



Submitted : 26 June, 2026

Accepted : 03 July, 2026

Published : 04 July, 2026

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**Keywords:** Addiction; Pornography; Co-addiction cannabis; Smartphone; Cameroon

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## Research Article

# Pornography Addiction in Cameroon: A Psychodynamic Analysis, Technological Changes, and Structured Therapeutic Approaches

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## Abstract

**Introduction:** The rapid spread of mobile technologies is changing access to sexual content in sub-Saharan Africa. This study analyses the psychodynamic and sociocultural factors contributing to pornography addiction in Cameroon to propose appropriate therapeutic approaches.

**Methods:** A series of illustrative and clinical cases was carried out at the CSAPA of Laquintinie Hospital in Douala. Semi-structured interviews explored the life histories and intrapsychic conflicts of two adult male patients who met the criteria for compulsive sexual behaviour disorder (ICD-11).

**Results:** The first case (age 31) illustrates a severe moral incongruity between his impulses and his Christian faith, with pornography serving as a form of self-medication to cope with anxiety and early-life trauma. The second case (age 23) highlights a poly-addiction (pornography and cannabis) functioning as neosexuality to avoid relationships and as passive resistance to an authoritarian father. At the local level, the smartphone provides a space for clandestine intimacy and an outlet in the face of sexual taboos and the rigidity of communication within patriarchal family structures.

**Discussion/Conclusion:** Pornography addiction in Cameroon is a symptom of deep-seated psychological conflicts. The study's limitations include the small sample size and the fact that the participants were all male. To optimise care, it is necessary to combine standardised tools (CPUI-9) with cognitive-behavioural therapy (CBT) techniques, while also addressing patients' co-addictions and cultural or spiritual factors.

## Introduction

Habit and addiction both result from repeated behaviours, but they differ in the degree of control exercised by the individual. While habit remains a regulated activity, addiction is defined as a disorder characterised by repeated consumption of varying intensity, the development of dependence, and the continuation of the behaviour despite known medical and social risks [1]. Today, technological advances make it possible to explore the detection of pornography addiction through neurophysiological and machine learning approaches, highlighting a possible biological basis for the phenomenon.

However, the clinical status of this behaviour remains a point of contention. While the narrative of the "porn addict" is becoming commonplace, the idea that pornography is a drug remains a debated concept, with some researchers viewing it as an "invention" or a medical construct rather than an established pathology [2]. Despite these reservations, clinicians have observed an explosion of publications on the "uncontrolled" use of sexual content since the 1990s, prompting professionals to refine their assessment and diagnostic tools [3].

In sub-Saharan Africa, this normalisation is being greatly accelerated by the widespread adoption of smartphones and mobile broadband, transforming these technological tools into



agents of a redefinition of personal space within traditional societies.

The accessibility and anonymity of the Internet have normalised this behaviour to the point that certain neurophysiological markers—such as those observed via electroencephalogram (EEG)—are being studied to identify patterns of addiction, including among the youngest individuals [4]. This consumption, which has become an integral part of contemporary culture, is leading to an increase in requests for consultation due to real-world consequences on sexual, relational, and professional life [3].

Even though the neurobiological mechanisms behind compulsion seem universal, the psychological triggers and how the disorder shows up can really differ depending on the sociocultural setting [2]. In an African context where real sexuality is taboo and family structures are quite hierarchical, connected screens often end up being a kind of safe space and a way to passively handle unspoken emotional conflicts. This article aims to present, through a series of illustrative cases of two patients in Cameroon, the psychodynamic and contextual factors that promote the emergence of this addiction. Rather than aiming for statistical generalisation, this work takes an approach designed to generate clinical hypotheses in order to suggest structured therapeutic perspectives, cognitive-behavioural therapy, and local cultural resources.

## Methodology

This is a qualitative, descriptive, and clinical study conducted at the Centre for Addiction Care, Support, and Prevention (CSAPA) at Laquintinie Hospital in Douala, Cameroon. The study used non-probability convenience sampling. The inclusion criteria were: being a male patient aged at least 18 years; seeking care on one's own initiative for distress related to the use of pornographic content; and meeting the criteria for compulsive sexual behaviour disorder according to the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11).

