such as substance abuse. The range of traumatic experiences they may face include; feelings of insecurity, witnessing extreme violence, family separation, abduction and incarceration.

Nouwen (1994) confirmed many priests and religious to be have been emotionally wounded and broken either as children or in the ministry by colleagues, parishioners, bishop or superior. He observed that if they are not healed emotionally, they themselves may tend to physically or sexually vent it on others, or, to emotionally hurt, wound, or abuse others. In Nouwen's view emotions speak and can instruct a person to do the unimaginable without a thought. Emotions always defeat reasoning in a battle; reasoning only returns after to ask emotions what it has done. Joyce Meyer (n.d) makes clearer Nouwen's position by stating that emotions have a voice; and when they are wounded, they may react like a wounded animal. This wounded animal, a clergy or a religious, may then become a Wounded Wounder (Nouwen, 1994).Machogu, et al., (2022)

emphatically state that this type of situation is greatly behind the bad name ascribed to some pastoral workers, and the church in general.

Most of the current coping measures are constructed around problem- and emotion-focused dominions (Yi Ding. et al., 2021). They hold strongly that problem-focused coping mechanisms may allow an individual greater perceived control over their problem, whereas emotion-focused coping may sometimes lead to a reduction in perceived control (maladaptive coping). Palamarchuk & Vaillancourt (2021) is of the opinion that individuals employ emotion-focused methods of coping when they perceive a situation as impossible to change. When people consider a troubling situation as controllable through action, they tend to be problem-focused in their approach. That is, they cope by attempting to handle their stressful situation, or minimizing the effects of the stressful situation on them. Elizabeth Scott (2022) advances that with emotion-focused coping individuals engage in self-preoccupation, fantasy, or other conscious activities related to affect regulation. This is most useful when the stressor is something that one cannot change. Adopting this coping style means people simply find ways to accept what they face right now, and not let it bother them.

Seguin & Roberts (2015), noted that specialist mental health services are often not available in many conflict-affected and resource-poor settings. So, if individuals harness coping tactics that support good mental health it would help reduce their need for specialist mental health services which are often limited in conflict or war areas (Palamarchuk & Vaillancourt, (2021). There is however very limited evidence on the relationship between coping strategies and mental health among conflict-affected populations in low and middle-income settings where the vast majority of conflict-affected populations live. According to duo, available evidence only limits the differences in coping strategies to between men and women.

Behavioural disengagement is hence associated with symptoms of depression among men and women; denial for men and women; and substance abuse for men and women. Whereas active coping is associated with less depression in men and women. Behavioural disengagement and substance abuse are significantly associated with symptoms of generalized anxiety and to any form of mental disorder among men. Humour, the use of emotional support, acceptance and religion are all significantly associated with a lower probability of any mental health condition (Seguin & Roberts, 2015).

Armed conflict directly and indirectly affects; physical, mental, and behavioral health. As Grasser (2022) observes, it can affect every organ system, and its impact can persist throughout the life course. Nancy Kingwood, (2019) says that unaddressed trauma will present itself as chronic diseases, panic attacks, eating and sleep disorders, and more. Anthony Bennett (lead pastor at Mount Aery Baptist Church, in Bridgeport) and a trauma-informed clergy, articulates that trauma cannot always be cured, but people will feel cared for when attention is given to its remedy. It is not possible for victims to heal from an illness whose presence and impact on their lives is underrated as in the case of clergy living in armed conflict zones and their mental health levels. For instance, there is no known specific research that addresses trauma among clergy living and serving in armed-conflict especially in Africa. Therefore, understanding and addressing the mental health concerns of these clergy should be a top global priority.

2.8.1. Summary of How Coping Strategies Effect on War-Trauma and Help Seeking Among the Clergy

Literature has pointed out social support and self-efficacy as coping resources which significantly determines an individual's psychological well-being and resilience in the face of trauma resulting from military conflict and arm extremism (Shimelash, 2023). An individual's exposure to war-related stressors and the potential for encountering life-threatening situations can severely impact his sense of control, competence, and social networks (Ben-Tzur, Zanbar, & Kaniasty, 2021). Palace, et al., (2023) therefore, call attention to the fact that high levels of self-efficacy and/or social support may empower individuals to confront and adapt to the challenges posed by trauma, thus, fostering a more resilient response.

The relationship between social support, self-efficacy, and trauma resulting from military conflict has only been mentioned in general terms. Current Literature has limited this relationship to children, women, refugees, and deployed soldiers. The clergy have been notoriously excluded. Most studies especially in Africa have ignored the fact clergy are also victims of military and armed conflict, as is the case with anglophone Cameroon and parts of the Sahel. A substantial body of research has examined risk-factors for poor mental health among conflict-affected civilian populations (Østergaard, et al. 2023; Hassan, et al. 2024), but little or no study has been done among the clergy especially those serving in the military conflict areas of Africa. Thus, there is no

research on how the clergy are protected and how they cope with traumatic war experiences. This is what this research sets out to examine.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0. Introduction

Research methodology is the process or the way you intend to execute your study (Deeptanshu & Shubham, 2022). This chapter describes the proposed research methods that were used in conducting the study and analyzing study results. The importance of this chapter in research is to; facilitate the selection of suitable methods, materials, tools and techniques relevant for the study. It further facilitates the understanding of suitable methods chosen, the order of accuracy of the results and the efficiency of the methods to be used in the study. Summarily, the chapter explains the steps that the researcher used as the “general principle to execute” this research (Hassan, 2024). The chapter thus, presents the highlight of the research design, research approach, research population, sample size and sampling procedures, data collection methods and techniques, data collection instruments/tools and justifications, validity and reliability of data collection instruments, data analysis, and ethical considerations.

3.1. Research Design

A research design is the “arrangement of conditions for data collection and analysis in a manner that aims to combine relevance to the research purpose” (McCombes, 2023; Kothari, 2004:31-32). A case study design has thus been used for this study. It allowed the researcher to avail a “detailed research inquiry into a single social process, organization or collectivity seen as a social unit in its own right” (McCombes, 2023; Bhandari, 2023). Therefore, the researcher limited the study to only diocesan clergy whose pastoral work is in the war-affected areas of Bamenda ecclesiastical province.

According to Bhandari, (2023) case studies are suitable for the qualitative approach to research because it enables the researcher to carry out “careful and complete observation of a social unit, be it a person, family, or an institution”. The researcher was able to gather fresh insights from the clergy as they experience this trauma daily.

3.2. Research Approach

The qualitative research approach which prioritizes the perspective of participants (Hassan, 2024) was used for this study. It involved collecting and analyzing non-numerical data (text, video, or

audio) to understand concepts, opinions, or experiences of the participants (Bhandari, 2023). Hassan (2024) holds that qualitative research approach research is useful when the objective is to explore the meaning of phenomena, understand the experiences of individuals, or gain insights into complex social processes. That is, as Hassan (2024); Bhandari, (2023); McMillan & Weyers, (2008pg.127) observed, it can be used to gather in-depth insights into a problem or generate new ideas for research. It thus involves; interviews, focus groups, ethnography, and content analysis as it focuses on individuals' experiences of events, processes and systems (Hassan (2024). The approach enabled the researcher to generate “experiential research which involves gathering information from people who have experienced in the problem being studied” (Bhandari, 2023). Thus, it guided the researcher to consider the catholic clergy as “endowers of meaning” (Miller and Brewer, 2003, pp. 238).

Qualitative research prioritizes the perspective of participants, allowing researchers to explore subjective experiences and understand the meanings that participants attach to their experiences.

3.3. Area of Study

The diocese of Kumbo is one of the five dioceses of the ecclesiastical provinces of Bamenda, which covers the entire Anglophone/English-speaking part of Cameroon. The diocese of Kumbo comprises administrative territories of Bui and Donga-Mantung divisions in the North West region of Cameroon covering 8,000km (3,090 square miles). By 2021, the diocese had 34 parishes (Cheney, 2021).

3.4. Research Population

Bhandari (2023) emphasizes that a population in research is the entire group that the researcher wants to draw conclusions about. He confirms that a population can be made up of anything researchers want to study; plants, animals, organizations, texts, countries, etc. However, in the social sciences, it most often refers to a group of people with specified characteristics (Thacker, 2022). The study population for this research work therefore consisted of 65 diocesan clergy from the diocese of Kumbo who have lived and worked there for a minimum of three to six years (2017-2023), and leaders of the Association of Diocesan priests in Kumbo (ADP). This is because they are the ones who have experienced war trauma since the crisis began in 2016. Therefore, they will be able to narrate the trauma as it unfolded to date. The diocese of Kumbo has 65 diocesan clergies

serving 30 out of the 34 parishes (4 parishes are served by religious clergy) in the Bui and Donga-Mantung divisions (the most affected areas by the separatist war).

3.5. Research Sample (Sample Size and Sampling Procedures)

Sample is the smaller group of individuals the research actually collect data from (Bhandari, 2023). Ali Khan, et al., (2023) underscore that sampling procedure which involves selecting a representative subset of the target population to gather data is crucial in research. In this regard, the researcher needs to determine the appropriate sampling method based on the research objectives and available resources. Bhandari, (2023) also emphasizes that a well-designed sampling approach must ensure that the findings are generalized to the broader population. A research sample is “a group from which information is obtained” (Bhandari, 2023; Fraenkel & Wallen, 2023. pg. 95). Sampling therefore, is the process of obtaining information about an entire population by examining only a part of it (Bhandari, 2023). In this study, the researcher used an ‘exploratory’ sample as advised by Bhandari, (2023); Denscombe (2014. pp. 32) who say that exploratory sampling is good for small-scale research to generate qualitative data in relatively ‘unexplored topics’ as a way to generate new ideas. In this study, the 65-diocesan clergy of the Diocese of Kumbo represented the research sample due to their lived experiences of war trauma. They were able to provide rich descriptions of their experiences and willingly articulated their experiences.

3.5.1. Sample Size

Experts in qualitative research argue that there is no straightforward answer to the question of ‘how many’ and which sample size. Sample size guidelines suggest range between 20 and 30 interviews to be adequate (Bhandari, 2023; Creswell, 2015). Interviewer and note taker have agreed that thematic saturation, the point at which no new concepts emerge from subsequent interviews, has often been achieved following completion of 20 interviews (Pandey & Pandey, 2019; Patton, 2002). Qualitative researchers have proposed 30 as a working number of interviews at which one could expect to be reaching theoretical saturation while using a semi-structured interview approach (Bhandari, 2023; Morse 2000). This however, can vary depending on the heterogeneity of respondents interviewed and complexity of the issues explored (Ali Khan, et al., 2023; Sandelowski, 1995).

Although there is no strict formula for determining sample size in qualitative research, scholars suggest that 20–30 interviews are sufficient to achieve data saturation (Creswell, 2015; Pandey & Pandey, 2019; Morse, 2000). Saturation refers to the point where no new themes or insights emerge from additional data (Sandelowski, 1995).

For this study, 36 participants were purposively selected which included, 12 members of the diocesan clergy, 12 members who were victims of kidnap, and 12 ADP leaders, drawn from 18 purposively selected parishes. Saturation was confirmed after the 33rd interview, when no new codes or concepts emerged; three additional interviews were then conducted to ensure consistency.

3.5.2. Sampling Procedure

Bhandari (2023) believes that even with a smaller defined research population, it is hardly possible for the researcher to collect data from every individual. This implies that the researcher instead, collect data from a sample. All the participants in this research work were chosen deliberately (purposively) because they reflect particular features; in this case, having lived and served in the war-torn area or been kidnapped. Hassan (2024); Bhandari, (2023); Pandey & Pandey, (2019) all confirm that research participants chosen in this fashion are able to provide the researcher with detailed account about their experiences of the phenomenon under consideration. The 18 parishes out of the 30 in Kumbo diocese were also purposively selected on the basis of their status of having been directly attacked (both by military and separatist militants) or are in the area with the greatest number of killings, gunfire exchange, in the last five years.

