SSM - Mental Health 5 (2024) 100298

Contents lists available at ScienceDirect

SSM - Mental Health

journal homepage: www.journals.elsevier.com/ssm-mental-health

Review

PTSD and complex PTSD manifestations in Sub-Saharan Africa: A systematic review of qualitative literature

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ARTICLE INFO

Handling Editor: Prof B Kohrt

Keywords:
Trauma
Complex PTSD
PTSD
Sub-saharan Africa
cultural scripts

ABSTRACT

Complex post-traumatic stress disorder (CPTSD) was introduced in the ICD-11 as a new diagnosis and was framed in accordance with WHO guidelines of clinical utility and cross-cultural applicability. CPTSD diagnosis comprises PTSD symptoms in addition to specific symptoms related to the organization of the self (DSO). Cross-cultural validity of the DSO symptoms is still being debated as cultural norms significantly influence how individuals perceive themselves and manage their emotions and relationships. The aim of this systematic review was to understand how PTSD and DSO symptoms were experienced and expressed by individuals from Sub-Saharan Africa (SSA) by exploring qualitative literature. Searches were conducted on nine databases using search terms for countries, methods, symptoms, and trauma exposure. Fifty studies were included. Results confirmed the presence of the three DSO clusters. However, their manifestation differed significantly from the defined diagnostic criteria, highlighting the importance of considering cultural factors in the diagnostic process. Additionally, the review indicated that structural factors played significant roles in shaping the interpretation of trauma-related distress in this cultural context. Thus, we propose to create and implement a cultural module as an add on to the actual CPTSD assessment tools to account for cultural and structural variations in the SSA population and improve diagnosis accuracy. In this perspective, more emic research is needed to gain a deeper understanding of how trauma-related distress is perceived, experienced, and interpreted in SSA.

1. Introduction

1.1. Complex post-traumatic stress disorder (CPTSD)

Complex post-traumatic stress disorder (CPTSD) is a newly recognized diagnosis that was introduced in the 11th edition of the International Classification of Diseases in 2022 (ICD-11) (WHO, 2019). It may develop as a result of exposure to prolonged or repetitive traumatic experiences that are particularly threatening or horrific, from which escape is difficult or impossible. This includes but is not limited to "torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse" (WHO, 2019). The specific nature of those experiences leads to significant and lasting disturbances in the psychological organization of the individual. To be diagnosed with CPTSD, one must present disturbances in self-organization (DSO) in addition to features of post-traumatic stress disorder (PTSD). In the ICD-11 revision, PTSD diagnosis is simplified with three core symptoms: 1. intrusions, 2. avoidance, and 3. persistent perception of threat. Similarly, DSO symptoms are labelled in three main clusters: 1. difficulties in affect regulation, 2. negative perception of the self, and 3. disturbed interpersonal relationships.

Diagnostic tools, i.e., the international trauma questionnaire (ITQ) and the international trauma interview (ITI) were developed based on the new definition of PTSD and CPTSD and consist of 12 items, with two items dedicated to each symptom cluster. The preliminary versions of both tools included 12 PTSD items and 16 DSO items based on previous work including an expert consortium (Cloitre et al., 2011), DSM-IV field trials for DESNOS, i.e., Disorder of Extreme Stress Not Otherwise Specified (van der Kolk et al., 2005), and Herman's (1992) first conceptualization of CPTSD. A study using the preliminary version of ITQ showed that the DSO symptoms were all equivalent in predicting diagnosis in a US sample (Shevlin et al., 2018). In line with the principles established by the WHO for the ICD-11 to focus on a limited set of core symptoms, the number of items included in the ITQ was reduced based on psychometric properties in a UK sample (Cloitre et al., 2018). The same items were then implemented in the ITI. The international applicability

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https://doi.org/10.1016/j.ssmmh.2024.100298
Received 12 September 2023; Received in revised form 27 December 2023; Accepted 19 January 2024
Available online 28 January 2024

of these selected criteria still needs to be investigated.

While the cross-cultural validity of PTSD has been the object of multiple studies (Hinton and Lewis-Fernandez, 2011; Marsella, 2010; Patel and Hall, 2021; Rasmussen et al., 2007), little is known about cultural validity of CPTSD and more precisely DSO symptoms. These symptoms are complex and require caution in interpretation, as the way individuals organise their self is intrinsically related to cultural norms (Heim et al., 2022). The notions of the self, emotion expression and regulation, and interpersonal relationships have been topics of interest in cultural psychology for decades (Heine and Ruby, 2010). While the etic approach whose aim is to study the same construct across contexts (Pike, 1967) seems to support the existence of the three DSO clusters cross-culturally (e.g., Ho et al., 2020; Hyland et al., 2017; Nickerson et al., 2016; Owczarek et al., 2020; Tay et al., 2018; Vallières et al., 2018), emic research to better understand and give voice to the insider perspective is needed. Indeed, each DSO cluster represents a constellation of possible manifestations and there is no evidence yet showing that this constellation is stable across cultures. Rather, evidence in cultural psychology tends to point out cultural differences in the way people express distress (e.g., Campos and Kim, 2017; De Jong et al., 2005; De Leersnyder et al., 2015; Heim et al., 2022; Kirmayer, 2007; Mesquita and Walker, 2003). In order to avoid "category fallacy", which is the erroneous assumption that a nosology can be applied anywhere without taking into account local expressions and etiologies (Kleinman, 1987), it is necessary to incorporate culture in our understanding of PTSD and CPTSD.