It should be noted that this study has methodological limitations inherent to its illustrative case series format. Based on a non-probabilistic convenience sample of just two patients, the results are not meant to be statistically generalised to the entire Cameroonian population. The main value of this research is to generate scientific and clinical hypotheses about a disorder that is still poorly documented in the region. Furthermore, the exclusive inclusion of male patients obscures the manifestation of this disorder in women, constituting a gender bias that should be addressed in future research.

Data collection relied on semi-structured clinical interviews. These interviews explored life history, the history of addiction, family dynamics, psychosocial impact, and underlying psychological conflicts. The data were then subjected to thematic content analysis and a psychodynamic interpretation of intrapsychic conflicts.

The study was conducted in strict compliance with the medical ethics charter. Complete anonymity was ensured

through the use of pseudonyms (Mr G.P.H. and Mr J.O.V.) and the modification of any elements that could directly identify the participants.

## Observation 1

Mr G.P.H., 31, is a married engineer with no children. An only child born out of wedlock in Douala, he sought treatment on his own initiative for a pornography addiction. For the past six months, he has been viewing pornographic videos and images daily on his phone or computer, whether alone at his desk or in secret at home, sometimes even in the presence of his wife. This compulsive behaviour is regularly accompanied by masturbation. Although his professional and social functioning remains unaffected, he suffers from constant internal tension and intrusive images that he can only alleviate through this behaviour.

Clinically, the patient presents with a compulsive sexual behaviour disorder according to the ICD-11, characterised by an inability to control his impulses despite moral distress and acute guilt. As a devout Christian, he experiences profound cognitive dissonance: he feels guilty for betraying his biblical values as well as his wife, whom he considers his primary emotional support.

His life history reveals a history of early trauma. At age 5, he was sexually abused by a teenage neighbour who used blackmail and secrecy to maintain the relationship. At age 10, he was introduced to pornography by his cousins, an exhilarating experience that marked the beginning of his escalating addiction. By age 12, he was already using late-night pornography as a refuge to cope with a romantic breakup.

During adolescence, he managed to remain abstinent by immersing himself in Bible study. However, at age 20, romantic setbacks caused him to relapse intermittently, a period during which masturbation became a regular habit. At age 25, he met his future wife and remained completely abstinent for six years. His relapse occurred at age 31, triggered by severe anxiety related to professional and family difficulties.

The care was provided by an addiction specialist doctor under the supervision of a psychiatrist, with one 45-minute session per week for 3 months, then biweekly for 6 months (24 sessions in total). The intervention used CBT techniques (cognitive restructuring for moral dissonance, stimulus management, and screen access control). The treatment relied on the patient's faith and marital attachment as motivation levers. No standardised treatment manual was used, with protocol fidelity ensured through clinical supervision, which is a limitation for the study's replicability. After nine months of follow-up, he had only one symptom relapse and remains abstinent.

## Observation 2

Mr J.O.V., age 23, is a single student with no children. The second of four brothers, he was initially treated at the CSAPA at Laquintinie Hospital in Douala for cannabis addiction. During his treatment, he spontaneously expressed significant



distress related to his compulsive use of pornography. His behaviour is all-consuming: he spends entire days and sleepless nights locked in his room viewing pornographic content while masturbating. This dual addiction (to cannabis and pornography) has led to complete social withdrawal, the abandonment of his studies, and his cessation of helping out at the family store.

Clinically, Mr J.O.V.'s profile indicates a complex dual diagnosis. He presents with a compulsive sexual behaviour disorder (ICD-11), associated with a severe cannabis use disorder and a characterised depressive episode. On examination, his mood is depressed, his demeanour is subdued, and he expresses intense guilt as well as self-accusatory thoughts ("I am a bad son"). Furthermore, he suffers from severe neurobiological tolerance: he is no longer able to experience genuine sexual arousal with his partner without the aid of virtual stimuli.

His life history is marked by cultural uprooting at age 15, when his family immigrated from Nigeria to Cameroon—a period that coincided with his initiation into cannabis use. At age 17, out of fear of approaching women, he began secretly watching pornographic films on television as a means of escape. At age 21, his cannabis addiction worsened, leading to a 21-day hospitalisation for a cannabis-induced psychotic episode. Despite five months of abstinence, he immediately relapsed into heavy use of cannabis and pornography upon his release.

