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Research Article

Subjective Experience and Psycho-trauma Disorder: Case Report of Infected People Covid-19 Quarantined in Cameroon

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Abstract

This article aims to identify the subjective experience of people infected by Covid-19, settings quarantine in Cameroon and evaluation of their psycho-traumatic disorder. The work on the subjective experience of Pédinielli [1] and Lainé [2] disease resulting from the phenomenological approach in clinical psychology has served as a theoretical frame of reference. We hypothesized that the psycho-traumatic disorder in people quarantined following exposure to COVID-19 was determined by their subjective experience. Data were collected by means of semi-structured telephone interviews with 02 subjects. After informed consent, then the PHQ-9 and IES-R health questionnaires were taken to assess their psycho-traumatic experience. The results obtained following the content analyzes show that the 02 clinical cases of this study present symptoms progressing to a psycho-traumatic disorder following their subjective experience, this in relation to the nature of the exposure, the representations, and the conditions of medico-psychosocial support they face. This research opens perceptives for reflection on the urgency of a remote psychological intervention via telephone in addition to face-to-face meetings for these people infected and/or affected by COVID-19, and by psychological care professionals.

Keywords: COVID-19; Infection; Quarantine; Subjective Experience; Psycho-trauma

Introduction

For many years with the onset of chronic pandemics such as HIV-AIDS, the issue of mental health and psychological suffering of patients and relatives has been at the center of discussions. This article aims to capture the psycho-traumatic experience of people infected with Covid-19 and in quarantine in Cameroon. According to WHO The coronavirus is a virus of the Coronaviridae family, related to SARS-CoV-2 and MERS which first appeared in Wuhan in December 2019, which was declared a pandemic on March 11, 2020 by the world organization of Health (WHO) Symptoms are marked by dry febrile cough, loss of taste and smell, shortness of breath and diarrhea in the first or second week of illness. Severe cases often progress rapidly to respiratory distress requiring intensive care. The clinical signs can be infectious, respiratory, digestive, neurological, cardiac or dermatological. The diagnosis is based on the epidemiological investigation and in particular the notion of close contact, the clinical manifestations and a battery of additional biological and radiological examinations Nko'o., *et al*. [3]. We define a "close contact" such as being within two meters of a suspected or confirmed patient or in a room or care area for an extended period without personal protective equipment or directly exposed to secretions from a person infected with SARS- CoV-2 (Lee, Kim, My-

oung., *et al*. [4]. The incubation period is 5 days on average (variation from 2 to 14 days), and can exceptionally reach 21 days. So far, there is no specific treatment although several molecules such as hydroxychloroquine or remdesivir and drugs from the traditional African pharmacopoeia seem to have promising results.

According to the WHO [5] from May 26 to June 1, 2020 d worldwide, 214 countries are affected with 6,057,853 confirmed cases, 371,166 deaths, or a case fatality rate of 6.1%. In Africa, 54 countries affected with 144,702 confirmed cases and 4,149 deaths, case fatality rate of 2.8%. In Cameroon, 6,752 confirmed cases, 199 deaths, case fatality rate of 2.9% and 3,629 people cured. Cameroon has passed the 6,000 case mark, the sixth most affected country in Africa after South Africa, Egypt, Nigeria, Algeria, Morocco.

No vaccine has been developed to date, the priority is on prevention, through massive screening, close surveillance and quarantine of confirmed positive or exposed cases depending on their clinical condition, hygiene measures associated with rigorous barrier gestures (hand hygiene, social distancing, face masks, quarantine) and multidisciplinary care (Nussbaumer- Streit., *et al*. [6], Li and Fan [7]). In Cameroon, Barrier measures have been investigated in order to reduce as much as possible the rate of spread of the virus. However, in view of their repercussions on the quality of life and the socio-economic balance of the country, certain measures have undergone modifications (the opening of bars and other commercial spaces, schools.) In terms of health, measures for the identification and monitoring (Medico-psychosocial) of new cases are reinforced with the support of the WHO.