1.2. How to account for culture in psychopathology?

Culture represents a way of understanding and interpreting the world, which is shared and constructed by individuals, and involves explicit and implicit rules (Kirmayer and Gómez-Carrillo, 2019). Culture expresses itself through dynamic norms, values, beliefs, symbols, and behaviors that individuals learn from the youngest age (Napier et al., 2014). Consequently, culture significantly influences the way individuals perceive, experience, and express their distress. The term 'cultural concepts of distress' (CCD) has been introduced in the DSM-5 to include these cultural variations in the understanding of mental disorders and their treatment (American Psychiatric Association, 2013). Cultural concepts consist of cultural idioms of distress (i.e., specific expressions), explanatory models (i.e., expected causes and perceived adequate care), and cultural syndromes (i.e., a set of symptoms which constitutes a disorder) (Lewis-Fernandez and Kirmayer, 2019). In their review, Rasmussen et al. (2014) reported 116 CCDs in trauma-exposed populations outside of North America and Europe highlighting the diversity of distress manifestations and the necessity to account for cultural variations. CCDs represent one way of including culture in the understanding of mental health problems and thus contribute to accurately diagnosing mental disorders and to propose adapted services of care.

Another relevant aspect is the understanding of norms and expectations in one given context, also called cultural scripts. Such scripts are shared schemas known and acknowledged in a group that guide individual's beliefs, values, expectations, and behaviors (Chentsova-Dutton and Ryder, 2019, 2020). They can be normative (i.e., socially approved by the group), or deviant (i.e., still comprehensible by group members but judged as abnormal and undesirable). Cultural scripts are essential to consider while studying psychopathology because they "draw the line between health and illness" and "inform us about possible causes, signs and symptoms" in a given context (Chentsova-Dutton and Ryder, 2019, p. 373). In their article, Chentsova-Dutton and Maercker (2019) discussed the cultural scripts of trauma highlighting common elements across cultures such as trauma-related memories and nightmares, as well as alternatives scripts which are embedded into culture and "can be understood as scripted deviations from cultural models of normalcy" (p.7). Cultural scripts can therefore provide valuable insight into how individuals from diverse cultural backgrounds may respond to repetitive or prolonged traumatic experiences.

1.3. Context

Sub-Saharan Africa (SSA) is a vast region that extends from the southern part of the Sahara Desert to South Africa. It includes 49 countries whose borders have been defined through colonisation in the 18th and 19th centuries. Since their independence, the creation of artificial borders resulted in several ongoing problems such as ethnic and cultural tensions within countries, political and economic instability, and disputes about the available resources often leading to armed conflicts and humanitarian crisis (Nguendi Ikome, 2012). Nowadays, the legacy of colonialism still contributes to the instability of most countries in the region. Currently, 35 armed conflicts are taking place in the region involving 18 countries and mostly including non-international armed conflicts against or within insurgent groups (e.g., Boko Haram, al-Shabaab) (Geneva Academy of International Humanitarian Law and Human Rights, 2023). Those situations of violence and insecurities caused many people to flee their homes. The 2022 global report from the United Nations High Commissioner for Refugees (UNHCR, 2023) announces a total of almost 39 million forcibly displaced persons from Sub-Saharan Africa out of a total 112.6 million worldwide. Of those, 66 % are internally displaced persons (IDPs) due to conflicts and natural disasters (UNHCR, 2023) living in refugee camps in dire conditions where basic human needs are not always provided for. Thus, most of them are still facing significant challenges related to living difficulties.

Indeed, countries in SSA are facing multiple and interconnected structural difficulties such as poverty, limited access to education, food, water and shelter, lack of health services, unemployment, and corrupted political systems (Transparency International, 2023; United Nations, 2023b). Sub-Saharan Africa has the largest share of extreme poverty rates globally with more than 475 millions people living on less than US $1.90 per day (Aikins & Du Toit McLachlan, 2022). Because of unequal power relationships intertwined with poverty and social norms, women and girls often face gender inequalities that expose them to different forms of violence, e.g., forced marriage, sexual exploitation, sexual and physical assaults, and domestic violence (United Nations Women, 2014) as well as unwanted pregnancies and high prenatal mortality. They often do not have the opportunity to leave the violent relationship because of the lack of financial, professional, and social resources, e.g., lower education level, unemployment, limited empowerment, and support network (Dickson et al., 2023). A meta-analysis estimates lifetime prevalence for physical or sexual partner violence at 32.9 % in West and Central Africa and 34.38 % in East and Southern Africa for women between 15 and 24 years old (Decker et al., 2015). Democratic Republic of Congo (DRC) showed the highest percentage with 61.61 %. Women's bodies have also been targeted in numerous conflicts notably in DRC and Rwanda. Rape is used to exert power over the civilians by abusing the reproductive body of the woman, humiliating their spouse, and destroying the social fabric of families and communities (Brown, 2012; United Nations, 2023a). This leads to strong discrimination against the victims and to their isolation, which further reinforces the vicious circle of violence making them even more vulnerable.

