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Defense mechanisms in the obstruction of the mentalization process among victims of humanitarian crisis in the Far North of Cameroon

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Abstract
This article falls within the scope of clinical psychology. It explores the impact of defense mechanisms on the mentalization process in victims of armed violence in the Far North of Cameroon, a region affected by attacks from the Boko Haram group for more than a decade. It also offers a theoretical-clinical reflection on psychic reconstruction in a humanitarian crisis context. Based on an in-depth clinical case study of an internally displaced person, the study highlights the complexity of the psychic response to psychic intrusions. The qualitative analysis, based on a semi-structured clinical interview and the DSQ-40 psychometric tool, reveals a prevalence of immature and neurotic defenses (splitting, repression, acting out, devaluation, isolation) indicating a disorganization of the 'Ego' associated with a collapse of the mentalization process in response to psychic intrusion. Indeed, these mechanisms, although adaptive, hinder symbolization and promote the somatic expression of trauma (evidence of the failure of the mentalization process). These findings emphasize the need for an integrative therapeutic approach aimed at exploring and modulating defense mechanisms to restore the work of thought and the psychic meaning of trauma.

Keywords: Psychological trauma, defense mechanisms, mentalization, Cameroon, humanitarian crisis

Introduction
For several decades, sub-Saharan Africa, and more particularly the Lake Chad Basin region, has been confronted with a succession of multifaceted crises combining chronic insecurity, armed conflicts, intercommunal violence, and persistent humanitarian emergencies. Cameroon, especially in its Far North region, is not immune to this dynamic. This area, historically marked by structural fragilities and socio-economic marginalization, has become the scene of extreme violence since the expansion of attacks by the jihadist group Boko Haram starting in 2013.

At the regional level, the Sahel is currently among the main hotspots of terrorism in the world, accounting for a significant share of attacks and deaths related to these acts. According to the Global Terrorism Index (GTI, 2023), four of the ten countries most affected by terrorism in 2022 are located in this area: Burkina Faso, Mali, Niger, and Nigeria. Cameroon, although often off the radar of international media, is particularly affected in its northern region by violence, armed incursions, and forced population displacements.

The human and social consequences of this security crisis are considerable: massive loss of human lives, internal displacement, disintegration of the local economic fabric, collapse of community ties, and erosion of the sense of collective belonging. In addition, there are profound psychological traumas that have a lasting impact on the mental and psychosocial health of civilian populations exposed to extremely violent events: kidnappings, massacres, rapes, torture, destruction of villages, sudden loss of loved ones, public humiliations, etc. (Dozio, 2020).

The World Health Organization (WHO, 2022) estimates that nearly 10% of people exposed to a humanitarian crisis will develop post-traumatic stress disorder (PTSD), a figure that likely underestimates the true extent of the phenomenon, particularly in contexts where access to mental health care remains limited. Moreover, beyond the clinically identifiable manifestations such as PTSD, depression, anxiety, or suicidal behavior, more diffuse

psychological responses also develop, such as somatoform disorders or chronic psychosomatic symptoms.

In our clinical practice within areas affected by Boko Haram attacks in the Far North of Cameroon, we have observed a notable prevalence of medically unexplained somatic complaints: diffuse pain, functional sensory disturbances, chronic gastritis, recurrent headaches, and even vision loss without an organic basis. These bodily expressions of psychological suffering align with the reflections of several authors such as Pierre Marty (1991), for whom somatization can be understood as a consequence of a deficit or collapse of the mentalization process.

Mentalization, understood as the ability to understand and represent one's own mental states as well as those of others, is often impaired in individuals exposed to major traumatic events. When it fails or becomes blocked, particularly due to archaic defense mechanisms, the trauma cannot be symbolized or integrated psychologically. As a result, psychological suffering is expressed in other ways, often through the body or through disruptive behaviors (acting out, isolation, internalized or externalized violence, etc.).

In this context, it becomes essential to examine the intrapsychic processes at work in the experience of trauma, and in particular the role of defense mechanisms in hindering mentalization. How can these mechanisms, often activated to protect the self from psychological collapse, paradoxically block the processing of trauma? What connections can be made between the context of prolonged violence, the psychic defenses mobilized, and the mentalization difficulties in victims ?

Thus, this article aims to conduct an in-depth analysis of the contribution of defense mechanisms in hindering the mentalization process among victims of humanitarian crises in the Far North of Cameroon. It will seek to explore the psychic dynamics specific to this context, drawing on insights from trauma psychopathology, psychoanalysis, and transcultural clinical practice.