Previous studies have described the psychological experience and mental health problems caused by pandemics like the Ebola virus, MERS and SARS. I n fact, these studies have shown that psychological distress and psychiatric disorders that typically occur as a result of a pandemic are due to the social gaze, stigma, obsessive thoughts of death in the patient, the loss of self-esteem and body image issues to name a few (Onyeaka, Zahid and Patel [8]; Sim [9]); Mohammed., *et al*. [10]; Everly [11] The evaluation of the state of stress of the patients quarantined and on hemodialysis revealed the importance of an early intervention as first psychological emergency for these patients from the diagnosis and the announcement of the result. Therefore, the first psychological support in an epidemic crisis situation proves essential to prevent psychiatric disorders by providing survivors with the compassion, listening, social and emotional support they need (Shah., *et al*. [12]).

With regard to quarantine, it must be said that the Cameroonian health system provides for three types of quarantine: home quarantine (self-isolation without medical assistance for asymptomatic patients), follow-up quarantine (confinement of suspicious persons/symptomatic for medical follow-up), and strict quarantine (isolation in an appropriate place of care, restriction of movement). Only the latter is really applicable for the moment. Given the limits in terms of health personnel and other socio-economic factors. That said, the quarantine and psychological monitoring of patients in the context of COVID-19 is therefore problematic in Cameroon with regard to the infrastructural conditions, the difficulty of providing psychological support and the representations that the populations have of. the pandemic and the conditions of the quarantine. Such a reality is not without effect on the psychological experience of infected or exposed people.

The work of psycho-phenomenologists in particular of Pédinielli on the subjective experience in situation defined the disease, seen by the patient, as "an individual experience comprising psychological, social, cultural repercussions" and described the original individual representations of the patients who had it. Result, as "theories" (Pédinielli [1]). The personal theories of patients should, according to Pédinielli be analyzed and integrated, since they play an important role in the way in which the patient explains the cause of his disease, behaves with regard to his care and his health modifies his investments and finally creates an imaginary space which will allow him to tame this disease. The notion of "work of the disease" was introduced by this same author, to translate the idea that organic disease leads to significant psychic changes, in the sense that it is "an experience, an internal event known ceptible of representation and generator of an investment game". This work must lead to a creation of meaning, a psychic reality specific to the subject faced with the situation he is going through. This justifies the interest of this study, the objective of which is to establish the link between the subjective experience and the psycho-traumatic experience in people exposed in quarantine in Cameroon. This research opens up avenues for reflection on remote psychological intervention via telephone in the face of a pandemic such as COVID-19. This research will therefore lead to the development of a protocol/guide for psychological intervention in a listening and crisis support unit, reconciling the clinic in the presence of that remotely via telephone. The work of Houssier, Kristaki, and Vlachopoulou, [13] hypothesized psychological support sessions by telephone in the context of Covid-19, with particular emphasis on its framework and its limits.

Study hypothesis

The work of Pedinielli [1] and Lainé [2] having shown that the subjective experience, in particular the cognitive and social representation systems that the patient develops in terms of "disease work" facilitates his adjustment or his psychic decompensation. From there we made our research hypothesis namely: "Psycho-traumatic disorder that develops patients quarantined is determined by their subjective experience".

Material and Methods

Since this study aims to identify the experiences of subjects in situation and precisely the subjective experience of quarantine and the COVID-19 pandemic in order to establish the link with psycho-traumatic disorder, we opted for the clinical method. It will be a question here of taking into account the experiences of these patients in their subjectivity.

After informed consent, semi-structured interviews via telephone, then questionnaires to assess the psycho-traumatic experience (PHQ-9 and IES-R) were taken in July with 02 cases quarantined following exposure to COVID-19 at Laquintinie Hospital in Douala. The data collected was then analyzed from the content analysis.

The telephone interviews were carried out in a listening framework set up in order to limit interference bias as much as possible. Two interviews lasting 45 minutes to 1 hour were performed with each patient. However, it is important to note the complexity in the completion of interviews and questionnaires by telephone. The observation and the visual contact which are fundamental in the helping relation are non-existent, nevertheless by building with the patient a framework of remote listening and by applying the principles of non-directivity (listening, attention, neutrality, non- judgment, empathy), we facilitate the free expression of one's affects.

Results and analysis

The results of this study are described in two phases, namely the comments of the interviews on a case-by-case basis, then the results arising from the questionnaires to evaluate the psycho-traumatic experience.

Commentary on case-by-case interviews

We have opted for a case-by-case analysis in order to better understand the singularity or at least the subjectivity of the situations and feelings when faced with the same problem of quarantine following exposure to COVID-19.