3.6. Data Collection Methods and Instrument “Procedures and Methods/Techniques

Ali Khan, et al., (2023) emphasize that how researcher gather data from participants or the environment is vital in conducting a research work. Some common data collection methods from which the researcher can select the most appropriate method based on his research objectives and the type of data required include; surveys, interviews, observations, experiments, content analysis, and focus groups (Hassan, 2024; Ali Khan, et al., 2023). This study thus used Key Informant Interviews (KIIs). Key informants are those whose social position in a research setting gives them specialist knowledge of the happenings that are more extensive, detailed, or privileged than other people (Kibuacha, 2024); in this case, they were the diocesan clergy. They provided more information and deeper insight into what is going on around them, the separatist war in Anglophone Cameroon.

Key Informant interviews therefore involved “interviewing a selected group of individuals (diocesan clergy) who were likely to provide needed information, ideas, and insights (Kibuacha, 2024) on war trauma. They are known to be few in number, probably ranging from 15 to 35 as explained by (Merriam & Tisdell, 2024; Subedi, 2021). The interviews were unstructured, in-depth; guided by open-ended questions to enable probing so as to obtain a “detailed investigation of each clergy’s personal perspective” (Ali Khan, et al., 2023).

3.7. Qualitative Data Quality Control

Ensuring rigour in qualitative research requires establishing trustworthiness, which includes credibility, dependability, conformability, and transferability (Lincoln & Guba, 1985). This study emphasized credibility and dependability as key to maintaining high-quality findings.

3.7.1. Credibility

Credibility refers to whether the findings accurately represent participants’ lived experiences (Shenton, 2004). It was ensured by:

Prolonged engagement with clergy through in-depth interviews.

Member checking, where interview summaries were shared with participants for verification.

Triangulation across categories of clergy (parish priests, kidnap victims, and ADP leaders).

Peer questioning with supervisors and colleagues to validate emerging interpretations.

3.7.2. Dependability

Dependability refers to the stability of findings over time (Nowell et al., 2017). It was enhanced by;

Maintaining an audit trail documenting methodological choices and coding decisions.

Using NVivo 15 for systematic coding and categorization of themes.

Stepwise replication of coding on subsets of data to confirm consistency.

3.7.3. Conformability and Transferability

Conformability was promoted by keeping spontaneous journals and documenting assumptions to minimize researcher bias (Creswell & Poth, 2018). Transferability was addressed by providing thick descriptions of the study context and participants, allowing readers to assess relevance to other conflict-affected populations.

3.7. Data Management and Processing

Data management is a multi-step process that involves obtaining, cleaning, and storing data to allow accurate analysis and produce meaningful results (Dhudasia, Grundmeier & Sagori, 2023). Bhandari (2023) also emphasizes the need for the researcher to properly manage data through the creation of a data management plan for organizing and storing his data. This is because he will need the data to transcribe interviews or perform data entry for observations.

A well-organized data will save time when it comes to analyzing it. It can also help other researchers validate and add to your findings (high replicability). The researcher used the five-stage process of data processing and management (Bingham, 2023; Creswell & Clarke, 2007pg 129) mentioned below:

Stage one: data preparation through transcription of the audible recordings of the interviews. Transcription means transforming audible recordings into a written form from which data will then be reduced and represented to make data readable and meaningful ((Ali Khan, et al., 2023; Bailey, 2008). It will enable the researcher to be familiar with the data (Hasse-Bieber, 2010).

Stage two: This involved data exploration to identify possible emerging themes or issues, and gaps for further data collection if need be (Dhudasia, Grundmeier & Sagori, 2023).

Stage three: At this stage, data analysis was done through computer-assisted qualitative data analysis software (CAQDAS). Denscombe (2014) notes that the best-known CAQDAS is NVivo; that using a CAQDAS will enable the researcher to code, categorize and store the data. Data was then be grouped into emerging categories, themes and concepts inductively, (Burnard, 2008), by searching for commonalities and contrasts in the data (Ali Khan, et al., 2023; Hasse-Bieber, 2010).

Stage 4: At this stage, the researcher presented or displayed the data using quotes, graphs, pie charts, word cloud, to back up the themes, categories and concepts.

Stage 5: Here, data will be validated and verified from the transcribed data or recordings.

3.8. Data Analysis

As Nowell et al., (2017) note, a trustworthy qualitative study should “demonstrate that data analysis has been conducted in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to

determine whether the process is credible” (pg. 1). Data analysis involves processing and interpreting the collected data to draw meaningful conclusions. It is the detailed examination of the data that has been collected in order to gain a better understanding of it (Ali Khan, et al., 2023; Denscombe, 2014. pg.243). Ali Khan, et al., (2023) opined that data analysis must be appropriate and accurate, based on the nature of the data and the research design. (Bhandari, (2023) states that qualitative analysis methods must align with the research questions and support the study’s conclusions. Data analysis for this study commenced after the first two stages of data processing mentioned in the previous section (3.7). Using computer-assisted qualitative data analysis software (CAQDAS), NVivo 15, the researcher analyzed the content of the data that had been transcribed (content analysis). The purpose was to look for hidden messages about war-trauma and help seeking, and their significance to the research through the frequency of occurrence of trauma-related symptoms. This will be identified through words and phrases related to Trauma which will be measured based on their frequency and then quantified (Pandey & Pandey, 2019; Denscombe, 2014).

Both the main interview guide and the focused group interviews were analyzed using thematic and content analysis approaches. Meaningful data will be categorized in accordance to the already developed themes from in accordance with the objectives for the study under the themes for literature. This will enable aligning of findings with the research themes.

3.9. Ethical Considerations

The researcher understood that while investigating ‘people’s experiences’ in qualitative research he/she enters a relationship with the researched (Business research methodology website, 2023). Therefore, the researcher has a responsibility of ‘creating a mutually respect win-win relationship in which participants are pleased to respond candidly and valid results are obtained,” (Creswell & Poth, 2018). Hassan (2024) gives some basic principles for ethically carrying out qualitative research that the researcher has applied. These are voluntary participation, protection of the dignity and safety of the research participants, confidentiality and anonymity, and benefits to research participants. Written consent was obtained, pseudonyms were used, and participants had the right to withdraw at any stage. Permissions were obtained from both the university and the diocese (Creswell & Poth, 2018).

3.9.1. Voluntary Participation

The researcher obtained informed consent from the research participants. Hassan (2024) notes that it can be a written ‘contract that specifies the ethical responsibilities to the participants. Therefore, as advised by Hassan (2024), the researcher provided research participants with a ‘general description of the research project’ in order to make them understand their participation and the responsibility of the researcher to them in terms of their protection, and how the information they give was used. The researcher also gave the participants the ‘freedom’ to withdraw from the research at any time in case they may experience more trauma or insecurity due to the study as advised by Pandey & Pandey, (2019).

3.9.2. Protection of the Dignity and Safety of the Research Participants (Confidentiality and Anonymity)

Confidentiality means that the identity of the participants was not disclosed to anyone, while anonymity means that even the researcher does not know the identity of the participants (Ali Khan, et al., 2023; Bhandari, 2023). Pseudonyms and coding of interviews was done for all the research participants as suggested by Hassan, (2024).

3.9.3. Benefits to Research Participants

McCombes (2023) says that qualitative research must benefit the participants by increasing awareness about the issues at hand, enabling people to be more aware of their choices, and providing the researcher with ‘new perspectives in otherwise it will be a learning experience for the researcher (Hassan, 2024; McCombes, 2023). The researcher will share the findings of the research with the responsible authorities for better management of war-trauma and mental health issues among the research population and beyond. In this case, copies of the research work will be sent to the Kumbo diocesan secretariat, the episcopal conferences of Bamenda and Cameroon respectively.

3.9.4. Permission to Carry Out Research

The researcher fulfilled all the necessary requirements set by the university in preparing the proposal and report so as to obtain permission from the university to carry out the research. Permission from the authorities of the church in the diocese (e.g., from the vicar general) was also sought before the research commenced.

3.10. Research Limitations

Research limitations are the factors that may affect the validity, reliability, or generalizability of your study (Pandey & Pandey, 2019; Creswell, 2009). Hassan (2024) affirms that these limitations can arise from various sources, including the design, data collection, analysis, or interpretation of the research. The researcher thus paid attention to the methodological limitations in qualitative research, a type of research that explores the meanings, experiences, or perspectives of people or groups in a natural setting (Cole, 2023). As Hassan (2024) notes, the researcher must acknowledge the study's limitations, including the fact that social media usage can vary significantly among individuals, and the study focuses solely on secular clergy in Kumbo, who may occasionally leave the network. The researcher will also discuss some strategies to address this anticipated research limitations.

The researcher expected some drawbacks to data collection, such as the potential for incomplete, inaccurate, or inconsistent data due to the availability, accessibility, or quality of the sources or methods. Moreover, as Pandey & Pandey (2019) assert, the data may be influenced by the researcher's subjectivity, bias, or expectations, or by the participants' self-presentation, social desirability, or recall. To combat these issues, the researcher carefully selected and prepared data sources and methods, built rapport and trust with participants, and used multiple sources or methods to triangulate and validate the data. Also, he documented and reflected on the data collection process, and ensured the confidentiality, security, and ethical treatment of the data (Dhudasia, Grundmeier & Sagori, 2023; Walliman, 2021).

The anticipated shortcomings of this qualitative research included the difficulty in investigating causality. This stems from the fact that this type of research is based more on opinion and judgment rather than results (Pandey & Pandey, 2019; Creswell, 2009). It was difficult for the researcher to grasp and replicate exactly what the respondents said in an interview. The researcher therefore, planned thoughtfully to ensure that the results he obtained were accurate, since there is no way to analyze qualitative data mathematically (Taherdoost, 2022).

Another anticipated limitation was objective results verification because the research method here is qualitative, which is open-ended and conversational communication (Hassan, 2024; Lenger, 2019). Köhler, Smith, & Bhakoo (2022) emphasize that this gives the participants more control over the content of the data to be collected than the researcher. The researcher may consequently

not be able to verify the results against the scenarios identified by the respondents, since there may be no statistical representation. In order to overcome this limitation, the researcher cross-referenced qualitative data with quantitative finding he obtained through the review of literature (Pandey & Pandey, 2019; Creswell, 2009).

Other anticipated shortcomings of this research included the limited time available for research, given the fact that the researcher combined class learning, external practicum, and research work simultaneously. He was, however, expected to travel to Cameroon to interview the respondents. To resolve this challenge, the researcher explored the option of carrying out online in-depth interviews using the available media (either Zoom meeting or Google Meet). This enabled the researcher to finish on time.

On a concluding note, the researcher has in this chapter described the proposed research method that has been used in conducting the study and analyzing study results. The significance of chapter in the research is that it has enabled the researcher's selection of suitable method, materials, tools and techniques relevant for the study. Moreover, it has simplified the researcher's understanding of suitable method chosen (qualitative research approach), the order of accuracy of the results and the effectiveness of the method used in this study. The chapter has therefore, presented the highlight of the research design, study population, study area, sampling procedures and sample size, data collection methods, quality control measures, data analysis and presentation, ethical consideration and to end with, the methodological limitations in qualitative research.