Methodology

This study was conducted in the Far North region of Cameroon, an area heavily affected since 2014 by the security crisis related to attacks by the Boko Haram group. This group, initially active in northeastern Nigeria, gradually extended its violent actions to Niger, Chad, and Cameroon, plunging civilian populations into a critical humanitarian situation. The study focuses on internally displaced persons who survived these attacks. Due to the specific nature of our research subject, we opted for non-probabilistic sampling by purposive selection, allowing us to choose a participant whose experiences were of particular interest for analyzing defense mechanisms and the mentalization process in a traumatic context.

The study is thus based on a single case, that of an adult man. The methodological choice focused on the clinical approach, and more specifically on the case study, in order to promote an in-depth understanding of individual psychic dynamics within a unique contextual framework. This method allows for highlighting the subjectivity of the traumatic experience and for apprehending the complex intrapsychic processes that cannot be fully captured by quantitative approaches. Data collection took place over two sessions. During the first session, we presented the research objectives, participation procedures, obtained the participant's informed consent, and clarified the conditions of confidentiality. The participant refused audio recording due to concerns related to the security context, which led us to favor handwritten note-taking.

The second session allowed for a deeper exploration of mentalization capacities through a semi-structured clinical interview and the administration of the DSQ-40 (Defense Style Questionnaire). The latter, developed by Andrews *et al*. (1993), enables the assessment of twenty defense mechanisms grouped into three categories: mature (such as sublimation or humor), neurotic (such as reaction formation or isolation), and immature (including splitting, projection, or somatization).

The data analysis was based on an interpretative reading of the interview content, cross-referencing the notes collected with the DSQ-40. We adopted a clinical approach enriched by psychoanalytic, psychosomatic, and ethno-psychopathological references, allowing for a detailed understanding of the material collected. The interview took place in the researcher's office within a hospital, in a setting that respected the ethics of psychology. Participation was voluntary and could be withdrawn at any time. An information note preceded the signing of the consent form, and the participant was assured of confidentiality throughout the process. Psychological support was offered in case of reactivation of distress during the interviews.

Clinical vignette of the Wambe case

To maintain confidentiality, the name mentioned for participants in this text is a pseudonym.

Context of the Meeting

The meeting with WAMBE took place within the framework of a community psychosocial intervention conducted by a humanitarian team supervised by the researcher, in response to an armed incursion that occurred in his village approximately six months earlier. This conflict situation had led to massive population displacement, significant human and material losses, as well as a state of widespread psychological distress within the community.

In this context, our team and I went to the village in the form of a mobile clinic to organize community awareness activities on mental health, conduct psychoeducation sessions, and provide psychological support. It was precisely during a psychoeducation session that we met WAMBE. He arrived accompanied by other villagers, visibly neglected, in a state of advanced bodily neglect. His smell and appearance seemed to bother some of the people present, although everyone expressed a sense of satisfaction in seeing him participate.

At the beginning of the session, WAMBE kept his head down, eyes closed, in a posture of absence. Gradually, as we discussed the possible manifestations of psychological suffering after a trauma, his attitude changed: he became attentive, silently nodding in agreement, murmuring 'that's true,' and broke down in tears at the mention of war and grief. At the end of the session, when an invitation was extended to those wishing to join a support group, WAMBE responded spontaneously by saying, 'Yes, I need it. What you are doing seems good.' He was then integrated into psychological care and invited to an individual psychological assessment interview beforehand. It was during this individual interview that WAMBE's story deeply moved me, to the point that I proposed that he also participate in a clinical research study on understanding

psychological phenomena in a traumatic context. After reading the information leaflet and the explanation of informed consent and the freedom to accept or refuse to participate in research without the risk of being excluded from psychological care, Wambe voluntarily agreed to participate in the research.

Medical History and Family Background

WAMBE is a 41-year-old man. Before the violent events that struck his region, he led a stable life as a successful merchant and farmer. He lived surrounded by his wife and five children, and enjoyed a supportive extended family environment including his two brothers and three sisters, all married and living in their own households.

The armed incursion into his village turned his life upside down. He lost everything: his house, wife, who tragically died during a complicated birth in the bush, as well as contact with his children. Separated from them in the chaos of flight, he supposes that they are said to have headed for Nigeria while he has retreated to another locality, where he lives now in a camp for displaced people, staying with his brother. He reports that he has lost all ability to feel physical or mental well-being since these events. His words are "Since the armed groups took everything from me, I have known hell. I have not never felt good again, neither in my body nor in my mind. »

Current Issue

During the individual interview, WAMBE mentions experiencing intense and continuous suffering. He says he is overwhelmed by intrusive memories of the war and the cries of his wife dying in childbirth. He explains that he no longer remembers the exact moment he lost sight of his children, which fuels deep guilt and a sense of abandonment. He adds that only consuming alcohol allows him to temporarily calm down, escape, or sleep: 'It makes me feel light and often plunges me into a sleep I wish were eternal.'