Case Agathe

History

Agathe is a 28 year old woman, married and mother of 02 children. A nurse, she works as an accompanist in a local health facility. She lives with her husband and her two children (5 years old and 3 years old). Without identifying the real context of exposure, it was confirmed to have COVID-19 following a sample and in-depth examinations at the General Hospital of Douala-Cameroon, then quarantined at home.

Circumstances of the exposure

It is difficult for Agathe to identify the context of her exposure because in addition to her professional occupations in a hospital environment, she carries out other commercial activities in order to better meet her family needs. These questions about the real circumstances of her exposure remain a distressing factor for her: "Well, to tell the truth I cannot determine how I came to be infected with COVID. Either with a patient or in transport, umm no I don't really know. (…)".

The diagnosis of a suspicion of infection with COVID-19 was made by the doctor during a consultation for various disorders that she presented (fever, fatigue, cough). Then in-depth examinations were carried out in the laboratory, the result was positive, hence its home quarantine.

"Really it's the doctor because the COVID screening I was not initially eligible in the first phase. It was when I arrived for a consultation after certain exams and it was where the doctor confirmed (...) we took the sample on April 13...".

Knowledge about the pandemic

Regarding the pandemic, Agathe says she has some knowledge of barrier measures via posters at the health facility where she practices and through social networks. She therefore has no real knowledge about the virus, which she considers to be a virus like any other defensively.

"Everyone says that leaves and we are finally lost (…) Well yes in the hospital and on the net, the barrier measures and all and so on (…) for me it is a disease like any other except that the contamina-

tion is faster. We do not know who has COVID, despite the barrier measures the context does not allow us to respect the barrier measures such as distancing since you will take public transport how you will be distant from the driver since he is carrying you".

Perception of the pandemic

Agathe's perception of the pandemic is reinforced by her knowledge through the research she carries out and her profession as an accompanist in an HIV care program in Cameroon.

"I take it like any disease as we will have to live with. Already even the assumption of responsibility is not mastered. Earlier I was following a medical researcher who said that chloroquine has its limits. We can only take precautionary measures…".

Psychological experience after the announcement of the result

Although Agathe is developing more adaptive capacities today, we note an anxious and psycho-traumatic experience after the announcement of the result.

"Yes I was a little anxious at times. Already that I had not accepted the diagnosis at the beginning I do not know if one can say that I made the denial. How can you say I have COVID when I don't have all the signs there? Loss of smell, cough (…) Really the first two weeks I slept, sometimes very late at midnight. I don't know what was holding me back but over time it goes very slowly (...) it was due to this pathology nor I was wondering when it ended, and after how to live afterwards so as not to be infected anymore, is-that I will be immune given that I have no response to date".

However, her experience with chronic diseases and the management of the anxieties associated with them facilitates her capacity for resilience in the face of COVID-19.

"(…) Good at the start when I was told about COVID I couldn't believe it. When I got to the hospital for malaria. We did the test and I didn't believe it. I took it like that, I was even in tears because I was scared (…) the doctor was having trouble announcing me… he was having a bit of trouble. I took it like that and I asked what to do (…) I am in the accompaniment of people who have such serious problems you see, HIV/AIDS and if I give them advice and even today I do not apply it is disappointing".

Social support

Agathe benefited from social support, in particular from her husband. Support that she found very necessary in this situation and in view of the stigmatizing behaviours that others may have in the face of people positive for COVID.

"My strength was my husband because he was close to me (…) I was not stigmatized except that I was weird because I was not used to this kind of thing. It was n't that easy".

The gaze of others and the feeling of stigma

Agathe's concerns are much more related to the gaze of others. She develops a fear of stigmatization in the professional context because at the family level, the information has remained confidential between her and her husband who so far has not shown any stigmatizing behaviour towards her.

"Of course, for my part, I have no problem since I have not informed the family except my husband (…) Within the framework of my work, I do not know yet because I do not know the reaction of my colleagues, are they going to reject me, are they going to accept me?"

To face it in anticipation, she develops defences by rationalizing, then by normalizing these stigmatizing attitudes that her colleagues could have towards her.

"(Weak intonation) I'm not going to blame them too much, their reactions because I myself don't know if I'm healed and I can't transmit. (…) At times it also stresses me. Yes it stresses me out".

The perception of quarantine

Following the positive diagnosis, the conditions of quarantine at home contrary to what she thought, in particular the screening of relatives, disinfection of the living environment, medical and psychological monitoring were not favorable for her psychological balance and would be a real causes of his psycho-traumatic experience.