CHAPTER FOUR

PRESENTATION AND DISCUSSION

4.1. Introduction

This chapter presents and discusses the results derived from the qualitative analysis conducted using NVivo 15 software on the data from the field on how War-Trauma is managed among Diocesan Clergy in the Diocese of Kumbo amid the Separatist War. The findings are structured in alignment with the five specific objectives of the study, thereby addressing the corresponding research questions. The discussion draws comparisons with previously documented and published studies to provide a deeper understanding of the mental health challenges faced by the clergy in the Kumbo Diocese amidst ongoing arms conflict. In this regard, the chapter not only interprets the emerging themes but also situates the results within the broader context of mental health research in conflict-affected regions such as South Lebanon, Mexico, Burkina Faso, Ethiopia, democratic republic of Congo, and Nigeria.

4.2. Presentation and Discussion of Results

This section presents, describes, and discusses the qualitative findings. Each subsection is framed under the major objectives of the study. Through thematic analysis, categories and sub-categories have been generated based on the transcribed interviews. Each theme is discussed to the existing literature to offer both a localized and comparative perspective on the effects of conflict on mental health and well-being.

Respondent categorization

The tables below describe the different categories of respondents interviewed for this research. The respondents were categorized as diocesan clergy (appendix 1), victims of kidnap (appendix 2) and leaders of the association of priests (appendix 3). These respondents shared their experiences about living and serving in the conflict area of the diocese of Kumbo, in the English-speaking part of Cameroon.

Table 1: Respondent Categorization for Appendix 1

Respondent category	Period in service (Years)	Frequency	Percentage (%)
Diocesan Clergy (Appendix 1)	4	3	25.00
	5	4	33.33
	6	3	25.00
	7	2	16.67

The above table presents the distribution of diocesan clergy respondents based on their years of service in the crisis hit region. The years of service range from 4 to 7 years. The majority of respondents (33.33%) have served for 5 years in the conflict zone, followed by those with 4 and 6 years of service (each representing 25%). The smallest group (16.67%) has 7 years of experience in this arms conflict area.

This distribution shows a fairly even representation of clergy with mid-range experience (4–6 years), with slightly fewer respondents at the higher end of the spectrum (7 years). This is significant for understanding the clergy’s exposure to the Anglophone Crisis and its associated war-trauma over a considerable period. Clergy with 5–7 years in service have likely spent much of their ministry during the height of the crisis (which escalated from 2016 onward), thus providing rich insight into the effects of prolonged exposure to trauma and trauma situation, and the evolution/progression of help-seeking behaviour.

Table 2: Respondent Categorization for Appendix 2

Respondent category	Year of Kidnapping	Frequency	Percentage (%)
Victims of Kidnap	2017	2	16.67
	2018	2	16.67
	2019	2	16.67
	2020	1	8.33
	2021	2	16.67
	2022	0	0.00
	2023	2	16.67
	2024	1	8.33

The above table 2 outlines the distribution of clergy who were victims of kidnapping/abduction between 2017 and 2024. The data shows a fairly consistent pattern of kidnappings/abductions, with most years registering two victims (16.67%). Notably, 2022 was the only year with no reported kidnappings among respondents. The highest frequencies occurred in 2017, 2018, 2019, 2021, and 2023. Fewer cases were reported in 2020 and 2024 (one case each).

Kidnapping/abduction incidents among clergy highlight the direct exposure to war-related violence, a core aspect of the trauma under investigation in this study. The distribution shows that kidnappings were not isolated to a single period but spanned across multiple years of the ongoing Anglophone Crisis, suggesting sustained insecurity and psychological threats faced by the clergy in their respective pastoral duties.

This pattern indicates a persistent high-risk environment in which diocesan clergy serve, affecting their mental health, sense of safety, and possibly their willingness or ability to seek help. For instance:

- Repeated exposure to kidnappings—either personally or through colleagues—could possibly lead to chronic trauma or PTSD-like symptoms.

- The absence of cases in 2022 may signal a temporary de-escalation of violence or underreporting, but the immediate resumption of kidnappings in 2023 and 2024 suggests continuing insecurity and uncertainty in the region at large.
- These experiences likely influence help-seeking behaviour, as clergy may either become more open to psychosocial support due to trauma or remain withdrawn due to fear, stigma, or distrust in formal systems.

Furthermore, the fact that clergy continue to be kidnapped even in recent years (2023–2024) reinforces the need for targeted trauma interventions, ecclesiastical support systems, and advocacy for the protection of religious workers in conflict zones.

Table 3: Respondent Categorization for Appendix 3

Respondent category	Period of Leadership (Years)	Frequency	Percentage (%)
Leaders in the Association of Diocesan Priests (Appendix 3)	4	3	25.00
	5	2	16.67
	6	4	33.33
	7	3	25.00

The table 3 categorizes the respondents based on their years of leadership service within the Association of Diocesan Priests. The leadership duration ranges from 4 to 7 years. The most represented group (33.33%) are those who have served for 6 years, followed by those with 4 and 7 years (each 25%), and the fewest have served for 5 years (16.67%).

This table is important for understanding how leadership experience within the diocesan clergy intersects with the experience of war-related trauma and help-seeking behaviour. Leaders often carry not only personal burdens from the conflict but also the collective concerns of their fellow clergy. This places them in a dual role as victims of the conflict and as pastoral caregivers or administrators tasked with supporting and caring for others.

Longer leadership experience (6–7 years) corresponds to a time frame deeply embedded in the Anglophone Crisis (which escalated from 2016 onward), implying that many of these leaders have administered their roles under conflict conditions. This may affect both their personal exposure to trauma and their response strategies for fellow clergy.

These leaders are critical informants on the availability, accessibility, and cultural attitudes toward mental health services within the Church structure. Their responses may reveal insights into the institutional support systems (or lack thereof), the role of peer counseling, and the internal barriers to help-seeking among the clergy.

Additionally, their perspective can shed light on coping strategies promoted within clerical leadership, the use of spiritual frameworks for trauma recovery, and whether leaders themselves are willing to model help-seeking behaviour or are constrained by expectations of spiritual resilience. Understanding the experiences and perceptions of these leaders is essential to identifying potential pathways for systematic pastoral care and trauma-informed leadership within the Diocese of Kumbo and the church in Cameroon and beyond.

4.2.1. Codebook Generated Using NVivo 15 Software

A codebook was developed based on the study objectives and the recurring themes and sub-themes that emerged from the data. The NVivo 15 software facilitated the systematic organization and analysis of qualitative responses. This analytical approach ensured that data coding remained consistent, objective-driven, and traceable across different interview categories.

The data were sourced from three main groups of respondents:

- **Appendix 1:** Interview guide for diocesan clergy
- **Appendix 2:** Interview guide for victims of kidnapping
- **Appendix 3:** Interview guide for leaders within the Association of Diocesan Priests

The "files" column in the codebook table reflects these three distinct categories of interviewees. The "references" column denotes the frequency with which each theme, sub-theme, or objective was cited across all transcripts. This method of coding is aligned with best practices in qualitative research, as described by Bazeley and Jackson (2013), who emphasize that a rigorous coding process enhances reliability and interpretative depth in qualitative data analysis.

The use of NVivo software has become increasingly prevalent in qualitative mental health research due to its capacity to handle large datasets, identify patterns, and support theory-building (Castleberry & Nolen, 2018). In this study, NVivo was instrumental in extracting meaningful insights from the interviews, which were then categorized into a codebook for ease of reference and discussion.

The thematic structure generated allowed the researcher to analyze the experiences of the clergy within the context of the ongoing arms-conflict, particularly focusing on the psychological impact, coping strategies, spiritual wellbeing, and institutional support mechanisms. Each of these themes is elaborated in the subsequent sections, where findings are linked with similar case studies and theories in mental health and trauma psychology.

4.2.2. Effect of Stress on Mental Health among the Clergy

This section discusses how stress negatively affects the mental health of clergy in Kumbo Diocese, Cameroon, amid ongoing armed conflict. The data, drawn from in-depth interviews and analyzed through NVivo 15, reveals multidimensional effects—psychological, physiological, behavioural, and spiritual. These findings are supported and enriched by both existing literature and new insights relevant to the realities of clergy working in conflict zones.

Table 4: Codebook for objective 1

Name	Description	Files	References
(Objective: 1) Effect of Stress	Objective 1. Effect of Stress on Mental Health among the Clergy	3	193
Behavioural changes	Including declining engagement in pastoral duties, strained relationships, or increased substance use.	3	26
Physical and physiological impact	These may include fatigue, burnout, insomnia, irritability, and emotional numbness, among others.	3	53
Sources of stress	Causes of stress among the categories interviewed	3	73
Spiritual and Moral Dilemmas	Includes Crisis of faith, ethical conflicts, and moral fatigue	3	41

The following are statements excerpted from the interviews conducted on effect of stress on mental health among the Clergy:

“It has been a time of coming to terms with my own vulnerability” (Kumbo, December 2nd. 2024).

“Listening to people narrate their ordeals with the terrorist fighters and government soldiers has been very overwhelming especially when time and again, I discover that I could do very little or nothing to help them go through their pains and sufferings”(Kumbo, January 21st. 2025).

“Since we are living the experience of a war situation where many people are killed daily, people are kidnapped and tortured, their rights and freedoms have been taken away, and even we the clergy become very careful of what we say in churches as we too are suspicious of the congregants” (Kumbo, November 23rd. 2024).

“Our ministry at this point in time is characterized by fear, anxiety, bitterness, suspicion.”

“Because we serve people who we sometimes know their position and negative contribution in the war, it becomes very frustrating and not motivating, and often provokes in us anger and bitterness” (Kumbo, December 2nd. 2024).

Sources of Stress

The narratives reflect clergy experiencing overwhelming emotional strain, particularly from listening to parishioners’ recount war-related traumas and daily sufferings (Table 4: Codebook for objective 1). One respondent noted, “It has been a time of coming to terms with my own vulnerability,” showing emotional over-identification with victims and a perceived inability to help key stressors for pastoral workers in crisis.

This resonates with Knox et al. (2002), who found that clergy in high-trauma contexts are frequently exposed to vicarious trauma due to their pastoral care roles. Additionally, Oden (2010) identified similar experiences among religious leaders in politically volatile zones, emphasizing the risk of PTSD as a consequence of repeated exposure to violence.

Suspicion and fear within congregations “we the clergy become very careful of what we say in churches...” highlight distrust as a critical source of stress. This mirrors Otieno (2016), who reported the erosion of community trust among clergy in Northern Uganda due to blurred lines between civilians and combatants, often leading to fractured spiritual communities and reduced pastoral safety.

Physiological and Psychological Impacts of Stress

The clergy reported insomnia, fatigue, and burnout, especially among those who had been kidnapped or displaced. These align with Proeschold-Bell et al. (2013), who documented how chronic overwork and trauma exposure lead to somatic complaints and sleep disorders in clergy. Insomnia's frequent mention in this study supports APA (2020), which highlights poor sleep as both a symptom and intensifier of trauma-related mental health issues.

The psychological effects of stress anxiety, depression, and cognitive difficulties further confirm the long-term damage described by McMinn et al. (2005). Persistent exposure to life-threatening situations in conflict areas can impair decision-making and emotional regulation, increasing vulnerability to mental illness (Palamarchuk & Vaillancourt, 2021).

Moreover, these findings echo Schwarzer (2024), who described psychosocial challenges like trauma, grief, and hopelessness as deeply damaging for populations in war-torn zones, particularly when compounded by a lack of external support structures.

Behavioural Changes

Behavioral symptoms such as irritability, reduced pastoral engagement, and alcohol use signify maladaptive coping strategies. This confirms Chandler's (2010) assertion that clergy under sustained stress may withdraw socially and resort to unhealthy self-medication. One interviewee's mention of serving people who have contributed to the conflict underscores the moral and emotional strain involved in ministering to perpetrators and victims alike.