Analysis of his case reveals that his multiple addictions serve as a coping strategy in response to a conflict-ridden family environment. He uses cannabis and pornography as outlets to escape the grip of a father described as authoritarian. The patient received antidepressant treatment (fluoxetine 20 mg/day) and psychotherapy provided by an addiction specialist doctor under supervision. The follow-up included a weekly 50-minute session over a period of 6 months (24 sessions in total). The CBT techniques focused on preventing relapse (related to cannabis), assertiveness toward his father, and managing social anxiety. Like in the first case, the absence of a standardised therapeutic manual limits the replicability of this approach. After six months of follow-up, although the frequency of viewings has decreased, Mr J.O.V. shows therapeutic resistance since addiction remains his only defence mechanism against paternal pressure.

	Case 1 (Mr G.P.H.)	Case 2 (Mr J.O.V.)
HisHistory of trauma	Victim of sexual abuse at the age of 5 by a teenage neighbour (under the seal of secrecy and blackmail); early introduction to pornography by his cousins at the age of 10.	Trauma related to a significant cultural and migratory uprooting when his family moved from Nigeria to Cameroon at the age of 15.

Family dynamics	An only child from an extramarital relationship; married, with no kids, he sees his current wife as his main pillar and emotional support.	Second of four boys; grew up in a conflict-ridden family environment under the control of a father described as authoritarian.
Co-addictions	No co-addiction reported; this is a pure behavioural addiction to screens (phone and computer)	Severe poly-addiction; behavioural addiction to pornography along with a serious cannabis use disorder (which has already led to hospitalisation for a cannabis-induced psychotic episode).
Moral incongruence	Very sharp; deep cognitive dissonance and intense guilt between his compulsive urges and his fervent Christian faith (biblical values).	Marked by a strong internalisation of family criticisms; expressed through self-blaming thoughts ('I am a bad son') and a characterised depressive episode
Response to treatment	Excellent response after 9 months of follow-up (only one relapse); strong therapeutic alliance thanks to the use of his faith and marital attachment as motivation levers.	Therapeutic resistance after 6 months of follow-up; although the frequency has decreased, the patient is not ready to give up his addictions, which serve as his only defence mechanism against his father's pressure.

The comparative examination of the two cases highlights fundamental clinical contrasts that shed light on the functional diversity of pornography addiction in the Cameroonian context. On one hand, Mr G.P.H.'s profile illustrates a trajectory rooted in early sexual trauma, where pornography use acts as an anxiety modulator and an attempt at self-medication in response to intrapsychic conflicts reactivated in adulthood. For this patient, suffering is maintained by moral incongruence exacerbated by deep religious beliefs, creating cognitive dissonance that fuels the vicious cycle of relapse. In contrast, Mr J.O.V. shows a trajectory marked by trauma from uprooting and a direct intergenerational conflict. Addictive behaviour doesn't show up in isolation here but comes together in a poly-addiction combining substances (cannabis) and screens, where the stimuli feed off each other to overload the reward system. Here, addiction acts as an adaptive defence mechanism: a way of avoiding relationships and a form of passive resistance to patriarchal authority.

These structural differences directly explain the disparity in therapeutic responses observed. The first case benefits from strong social integration and powerful motivational levers (faith, marital alliance), which promote a quick restoration of inhibitory control. The second case, stuck in total social withdrawal and comorbid depressive symptoms, shows significant therapeutic resistance. Addiction here serves such a central psychic survival function in relation to the family environment that it is difficult for the patient to give it up in the short term. This comparison shows that a standardised approach to pornography addiction in Cameroon cannot do without a detailed psychodynamic analysis, tailoring treatment according to whether the disorder follows a logic of post-traumatic relief or a dynamic of intra-family protection and rebellion.

## Discussion

### Discussion of case 1

Mr G.P.H. uses pornography as a tool for managing stress. His relapse at age 31, triggered by professional difficulties, demonstrates that the compulsive behaviour acts here as an attempt at self-medication against anxiety. The fact that he views this content at the office, despite the professional risks involved, illustrates the loss of control typical of behavioural addictions described by Karila and Benyamina [2]. This dynamic confirms that repeated screen use allows the patient to regulate internal tension, transforming solitary sexual activity into a psychological survival strategy to cope with a reality that has become too difficult to bear [5-7].