"Loud tone, rapid speech (…) me in principle I think that when you track someone you see his entourage. I came with my husband, he was not detected. Home disinfectants were not done at home, I managed alone at my level to protect my family. The government has a lot to do to alleviate this pandemic (…) For a good quarantine, the patient does not have to go home. He has to stay in the hospital because we have to find out how he is on a daily basis. Seeing at home is what he can ensure this quarantine being at home not letting him go like that".

Bibi case

History

Bibi is a 29-year-old adult. Single and without children, she works as a doctor in a health facility. Before her exposure, then quarantine, she developed a fever for over a month. This had already required his sick leave. The quarantine therefore comes at her home at a time when she was barely returning from her medical rest. Her exposure results from the multiple cases recorded in May in her health facility and with which she was in direct contact.

Circumstances of the exposure

Bibi's exposure occurred in his work environment after direct contact without taking precautions with confirmed cases that were later positive for COVID-19: "Since I work in a hospital where we had several colleagues who tested positive for COVID, for a week we had at least four to five that. The people we work with, we had to interact without taking the necessary precautions (…) I was quarantined in May (…)".

Knowledge about the pandemic

Bibi has quite a strong knowledge of the pandemic. Her knowledge is enriched by her profession as a doctor and the research she carries out on the subject.

"(…) It was in March that it started to be felt, before we didn't even believe too much in that (…) My knowledge is enough. The causal agent which is a virus, the modes of transmission, the precautions to be taken, I think I have a fairly extensive knowledge".

Although scientific arguments are raised on the origin of the pandemic in Africa, she develops an anxiety related to the perception she has of the origin of this virus.

"I have the impression that this is something, in fact I have the impression that in Africa we suffer from the problems of others. In my head in Africa we suffer the things of others (...) I don't know in fact deep down that it annoys me, COVID annoys me. We suffer the consequences of other people's problems (...)".

Africa, according to her, would suffer the consequences of Western clinical failures. This perception and this feeling of victimology which animates it would be one of the causes of the psychological distress which it expresses: " Since we are not equipped enough to fight we suffer and we do not know because it comes from elsewhere, we knew that it comes from elsewhere and we did nothing and now it is the population that suffers the consequences without even understanding and we even in the hospital we suffer their ignorance is a bit like that".

Pandemic perception

As for his perception of the pandemic, we note ambivalence in his remarks. Although she is a health worker and has information about the pandemic, she remains uncertain about her care: "It's serious. No it's very serious for me I'm afraid it will remain serious but as the rest of the world will stop talking about it we will also stop talking about it without solving the problem. We will follow the trend as usual".

Psychological experience after announcement

The announcement of the diagnosis of suspicion and the immediate treatment of Bibi had an impact on her psychological experience. She evokes symptoms of a psycho-traumatic nature following her quarantine and in the face of this suffering, she has developed defences, in particular repression and rationalization in order to be able to overcome her anxieties.

"(…) Yes well I had a pretty good life in my forties, I had a pretty good emotional experience. I tried to disconnect myself from that, I tried to rationalize in fact to list everything I know about the disease by telling myself that it will be okay (…) I even made a blockage of the kind it is not like I had emotions and I experienced those emotions and then I went through that phase. I made a psychological blockage and act as if nothing had happened… I have already known worse than that so you understand (…) Fatigue, let's say psychological fatigue. Not to talk too much, I didn't pick up the phone, I didn't want to do anything, I was tired, psychologically tired (...) I had a drop in my appetite but I don't know if it is related to because it's been a long time since I had no appetite as usual. But I don't have the impression that it got worse".

The life of the quarantine

Bibi's quarantine conditions were viewed negatively by the latter. She evokes a failure to take into account her suffering and her concerns by the hierarchy before her quarantine.

"(…) At the beginning I was frustrated because we refused. I had not had favourable answers (…) before I was frustrated I said that

I had a problem, that I needed support and on the other side they tell me it's okay, it's okay to go when I know it is serious and it may not go well if I am not heard, if I do nothing (…)".

This feeling of disappointment that she expresses with respect to her direct hierarchy is also projected towards the managerial system as a whole. It expresses the shortcomings experienced by the Cameroonian health system in the management of this pandemic. Situation exhibitors, health personnel at greater risk of infection with COVID-19.

