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Prevalence and Socioeconomic Determinants of Depression and Psychosis Among Adults in Bamenda, North West Cameroon.

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ABSTRACT

Mental health disorders, particularly depression and psychosis, are major public health concerns in urban centers of low- and middle-income countries. In conflict-affected areas such as Bamenda municipality in Cameroon, socioeconomic instability, unemployment, low income, and poor community safety may worsen these health conditions, yet evidence linking these factors to depression and psychosis is limited. This study examines the association between socioeconomic factors and mental health outcomes (depression and psychosis) among adults in Bamenda municipality. This cross-sectional survey included 350 adults (161 males and 189 females) of ages 15 to 45 years. Data was collected using a pre-tested structured questionnaire and depression and psychosis were assessed using the simplified guidelines for mental health of the Regional Hospital Bamenda. Socioeconomic variables included income, employment status, educational attainment, marital status, and perception of community safety Seemingly Unrelated Regression (SUR)

analysis was used to examine the relationships between the socioeconomic variables, social support and mental health outcomes. Results showed that earning above 200,000 FCFA (β = -0.231, $p < 0.05$), and being employed (β = -0.222, $p < 0.01$) were significantly protective against depression. Similarly, earning above 200,000 FCFA (β = -0.157, $p < 0.01$) and being employed (β = -0.193, $p < 0.01$) were significantly protective against psychosis. Results also showed that being married increased symptoms of depression (β = 0.289, $p < 0.01$) and psychosis (β = 0.257, $p < 0.01$). Conversely, perceptions of neighborhood safety were protective against depression (β = -0.115, $p < 0.01$) and psychosis (β = -0.136, $p < 0.01$), while social engagement reduced symptoms of depression (β = -0.0997, $p < 0.01$) and psychosis (β = -0.0921, $p < 0.01$). Findings also revealed a high overall prevalence of mental health disorders among respondents, with 65.7% reporting symptoms of depression and 73.1% reporting symptoms of psychosis**,** while 34.3% and 26.9% reported no symptoms of depression and psychosis respectively. These findings highlight the importance of socioeconomic stability, safe neighborhoods, and social support in mitigating mental health disorders. Interventions should target income security, employment, community safety, and social engagement to reduce the burden of depression and psychosis in conflict-affected regions.

Keywords: Mental health, socioeconomic determinants, depression, psychosis, Bamenda municipality

INTRODUCTION

Mental health forms an integral component of overall health, influencing every aspect of human existence. WHO (2019) defines it as “a state of well-being in which an individual realizes his or her abilities, can cope with normal life stresses, can work productively, and is able to contribute to their community.” Around the world, mental health conditions such as depression, psychosis, and other common mental disorders (CMDs) are increasingly prevalent. Statistics reveal that one in four people will experience a mental health challenge at some point in their lifetime, illustrating the universality of the issue (World Health Organization, 2019).

The consequences of poor mental health extend far beyond the affected individual, imposing substantial social and economic costs on families, communities, and nations. Recent global data show that mental health conditions such as depression and psychosis now affect more than 1 billion

people worldwide and impose severe economic consequences. According to the World Health Organization's Mental Health Atlas 2024 and associated reports, depression and psychosis alone cost the global economy an estimated US $1 trillion annually in lost productivity**,** far exceeding direct healthcare expenditures. Alarmingly, this figure is projected to nearly double, reaching USD 6 trillion by 2030 if effective interventions are not implemented.

Mental health disorders in Africa have become a significant public health concern. The World Health Organization (WHO, 2023) reports that mental, neurological, and substance-use disorders account for approximately 6% of the total disease burden in the African Region, measured in disability-adjusted life years (DALYs). Additionally, an estimated 150 million individuals in the WHO African Region are living with a mental health condition, yet access to adequate and decentralized mental health care services remains limited (WHO, 2023). This disparity underscores the urgent need for comprehensive mental health strategies across the continent.