Physically, he shows great weakness. He is often supported while walking, says he can no longer see clearly, and exhibits a general disinterest in his surroundings. He confides that he no longer feels pleasure or taste, even when eating. He says he avoids social interactions, preferring isolation, as voices and memories constantly overwhelm him, 'water now has more taste in my mouth than food.'

Regarding the evaluation of his defense mechanisms via the Defense Style Questionnaire 40 (DSQ-40), Wambe will have positive responses to the following questions: 09 (repression), 13 (devaluation); 11 (acting out); 19 (splitting); 34 (isolation); 20 (acting out); 22 (splitting); 29 (repression); 36 (passive aggression)

Table 1: Responses analyzed according to the defense mechanisms of the Wambe case

Corresponding	Defense Category	Positive Assertion
Mature defenses	-	-
	Insulation	Q34
	Repression	Q9 and Q29
Immature defenses	Passive aggression	Q36
	Devaluation	Q13
	Acting out	Q20 and Q11
	Split	Q19 and Q22

3. Results

Defense mechanisms and obstruction of the mentalization process

The analysis of Wambe's case highlights a collapse of the mentalization process, largely influenced by the use of immature and neurotic defense mechanisms in response to extreme traumatic experiences. The sudden and violent loss of his emotional, social, and physical anchors, following an armed incursion, caused a psychological breakdown manifested by a severe disruption of his connection to himself and others, as well as a massive retreat into primitive defenses. Among the most prominent mechanisms, we find:

- **Splitting (Q19, Q22)**: Wambe demonstrates a dichotomous view of the world, typical of splitting: everything is perceived in extreme terms, without nuance. He speaks of his past life as 'stable, happy,' and his current life as 'hell.' This functioning reflects an inability to integrate the ambivalent aspects of psychic reality, hindering the capacity to mentalize contradictory emotions (e.g., love and hate for lost loved ones). This obstructs symbolization, which is necessary for processing trauma.
- **Repression (Q9, Q29)**: Although he evokes a lingering guilt related to the loss of his children, Wambe is unable to recall the exact circumstances of their separation. This mnemonic blur can be interpreted as a mechanism of repression aimed at avoiding total psychological collapse, at the cost of emotional and narrative freezing. This type of defense suspends access to subjective narration, thereby also blocking the process of mentalization.
- **Isolation (Q34)**: Isolation allows Wambe to talk about events with a great emotional charge (such as the cries of his dying wife) without apparent conscious affect. This affective dissociation blocks access to an integrated emotional understanding, which is nevertheless essential to the mentalization process.
- **Devaluation (Q13)**: Wambe expresses a radical drop in self-esteem, perceiving himself as a useless, worthless being. This defense, although self-punitive, serves as protection against intolerable affects such as shame, loss of control, or helplessness. It contributes to the disorganization of the Self and impairs the ability to represent oneself as a thinking subject, capable of being thought of by others.
- **Acting out (Q11, Q20)**: His use of alcohol as an escape from psychological suffering constitutes an acting out. It does not symbolize his affects but rather vents them through immediate and self-destructive behaviors. This mechanism reflects a failure to mentally process the emotion, preventing the transformation of the emotional experience into conscious representations.
- **Passive aggressiveness (Q36)**: The muted complaint, self-abandon (neglect, isolation), and apparent indifference to care suggest aggressiveness turned against oneself. This mechanism, difficult to recognize, makes the therapeutic relationship more complex, as it silently undermines any attempt at support from others, thereby hindering any co-construction of meaning.

Impairment of Mentalization Abilities

With WAMBE, the impairment of mentalization abilities is evident on both the psychic and bodily levels. The lack of

symbolic processing of the traumatic experience leads to a displacement of anxiety onto the body, resulting in pronounced psychosomatic symptoms. The individual reports chest pains, headaches, sleep disturbances, and a gradual disinterest in food and social relationships. He describes a sensation of pain "that goes down into the chest when he swallows," reflecting a somatization of psychological suffering. This process illustrates the inability to transform emotional burden into mental representations, leading to a bodily expression of the trauma.

Furthermore, the disorganization of temporal and spatial references reinforces this alteration in mentalization. WAMBE sleeps outside the house to "avoid the noise in his head," a sign of confusion between internal reality and the external environment. The use of alcohol as the only means of soothing reflects an inability to symbolize and regulate affect in any way other than through action. However, the listening stance adopted during the psychoeducation session, as well as the tears expressed at that moment, indicate a persistence of emotional resonance and the potential for reactivating the mentalization process, provided that a secure therapeutic framework can be established.