The finding on social withdrawal supports Doolittle (2010), who cautioned that isolation among clergy is both a consequence and a catalyst of emotional collapse. In such contexts, pastoral workers may avoid interactions that remind them of their vulnerability, leading to further spiritual and social alienation.

Additionally, these behavioral shifts can be understood in the framework of emotion-focused coping, which Yi Ding et al. (2021) explain as a response to uncontrollable stressors often adopted when individuals perceive no way to solve or change their circumstances.

Spiritual and Moral Dilemmas

Expressions of spiritual despair "prayers seem not to reach God" illustrate spiritual fatigue, which is a hallmark of trauma-related moral injury. This spiritual exhaustion aligns with Proeschold-Bell

& LeGrand (2010), who noted that clergy in extreme stress lose their sense of divine connection, especially when pastoral care efforts seem ineffective in relieving suffering.

Gubi & Korris (2015) further emphasized how trauma can generate theological conflict, particularly when clergy struggle to reconcile divine justice with the chaos around them. Nouwen (1994) also describes clergy as “wounded healers,” but warns that unresolved emotional wounds can lead to wounded wounders a dynamic echoed in this study through expressions of bitterness and resentment.

Integrating with Broader Literature

The results affirm Palamarchuk & Vaillancourt (2021) and Luszczynska et al. (2009) in highlighting the crucial role of personal and social resources—especially self-efficacy and social support—in mitigating the effects of trauma. In conflict settings where institutional support is weak or absent, coping strategies are either underdeveloped or maladaptive.

However, Seguin & Roberts (2015) underscore that in many low-resource, conflict-affected areas like Kumbo Diocese, formal mental health services are nearly non-existent, making it imperative that community-based mental health strategies be supported. This includes empowering clergy with resilience training and safe pastoral spaces to share their burdens.

Unfortunately, as Grasser (2022) and Kingwood (2019) argue, unaddressed trauma among such populations may manifest as chronic disease, emotional breakdown, and even spiritual collapse, all of which were evident in the responses from this study.

The qualitative findings reveal that clergy in Kumbo Diocese endure significant stressors related to violence, insecurity, spiritual disillusionment, and social breakdown. These stressors manifest as psychological, behavioral, and spiritual dysfunctions, which are compounded by a lack of structured mental health interventions. Drawing from the literature, there is a clear call for integrated psychosocial support systems, increased research on clergy-specific trauma, and culturally relevant mental health models that consider the unique spiritual and pastoral vocation of clergy in conflict zones.

This section presents findings on the effects of stress on the mental health of the clergy in Kumbo Diocese, Cameroon. The discussion is informed by both primary qualitative data analyzed using NVivo 15 and a review of existing literature. Stress among clergy is a critical concern, particularly

in conflict-affected areas, as it compromises their pastoral and psychological well-being, ultimately affecting their ability to serve their communities.

4.2.3. Anxiety and Its Effect on Mental Health

Anxiety emerged as a dominant theme in the mental health experiences of clergy in the conflict-stricken Kumbo Diocese. Triggered by persistent insecurity, exposure to violence, and a breakdown of trust within communities, anxiety symptoms were especially prevalent among clergy who had survived kidnappings. Based on NVivo coding, anxiety-related statements constituted the highest number of references under objective two, totaling 85, highlighting the deep psychological toll conflict takes on frontline religious leaders. This is apparent in Table 5: Codebook for Objective 2.

Table 5: Codebook for Objective 2

Name	Description	Files	References
(Objective: 2) How Anxiety Affects Mental Health	Anxiety and Its Effect on Mental Health	3	200
Impact on Ministry	Includes hesitancy in public engagements, decreased effectiveness in leadership roles, or avoidance behaviors.	3	51
Manifestations of Anxiety	Chronic worry, panic attacks, hyper-vigilance, restlessness, and difficulty concentrating.	3	64
Triggers of Anxiety	May include Fear of attacks, uncertainty about the future, threats to life, and witnessing violence.	3	85

Here are some of the statements excerpted from the interviews conducted on anxiety and its effect on mental health:

“I often feel anxious because the fear of violence to me at the confessional is very real.”

“Sometimes during confessionals, I am not fully present to the person before me at that moment because what they tell me makes me drift away to remembering my personal inner struggles. All this makes me fail to sleep or even concentrate fully on important issues” (Kumbo, November 23rd. 2024).

“Since we are living the experience of a war situation where many people are killed daily, people are kidnapped and tortured, their rights and freedoms have been taken away, and even we the clergy become very careful of what we say in churches as we too are suspicious of the congregants” (Kumbo, December 19th. 2024).

“Our ministry at this point in time is characterized by fear, anxiety, bitterness, suspicion. Because we serve people who we sometimes know their position and negative contribution in the war, it becomes very frustrating and unmotivating, and often provokes in us anger and bitterness.” (Kumbo, December 2nd. 2024).

“Being involved in helpless human suffering is perhaps, the most common experience for me sometimes I get worried when I remember the sufferings and pain that the people go through and this brings me anxiety and keeps me in the state of sleeplessness” (Kumbo, January 20th. 2025).

Participant Voices and Core Themes

Respondents repeatedly described feelings of persistent fear, emotional disconnection, and disrupted cognitive functioning. One participant stated:

“I often feel anxious because the fear of violence to me at the confessional is very real... sometimes I am not fully present to the person before me... I fail to sleep or even concentrate fully on important issues” (Kumbo, January 23rd. 2025).

Another added,

“Our ministry at this point in time is characterized by fear, anxiety, bitterness, suspicion... being involved in helpless human suffering is perhaps, the most common experience for me... I get worried when I remember the sufferings and pain that the people go through and this brings me anxiety and keeps me in the state of sleeplessness” (Kumbo, December 2nd. 2024).

These excerpts highlight the dual burden clergy face: providing support while enduring their own psychological mayhem/ distress. Such narratives strongly resonate with findings by Brewin et al. (2000), who assert that people subjected to prolonged traumatic stressors—particularly those in active conflict zones—are at heightened risk of developing persistent anxiety and hyper arousal.

Triggers of Anxiety

Anxiety among clergy in Kumbo Diocese was often provoked by;

1. Fear of direct attacks
2. Mistrust within the congregation
3. Unpredictability of future events

This is consistent with Gartner et al. (2016), who noted that frontline workers such as religious leaders often experience heightened anxiety due to continuous exposure to uncertainty and fear of betrayal. In contexts of war, suspicion within previously trusted circles becomes commonplace, leading to chronic tension and psychological fragility. Mollica (2006) further confirms that community-level mistrust in conflict-affected regions exacerbates symptoms of anxiety and post-traumatic stress disorder (PTSD).

Respondents reported that even their sacred duties such as hearing confessions were now spaces of heightened vulnerability. This psychological distress aligns with Faucett et al. (2013), who observed that spiritual leaders operating under duress show heightened levels of psychological symptoms, particularly when their work settings become unsafe.

Manifestations of Anxiety

Key manifestations of anxiety reported include Persistent worry and emotional restlessness, Hyper-vigilance, Cognitive disorientation and reduced concentration, Sleep disruption

These symptoms reflect the criteria for generalized anxiety disorder (GAD) as outlined in the DSM-5 (APA, 2013). Respondents described an inability to relax, constant scanning for threats, and difficulty maintaining focus, symptoms corroborated by Hill et al. (2003) in their work on trauma-affected professionals.

Such prolonged cognitive stress and emotional fatigue directly impair job performance. This echoes findings by Maslach and Leiter (2016), who connected emotional exhaustion and anxiety to reduced occupational functioning, particularly in caregiving and leadership roles.

Impacts on Mental Health and Leadership

Anxiety among clergy in Kumbo has led to Withdrawal from leadership roles, Avoidance of community interaction, diminished spiritual engagement, and Secondary onset of depression.

This is supported by Francis et al. (2004), who demonstrated that anxiety often reduces clergy's effectiveness by undermining their capacity to provide pastoral care, maintain trust-based relationships, and lead with confidence. As described by one respondent:

“I feel very unable and very limited in how much I can truly offer.”

This sense of incapacity is consistent with Bandura's (1997) self-efficacy theory, which states that repeated traumatic setbacks erode an individual's belief in their competence and ability to affect positive outcomes.

Avoidance behavior such as reducing pastoral visits or limiting public speaking—serves as a psychological defense but can damage long-term ministry effectiveness. The World Health Organization (2017) has acknowledged that avoidance is a common response to trauma but warns that it may worsen social isolation and hinder recovery if prolonged.

The qualitative data resonates with themes from the earlier literature review. It was established that religious leaders in conflict zones are at risk of mental health decline due to role strain, exposure to violence, and spiritual dissonance (Koenig, 2009; Curlin & Hall, 2005). The current findings deepen this understanding by illustrating the clergy's inner conflict: while they are expected to offer hope, they are themselves overwhelmed by fear and anxiety, undermining their spiritual and emotional resilience.

Moreover, the clergy's distrust of the congregants and the security forces—some perceived as informants or collaborators—mirrors findings in conflict psychology, where trauma erodes social cohesion (Masten & Narayan, 2012). This reinforces the idea that clergy are not merely spiritual leaders but also conflict survivors whose own psychological and emotional healing is imperative.

4.2.4. Depression and Its Effect on Mental Health

Depression emerged as a significant psychological consequence for clergy in Kumbo Diocese, largely stemming from continuous exposure to violence, displacement, and unresolved trauma (see; Table 6: Codebook for Objective 3). While often interlinked with anxiety, depression manifests with more profound emotional exhaustion, loss of purpose, and existential despair. According to the American Psychiatric Association (2013), anxiety frequently serves as a precursor to depression, a pattern clearly observable among the clergy interviewed. To make the

psychosocial and emotional burden of the people living the war-situation clearer, a participant had this to say:

“Our hearts are full of sorrow, we live in fear, trauma, and complete despair due to the fast-degenerating security situation. What was once a beacon of peace and academic excellence has now become a killing field, and the people feel completely abandoned. The diocese and the ecclesiastical province of Bamenda has become the scene of repeated bloodshed: recently, a civilian teacher was brutally murdered by ambazonia terrorists — a man dedicated to shaping the minds of our youth. Just four days later, a member of one the service providing agency was shot dead with no reaction from the security forces stationed just meters away. We are terrified. Parents are withdrawing their children from school. Students live in constant panic. Economic life is crumbling. And sadly, the security architecture meant to protect us seems to be collapsing. We are in desperate need of a strong, reliable, and professional military presence and not more police who extort and abandon their duties” (Kumbo, January 13th. 2025).

Table 6: Codebook for Objective 3

Name	Description	Files	References
(objective: 3) how depression affects mental health	Depression and Its Effect on Mental Health	3	163
Impact on Vocational Calling	Doubt in religious calling, loss of hope, and suicidal thoughts.	3	36
Social Isolation and Loneliness	Breakdown of support networks, loss of family, despair and feeling abandoned, and distrust.	3	50
Symptoms of Depression	Persistent sadness, fear, loss of motivation, withdrawal from community and ministry.	3	77

Participant Narratives

Participants provided deeply personal testimonies of despair, fear, loss of motivation, feeling of abandonment, distrust, social isolation and emotional numbness as described in Table 6: Codebook

for Objective 3 above. A particularly moving statement captured the psychological burden of arms-conflict:

“This war has brought a lot of helplessness among the people... Frankly speaking, sometimes I feel like hiding away from people... I get so many sleepless nights as most times when I close my eyes it’s like I can still hear the cries of the people who were being tortured” (Kumbo, December 2nd. 2024).

“This war has brought a lot of helplessness among the people” (Kumbo, January 24th. 2025).