The prevalence of mental health disorders in sub-Saharan Africa is closely linked to various socioeconomic determinants. Factors such as poverty, unemployment, limited educational opportunities, and inadequate living conditions have been identified as significant contributors to the onset and exacerbation of mental health issues (Patel *et al*., 2018). Studies indicate that individuals facing economic hardships are more susceptible to conditions like depression and psychosis, highlighting the interplay between economic status and mental well-being (Lund *et a*l., 2010).

In countries like Cameroon, particularly in conflict-affected regions such as the North West Region, the challenges are further compounded. Ongoing insecurity, community safety concerns, and socioeconomic instability exacerbate the prevalence of mental health disorders. These conditions not only increase the risk of developing mental health issues but also hinder access to appropriate care, creating a vicious cycle that is difficult to break (Burns, 2015).

Understanding the interplay between socioeconomic factors and mental health is essential for designing effective interventions and evidence-based policies. The aim of this study is to determine the prevalence of depression and psychosis and assess relationships between socioeconomic factors and these mental health outcomes among adults in the Bamenda municipality.

Materials and Methods

Study Subjects

This study was conducted in the Bamenda I, II, and III municipalities of the North West Region of Cameroon, an area significantly affected by the ongoing socio-political crisis. The study employed a cross-sectional design, providing a snapshot of the current state of mental health (depression and psychosis) and its associations with socioeconomic factors at a specific point in time. The study population comprised adults aged 15-45 years who had lived in Bamenda for at least six months prior to the study, ensuring adequate exposure to the prevailing socioeconomic and security conditions. Inclusion criteria included adults aged ≥15 years, both males and females, and individuals who provided informed consent. A total sample size of 384 adults was determined using Cochran's formula, adjusted for the finite population of 614,809, assuming a 95% confidence level, 5% margin of error, and an estimated prevalence of poor mental health of 50%. A multistage sampling technique was employed, first stratifying Bamenda into its three subdivisions to ensure geographical representation, then randomly selecting neighborhoods within each subdivision, and systematically approaching households by visiting every third household. In households with more than one eligible adult, one participant was randomly selected using a ballot technique. This procedure ensured that participants were drawn from diverse socioeconomic backgrounds, capturing variations in income, education, and living conditions across the municipality.

Instrumentation

A structured questionnaire was designed and administered to collect data on socioeconomic factors and mental health outcomes among adults in Bamenda municipality. The instrument was organized into several sections aligned with the study objectives. Section A captured respondents' demographic characteristics, Section B assessed monthly income, Section C examined educational attainment, Section D recorded employment status, Section E gathered information on housing conditions, and Section F assessed perceptions of community safety.

Data collection

Data were collected using a structured questionnaire administered to adult residents of Bamenda municipality. The questionnaire was administered through face-to-face interviews to ensure clarity

of questions and to accommodate respondents with varying levels of literacy. Prior to data collection, the purpose of the study was clearly explained to each participant, and informed consent was obtained.

Trained research assistants conducted the interviews and guided respondents through the questionnaire, ensuring that all items were clearly understood and accurately completed. Confidentiality and anonymity of responses were assured throughout the data collection process. Completed questionnaires were checked daily for completeness and consistency to minimize errors and missing data before analysis.

Mental Health Disorders

Depression

Depression was assessed using symptom-based items included in the structured questionnaire. Respondents were asked to indicate whether they had experienced selected depressive symptoms within the two weeks preceding the survey. These symptoms included persistent sadness, sleep disturbances, fatigue, loss of appetite, feelings of guilt, loss of interest or pleasure, irritability, social withdrawal, feelings of loneliness, and thoughts of self-harm. Responses were used to determine the presence of depressive symptoms among participants. The assessment was guided by the diagnostic criteria outlined in the Simplified guidelines for mental health of the Regional Hospital Bamenda, which requires the presence of at least five symptoms during the same two-week period, with at least one of the symptoms being either persistent sadness (depressed mood) or loss of interest or pleasure (anhedonia). In this study, respondents who reported experiencing five or more of the listed symptoms within the specified two-week period were classified as having depressive symptoms. Responses were therefore used to determine the presence or absence of depressive symptomatology among participants.