An analysis of his life history reveals that this defence mechanism is rooted in early sexual abuse that occurred at the age of 5. Having been initiated under a veil of secrecy and emotional blackmail, Mr G.P.H. developed at an early age a complex association between pleasure, fear, and reward. This finding aligns with the observations of Carnes, who emphasises that the majority of individuals suffering from sexual addiction have experienced traumatic or confusing events during their childhood [8]. Furthermore, early exposure to pornography at age 10 may have left a lasting mark on his reward system [4], cementing visual stimulation as a quick means of relieving internal tensions. In adulthood, the practice carried out “in secret” is likely nothing more than an unconscious reenactment of an unresolved past trauma.

The most striking feature of this case is the intensity of the patient’s guilt, exacerbated by a major “moral incongruence” between his impulses and his Christian values [9]. Research highlights that, among deeply religious individuals, distress is less related to the frequency of use than to the shame felt toward God and one’s spouse [10]. This disconnect creates a vicious cycle in which guilt generates additional stress, pushing the individual back toward addictive behaviour as a means of self-soothing [2,3].

Finally, the relative success of the therapy (only one relapse in 9 months) can be attributed to the preservation of social and spiritual bonds. In the Cameroonian context, the effectiveness of care depends on aligning treatment with the individual’s values [6]. Rather than ignoring them, supportive psychotherapy drew on the individual’s attachment to his wife and his Christian identity as motivational drivers. Faith can help transform distress into positive motivation (prayer, meditation), while the partner’s support restores genuine intimacy, which acts as a neurobiological counterbalance to virtual and solitary stimulation [3, 10].

In practical terms, the clinical management of Mr G.P.H. shows the effectiveness of a targeted application of Cognitive Behavioural Therapies (CBT), even without a standardised protocol. The therapeutic alliance relied on cognitive restructuring techniques in response to moral dissonance and strict management of environmental stimuli (tight control over screen access at the office). This CBT-focused approach is

supported by international literature as the treatment of choice to restore inhibitory control and restructure faulty guilt-related cognitions [11]. Nevertheless, formalising this type of intervention in Cameroon presents challenges related to the lack of contextualised therapeutic manuals, which is a major limitation for reproducing and standardising the evaluation of therapists’ adherence to the protocol. To overcome this bias, systematic clinical supervision by a senior psychiatrist is essential to validate the structure of the sessions (lasting 45 to 50 minutes, weekly follow-up) and ensure the proper application of restructuring techniques. For future treatment in Cameroon, clinical assessment would be enhanced by the systematic integration of standardised and internationally validated scales (such as the Cyber Pornography Use Inventory—CPUI-9) in order to objectively measure the severity of compulsive behaviour at the beginning and end of follow-up. Researchers particularly recommend the use of the CPUI-9 to distinguish between actual behavioural addiction and mere moral distress linked to the patient’s religious beliefs [12].

### Discussion of case 2

Unlike an isolated addiction, Mr J.O.V. exhibits a co-occurrence of an illicit substance (cannabis) and a compulsive behaviour (pornography). This association is not coincidental: he uses cannabis as a sensory catalyst to intensify the experience of pornography and masturbation—an effect that amplifies orgasm and tactile pleasure, which has been documented in the majority of users [13]. This synergy between chemical and behavioural stimulation saturates the reward circuit. This could explain why his previous five-month period of abstinence was not enough to resolve the disorder: the dopaminergic system remains programmed to seek out this specific hyperstimulation, making the treatment of the behaviour as complex as that of biochemical addiction [3].

Biographical analysis reveals that pornography serves here as a substitute for a real-life relationship deemed anxiety-inducing. Having begun viewing pornography at age 17 out of “fear of approaching girls,” the screen has become for the patient a transitional object that protects him from the emotional vulnerability of face-to-face romantic encounters. This difficulty extends to his current romantic relationship, where he is only able to feel arousal through mediated imagery. This phenomenon of “neosexuality,” theorised by McDougall [14], illustrates how the individual constructs an imaginary world to compensate for an inability to invest in a connection with another person, preferring absolute control over the image to the unpredictability of human interaction.