“Many clergy in the diocese have lost hope in service because of what they have witnessed, they don’t trust anyone anymore not even the catholic congregation” (Kumbo, December 2nd. 2024).

“Frankly speaking, sometimes I feel like hiding away from people and stay alone because nothing seems to be working as an attempt to ending the war and sparing our people the so much pain and suffering brought to us by this aimless and irrational war” (Kumbo, November 23rd. 2024). He continued;

“I struggle with migraines and a lot of worry for the people here and for myself.”

“This has taken an emotional toll on my life that each time a fellow member of the clergy narrates his experience and stories it seems one is worse than the one with no hope of a solution for our congregation” (Kumbo, November 20th. 2024).

“I had a lot of fear and very many sleepless nights filled with negative and disturbing thoughts and feelings. I have since failed to tell my story until today that I am now speaking with you about it.” (Kumbo, December 12th. 2024). The respondent added;

“I get so many sleepless nights as most times when I close my eyes it’s like I can still hear the cries of the people who were being tortured.”

“There was nothing good to write home about. My first week was filled with very negative emotions about everything that happened to an extent that I felt I should do something to those people to avenge for the pain caused. I was angry” (Kumbo, December 12th. 2024).

“After we were released the first week after the incident was a painful one as flood of emotions came breaking in for each and every one of us differently. Personally, I would experience many sleepless nights as every time I tried to close my eyes it was like I could still hear the screams of people being tortured. I lived in so much anxiety and depression as every time I stepped out of the house to go to work, I would get anxious about meeting strangers as I would assume that they wanted to hurt me” (Kumbo, December 19th. 2024).

“I had a lot of bitterness and so much sadness for what the separatist fighters are doing to the kidnapped people, how they are burning down churches and schools.”

“I experience sleepless nights as every time I close my eyes, I can still hear the loud voices of the separatist fighters telling people to keep quiet the day of my abduction” (Bambui, December 12th. 2024).

Such experiences demonstrate the prolonged emotional suffering common to trauma survivors. The quote reflects classic depressive symptoms—social withdrawal, hopelessness, intrusive thoughts which are intensified by exposure to collective suffering and loss. Similar patterns are recognized by Heinze and Horn (2009), who observed that individuals in unstable or conflict-prone environments often display depressive tendencies, including fear-based avoidance, emotional fatigue, and loss of social engagement.

Symptoms of Depression

The analysis using NVivo revealed that depression was the most frequently coded mental health theme under objective three, with 77 references (Table 6: Codebook for Objective 3). Commonly reported symptoms included Persistent sadness, Emotional numbness, Withdrawal from community and church duties, Lack of motivation, Sleep disturbances.

These are consistent with persistent depressive disorder (dysthymia) as defined by the APA (2013). The diminished pastoral engagement and emotional detachment are particularly concerning for religious professionals, whose identity and function are closely tied to their relational and spiritual service. As noted by Hill et al. (2003), trauma-exposed clergy may experience disrupted functioning due to accumulated emotional exhaustion and a depleted sense of calling.

One respondent stated:

“After we were released... I would experience many sleepless nights... every time I tried to close my eyes it was like I could still hear the screams of people being tortured” (Kumbo, December 12th. 2024).

This statement reveals symptoms consistent with post-traumatic depression, marked by intrusive recollections, hyper-vigilance, and emotional shutdown. These manifestations reflect what Maslach and Leiter (2016) describe as burnout in helping professions, where chronic exposure to suffering diminishes emotional reserves and cognitive vitality.

Social Isolation and Loneliness

Depression among clergy is aggravated by disrupted social support systems. Many have lost family members or intentionally distanced themselves from loved ones to protect them. This withdrawal has dismantled traditional sources of emotional refuge. The erosion of trust among clergy and community fueled by fear of betrayal or surveillance has deepened their psychological isolation. This aligns with findings by Masten and Narayan (2012), who emphasize that exposure to sustained violence weakens social capital, which is vital for emotional recovery and resilience. In war-affected societies, community disintegration exacerbates loneliness and fosters feelings of abandonment and despair, particularly for clergy who often serve as anchors of social cohesion.

Impact on Vocational Calling

Clergy depression has also manifested in existential and spiritual crises. Several respondents expressed doubts about their religious calling and questioned God's presence amid suffering. One interviewee/respondent admitted:

“Prayers seemed not to reach God.”

This statement highlights a spiritual struggle a critical component of depression in religious leaders. According to Pargament (2007), when religious coping fails to provide meaning during trauma, spiritual disillusionment may occur, intensifying depressive symptoms and leading to reduced engagement in ministry.

This form of despair, also referred to as "spiritual disconnection", undermines the clergy's identity and effectiveness. In highly spiritual vocations, such as the Catholic priesthood, where faith and vocation are inseparable, unresolved trauma can destabilize one's entire worldview (Koenig, 2009).

Physical Manifestations

The most prominent physical manifestation was Loss of Appetite and Fatigue.

A substantial number of respondents also reported loss of appetite, weight loss, fatigue, and physical exhaustion symptoms that severely impacted their productivity and capacity to fulfil their pastoral roles. This is consistent with the World Health Organization (2022), which recognizes appetite disturbance as a hallmark of depression and notes that malnutrition can intensify mental health disorders by disrupting cognitive and emotional regulation.

Fatigue, compounded by sleeplessness, was another common issue. These physical symptoms represent a psychosomatic response to trauma, where emotional distress manifests through bodily complaints a well-documented phenomenon in both trauma literature and pastoral care studies (Francis et al., 2004).

The findings strongly support the literature reviewed earlier. Studies have consistently shown that clergy in high-risk environments, such as conflict zones, suffer significant mental health challenges, with depression being one of the most severe and enduring (Curlin & Hall, 2005; Koenig, 2009). The testimonies also confirm the literature suggesting that occupational trauma, when coupled with social breakdown and spiritual alienation, increases vulnerability to depression (Maslach & Leiter, 2016; Pargament, 2007).

These findings emphasize the urgent need for psychological and pastoral support mechanisms tailored to conflict-affected religious workers. Spiritual interventions alone are often insufficient; integrated approaches addressing emotional, cognitive, social, and spiritual dimensions of trauma are essential.

4.2.5. Coping Mechanisms and Their Impact on Mental Health Care Seeking

In the context of the prolonged socio-political conflict in the Kumbo Diocese, clergy have developed a range of coping strategies to manage the mental health consequences of stress, trauma, and existential fear. Based on Lazarus and Folkman's (1984) coping theory, responses among participants were classified into problem-focused, emotion-focused, and meaning-focused strategies, with the majority gravitating toward meaning-focused coping rooted in spirituality as seen on table 7 below indicating a number of 100 references for all the 3 files.

Table 7: Codebook for Objective 4

Name	Description	Files	References
(objective: 4) how coping mechanisms impact mental health	Coping Mechanisms and Their Impact on Mental Health Care Seeking	3	159
Barriers to Seeking Mental Health Care	Stigma, cultural perceptions, lack of access to mental health services, and financial constraints	3	44
Common Coping Strategies	Prayer, meditation, counselling, social support, and avoidance behaviors.	3	100
Effectiveness of Support Systems	Role of church, peer support, and external organizations in promoting mental well-being.	3	15

Members stated the following with regard to coping mechanisms and their impact on mental health care seeking;

“Our hope is only in God and we believe that he will make things better for us” (Kumbo, December 12th. 2024).

“I always engage myself in bible study to combat my fears and pains” (Bambui, December 19th. 2024).

“I love singing because it relaxes me but with the noise outside, I am not able to do it” (Kumbo, January 21st. 2025).

“I have become accustomed to praying with the community and individually” (Kumbo, December 2nd. 2024).

“Some of us the clergy have turned to maladaptive styles of living to cope with the situation. For instance, some of my fellow clergy, including myself, who were not drinking alcohol before the war, now seem to be obsessed with it” (Kumbo, December 2nd. 2024). The respondent continued;

“Personally, I do a lot of journaling about everything am going through and many times I have ended up crying by myself”

“God is our hope and we spend much time in prayer and serving the people but we have still not found completeness here” (Kumbo, December 2nd. 2024).

“Hoping in god is the only thing we can cling to as he is the only solution during this difficult time” (Kumbo, December 12th. 2024).

“I personally spend much time in meditation to try and cope” (Kumbo, December 19th. 2024).

“Practicing gratitude has helped me to appreciate God for my life and the lives of many others including the things he does, small or big.”

“Engaging in group therapy has been one of our most effective coping strategies as we are all able to share our personal lives, encouraging each other while praying for one another” (Kumbo, December 19th. 2024).

“Hoping and trusting in God has been one of my greatest coping strategies” (Kumbo, December 12th. 2024).

Dominance of Spiritual and Religious Coping

A strong reliance on religious and spiritual practices emerged as the most prevalent coping mechanism, cited over 100 times in the coding for objective three. This included prayer, Bible study, meditation, rosary devotion, singing, and communal worship. As one clergy member articulated:

“Our hope is only in God and we believe that He will make things better for us.”

This aligns with Pargament (1997), who identified religious coping as a central strategy among believers confronting crisis. For many clergy, faith practices help assign meaning to suffering and foster resilience in the face of despair. This finding is consistent with earlier observations from the

literature review indicating that spiritual leaders often utilize their faith as both a refuge and a framework for interpreting adversity (Koenig, 2009).

Engaging in regular prayer and scriptural reflection, as reported by participants, contributes to a cognitive reappraisal of distressing experiences. Anandarajah and Hight (2001) argue that spirituality enhances coping by promoting inner peace and acceptance, and reduces the psychological impact of trauma by placing suffering within a transcendent narrative.

Another respondent noted:

“Practicing gratitude has helped me to appreciate God for my life and the lives of many others...” (Kumbo, December 12th. 2024).

This is reflective of what Fredrickson (2001) describes as the “broaden-and-build theory of positive emotions,” where practices like gratitude cultivate mental strength and broaden emotional resources over time.

Emotion-Focused and Behavioral Strategies

Several clergies also adopted emotion-focused coping mechanisms, including journaling and singing. One respondent shared:

“Personally, I do a lot of journaling about everything I’m going through and many times I have ended up crying by myself.”

Such behaviours serve as cathartic outlets for emotional release and are known to be therapeutic. According to Pennebaker and Seagal (1999), expressive writing can alleviate distress by helping individuals structure traumatic experiences and gain clarity.

Additionally, a few respondents noted the use of maladaptive strategies, such as alcohol consumption:

“Some of us the clergy have turned to maladaptive styles of living... now seem to be obsessed with alcohol.”

This behavior represents a coping mechanism that may offer temporary relief but can contribute to long-term psychological and physical harm. As noted by Lazarus and Folkman (1984), maladaptive coping often arises in settings where stressors are perceived as uncontrollable and resources are limited.

Community Support and Group Coping

While spiritual practices were individualized, communal coping also played a vital role. Group therapy, peer interaction, and collective prayer were widely praised:

“Engaging in group therapy has been one of our most effective coping strategies... we are all able to share our personal lives, encouraging each other while praying for one another.”

This mirrors the findings of McKenzie et al. (2004), who emphasized the value of informal support networks in underserved communities. Peer support enhances resilience by promoting empathy, reducing isolation, and fostering shared hope among affected individuals. Such dynamics were evident in the clergy’s recounting of supportive group activities, even amidst disrupted infrastructure and ongoing insecurity.

Barriers to Mental Health Care Seeking

Despite recognition of the need for professional care, formal mental health services remained significantly underutilized. Reasons included Logistical constraints (inaccessibility of clinics), the withdrawal of humanitarian organizations, and stigma around psychological services, Fear of exposure or retaliation due to conflict dynamics.