Psychosis

Psychosis was assessed through questionnaire items addressing common psychotic features. Participants were asked about experiences of hallucinations (auditory, visual, or sensory), delusions such as persecution, grandeur, or ideas of reference, bizarre behaviour, impaired judgment, neglect of personal hygiene, aggression, and social withdrawal. These indicators were used to identify participants exhibiting psychotic symptoms. To determine the presence of psychotic symptoms, a respondent was classified as exhibiting psychosis if they reported

experiencing at least one core psychotic symptom (hallucinations or delusions) within the past two weeks or more, particularly if the symptom was recurrent or associated with functional impairment (e.g., difficulty working, studying, or maintaining social relationships). Additional supporting symptoms such as bizarre behaviour, severe social withdrawal, or marked self-neglect were considered to strengthen the classification. Responses were therefore used to categorize participants as either exhibiting psychotic symptoms or not. (Simplified guidelines for mental health of the Regional Hospital Bamenda)

Socioeconomic Variables

Data on socioeconomic variables were collected using the structured questionnaire, which included dedicated sections addressing income, education, employment, housing, community safety and social support.

Income

Participants reported their approximate monthly income, which was used to classify respondents into income categories.

Educational Attainment

Educational level was recorded as primary, secondary, undergraduate, or postgraduate.

Employment Status

Employment status was captured as employed or unemployed. This variable was used to evaluate the effect of job security and unemployment on mental health status.

Housing Conditions

Housing conditions were assessed through questions on home ownership and monthly rent or rental charges. Monthly rent was categorized to reflect varying levels of housing affordability as follows: no rent (owner-occupied), 0–25,000 FCFA, 25,001–50,000 FCFA, 50,001–100,000 FCFA, and above 100,000 FCFA. In addition, respondents' level of income was assessed using the following categories: 0–50,000 FCFA, 50,100–100,000 FCFA, 100,100–150,000 FCFA, 150,100–200,000 FCFA, and 200,100 FCFA and above. These indicators were used to determine housing stability, affordability, and overall socioeconomic status as social determinants of mental health.

Community Safety

Perceived community safety was assessed using self-reported items capturing participants' feelings of safety within their neighbourhood. This variable examined the influence of environmental factors on stress levels and psychological well-being.

Social support

Social support was operationalized using a single self-report item that measured the frequency of study participants' engagement in social activities per week. Higher frequencies were interpreted as indicating stronger levels of social support and social connectedness, while lower frequencies suggested limited social interaction and potentially weaker perceived support networks. This item provided a simple quantitative indicator of the respondent's level of social involvement.

Statistical Analysis

Seemingly Unrelated Regression (SUR) analysis was employed to examine the associations between socioeconomic variables and mental health outcomes, allowing for the simultaneous estimation of multiple related regression equations while accounting for potential correlations among the error terms of the dependent variables. Descriptive statistics, including means, standard deviations, frequencies, and percentages, were first computed to summarize demographic, socioeconomic, and mental health characteristics of the study population. The SUR model was fitted to assess the joint effects of the socioeconomic determinants on the two mental health outcomes, providing more efficient and unbiased parameter estimates compared to separate ordinary least squares regressions. Model diagnostics, including tests for multicollinearity,

heteroscedasticity, and normality of residuals, were conducted to ensure the robustness and validity of the results. Statistical significance was determined at a 5% level ($p < 0.05$), and all analyses were performed using SPSS 21.

Ethical Considerations

Ethical clearance was obtained from the *Regional Ethics Committee for Human Health Research (CERSH)*, North West Region, and administrative authorization from the *Regional Delegation of Public Health*. Written informed consent was obtained from all participants, and confidentiality was strictly maintained.