Furthermore, the SSA region faces unique challenges due to climate change. Rising temperatures and sea levels, and irregular rainfall patterns are causing more frequent and severe natural disasters which are affecting various aspects of life in the region, including food security, access to shelter and clean water, and public health (Ayanlade et al., 2022; International Monetary Fund, 2020). These changes are likely to exacerbate conflicts over resources and lead to widespread displacement and secondary migration (Rigaud et al., 2018).

Exposure to multiple forms of violence has a strong impact on the mental and emotional burden experienced by individuals (Amuyunzu-Nyamongo, 2013). However, there is limited epidemiological data on mental health in the SSA region. Only a few countries present data for

common mental disorders and the latter are often incomplete. According to the latest results of the Global Burden of Disease study (GBD) (2020)[1] in the SSA region, the estimated prevalence of depressive disorders in the adult population (20+ years old) is 6.2 %, while the prevalence of anxiety disorders is estimated at 4.4 %. The GBD study did not include data on the prevalence of PTSD. Instead, a meta-analysis including 10 out of the 49 countries in the SSA region reported an estimated pooled prevalence of 22 % for PTSD (Ng et al., 2020). The authors noted a significantly higher prevalence of PTSD in regions exposed to war and armed conflicts compared to unexposed regions (30 % and 8 %, respectively). Conflict exposure accounted for 22.8 % of the variance. Another meta-analysis, focusing of African migrants worldwide, reported a pooled prevalence of 33,2 % for depression, 34,6 % for anxiety, and 37,9 % for PTSD (James et al., 2022). Migrants currently residing in SSA exhibited higher prevalence rates for depression and anxiety, but not for PTSD. Results must be treated with caution as the scales used have often not been validated in the SSA context and symptom presentation may include cultural variations (Hinton et al., 2018, 2019; Kleinman, 1977).

Currently, there has been limited qualitative research conducted on cultural variations of mental health within the SSA context, with the available research mostly focusing on CCDs. Three main reviews have been conducted; the first one focusing on phenomenology and etiology of mental illness (Patel, 1995); the second one on CCDs and psychiatric disorders (Kohrt et al., 2014); and the third one on trauma-related CCDs (Rasmussen et al., 2014). Together, they included a total of 37 articles with samples of 20 of the 49 SSA countries. Despite these previous works, there is still a lack of research that specifically examines the cultural variations in symptom manifestations, particularly concerning DSO symptoms within SSA. Consequently, further research in this area is crucial to gain a comprehensive understanding of how DSO symptoms manifest across different cultures.

1.4. Aim

The aim of our review is to systematically explore the qualitative literature reporting on symptoms and difficulties experienced by people originated from Sub-Saharan Africa who have been exposed to trauma. To better understand how distress is experienced in this region and if salient symptoms differ from the ones proposed in contemporary diagnostic tools, we not only include symptoms of PTSD and CPTSD as defined in the ICD-11 but also trauma-related local manifestation of distress and their perceived causes and consequences. We also pay particular attention to the structural factors which tend to exacerbate the distress and how they are perceived by the affected populations.

2. Methods

The Preferred Reporting Items for Systematic reviews and Meta-analyses (PRISMA) guidelines were used to ensure transparency in reporting the process and results of this systematic review (Page et al., 2021). The protocol has been registered on Prospero prior to the start of the research (ID: CRD42022299633).

2.1. Search strategy

Qualitative literature related to PTSD and CPTSD phenomenology in Sub-Saharan Africa was examined through the systematic search of peer-reviewed journal articles in English and French. Nine databases were searched: seven in English and two in French, respectively PsycINFO, MEDLINE, Pubmed, CINAHL, Anthrosource, SocINDEX, Web of Science, and Pascal et Francis, and SantéPsy. Various search terms grouped into four main categories were used: 1) SSA countries; 2) qualitative methods; 3) symptoms and difficulties related to trauma; and 4) exposure to traumatic events. Search terms are presented in Table 1. When available, MeSH terms were employed. Searches on all databases were conducted on February 7th' 2022 and were repeated one year later (i.e., February 7th' 2023) to identify any additional articles published during that period. In addition to electronic searches, we completed hand searches.

2.2. Study selection process

For the search strategy, the SPIDER tool was used. It defines criteria that fit the needs and objectives of qualitative research, i.e., Sample, Phenomenon of Interest, Design, Evaluation, and Research type (Cooke et al., 2012). Table 2 presents the inclusion criteria used to select the studies. All included samples must have been exposed to at least one traumatic event; or be key informants discussing the consequences of trauma exposure, e.g., mental health professional, community members, religious leaders, traditional healers. Only studies conducted on samples from sub-Saharan Africa, i.e., on individuals from one of the 49 countries identified, were included. Where articles used mixed samples (e.g., different countries or age groups), only data from the target sample were extracted. If it proved impossible to connect the data to the target group, the articles were excluded. Studies reporting on indirect trauma exposure, e.g., transgenerational trauma or vicarious trauma, and single case study were also excluded.