According to Roberts et al. (2008), conflict environments often paralyze healthcare systems, rendering psychological interventions unavailable. Similarly, the presence of ongoing violence discourages open engagement with formal services, as confidentiality and safety cannot be guaranteed.

Role of the Church and Support Systems

The Church emerged as a crucial actor in both spiritual and psychosocial support. Clergy found safety and strength through parish life and pastoral service.

“The presence of our parishes keeps the community in Kumbo Diocese turning to us, the clergy, looking for comfort and consolation.” (Kumbo, December 2nd. 2024).

This aligns with Koenig (2009), who found that faith institutions in crisis zones often serve as anchors of stability, offering more than just spiritual guidance—they provide emotional support, social organization, and even physical protection.

Additionally, retreats and religious gatherings were cited as safe spaces for healing. Such activities allowed clergy to experience restoration and spiritual refreshment, echoing insights from Trevino et al. (2010) that religious retreats can function as therapeutic interventions, particularly for clergy and faith leaders.

These findings confirm what was highlighted in the literature review: that clergy in crisis contexts lean heavily on spirituality as a coping tool and a survival mechanism. The predominance of meaning-based coping reinforces the centrality of faith in the lives of religious leaders during traumatic experiences (Pargament, 1997; Koenig, 2009). However, while spiritual resources are critical, they are not substitutes for professional psychological care, a point also emphasized by Umberson and Montez (2010), who argue that integrated support systems—spiritual, emotional, and clinical—offer the most effective outcomes for trauma-affected populations.

These insights also reflect the limitations of existing mental health infrastructure in conflict zones and highlight the critical role of local religious institutions in bridging the gap. As such, there is a clear need for collaborative interventions that blend traditional coping mechanisms with modern therapeutic models to improve mental health care accessibility for clergy in Kumbo and similar settings.

4.2.6. Effect of Coping Strategies on War-Trauma and Mental Health

The prolonged conflict in Kumbo Diocese has severely impacted the psychological well-being of clergy, with varied coping mechanisms yielding mixed results. From the narratives collected, three core themes emerged in relation to this objective: religious coping, psychological coping, and external interventions. This is evident in Table 8: Codebook for objective 5.

Table 8: Codebook for objective 5

Name	Description	Files	References
(objective: 5), The effect of coping strategies on war trauma and mental health	Effect of Coping Strategies on War-Trauma and Mental Health	3	134
Long-Term Impact on the Diocese	Effects on leadership, congregation morale, and continuity of religious services.	3	20
Post-Traumatic Stress Symptoms	Flashbacks, nightmares, emotional detachment, and hyper arousal.	3	17
Religious, Psychological Coping, and External Interventions	Use of faith, scripture, and religious gatherings to manage trauma, NGOs, humanitarian organizations, and the government in supporting clergy mental health.	3	97

The dominant frequency (97 references) suggests a deep entrenchment of these strategies within clergy responses to trauma. Some of the key respondent statements include;

“Trusting in God has been my greatest coping strategy and has helped me to manage my fears.”

“During my kidnap, the clergy, community, and my family kept praying for me and this too helped me to cope. We sometimes go for retreats and holidays to cope and bring joyful emotions to us to help us forget our bitter moments but this only works for a short while. I always practice journaling to help me let go of all the pain I have towards the kidnap experiences but I cannot exhaust everything, I still experiences this pain and fear for the unknown. I also talk to different people to seek encouragement but personally, I do a lot of journaling about everything am going through and many times I have ended up crying by myself” (Kumbo, December 19th. 2024). He added;

“I personally practice the habit of gratitude where I journal in my book about things, I am grateful for in each day so as to be positive feelings. Life has been the most grateful thing I mediate on because of almost losing my life after experiencing that near-death situation.”

“Practicing gratitude has helped me to appreciate God for my life and the lives of many others including the things he does, small or big. This helps me to live one day at a time and to live in the present moment” (Kumbo, January 21st. 2025).

Persistence of Post-Traumatic Stress Symptoms

Despite the clergy’s proactive use of religious and personal coping mechanisms, many participants continue to exhibit symptoms characteristic of post-traumatic stress disorder (PTSD). These include nightmares, emotional numbness, hyper arousal, and recurring flashbacks. One respondent described lingering effects:

“I always practice journaling to help me let go of all the pain I have towards the kidnap experiences, but I cannot exhaust everything...”

This aligns with the APA (2013) diagnostic criteria for PTSD, suggesting that trauma responses remain unresolved in many cases. Such symptoms underscore the limited long-term effectiveness of informal strategies and the urgent need for specialized trauma-informed care (Mollica et al., 2004).

Role and Limits of Religious and Psychological Coping

While religious coping remains a central pillar in the clergy’s attempt to manage trauma, its effectiveness appears to be both emotional and temporal. Activities such as Mass attendance, prayer, retreats, and group worship have provided relief and promoted collective resilience. As one clergy member expressed:

“Trusting in God has been my greatest coping strategy and has helped me to manage my fears.”

This supports the findings of Pargament (1997), who argues that religious coping can foster emotional stability and provide existential meaning during adversity. However, the effectiveness of such strategies diminishes over time for some individuals. For instance, a participant shared:

“God is the only solution to all this, but we sometimes feel like God is taking really long to answer our prayers.”

This tension reflects a crisis of faith, which Ai et al. (2005) identified as a common phenomenon among trauma survivors relying heavily on spiritual frameworks. The emotional exhaustion and spiritual disillusionment experienced by some clergy reveal the psychological limits of religious reliance when trauma remains unprocessed or unresolved.

Other emotional and behavioral strategies like journaling, practicing gratitude, and meditation were also prevalent. Respondents described these as essential outlets for personal reflection and emotional regulation:

“I personally practice the habit of gratitude...this helps me to live one day at a time and to live in the present moment.”

According to Emmons and McCullough (2003), gratitude practices are associated with improved mood and psychological well-being. Yet, as evidenced in this study, such practices are often insufficient to counteract the full impact of cumulative trauma exposure.

The Scarcity of External Psychological Interventions

The clergy repeatedly emphasized the absence of comprehensive professional mental health services. While some NGOs have supported child protection, trauma counselling, and basic psychosocial interventions, these are not sufficiently structured to support clergy and other adults suffering from chronic trauma.

“We sometimes go for retreats and holidays... but this only works for a short while” (Kumbo, December 2nd. 2024).

Such short-term relief measures are consistent with observations from Patel et al. (2010), who argue that task-shifting mental health support to community-based providers is necessary in low-resource conflict settings. The lack of follow-up services, psychiatric care, and trauma-informed counselling severely limits recovery and increases the likelihood of maladaptive coping, such as alcohol use and emotional withdrawal, both reported by respondents.

Institutional Implications and Long-Term Impact

The war has left deep institutional scars. Several clergies disclosed that personal psychological distress has affected their spiritual leadership, interpersonal engagement, and capacity to minister effectively. One clergy member reflected:

“Church services and prayers are disrupted and interfered with by stress.”

The emotional toll has also translated into reduced church attendance and community morale. This mirrors findings by Silove et al. (2017), who highlight that trauma among leadership figures in crisis zones can trigger broader community disengagement and faith destabilization.

However, the continued functionality of church operations, despite adversity, has proven a critical stabilizing factor. Another respondent noted:

“Continuous functioning of all our parishes has helped us to stay relevant in responding to the spiritual and pastoral needs of our people” (Kumbo, December 2nd. 2024).

This supports Fernando and Ferrari (2011), who assert that faith-based institutions can foster collective healing and offer resilience pathways through rituals, social bonding, and cultural continuity.

The findings from this section reinforce the earlier literature review’s assertion that religious coping is both a strength and a limitation. It helps clergy construct meaning and maintain psychological stability, but without access to structured therapeutic services, such coping can become unsustainable. The persistence of trauma symptoms despite these efforts confirms the limitations of emotion-focused coping in high-intensity conflict zones (Lazarus and Folkman, 1984). Furthermore, the clergy’s appeal for external support highlights the urgent need for integrated psychosocial frameworks that include both traditional religious coping and evidence-based mental health interventions (Betancourt et al., 2010).

In conclusion this chapter has presented the key findings arising from the analysis of data related to the experiences of war-related trauma and the corresponding help-seeking behaviour among the diocesan clergy of Kumbo Diocese in Anglophone Cameroon. The results reveal that a significant proportion of the clergy have been directly or indirectly exposed to war-related violence, displacement, loss of family members, and persistent insecurity due to the ongoing Anglophone crisis. These traumatic experiences have manifested in symptoms commonly associated with

psychological distress, including anxiety, insomnia, emotional withdrawal, and, in some cases, symptoms suggestive of post-traumatic stress disorder (PTSD).

Despite the psychological burden, the findings indicate a generally low level of formal help-seeking among the clergy, with many preferring informal support systems such as prayer, peer dialogue, and spiritual retreats. Cultural expectations, stigma surrounding mental health, and limited access to professional psychological services emerged as major barriers to formal help-seeking. Additionally, the clergy's spiritual roles and identity appear to influence their coping strategies, often reinforcing a reliance on faith-based interventions over clinical mental health support.

These findings underscore the urgent need for targeted mental health interventions, contextualized within the cultural and spiritual realities of the diocesan clergy. The chapter has laid the groundwork for the discussion and policy recommendations presented in the next chapter, aimed at strengthening psychosocial support and reducing barriers to help-seeking within this vulnerable population.

In conclusion, religious leaders in Kumbo diocese due to the ongoing arms conflicts in the region face unique, ongoing stressors that is likely going to increase risks for psychosocial and vocational vulnerabilities. This situation may be worsened by the fact that these clergy who serve as frontline workers for their faith communities in the mostly rural diocese of Kumbo are not very much help-seekers than givers, a situation which Vandevender et al. (2019) say prevent the clergy from pursuing traditional mental health care. In this regard, findings confirm with Vandevender et al. (2019) that the tendency to provide care and support for the so many help-seekers in Kumbo amidst the ongoing arms conflict places clergy in a position to assist individuals experiencing posttraumatic stress reactions. This responsibility and strain of supporting war-trauma victims however, has the potential to increase rates of burnout and secondary traumatization in clergy. This study utilized a consensual qualitative research design to explore war-related trauma and the corresponding help-seeking behaviour among the diocesan clergy of Kumbo Diocese in Anglophone Cameroon.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1. Introduction

This chapter provides a critical summary and discussion of the findings presented in Chapter 4 in relation to the existing literature and the conceptual framework that underpins the study. It also presents conclusions drawn from the findings and the recommendations. It does not exclude areas for further course of action and research interventions. The aim of the chapter is to interpret the implications of the results on the mental health of the clergy in the Kumbo Diocese amidst the Anglophone crisis in Cameroon, specifically about stress, anxiety, depression, coping mechanisms, and war-related trauma. The discussion also evaluates the effectiveness of mental health interventions and suggests implications for policy and pastoral practice.

5.2. Depression, Anxiety, and Clerical Mental Health

The findings revealed that depression and anxiety are widespread among members of the clergy in the Kumbo Diocese, largely resulting from continuous exposure to violence, fear of abduction, social isolation, and disrupted pastoral responsibilities. This aligns with previous studies that emphasize how persistent exposure to violent conflict and insecurity significantly affects psychological well-being (Steel et al., 2009; Tol et al., 2013).

Consistent with the findings of Bolton et al. (2000), depression in this study was characterized by loss of motivation, withdrawal from community, persistent sadness, and doubt in religious vocation. Furthermore, these depressive symptoms have not only affected individual well-being but have also disrupted religious services and the morale of the congregation. This is in line with Masango (2015), who highlighted the direct influence of clergy mental health on religious leadership and community stability.