Furthermore, the patient’s inability to experience pleasure with his partner without pornographic images is a clinical marker of neurobiological tolerance. The constant virtual stimulus has raised his arousal threshold to a level that reality can no longer reach [3,4]. This sexual numbness, in turn, fuels his sense of guilt, driving him to consume more cannabis to soothe himself, thereby perpetuating the vicious cycle.

Finally, Mr J.O.V.’s addiction takes on the dimension of passive resistance against a father described as authoritarian



and controlling [2,3]. Shutting himself in his room and using prohibited substances constitute the only space of autonomy he has found to escape his father's grip [5]. However, this quest for relief comes up against a massive "moral incongruity." The patient internalises his family's reproaches, which leads to feelings of self-blame and a depressive mood. As Grubbs [9] explains, the perception of oneself as a "bad son" fuels psychological distress and complicates withdrawal, as long as the relational conflict with the father remains unresolved.

The rise and explosion of pornography addiction in Cameroon are closely linked to the shifts in the regional digital ecosystem. In sub-Saharan Africa, mobile technologies are progressing rapidly. By 2026, mobile broadband usage (3G, 4G, and the gradual introduction of 5G) dominates the connectivity landscape, with 4G alone accounting for nearly half of the region's total connections. In Cameroon, this transition is especially noticeable: recent data show that the country has over 25.5 million active mobile connections (covering more than 86% of the population), with more than 83% of these being high-speed connections, and usage reaching around 42% of the total population [15].

This technical accessibility is largely driven by the widespread adoption of low-cost smartphones, allowing the less wealthy social groups to access a mobile connection, even if the cost of mobile data remains a barrier [15]. At the same time, social networks and instant messaging apps (such as WhatsApp, Telegram, or Facebook, the latter having several million adult users in Cameroon) have profoundly changed how content is shared. The emergence of private and encrypted chat channels on these apps allows the large-scale sharing of pornographic media, in an asynchronous, free, and unrestricted way without parental or state control [16].

So, accessing pornographic content no longer requires a family computer or a conscious search on websites. Smartphones, combined with mobile broadband and instant messaging, provide constant access to this content. This turns the experience into a tool for immediate and compulsive self-medication, directly affecting the patients' reward system in response to everyday stress [16].

Although the dynamics of these two cases (trauma, conflict with the father) echo Western theoretical concepts, their manifestation is inextricably linked to contemporary Cameroonian reality. The surge in this disorder in Douala may be catalysed by the rapide démocratisation of mobile Broadband and the availability of affordable smartphones, which bypass traditional barriers. In urban Africa, the smartphone has become a space for individualisation and clandestine intimacy in the face of ancestral social control [17]. In a society where actual sexuality remains a strong taboo and is governed by strict codes of masculinity, the screen becomes a space of retreat. This observation aligns with the work of Atilola [18] and Mgbako [19], who point out how technological changes in sub-Saharan Africa are redefining access to intimacy and providing a secret outlet for sociocultural blockages. This digital transition is

transforming representations of masculinity and offering an outlet for a youth caught between tradition and modernity [20]. Addiction is not merely a loss of biological control; in this context, it is likely a reflection of a cultural transition in which virtual hyperconnectivity compensates for the inability to verbalise emotional conflicts within often patriarchal family structures. This retreat into the virtual world thus serves as a response to the rigidity of intergenerational communication and non-negotiable parental authority [21].

## Conclusion

Pornography addiction in Cameroon is not merely a screen addiction, but a symptom of deep-seated psychological conflicts. The cases mentioned show that it serves as an emotional coping mechanism in the face of trauma or family and religious pressures. Breaking this cycle requires addressing the underlying conflict and any co-addictions (such as cannabis). To achieve recovery, treatment must be based on open communication, spousal support, and the patient's values in order to restore genuine intimacy. To address this public health challenge, it is imperative to move beyond isolated observations. Clinicians in sub-Saharan Africa need an integrated therapeutic decision tree that combines the management of biochemical comorbidities (such as cannabis use) with the adaptation of therapies to local spiritual values. Finally, further studies are needed in sub-Saharan Africa to better tailor care to this rapidly growing disorder.

## Acknowledgements

### Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

### Authors' contributions

H.B. was the treating clinician and wrote the text and contributed to the literature search; E.E. reviewed and finalised the manuscript; All authors have read and approved the manuscript.

### Funding information

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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