"The leadership's anger towards the country and the leaders because I have the impression that all the decisions that are taken are to protect themselves and not necessarily for us. We say things on paper and in the field we have the impression of being abandoned (…) when someone says that I would have liked you to be in quarantine for a long time, but the chefs don't want to. We have the impression that we are being sacrificed because we want to do the job but we do not take the necessary measures to protect ourselves. We have the impression that we are protecting economic interests and we are sacrificing people (…)".

Social support and feelings of stigma

During her quarantine period, Bibi received social support, particularly from family and colleagues on duty. No feeling of stigmatization or self-stigmatization is expressed by the latter: "I had a lot of support, I was supported enough (...) I did not have the impression that I was looked, stigmatized".

Questionnaire results (IE S - R and PHQ-9)

Score by Case	PHQ-9	IES-R	Interpretation
Agathe score	10	22	Presence of acute stress with predominance of avoidance symptoms and neuro-vegetative manifestations.
Bibi score	12	21	Symptoms progressing to acute stress with predominance of avoidance and reviviscence behaviours.

Table 1: Scores on the questionnaires for evaluating the psycho-traumatic experience.

Discussion

It will be a question here of making a brief reminder of the phenomenological approach of subjective experience according to Pedinielli's model, then confronting our results with this theory.

Brief review of the phenomenological approach to the subjective experience of Pedinielli [1]

For Pedinielli [1], the experience of the disease in a phenomenological clinic is above all to be understood as a subjective experience, specific to each subject. Based on the work of Leriche [14], Pedinielli starts from the postulate that the "doctor's disease" differs from the "patient's disease". If the first agrees to understand the disease from an objective view of clinical symptoms, the "disease of the patient" raises the meaning of the disease for the patient. The symptoms present thus mobilize all of the patient's mental defences. Therefore, they do not register only at the somatic level, but also at the psychic level. Speaking of the disease in Africa and Cameroon in particular, it is rarely a given individual, it is always the direct or indirect manifestation of a cosmic disorder causing immediate effects on social organization and interpersonal relationships between individuals of u same group (Tsala Tsala [15]; Nguimfack [16]; Mayi [17]). The subjective experience of the disease that we are addressing in the context of COVID-19 becomes a carrier of cognitive and social representations for the patient in quarantine.

Discussion proper

Speaking of cognitive representations, we must note that they are established according to the level of information available to the subject before he is confronted with the disease. This is the level of collective knowledge about the disease. The information given by the social and medical environment at the time of the announcement seems to constitute another field favoring the emergence of representations. Finally, it is the experience of the disease, at a somatic but also psychic level that produces representations. The construction of representations from these three sources associates both conceptual processes calling on abstract information or assumptions, and schematic processes established using concrete information, resulting from the subject's experience (Leventhal and Diefenbach, 1992 cited by Lainé [2]. Within the framework of COVID-19 in Cameroon, various sources of information come into play, namely scientific reports, the media, popular discourse, administrative reports. The sometimes-contradictory information in

their hypotheses on the pandemic leaves the populations and the future patient in a paradoxical situation. The cognitive representation of COVID-19 in terms of information and knowledge is therefore problematic in people who have been quarantined the resulting psycho-traumatic suffering is the consequence, as is the case with Bibi and Agathe.

"How can you say I have COVID when I don't have all the signs there? Loss of smell, cough (…) Really the first two weeks I slept, sometimes very late at midnight. I don't know what was holding me back, but over time things go slowly (…) it was due to this nor pathology (…)" affirmed Agathe. The cognitive representation of the disease here stems from personal information and knowledge she has of the pandemic as a result of her investigations. The questioning of the diagnosis and the resulting signs of psychological distress reflect his subjective experience.

She continued: "Everyone says that by and we are finally lost (...) Okay yes in the hospital and on the net, the barrier measures and all and so on (...) for me it's a disease like any other except that the contamination is faster. We do not know who has COVID, despite the barrier measures the context does not allow us to respect barrier measures such as distancing since you will take public transport how you will be distant from the driver since he is carrying you (...)". In addition to the informational paradox in which it is confronted, it evokes the hypothesis of a less protective social context. This describes a feeling of perceived vulnerability to COVID-19 and its care in Cameroon.