The symptom of loss of appetite and fatigue, reported by several clergy members, echoes the findings of Kessler et al. (2003), who identified somatic symptoms such as insomnia, appetite loss, and poor concentration as key indicators of clinical depression. The emergence of hyper-vigilance and insomnia is also consistent with post-traumatic stress disorder (PTSD) indicators found in conflict-affected populations (American Psychiatric Association, 2013).

5.3. Role of Social Isolation and Loss of Trust

Social isolation, as observed in the clergy's reluctance to visit family or engage in communal activities, underscores a key consequence of chronic trauma. Several respondents reported mistrust toward others for fear of being spied upon and betrayed to separatist groups. This breakdown of support networks due to fear and violence is a common finding in war-torn communities (Barber, 2013). Research has long established the protective role of social support in mitigating stress and mental illness (Cohen and Wills, 1985), and its absence has been associated with heightened depressive symptoms.

Additionally, the loss of family members, whether through death or separation, contributed to psychological distress, consistent with the grief and trauma literature (Raphael et al., 2001).

5.4. Spiritual Coping and Meaning-Making

A dominant theme in this study is the use of spiritual coping mechanisms. Members of the clergy engage deeply in prayer, scripture reading, and spiritual retreats. Such meaning-focused coping aligns with the work of Park (2010), who argued that in highly stressful contexts where individuals have little control, finding meaning becomes a powerful coping strategy.

The use of religious coping mechanisms is consistent with Pargament (1997), who describes positive religious coping as a resource for hope, comfort, and community solidarity in times of adversity. However, the findings also highlight spiritual struggles, with some clergy expressing doubt in God's responsiveness, revealing the complex interplay between faith and mental distress (Exline, 2002). Despite this ambivalence, the church's continuous functioning was perceived as a source of strength and resilience by many.

This also resonates with the findings of Smith et al., (2000) that religion can provide those experiencing a traumatic situation with a wide range of resources with which to cope and find empowerment in situations where there is very little personal control. The findings also confirm that of Hill & Pargament (2003) which reported these resources to be stemming largely from the structural and social aspects of faith and religious practices, including support from one's congregation or faith community, receiving the ministry and guidance of one's clergy or faith leaders, and reflecting on the messages in relevant religious literature or texts.

Likewise, finding affirms Smith (2004) whose research indicated that trauma and spirituality are areas that interact when a survivor tries to make sense of and recover from a traumatic experience.

He further asserted that both trauma and spirituality may serve as a facilitator for growth and greater understanding or may lead to isolation, confusion, and despair which has also been echoed by the finding of this particular study.

The adoption of religious practices and spirituality as a coping mechanism by the clergy of Kumbo in the ongoing arms-conflict in region corresponds with Parks et al (2017) explored the impact of religious coping on the development of posttraumatic stress symptoms and perceived growth among U.S. veterans returning from Iraq and Afghanistan. They however, reported negative religious coping to increase the presence of PTSD symptoms and decrease a person's perception of posttraumatic growth unlike positive religious coping.

It therefore appears that the clergy in Kumbo whose worldview is influenced by a religious belief system that involves an ongoing existential dialogue are more likely to find meaning in major traumatic situations and experience posttraumatic growth. This is untrue for those clergy whose religious framework is characterized by anger, fear, mistrust or doubt.

It must be made clear here that not everyone who experiences trauma is able to find or make meaning of it and may instead experience greater alienation and despair as a result, which demands for immediate and serious professional psychosocial interventions through the setting of systems and structures to address this need.

5.5. Counselling and Peer Support

The findings suggest that psychological counselling and peer support play a critical role in mitigating trauma. Although not widespread, access to counselling during retreats, deanery meetings, and recollections helped clergy members express their feelings and find solidarity in shared experiences. This aligns with the broader literature on peer-based mental health interventions, especially in humanitarian settings (Tol et al., 2011).

Additionally, the study corroborates the idea that peer and community-based interventions are more culturally acceptable and sustainable in contexts where formal mental health infrastructure is lacking (Patel et al., 2007). Nonetheless, the limited availability of professional psychological services in the Kumbo Diocese suggests a significant gap in mental health care, a concern echoed by WHO (2021), which notes the scarcity of mental health professionals in conflict-affected African regions.

5.6. Effectiveness of External and Institutional Support

The role of the church in sustaining morale and offering support was emphasized repeatedly. Through pastoral services, refuge, and strategic clergy transfers, the church was able to provide both practical and emotional support, reinforcing the importance of institutional resilience during crises. These findings mirror those of De Jong et al. (2000), who stress the significance of faith-based institutions in community healing in post-conflict societies.

The contributions of NGOs and humanitarian agencies, although recognized, were described as insufficient, revealing a critical need for increased governmental and international support in mental health provision. Furthermore, the withdrawal of some organizations due to insecurity has weakened the support system, leaving clergy and community members to rely mostly on each other.

5.7. War-Trauma and Long-Term Consequences

The findings indicate that the clergy continue to experience symptoms of PTSD, including nightmares, flashbacks, and emotional detachment, despite attempts at spiritual and social coping. This suggests that while these strategies provide some relief, they are not wholly sufficient to address the complex and enduring impact of trauma. The cumulative nature of stress, as evidenced in the declining mental health of some clergy members, underscores the chronic psychological burden of prolonged exposure to war (Silove et al., 2000).

Moreover, the long-term impact on church leadership and continuity of pastoral services suggests a concerning trend. Clergy members, overwhelmed by psychological distress, have become less effective in their ministerial roles, resulting in reduced congregational participation and morale. This decline in spiritual and institutional engagement supports the findings of Herman (1997), who emphasized how trauma can erode not only individual functioning but also broader communal structures.

5.8. Summary

The findings reveal that the clergy of Kumbo Diocese are experiencing high levels of depression, anxiety, and trauma due to the ongoing arms-conflict. Spirituality, peer support, and church-led initiatives serve as primary coping strategies, though their effectiveness is mixed. While the church remains a pillar of support, there is a clear need for enhanced mental health interventions,

especially from professional psychological services and humanitarian agencies. The long-term psychological and institutional effects of the arms-conflict remain a concern for the future of religious and community life in the region.

5.9 Conclusion

The prolonged conflict in the North-West region of Cameroon, and more specifically in Kumbo Diocese, has had a devastating effect on the mental health of clergy. Key findings confirm that the clergy are grappling with cumulative psychological distress, primarily driven by the fear of abduction, exposure to violence, and grief due to the loss of loved ones and community members. These findings are consistent with earlier studies on conflict-affected clergy and humanitarian workers (Betancourt et al., 2013; Fernando & Ferrari, 2011).

The psychological symptoms exhibited by the clergy, including insomnia, hyper-vigilance, depression, emotional fatigue, and a decline in pastoral performance, indicate serious mental health challenges that require immediate attention. This aligns with the World Health Organization's (2022) assertion that unaddressed psychological trauma, especially in prolonged crisis zones, can lead to long-term cognitive and emotional dysfunction. It also resonates with Murthy & Lakshmi Narayana (2006) who argue that 10% of people who experience traumatic events end up with serious mental health problems, and another 10%, develop behaviour that will hinder their ability to function effectively.

This means that an estimated 6% of the clergy will experience serious mental health disorder, and another 6% become dysfunctional out of the 65 who are currently working in Kumbo; if the war trauma is poorly managed. This will be detrimental to the population in Kumbo where an estimated 2500 people are served per priest (Chenny, 2022).

The study also confirms that meaning-focused coping strategies, such as religious devotion and peer-engagement, are crucial in buffering psychological distress. This reflects findings from Pargament (1997), who emphasized the role of spiritual practices in constructing meaning and mitigating trauma. Nevertheless, the effectiveness of these strategies is significantly limited by the absence of formal psychological interventions, revealing a pressing need for integrative care models that combine pastoral and professional mental health support.

6.0. Recommendations

Given the multiple and diverse demands placed upon clergy of Kumbo due to the ongoing arms-conflict in Anglophone region of Cameroon, it is imperative that Church leaders in the diocese and the ecclesiastical province at large engage in coping and self-care practices to maintain psychological and physical health. This calls for the diocesan leaders to provide professional counseling services to members of the clergy and their congregations for the proper and holistic management of psychological and emotional distress consequent of serving in the arms-conflict region. Participants however, have reported using a variety of coping strategies, including “giving it all to God” through prayer. The clergy serving in the conflict zones of Cameroon and other countries in sub-Saharan African need to reflect on ways they manage the psychological and emotional distresses consequent of the conflicts. This will enable them to adopt a holistic interventional approach which is very much needed in such situations. Other recommendations are to include:

6.0.1. Capacity Building

Training workshops and retreats facilitated by mental health professionals should be organized regularly to equip clergy with stress management skills and awareness of trauma symptoms. As posited by Hoge et al. (2005), building resilience through education and awareness is vital for long-term pastoral efficacy.

Encouraging interdisciplinary collaboration between theologians, clinical psychologists, and humanitarian workers can foster holistic approaches to clergy care.

6.0.2. Strengthening Social Support

Peer support groups, both informal and structured, should be encouraged across parishes. These groups can serve as platforms for storytelling, collective grieving, and healing, all of which are foundational in trauma recovery (Herman, 1992).

Clergy associations should engage cultural and community leaders in creating safe spaces for dialogue, reconciliation, and spiritual rejuvenation.

6.0.3. Enhancing Mental Health Access

The Church should invest in the training of lay counselors and clergy in basic psychological first aid to supplement limited professional services.

Tele-mental health solutions, including online counseling and therapy platforms, should be explored for remote mental health care delivery. Given the ongoing conflict, virtual services can reduce accessibility barriers.

6.0.4. Policy and Institutional Support

The Catholic Church hierarchy, both within and outside Kumbo Diocese, should prioritize the establishment of trauma recovery programs specifically tailored to clergy needs. Structured programs involving both theological and psychological dimensions can restore vocational clarity and emotional stability.

The Cameroonian government, in collaboration with international partners, should enhance security and access to psychosocial services in conflict regions. Safe zones for mental health outreach should be considered in heavily affected dioceses.

6.0.5. Limitations and Opportunities for Future Research

Whereas the current study confirms findings documented previously in the literature and expands knowledge related to war-trauma management, it is not without limitations. The sample size was comprised of 36 total participants, only from among the Roman Catholic diocesan clergy. Thus, future research should strive to use a research population that is inclusive of all the members of the clergy working in the diocese for comparative research work. It is possible that the experiences and perspectives offered by these participants are not entirely representative of all the clergy members' experiences and management of war-trauma. Also, additional research is needed.

Further studies should explore the intersection of trauma, theology, and resilience among clergy in conflict zones.

Comparative research across other dioceses affected by conflict in Sub-Saharan Africa would broaden the understanding of clergy mental health in fragile contexts.

Mental health challenges of clergy in conflict zone according to the age groupings/years of pastoral ministry.

6.0.6. Final Remarks

This study sheds light on an often-overlooked dimension of conflict—its spiritual, pastoral and psychological toll on religious leaders. The findings highlight that the clergy of Kumbo Diocese are not only spiritual shepherds but also victims of the trauma that afflicts their congregations. A strategic, multi-level intervention—anchored in both faith and science—is therefore crucial in safeguarding the mental well-being and vocational integrity of the clergy. With the ongoing conflict, it is vital to respond to their needs with urgency, compassion, and systemic support.