A total of 12284 references, including duplicates, were retrieved (see Fig. 1). To facilitate the screening phase, the software Cadima was used

Table 1
Search terms for each main category.

Search terms
Search concept 1, countries of the SSA region: Angola/Angolan/Benin/Beninese/Batswana/Bechuanaland/Botswana/Botswanan/Tswana/Burkina Faso/Burkinab*/Burkinese/Burundi/Burundese/Burundian/Cameroon/Cameroonian/Cabo Verde/Cabo Verdean/Cape Verde/Cape Verdean/Central African Republic/RCA/Centrafric/Central African/Chad/Chadian/Comoros/Comorian/Democratic Republic of the Congo/DRC/Congolese/Djibouti/Djiboutian/Equatorial Guinea/Equatoguinean/Eritrea/Eritrean/Eswatini/Swaziland/Ngwan*/Swazi/Emaswati/Liswati/Ethiopia/Ethiopian/Gabon/Gabonese Republic/Gabonese/Gambia/Gambian/Ghana/Ghanaian/Guinea/Guinean/Guinea-Bissa*/Ivory Coast/Yvorian/Kenya/Kenyan/Lesotho/Lesothan/Mosotho/Massouto/Basotho/Basutoland/Bassouto/Liberia/Liberian/Monrovia/Madagascar/Madagasikara/Malagasy/Malagasies/Malawi/Malawian/Mali/Malian/Mauritania/Mauritanian/Maurice/Mauritius/Mauritian/Mozambique/Mozambican/Namibia/Namibian/Niger/Nigerien/Nigeria/Nigerian/Republic of the Congo/Rwanda/Rwandan/Rwandese/Sao Tome/Santomean/Senegal/Senegalese/Seychelles/Seselwa/Sierra Leone/Sierra Leonean/Somalia/Somalian/Somaliland/South Africa/South African/RSA/South Sudan/South Sudanese/Sudan/Sudanese/Tanzania/Tanzanian/Togo/Togolese/Uganda/Ugandan/Zambia/Zambian/Zimbabwe/Zimbabwean
Search concept 2, methodology: Qualitative/mixed methods/ethno*/emic/cultur*/anthropo*/phenomenology
Search Concept 3, distress: Mental health/PTSD/posttraumatic stress disorder/post-traumatic stress disorder/complex PTSD/CPTSD/C-PTSD/complex posttraumatic stress disorder/complex post-traumatic stress disorder/self-concept/disturbances in self-organization/emotional disturbances/emotional regulation/emotional trauma/affect dysregulation/emotional control/emotional dysregulation/shame/guilt/self-worth/self-esteem/dissociation/identity crisis/identity/identity formation/ego identity/possession/borderline personality disorder/BPD/borderline traits/psychological stress/distress/psychological distress/psychiatric symptoms/psychological symptom/psychological dysfunction/emotional states/emotional distress/psychiatric condition/interpersonal relationships/interpersonal/interpersonal interaction/social support/family support/coping behavior/resilience/resilient/protective factors/transcultural psychiatry/cultural concepts of distress/CCD/cultural sensitivity/idioms of distress/explanatory models/culture-bound/syndromes/culture-bound/folk psychology/folk medicine/folk illness
Search Concepts 4, traumatic exposure: violence/war/trauma/trauma*/prisoners of war/political violence/emotional abuse/physical abuse/abuse of power/child abuse/verbal abuse/abuse/sexual abuse/torture/disaster*/conflict*/refugee*

[1] The GBD study includes 46 of the 49 countries in SSA region with variable sample sizes.

Table 2
SPIDER inclusion criteria.

Sample	Adult (18 or over) and young (from 14) populations from the following countries: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Republic of the Congo, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Tanzania, Togo, Uganda, Zambia, Zimbabwe
Phenomenon of Interest	Experiences of traumatic stress with a particular interest on cultural understanding of trauma-related distress
Design	Empirical peer-reviewed articles using qualitative methods to collect data, e.g., interviews, focus groups, observation, case reports, and to conduct the analysis, e.g., thematic analysis, grounded theory, phenomenological analysis, narrative analysis
Evaluation (Outcome)	Symptoms and difficulties arising as a result of a prolonged and repeated exposure to trauma or of a single traumatic event, as well as the impact of cultural and structural factors on these difficulties.
Research Type	Qualitative and mixed-methods research

(Kohl et al., 2018). It is a free online tool allowing teamwork and dealing with the randomization and the distribution of references to the different team members, as well as the notification of any conflicts. To test the clarity of the inclusion and exclusion criteria, 100 references were screened independently by the four group members (MB, NH, and two master students) and disparities were discussed. Then, all titles and abstracts were screened by two independent screeners (MB did all of them, and other team members one third each). Conflicts were discussed and resolved using a consensus approach. When no agreement was found, a senior researcher (EH) was involved in the discussions and made the final decision. The same process was applied for the full text screening. When screening the latest publications, i.e., after having rerun the search, MB and NH screened independently all the references.