Interpretation and discussion of results

The clinical analysis of Wambe's case reveals a defensive functioning dominated by immature and neurotic mechanisms, indicating a profound disorganization of the Ego in the face of traumatic intrusion. As Freud (1926) reminds us, defense mechanisms are automatic psychic processes aimed at protecting the psychic apparatus against anxiety induced by unbearable affects. In Wambe, their massive deployment reflects a desperate struggle to preserve a psychic balance threatened by the sudden loss of emotional and social references, the confrontation with death, and the collapse of the symbolic framework.

Splitting appears as the central mechanism of this defensive dynamic. By describing his past life as 'stable and happy' and his current life as 'hell,' Wambe illustrates what Kernberg (1976) describes as a division of the Self between idealized and persecutory poles. This splitting, although adaptive in the short term, prevents the integration of contradictory experiences and blocks the process of mentalization (Fonagy & Target, 1997). The terror and psychological shock, linked to the sudden confrontation with the death of his loved ones, have frozen his psychic functioning in a state of emotional survival where symbolization becomes impossible.

Repression manifests itself through partial amnesia surrounding the disappearance of her children: ‘I no longer remember the exact moment when I lost them.’ This process, as described by Freud (1915), keeps intolerable representations out of the field of consciousness, in this case the feelings of guilt and helplessness in the face of loss. While it helps to prevent collapse, it also hinders the development of an autobiographical narrative, an essential condition for mentalization and the continuity of the self (Roussillon, 2010).

The isolation mechanism (Anna Freud, 1936) can be observed in Wambe's ability to recount traumatic scenes such as "the cries of my wife dying in childbirth" without any apparent affect. This dissociative process, described as early as Janet (1889), aims to compartmentalize emotion to prevent psychic disorganization, but at the cost of a rupture between thought and feeling. This affective dissociation blocks integrated emotional understanding, preventing the symbolic representation of the experience.

Devaluation and passive-aggressiveness, for their part, express an internalized hatred and a feeling of unworthiness: Wambe describes himself as "useless" and "worthless." According to Klein (1946), this self-deprecation reflects an introjection of the persecutory object and an archaic guilt, in which the subject turns against himself the aggression associated with loss. Green (1983) refers in this regard to a dynamic of "de-objectalization," in which the destruction of the connection to the other allows avoiding any new relational breach.

The passage to action, through alcohol consumption, illustrates an attempt at immediate affective regulation, without symbolic mediation. 'It makes me feel light and plunges me into a sleep I wish would last forever,' he confides. This action, according to Cahn (2002), replaces thought when mentalization capacities are deficient. Alcohol here acts as an external excitation shield (Freud, 1920), intended to temporarily neutralize unbearable internal tension.

The multiplicity and rigidity of these defenses indicate a failure of the excitatory barrier and a general weakening of the Ego (Freud, 1920). Their coexistence—splitting, repression, acting out-reveals a hierarchical disorganization typical of severe post-traumatic states (Lebigot, 2005). Wambe's psychic apparatus seems to function through disjointed fragments, unable to articulate representations and affects, which blocks the symbolic transformation of the traumatic experience.

These results support the contributions of Fonagy and Target (1997), who suggest that massive traumas lead to a deactivation of the reflective function in favor of primitive defense mechanisms. The inability to represent one's own mental states or those of others hinders emotional regulation and reinforces avoidant behaviors. Stupefaction and fear (Crocq, 1999) interrupt thought, making the experience unrepresentable and leading to a bodily or behavioral expression of the trauma.

However, certain clinical indicators, notably the tears shed during the psychoeducation session and the attentive listening, testify to the persistence of the potential for mentalization. These manifestations of affect indicate that beneath the defensive armor, a minimal relational capacity remains, which can potentially be reactivated in a containing therapeutic setting. According to Roussillon (2010), symbolization can reopen once the individual finds a space where their experiences are received and reflected upon with others.

Thus, the defense mechanisms in Wambe should be understood as attempts at psychic survival in the face of extreme trauma, rather than as purely pathological manifestations.

Conclusion

This research highlights that, when faced with extreme trauma, the human psyche mobilizes archaic defenses aimed at maintaining a threatened continuity of the self. In Wambe, mechanisms of splitting, repression, and acting out constitute attempts to safeguard the ego, but at the cost of a blockage in symbolization and mentalization. These results confirm the idea that trauma is not only a psychic breach, but also a rupture of connection and meaning, where suffering becomes unspeakable and is displaced onto the

body or action. However, the presence of shared emotions in a supportive relational framework shows that psychic reconstruction remains possible. Therapeutic work, by promoting containment, speech, and making sense, can enable the reactivation of mentalization capacities and the restoration of the bond to oneself and to others. In conclusion, this study encourages us to consider the clinic of trauma not only as individual repair but also as a process of reconstructing the symbolic fabric destroyed by violence.

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