General Conclusion

There are many conflicts and wars globally in this first quarter of the 21st century. The study has therefore examined health seeking behaviour among the clergy traumatized by war and conflicts. This makes the study important for programme development and aid theme especially those traumatized by wars in Kumbo Diocese. The study focused at addressing a contemporary challenge due to armed conflicts in low resourced communities especially in Africa through delving into the lived experiences of clergy during mission work by using qualitative approach to research. The rigour of qualitative research has permitted exploring, understanding, and explaining trauma and health seeking behaviour as social realities. Emphasis was put on the practical consequences and real-world application of ideas, beliefs, values, and attitudes. The theoretical framework and literature review links the study to the existing knowledge about trauma and health seeking behaviour. The study findings may contribute to improving health service delivery to populations under conflict/war ravaged areas and to provide insightful knowledge about trauma and health/help seeking behaviour. It underpins Sustainable Development Goal 3: Good Health and Well-being and supports the realization of other WHO goals. This study, consequently, has the potential to not only contribute to both knowledge and practice on mental health and counselling psychology and the overall well-being of the clergy but also other persons traumatized by wars. These realizations are fundamental for health practitioners in designing programmes that can enhance health seeking behaviour and enhance mental health work with the affected communities towards the improvement of their well-being.

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APPENDICES

Appendix 1: Interview Guide for the Diocesan Clergy

Dear Sir/Madam

My name is Ngirnyu Blasius, I am conducting a study about “*War-trauma and mental health care among the clergy of the diocese of Kumbo, in Anglophone Cameroon*”. You are selected by chance to participate in this study.

This study intends to solve the emotional suffering among the clergy victims of war through the use of community coping strategies towards their mental wellness especially in the event that most mental illnesses have spiritual interpretation yet cultural and community support would be of help especially among the clergy.

Your views are very profound to help improve the mental wellbeing of clergy in this area. Your responses you provide are only for academic and policy purposes and will be kept confidential. In case the researcher identifies risks to mental health, referral for counseling will be suggested and agreed upon with the respondent.

It is your choice to participate in this study. You have the right to stop the interview especially when you are not feeling okay. In such cases the interview will resume after the break or on a later date of your choice.

Do you want to participate in this study?

Yes No

1. How long have you served as a clergy in this area?
2. Share your experience of serving amidst conflict of war in Kumbo Diocese.
3. How would you explain the mental health of the clergy in this area?
4. Do you think depression is related to mental health care among the Clergy in Kumbo Diocese in Cameroon?
5. Of what impact are the coping strategies on war trauma and mental health care among the Clergy in Kumbo Diocese in Cameroon?
6. How would mental health care among the clergy be improved in Kumbo Diocese?

END

Appendix 2: Interview Guide for the Victims of Kidnap

Dear Sir/Madam

My name is Ngirnyu Blasius, I am conducting a study about “War-trauma and mental health care among the clergy of the diocese of Kumbo in Anglophone Cameroon”. You are selected by chance to participate in this study.

This study intends to solve the emotional suffering among the clergy victims of war through the use of community coping strategies towards their mental wellness especially in the event that most mental illnesses have spiritual interpretation yet cultural and community support would be of help especially among the clergy.

Your views are very profound to help improve mental wellbeing of clergy in this area. Your responses you provide are only for academic and policy purposes and will be kept confidential. In case the researcher identifies risks to mental health, referral for counseling will be suggested and agreed upon with the respondent.

It is your choice to participate in this study. You have the right to stop the interview especially when you are not feeling ok. In such cases the interview will resume after the break or on a later date of your choice.

Do you want to participate in this study?

Yes No

1. In which year were you kidnaped?
2. May you kindly share with me your experience of kidnap by separatist war in Kumbo Diocese?
3. If you could recall, how were your emotional reactions the first week after that incident?
4. As a clergy, how was your daily life affected months after the incidence?
5. Would you think that coping strategies impact on war trauma and mental health care among the Clergy in this area? Justify your answer?
6. Suggest ways to improve mental health care among the clergy in Kumbo Diocese?

END

Appendix 3: Interview Guide for the Leaders in the Association of Diocesan Priests

Dear Sir/Madam

My name is Ngirnyu Blasius, I am conducting a study about “War-trauma and mental health care among the clergy of the diocese of Kumbo in Anglophone Cameroon”. You are selected by chance to participate in this study.

This study intends to solve the emotional suffering among the clergy victims of war through the use of community coping strategies towards their mental wellness especially in the event that most mental illnesses have spiritual interpretation yet cultural and community support would be of help especially among the clergy.

Your views are very profound to help improve mental wellbeing of clergy in this area. Your responses you provide are only for academic and policy purposes and will be kept confidential. In case the researcher identifies risks to mental health, referral for counseling will be suggested and agreed upon with the respondent.

It is your choice to participate in this study. You have the right to stop the interview especially when you are not feeling ok. In such cases the interview will resume after the break or on a later date of your choice.

Do you want to participate in this study?

Yes No

1. How many years have you been in leadership in the Association of Diocesan Priests?
2. As a leader, how has the separatist war affected mental health among your clergy in Kumbo Diocese?
3. Do you think stress and anxiety is related to mental health care among the Clergy in Kumbo Diocese in Cameroon?
4. Do you think community support mechanisms impact on mental health care among the Clergy in Kumbo Diocese in Cameroon?
5. Of what impact are the coping strategies on trauma due to war and mental health care among the Clergy in Kumbo Diocese in Cameroon?
6. How would mental health care among the clergy be improved in Kumbo Diocese?

END

Appendix 4: Text Search Queries and Word Clouds



Figure 3: Text query for "fear" objective 1

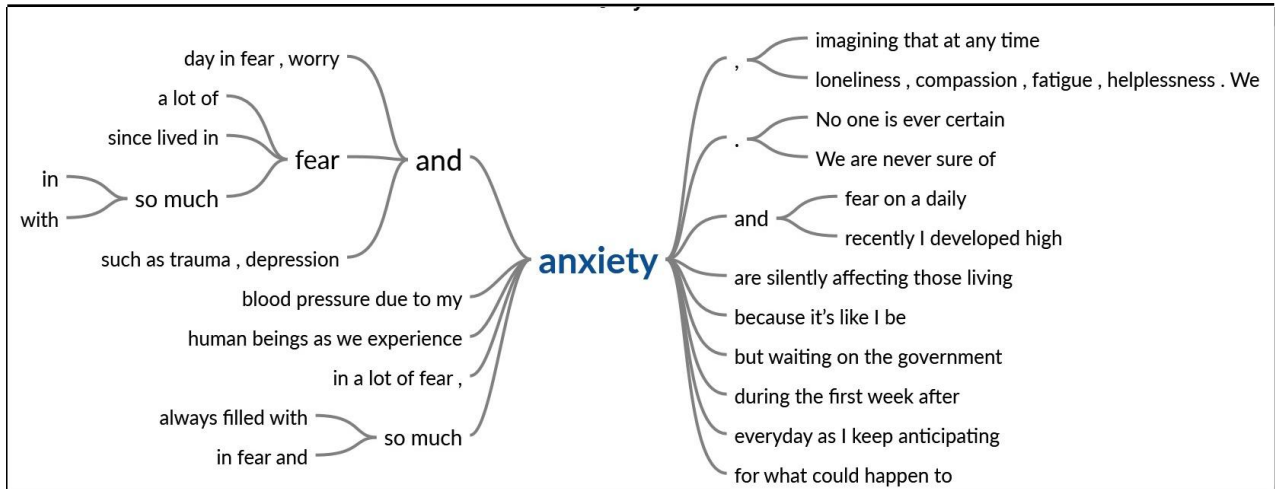


Figure 4: Text query search for "anxiety" objective 2

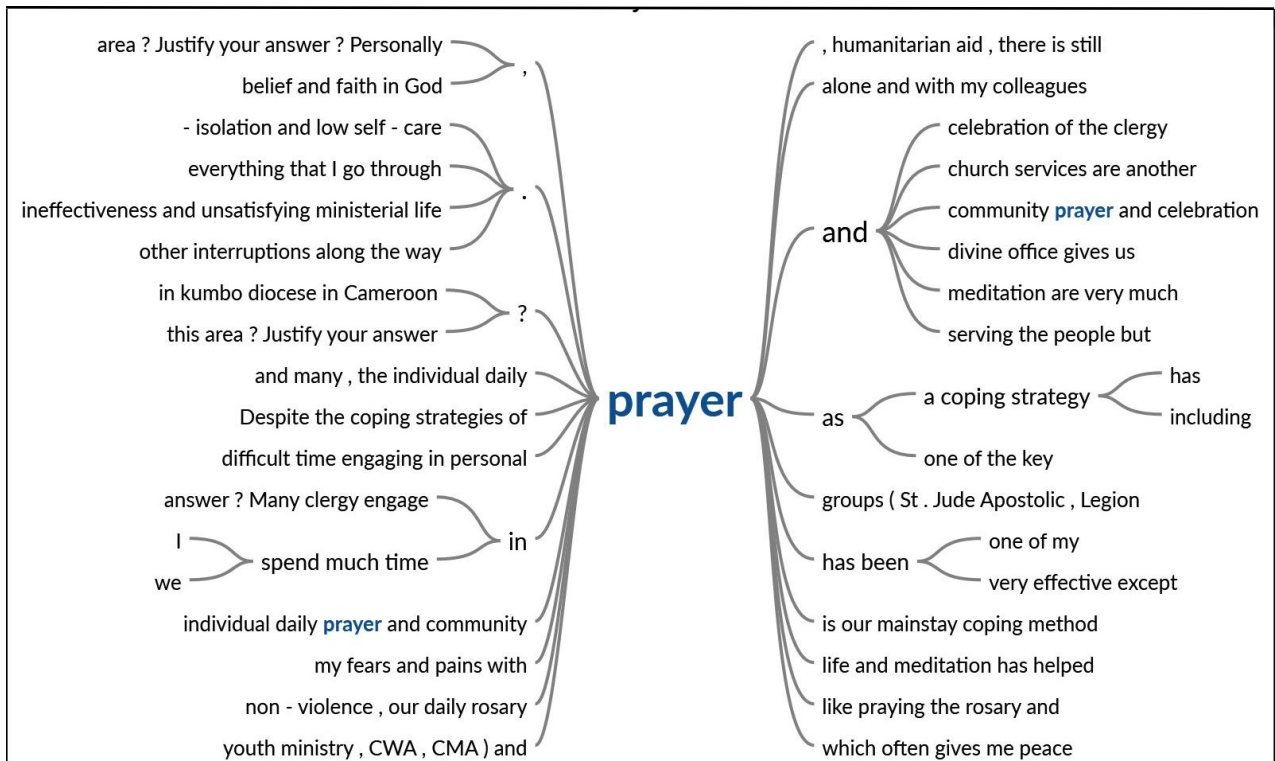


Figure 5: Text query search for "Prayer" objective 4

Appendix 5: Letter of Introduction



making a difference

Department of Development Studies
School of Arts and Social Sciences
Email: sassadmin@umu.ac.ug

Nkozi, 21st November, 2024

Your ref:

Our ref: ma pt introduction letter 23-24

Dear Sir / Madam,

Ref: Letter of Introduction.

This is to introduce to you. *NGIRNYU Blasius* Reg. No 2021-M372-20309 who is a postgraduate student in the Department of Development Studies at Uganda Martyrs University - Nkozi. He is required to carry out research on the topic: *"War-Trauma and Help Seeking Behaviour among the Clergy of Kumbo Diocese, Anglophone Cameroon."*

This is a requirement for the award of a Master's Degree in Mental Health Counselling Psychology.

I would like to request you to render him assistance in collecting the necessary data for writing his Dissertation.

Thank you in advance for your assistance.

Your sincerely,

for  Mr. Ahowaku Isaac
Head of Department
Dept. of Development Studies
School of Arts and Social Sciences