Results

Table 1 below presents the demographic characteristics of respondents in this study. The findings show that young adults dominated the sample, with 64.3% aged between 15 and 25 years, highlighting that mental health concerns are particularly prevalent among youth. Females constituted a slightly higher proportion (54%) than males (46%), suggesting greater female participation. A significant majority (73.7%) were single, a factor that may affect emotional and social support systems. Educationally, most respondents had attained at least secondary education (48.3%), with an additional 31.7% holding undergraduate degrees, indicating a relatively educated population. Despite this, economic conditions appeared challenging, as 60% of respondents earned below 50,000 FCFA per month. Geographical representation were Bamenda I (41.4%), Bamenda III (38%), and Bamenda II (20.6%).

Table 1: Descriptive characteristics of the study participants

Variables	Categories	Frequency	Percentage
Age	15 – 25	225	64.3%
	26 – 35	93	26.6%
	36 – 45	28	8%
	Above 45	4	1.1%
Gender	Male	161	46%
	Female	189	54%
	Single	258	73.7%

Marital status	Married	82	23.4%
	Widowed / Divorced	10	2.9%
Residence area	Bamenda 1	145	41.4%
	Bamenda 2	72	20.6%
	Bamenda 3	133	38%
Income	0 – 50,000	210	60%
	50,001 – 100,000	70	20%
	100,001 – 150,000	48	13.7%
	150,001 – 200,000	9	2.6%
	Above 200,000	13	3.7%
Education	Primary	15	4.3%
	Secondary	169	48.3%
	Undergraduate	111	31.7%
	Postgraduate	55	15.7%

Table 2 presents statistics on the prevalence of depression and psychosis among adults in Bamenda Municipality. The results indicate a relatively high occurrence of mental health disorders within the study population. Specifically, 65.7% of respondents reported experiencing symptoms of depression, while 34.3% showed no depressive symptoms. Similarly, psychosis was prevalent among 73.1% of participants, compared to 26.9% who did not report psychotic symptoms.

Table 2: Overall prevalence of depression and psychosis

Mental health disorders	**Frequency**	**Percentage**
Depression		
Yes	230	65.7
No	120	34. 3
Psychosis		
Yes	256	73. 1
No	94	26.9

Table 3 summarizes self-reported depression symptoms experienced by respondents within two weeks prior to the survey. The findings indicate a high prevalence of depressive symptoms among adults in Bamenda Municipality. Key indicators such as persistent sadness (80.6%), discouragement (77.4%), feelings of failure (79.1%), uselessness (73.7%), and isolation (78.0%) were widely reported, suggesting moderate to severe depression among many respondents.

Sleep disturbances were also notable, with insomnia (55.7%) and fatigue (69.7%) frequently mentioned. Additionally, anorexia (76%), feelings of guilt (75.4%), and irritability (77.1%) were common. Alarmingly, 58.9% of participants reported self-aggressive behaviors.

Table 3: Depression indicators

Indicators	**No**		**Yes**	
	Freq.	**%**	**Freq.**	**%**
Sadness	68	19.4%	282	80.6%
Insomnia (Cannot sleep)	155	44.3%	195	55.7%
Asthenia (extreme fatigue)	106	30.3%	244	69.7%
Anorexia (loss of appetite)	84	24%	266	76%
Guilt (feels guilty)	86	24.6%	264	75.4%
Discouragement	79	22.6%	271	77.4%
Feeling of bad luck “I will never be able to succeed; I am always a loser” (feeling of failure)	73	20.9%	277	79.1%
Feeling of uselessness	92	26.3%	258	73.7%
Isolation	77	22.0%	273	78.0%
Dislike of everything, dark thoughts	81	23.1%	269	76.9%
Irritability, susceptibility (easily upset)	80	22.9%	270	77.1%
Neglected out fit	69	19.7%	281	80.3%

Weight loss	76	21.7%	274	78.3%
Weight gain	83	23.7%	267	76.3%
Disinterest (no longer interested in usual activities)	70	20.0%	280	80.0%
Decreased pleasure and desire	74	21.1%	276	78.9%
Feelings of loneliness and abandonment	114	32.6%	236	67.4%
Self-aggression, threatening to hurt oneself, refusing treatment.	144	41.1%	206	58.9%

Table 4 presents self-reported psychotic symptoms among respondents in Bamenda Municipality. The results reveal a significant prevalence of psychotic experiences. About 33.1% of participants reported hearing threatening voices, and 44.9% heard noises in their heads, suggesting notable auditory hallucinations. Sensory hallucinations were common, with 77.4% reporting strange smells and 31.1% seeing frightening things.