Reasons for full text exclusion were the following: wrong outcome (e.g., no symptoms, no clear exposition to trauma, general distress), wrong population (e.g., mixed samples, participants under 18 years old, no SSA regions), wrong methodology (e.g., quantitative methods, single case study), listing of symptoms without phenomenological description, no empirical research, no access to full text, duplicates, dissertations, language, and one retracted article. Due to the significant number of articles focusing on CCDs that were retrieved (N = 29), we have decided not to include them in this review. The reason is the limited space available to fully develop and provide a detailed description of those phenomena. Instead, these findings will be reported in a separate article (Bovey et al., 2024 [manuscript in preparation]).

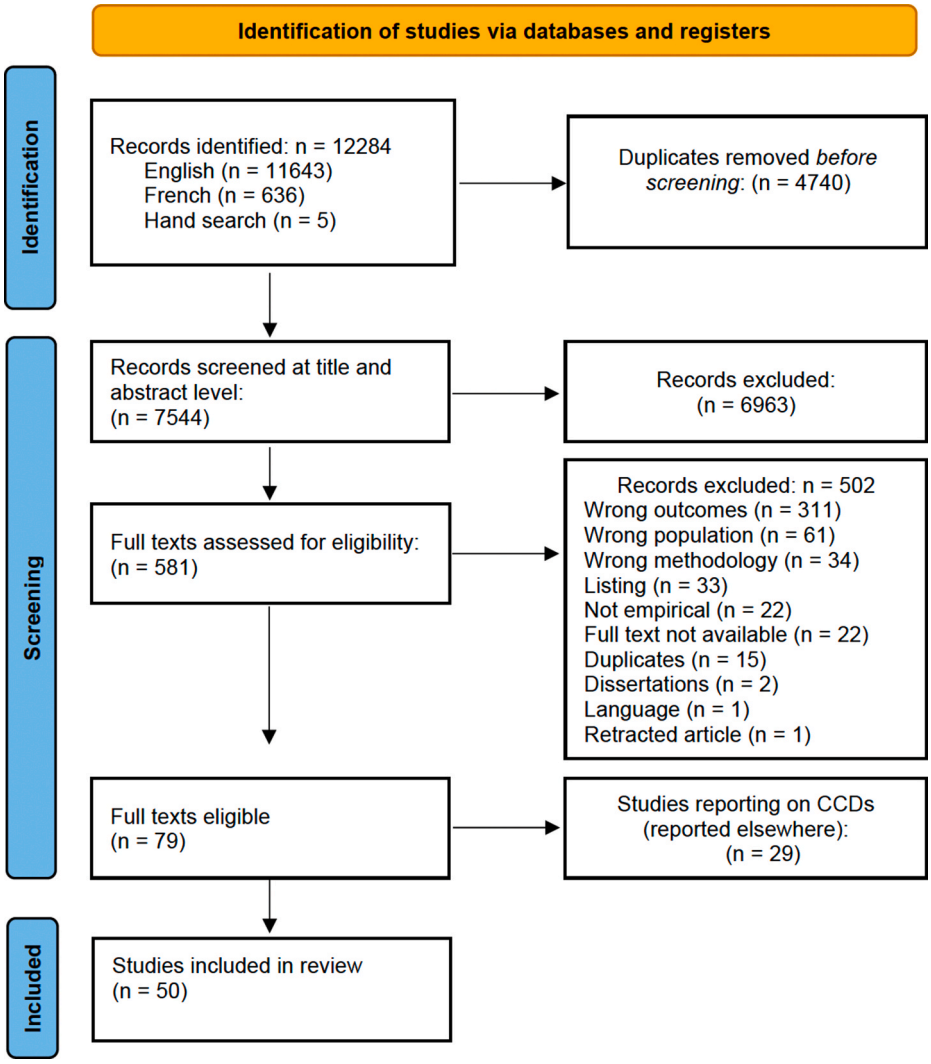

Fig. 1. PRISMA flow diagram.

2.3. Data extraction and synthesis

The framework by Tong et al. (2012), enhancing transparency in reporting the synthesis of qualitative research (ENTREQ), was used to synthesize and report the data from the 50 articles included in our review. We used a combination of framework synthesis (Brunton et al., 2020) and thematic synthesis (Thomas and Harden, 2008) in order to code data from the selected primary studies. The aim was to systematically report how trauma-related distress was experienced and expressed by individuals from SSA region, focusing on the main symptoms of PTSD and CPTSD described in the ICD-11, as well as on specific cultural manifestations. Both inductive and deductive approaches were used.