Bibi in the same wake underlined: It's serious. No it's very serious for me I'm afraid it will remain serious that as the rest of the world will stop talking about it we will also stop talking about it without solving the problem. We will follow the trend as usual (...) Since we are not sufficiently equipped to fight we suffer and we do not know because it comes from elsewhere, we knew that it comes from 'elsewhere and we did nothing and now it is the population who suffers the consequences without even understanding and we even in the hospital we suffer their ignorance is a bit like that".

Regarding the social representations which integrate the subjective dimension of the experience of the disease, they are marked by the culture and the time in which they are part (Blois-Da Conceiçao., *et al*. [18]). it has been shown that within the same culture, one could observe a strong diversity of social representations, varying mainly according to the level of social integration of the subject (Zani [19]). of his illness, by the patient, is an important object of study in clinical psychology and psychopathology. These theories, called "secular or personal, as Lainé [2] underlines, are based on shared social representations, which have been described empirically in a anthropologique or social perspective (Galand and Salès-Wuillemin [20]) and original designs, built by the individual. They may conflict with medical concepts that the individual accepts however only partially, and strongly influence the representation of the disease and, consequently, the ability to experience the disease over time, adherence to treatment and, ultimately, the evolution of symptoms (Schiaffino, Shawaryn., *et al*. Blum, [21]).

The clinical cases in particular the case of Bibi doctor is an illustrative example. The representations that she has constructed are not totally in agreement with the medical ones although she is part of it. The discourse on the pandemic, its origin and its treatment is much more based on social representation before being subjective. Subjectively, she perceives the quarantine in a positive way, however, she develops a feeling of victimization following ideas about the pandemic, its origin, and the management of health personnel involved in the management of this pandemic in Cameroon. The psychological suffering that she develops as a result is a repercussion: "At the beginning I was frustrated because we refused. I had not had favorable answers (...) before I was frustrated I said that I had a problem, that I needed support and on the other side they tell me it's not serious, that will be okay when I know it's serious and it might not be okay if you don't hear me, if I don't do anything (...) I have the impression that it's something, in fact I I have the impression that in Africa we suffer the problems of others. (…) I don't actually know deep down inside me, it annoys me, COVID annoys me".

Another dimension of the subjective experience of quarantine in the context of COVID-19 lies in the nature of the social support perceived by the patient. The social support received is a subjective measure of "the effective help given to an individual by his entourage" (Conceiçao, [17]). It is an active support, materialized by concrete actions that the entourage also brings family, friendly, professional or even medical. This support can have different functions. House [22] retains four main ones, namely: emotional, material or financial support, informative, and esteem support. COVID-19, this support is essential to overcome the feeling of rejection, stigmatization, self-stigmatization. The cases of Bibi and Agathe presented

in this study benefit from the support of both their family and professional circles. Which will be of a capital contribution for their adaptation thereafter.

Conclusion

In a clinical approach, we attached importance to the subjective experience of the COVID-19 pandemic among people quarantined in Cameroon. Indeed, the WHO [5] already described the quarantine of people after exposure as an essential strategy aimed at reducing the risk of infection and spread of the virus in the community. However, the conditions which frame this action, in particular the isolation of people, the stigmatizing social gaze towards them, as well as the subjective experience that results from it, would have consequences on the psychological or at least psychopathological level. Quarantine therefore becomes a fairly difficult situation which occurs at a time when the pandemic continues to cause loss of human life. Work on subjective experiences of the disease has already shown that various cognitive, social and phantasmal representations of the pathology are put to work, thereby facilitating the emergence of a psychological disorder or allowing patients to adjust better (Pedinielli [1]). Through the two clinical cases illustrated in this article, we have captured the subjective experience of patients quarantined in Cameroon following exposure to COVID-19. It follows that following the same traumatic situation as the occurrence of a pandemic, various psychological reactions can occur in the sense of an adaptation or a decompensation, this in connection with the various experiences of the individuals. Although the psycho-traumatic experience is present following the announcement in patients, its severity and persistence vary according to the " Psychic work on the disease", through its social, cognitive, phantasmatic and a sense of perceived social support. What Pedinielli called a subjective experience of the disease. The investigative approach used, in particular the semi-structured interviews and the completion of questionnaires for the assessment of psychological suffering (PHQ-9 and IES-R) via telephone, given the context that does not facilitate a face-to-face meeting, opens up avenues for reflections on the challenges of a remote psychological support and listening protocol via telephone in addition to the meetings in Cameroon.

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