Delusional symptoms were also widespread 74.3% felt their thoughts or energy were being stolen, and 72.6% reported exaggerated beliefs of greatness. Behavioral disturbances were evident, with 48.9% exhibiting strange behavior, 68.6% showing bizarre social contact, and 69.1% displaying fixed attention. Additionally, 68.3% reported neglecting basic self-care, while 75.1% showed poor judgment and 72.9% displayed aggressive or distrustful behavior.

Emotional and social symptoms were also pronounced: 52% experienced anguish, 73.4% reported social withdrawal, and 58.9% engaged in soliloquy, with 71.1% showing disorganized or hermetic speech

Table 4: Psychosis indicators

Indicators	**No**		**Yes**	
	Freq.	**%**	**Freq.**	**%**

I hear noises that threaten, insult, order, harass, terrify(auditory hallucination)	234	66.9%	116	33.1%
I have noises in my head	193	55.1%	157	44.9%
Smells unpleasant, strange odours, etc (sensory hallucination)	79	22.6%	271	77.4%
Sees weird, strange, scary things (visual hallucination)	241	68.9%	109	31.1%
Says he or she is talked about on TV or radio, when he/she walks down the street	284	81.1%	66	18.9%
I feel like my ideas are ideas, energy, thoughts being stolen and I am being hurt	90	25.7%	260	74.3%
I feel I am the biggest , strongest, most beautiful, intelligent and richest; I am the one who has the most money(ideas of greatness)	96	27.4%	254	72.6%
Strange behaviour	179	51.1%	171	48.9%
Refuses state of illness	166	47.4%	184	52.6%
Bizarre contact (cold, indifferent)	110	31.4%	240	68.6%
Attitude of one who listens and who is fascinated	108	30.9%	242	69.1%
Anguish (fear without object, afraid without being able to say what frightens him)	168	48%	182	52%
Hermeticism (speaks without being understood, strange or coded language)	101	28.9%	249	71.1%
Withdrawal (tends to withdraw from people)	93	26.6%	257	73.4%
Soliloquy (speaks alone)	144	41.1%	206	58.9%
Refuses to eat, talk, wash (physical neglect)	111	31.7%	239	68.3%
Wrong interpretations (impaired judgement)	87	24.9%	263	75.1%
Aggressive distrustful	95	27.1%	255	72.9%

Table 5 highlights key socioeconomic characteristics of the study population. A substantial proportion of respondents were unemployed (61.1%) and lacked homeownership (92.9%), indicating widespread economic vulnerability. Housing costs varied, with most participants paying relatively low rents, reflecting limited financial capacity. Notably, a majority of respondents

(79.4%) reported feeling unsafe in their neighborhoods, suggesting that perceived community insecurity may be a significant contextual stressor. These findings underscore the challenging socioeconomic and environmental conditions that could contribute to the high prevalence of mental health disorders observed in the municipality.

Table 5: Distribution of study participants with respect to socioeconomic variables

Variables	Categories	Frequency	Percentage
Employment status	Unemployed	214	61.1%
	Employed	136	38.9%
House ownership	No	325	92.9%
	Yes	25	7.1%
House rent	None	20	5.7%
	1 – 10,000	116	33.1%
	11,000 – 30,000	98	28%
	31,000 – 50,000	69	19.7%
	51,000 – 100,000	33	9.4%
	101,000 – 200,000	12	3.4%
	Above 200,000	2	0.6%
Neigborhood safety	No	278	79.4%
	Yes	72	20.6%

Regression analysis showing relationships between socioeconomic variables and mental health disorders

Table 6 below presents the results from the Seemingly Unrelated Regression (SUR) model used to identify the socioeconomic determinants of four mental health disorders: depression, psychosis, alcohol-induced disorders, and drug use disorders. This method allows for simultaneous estimation of multiple related mental health outcomes while accounting for correlated error terms, improving the precision of estimates.