First, the core symptoms of PTSD and CPTSD were defined as descriptive themes (i.e., intrusions, avoidance, persistent perception of threat, affect dysregulation, negative self-concept, and disturbed relationships) to help us cluster manifestations of trauma-related distress. Any additional features were recorded and later conceptualized (e.g., dissociative features, physical symptoms, idioms of distress). Then, an inductive approach was applied to have a deeper understanding of symptom presentations by analysing how the distress was narrated, as well as the context, the perceived causes, and consequences of the latter. Coding and extraction were facilitated using NVIVO 1.7.1. and were conducted by MB. As the first and second authors already worked together on another systematic review on the same topic but in MENA region (Hosny et al., 2023), intercoder reliability was not reassessed for this study.

When available, the following descriptive information was extracted for each article: country of fieldwork, ethnic background of the sample, number of participants, gender, sample specific characteristics when relevant (e.g., sexual orientation, professions), type of trauma exposure, study purpose, methodological design, and method of analysis. Thereafter, line by line thematic coding was performed using the predefined framework to identify features of distress presented in the results sections of primary articles, and to cluster them into the descriptive themes. Triangulation meetings were organized to discuss the codes and their assignment to a particular theme. The process was iterative. Finally, analytical themes were developed.

2.4. Quality assessment

The quality of the studies included in this review was assessed using the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist (Tong et al., 2007). MB and NH independently assessed the quality of 20 % of included studies (N = 10). Agreement was substantial (90 %) using Cohen's K (k = 0.799). The remaining articles were assessed by MB. A scoring system was created attributing one point for each criterion met from the checklist. No studies were excluded based on this score, but it allowed us to adopt a critical view of the studies ranking the lowest.

3. Results

3.1. General description

Our review includes 50 peer-reviewed articles published between 2002 and 2023 reporting on 19 countries in the SSA region. Descriptive information as well as study IDs are provided in Table 3 (see Appendix A for the full references list of included articles). Three groups of authors published articles using the same sample, we thus decided to cluster them together for the analysis (studies 8, 14, and 40). From now on, numbers provided refer to the 47 studies using different samples. Most studies were conducted on samples from South Africa (N = 13), followed by DRC, Rwanda and Uganda (N = 6), Ethiopia and Nigeria (N = 5), Somalia (N = 4), Sudan (N = 3), Burundi (N = 2), Central African Republic, Eritrea, Gambia, Kenya, Mozambique, Namibia, Senegal, Sierra Leone, Tanzania and Zambia (N = 1) (see Fig. 2). Some studies incorporated mixed samples from various backgrounds. Field work was carried out either in participants' country of origin or in their resettlement country. Seven studies reported on refugees living either in neighboring countries (N = 2) or in high-income countries (N = 5), and two studies on internally displaced persons in Nigeria.

More than half of the studies reported on female (N = 27) and two on male samples only, and the rest on mixed samples (N = 18). Some studies also included couples (N = 1) or parent-child pairs (N = 2). Seven studies included key informants such as health workers, traditional healers, or community members. Participants' age ranged from 18 to 80 years old. Data were collected through individual interviews, focus groups, observations, and free listing activities. Different types of violence were reported: interpersonal violence (including intimate partner violence [IPV], gender-based violence [GBV], sexual violence, sex trafficking, robbery, street crime, aggression, forced marriage, forced labor, female genital mutilation/cutting [FGM/C], childhood sexual abuse), war violence (including armed conflicts, assault, genocidal rape, numerous losses, torture, imprisonment, abduction, child soldier), political violence (including minorities persecution, incarcerations, forced sterilization), witnessing killings and severe injuries, and accidents. Participants were often exposed to multiple forms of violence. Depending on the study, participants were either still living in ongoing violence (e.g., persecution of minorities, IPV), in refugee camps with poor living conditions, in post-genocidal societies, in post-conflict societies where political power is unstable, or as refugees in western countries.

To start with, cultural aspects related to the interpretation of traumatic experiences will be addressed. Then, phenomenology reported in the primary studies will be presented along four main categories: manifestations corresponding to PTSD symptoms (N = 36), those relevant to DSO (N = 45), meaningful cultural idioms of distress (N = 12), and other symptoms (N = 43). In the coming sections, description of symptoms, their causes and consequences will be described, and relevant cultural information will be presented when available. All studies present outcomes that belong to more than one category.

3.2. Quality assessment

The quality of the included studies was assessed using COREQ checklist (Tong et al., 2007). Scores ranged from 8 to 25 out of a possible maximum of 32 points, indicating varying levels of quality. However, almost three-quarters of the studies scored 17 points or above, indicating a moderate to high level of methodological rigor. For a detailed breakdown of each article's assessment using the COREQ checklist and their overall score, please refer to Appendix B.

3.3. Traumatic experiences

Only articles that featured traumatic experiences meeting the criteria outlined in the ICD-11, which characterizes them as "an event or situation of an extremely threatening or horrific nature" (WHO, 2019) were included. However, narratives provided information on how culture influences the way traumatic experiences were interpreted in a given context. One important aspect that was present in many cultures from SSA was the violation of social and/or religious norms and the resulting community judgement that was associated with the traumatic experience. Regardless of the specific traumatic experience, participants consistently reported experiencing greater distress related to the social consequences of these events rather than solely focusing on the individual suffering inherently associated with the abuse. For example, women who have been sterilized against their will by the Namibian government were mostly reporting their loss of status and self-worth due to the inability to reproduce, which was an important value in the community (3).