Income was a significant predictor of mental health in several brackets. Respondents earning between 100,001 and 150,000 FCFA reported significantly fewer symptoms of depression (β = -

0.148, p < .05), and psychosis (β = -0.157, *p < .01),* when compared to the group of individuals earning less than 50,000 FCFA. A similar protective effect was observed among those earning above 200,000 FCFA, who showed significantly reduced symptoms of depression (β = -0.231, and *p < .05*), psychosis (β = -0.217, *p < .05* These findings suggest that higher income levels are associated with better mental health outcomes, potentially due to reduced financial stress and increased access to resources. However, income brackets between 50,001–100,000 FCFA and 150,001–200,000 FCFA did not yield significant effect on mental health, indicating that the mental health benefits of income may only become evident at higher levels.

Employment status was consistently associated with reduced mental health symptoms across all disorders examined. Being employed was significantly associated with lower levels of depression (β = -0.222, *p < .01*), and psychosis (β = -0.193, *p < .01*). These findings highlight the importance of employment in supporting mental well-being, possibly through increased financial stability, routine, and social inclusion.

Contrary to expectations, educational attainment did not show significant associations with mental health disorders. Both secondary and higher education had positive but non-significant coefficients across all outcomes. This may suggest that in the Bamenda context, educational achievement does not automatically translate to improved mental health, possibly due to high levels of graduate unemployment or underemployment, which may result in psychological distress.

Interestingly, marital status showed a positive and significant association with mental health symptoms. Married individuals reported significantly higher symptoms of depression (β = 0.289, *p < .01*), and psychosis (β = 0.257, *p < .01*). These findings challenge the common assumption that marriage acts as a protective factor for mental health. It is possible that in the context of this study, marital responsibilities or relationship strains may be contributing to elevated stress levels.

Neighborhood safety was another key determinant. Feeling safe in one's neighborhood was significantly associated with fewer symptoms of mental disorders across all models, with coefficients ranging from -0.115 to -0.136 (*p < .01*). This supports the idea that perceived safety and environmental stability play crucial roles in psychological well-being.

Engagement in social activities also had a strong inverse relationship with mental health disorders. Individuals who reported higher social participation experienced significantly fewer symptoms of

depression (β = -0.0997, *p < .01*), and psychosis (β = -0.0921, *p < .01*. These findings reinforce the protective role of social networks and interpersonal interactions in mental health.

Gender was a significant predictor, with males more likely to report symptoms across all four mental health outcomes. The coefficients for male gender ranged from 0.0905 to 0.109 (p < .01), suggesting that males may be at a greater risk of experiencing mental distress, possibly due to societal expectations or a lower tendency to seek help.

Regarding age, individuals aged 26–35 years reported significantly lower levels of symptoms in all four mental health domains compared to the youngest age group (likely 15–25). The coefficients ranged from -0.0899 to -0.104 (p-values between < .10 and < .05). This indicates a slight mental health improvement in early adulthood, possibly due to greater life experience and stability. Older age groups (36–45 and above 45) were not significantly associated with mental health outcomes, although the coefficient for those above 45 was positive, indicating a possible trend toward worsening mental health with age.

Model diagnostics showed R-squared values between 0.263 and 0.274, indicating that about 26% to 27% of the variation in mental health outcomes is explained by the model. The Chi-square statistics for each model were statistically significant *(p < .001*), confirming the overall explanatory power of the models.

Table 6: Seemingly Unrelated Regression (SUR) Estimates of the Effect of Socioeconomic Variables on Depression and Psychosis Among Adults in Bamenda Municipality

VARIABLES	Depression	Psychosis
Income(<50,000)		
Income 50,001 – 100,000	-0.0133	-0.0273
	(0.0572)	(0.0511)
Income 100,001 – 150,000	-0.148**	-0.157***
	(0.0662)	(0.0592)
Income 150,001 – 200,000	-0.0664	-0.0453
	(0.122)	(0.109)
Income above 200,000	-0.231**	-0.217**
	(0.109)	(0.0975)

Employment (Unemployed)		
Employment status (employed)	-0.222***	-0.193***
	(0.0391)	(0.0349)
Education (Primary)		
Seconday education	0.0877	0.0826
	(0.0958)	(0.0856)
Higher education	0.109	0.0965
	(0.0995)	(0.0890)
Marital Status (Single)		
Marital status (married)	0.289***	0.257***
	(0.0508)	(0.0454)
Neighbourhood safety (no)		
Neighbourhood safety (yes)	-0.134***	-0.115***
	(0.0477)	(0.0427)
Engagement in social activities	-0.0997***	-0.0921***
	(0.0232)	(0.0207)
Gender (female)		
Gender (male)	0.106***	0.0905***
	(0.0386)	(0.0345)
Age(15–25 years)		
Age 26 – 35	-0.104*	-0.0899*
	(0.0537)	(0.0480)
Age 36 – 45	-0.0626	-0.0410
	(0.0836)	(0.0747)
Age above 45	0.140	0.150
	(0.189)	(0.169)
Constant	0.406***	0.478***
	(0.110)	(0.0979)
Observations	350	350
R-squared	0.264	0.265
Chi-square	125.82	126.17

p-value	0.0000	0.0000

Note: Standard errors in parentheses; *** *p<0.01*, ** *p<0.05*, * *p<0.1*

Discussions

The findings of this study highlight the significant role of socioeconomic and community factors in shaping mental health outcomes among adults in Bamenda municipality. Socioeconomic stability, particularly income and employment, appears to offer protective effects against both depression and psychosis. This aligns with international research suggesting that financial security and gainful employment provide individuals with material and psychological resources to cope with stress and daily challenges (Lund et al., 2010; Patel et al., 2018). In the Bamenda context, where conflict and economic instability are prevalent, these protective effects are particularly salient, as they may buffer the psychological burden associated with insecurity and limited access to resources.

Education, however, did not emerge as a significant protective factor, which diverges from findings in other global contexts where higher education often correlates with improved mental health (Marmot, 2015). One plausible explanation in Bamenda is the mismatch between educational attainment and employment opportunities, where higher qualifications may not translate into economic security or social advancement, thereby limiting their expected mental health benefits.

Community-level variables, including perceived neighborhood safety and social engagement, also appear critical for psychological well-being. This is consistent with social capital theory, which emphasizes the importance of trust, cohesion, and collective efficacy in supporting mental health (Kawachi & Berkman, 2001; Nguyen et al., 2019). In conflict-affected settings like Bamenda, safe and socially supportive environments may serve as buffers against emotional distress, highlighting the importance of community interventions in mental health promotion.

Demographic patterns in this study suggest context-specific vulnerabilities. For example, males showed increased psychological burden compared to females, which may be explained by cultural expectations that men serve as primary providers during periods of economic hardship. Similarly, marital status did not have the typically protective effect often observed in other studies (Simon,

2014); instead, marriage may introduce additional responsibilities and stressors in this setting, suggesting that relationship quality and household stability are more critical determinants of mental health than marital status alone.

While these insights are valuable, several limitations should be considered. The cross-sectional design precludes causal inference, self-reported measures may introduce bias due to stigma, and the use of simplified screening guidelines may limit diagnostic precision. Moreover, focusing on a single municipality restricts the generalizability of the findings.

In conclusion, mental health outcomes in Bamenda are strongly influenced by socioeconomic and community conditions. Policies promoting economic empowerment, employment opportunities, community safety, and social support are likely to yield significant benefits. Future research should consider longitudinal designs and standardized clinical instruments to better understand causal mechanisms and enhance the generalizability of findings.

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