Other studies (e.g., 10,30) emphasized the role of culture or religious beliefs in the apprehension of the traumatic experience and its

Table 3
Descriptive table.

Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
1	Alio et al. (2022)	Senegalese Muslim	Dakar, Senegal	Structural violence; emotional, physical and verbal violence; incarceration	30 adult men (18–55yo)	To understand what it is to be a man who has sex with other men living with HIV within the Senegalese Muslim cultural context.	DSO	In-depth interviews; combination of ethnography and phenomenology (DuFour 2021; Dew 2007; Maso 2001), and data triangulation (Katz and Csordas, 2003)
2	Baholo et al., 2014	South African	Metropolitan area in Gauteng Province, South Africa	IPV; including physical, emotional, and sexual abuse	11 adult women (10 African descent; 1 Indian descent)	To examine the types of abuse experienced by the women, understand what led them to leave the abusive relationship, and what kind of support facilitate this process	PTSD, DSO	Semi-structured interviews; thematic analysis (No specific methodology mentioned)
3	Bakare and Gentz (2020)	Namibian	Khomas region, Namibia	Forced and coerced sterilization	7 adult women	To understand how forced sterilization changed their life, how they cope, what meanings is related to being sterilized, the impact on mental health and consequences of forced sterilization	DSO	Semi-structured interviews; content analysis (Blanche et al., 2006)
4	Booysen and Kagee, 2021	South African, one Congolese (DRC)	South Africa	War violence; street assault; rape and sexual assault as a child; rape as a young adult	7 adult women	To investigate the preliminary effectiveness of a brief prolonged exposure (PE) intervention for PTSD in a resource-constrained setting	PTSD, DSO	Case study; (No specific methodology mentioned)
5	Chiara et al., 2022	Nigerian migrants	Italy	Sex trafficking; sexual and psychological violence; structural violence	5 women (20–30yo)	To expand the voice of trafficking survivors, taking into account the polyphony and narratives that can facilitate or hinder post-traumatic growth in therapeutic work.	PTSD, DSO	Psychological interviews; narrative approach (White and Epston, 1990), and thematic analysis (Brluaun and Clarke, 2006)
6	Christie et al. (2020)	South African	Khayelitsha, a township outside Cape Town in South Africa	Physical and sexual assault; accident; imprisonment, robbery; assaultive violence	30 adult parents (28 mothers; 2 fathers)	To understand from the parent's perspective about whether and how their trauma impacted themselves and their parenting behaviors	PTSD, DSO	Semi-structured interviews; inductive thematic analysis (Braun and Clarke, 2006)
7	Denov and Piolanti (2019)	Rwandan	Rwanda	War violence; genocidal rape conducting to unwanted pregnancy; structural violence	44 adult mothers	To examine the themes of mental health, stigma, and coping strategies in mothers of children born of rape during the Rwandan genocide and discuss how mental health and psychosocial support (MHPSS) programs may support healing and recovery	PTSD, DSO	Semi-structured interviews; grounded theory approach (Creswell, 2013)
8	Duma et al. (2007) (part I and II)	South African	South Africa	Sexual assault	10 adult women	To explore and analyze the journey of recovery which is undertaken by women who have	PTSD, DSO	In-depth interviews; longitudinal grounded theory (Strauss and Corbin, 1990; 1998)

(*continued on next page*)

Table 3 (*continued*)

Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
						been sexually assaulted		
9	Eagle and Kwele, 2021	South African	South Africa	Accidents; aggression; violence; street crime; sexual harassment; gender-based crime	10 adult women (African descent)	To identify and explore the forms of violence that young women were exposed to and the subjective impact this had upon them, as well as to elaborate what kinds of coping mechanisms they employ to manage commuting-related stress	PTSD	Semi-structured interviews; thematic analysis (Braun and Clarke, 2006)
10	Haruna et al., 2021	Kanuri, Nigerian	Damaturu, Nigeria	Witnessing killings and severe injuries; witnessing lethal accidents; sexual assaults	32 adults (F = 16, M = 16)	To ascertain religiosity and spirituality's role in response to PTSD functional adjustment among Kanuri people	PTSD, CCD	In-depth interviews and focus group discussions; thematic analysis (Braun and Clarke, 2006)
11	Horn (2010)	Refugees from Sudan, Somalia, Rwanda, Uganda, Burundi, Congo, and Ethiopia	Kakuma refugee camp, Kenya	War violence (e.g., losses); prolonged displacement; structural violence (e.g., poverty, lack of food, insecurity)	Free listing: 52 adults (F = 27, M = 25); Key informants (F = 5, M = 3)	To identify and understand more about the emotional problems experienced by refugees in Kakuma refugee camp	PTSD, DSO	Free listing and semi-structured interviews, (No specific methodology mentioned)
12	Hughes et al. (2021)	Rwandan	4 provinces including Kigali, Rwanda	Harassment and abuse; rape and sexual abuse; forced marriage; abandonment by closed ones; being forced to end a relationship; structural violence	20 adult women, (lesbian = 17, bisexual = 3)	To explore traumatic experiences lived by lesbian and bisexual women, as well as their perceptions of mental health and health care access to better understand health needs and availability of care	DSO	Semi-structured interviews; thematic analysis (Braun and Clarke, 2006)
13	Igreja et al. (2006)	Mozambican	Mozambique	Forced labor (*gandira*); war violence (e.g., combat situations, forced separation; losses); physical torture; imprisonment; sexual abuse; structural violence (e.g., lack of food and water, no shelter, lack of medical care)	60 adult women	To explore the scope and nature of women's suffering by (1) identifying the most overwhelming experiences of women during and after the war; (2) assessing the most prevalent posttraumatic stress symptoms; (3) studying various local manifestations of psychosocial distress, and their expression in behavior, language, and meanings; and (4) determining the availability of local resources to deal with the predicaments of women	PTSD, DSO	In-depth interviews and observation (No specific methodology mentioned)
14	Kagee, 2004a; 2004b	Xhosa, South African	South Africa	Detention, torture	20 adults, former detainees (F = 7, M = 13)	To explore the circumstances of detention, the participant's thoughts and feelings at the time, recollections of experiences in detention, present thoughts and feelings about the experience,	PTSD, DSO, idioms	In-depth interviews; categorizing process in grounded theory (Strauss, 1987)

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Table 3 (*continued*)

Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
						and present problems related to the experience		
15	Kahn & Denov (2022)	Rwandan	Rwanda	War violence; genocidal rape conducting to unwanted pregnancy; structural violence	44 adult mothers (33–52yo), and 60 youth (F = 29, M = 31; 19 to 21yo)	To better understand the complexity in lives of children born of genocidal rape and their mothers through the multi-layered, culturally enhanced bioecological theory. In order to offer policy and/or practice recommendations	PTSD, DSO	In-depth interviews, and focus groups; hybrid inductive and deductive analysis (Gilgun, 2004; 2005) using thematic analysis (Braun and Clarke, 2006)
16	Kaiser et al. (2020)	Nigerian, internally displaced persons (IDPs)	Borno state, Nigeria	War violence; structural violence; displacement; community violence	Free listing: 66 adults, IDPs and community members (F = 32, M = 34); Interviews and focus group: 24 key informants (F = 13, M = 11)	To identify mental health and psychosocial (MHPS) problems, risk factors, and existing resources among conflict affected communities (IDPs, host communities, and returnees), in Borno State, Nigeria	PTSD, DSO, idioms	Mixed-method, free listing, semi-structured interviews, and focus group (No specific methodology mentioned)
17	Kandemiri (2019)	Congolese refugees	Johannesburg, South Africa	War violence; sexual violence; genocide; torture; political persecution; loss of loved ones; structural violence	10 adult women	To understand the impact of forgiveness on the mental wellbeing of Congolese refugees and asylum seekers post-war experience	DSO	Semi-structured interviews; thematic analysis (No specific methodology mentioned)
18	Keynejad et al. (2023)	Ethiopian	Rural regions, Ethiopia	IPV; structural violence	16 pregnant women, 12 health workers	To explore pregnant women and health workers' perspectives and experiences of IPV and its relationship to mental health in order to adapt a brief psychological intervention for rural Ethiopian antenatal care	PTSD, DSO	In-depth interviews; thematic analysis (Braun and Clarke, 2006)
19	Knettel et al. (2019)	South African	Cape town, South Africa	Sexual abuses during childhood and/or adulthood; physical assaults; IPV; structural violence	31 adult women	To examine mechanisms, facilitators, and barriers to change in the intervention (ImpACT). Data included participant descriptions of the values informing their care, barriers to participation, and perceived benefits of the intervention related to coping with trauma and improving care engagement	PTSD, DSO	Workbooks and open-ended questions; applied thematic analysis (Guest, MacQueen and Namey, 2012) and consensual qualitative research (Hill et al., 2005).
20	Koegler et al. (2019)	Congolese	DRC	Conflict-related sexual violence	12 adult women	To explore the factors contributing to improvement in mental health for survivors of conflict-related sexual violence who participated in solidarity groups	PTSD, DSO	Culturally appropriate interviews; thematic analysis (Braun and Clarke, 2006)
21	Liebenberg and Papaikonomou, 2010	South African	South Africa	Childhood trauma (e.g., emotional abuse, feelings of	5 adults (F = 3, M = 2); 4	To shed some light on the impact of some types of childhood	DSO	Semi-structured interviews, case notes, reports, clinical

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Table 3 (*continued*)

Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
				being rejected, being obliged to keep family secrets)	Caucasians and one Asian	maltreatment by introducing the reader to the proposed link between childhood maltreatment and the symptom constellation known as complex trauma within the paradoxical remedial context of bariatric surgery as a positive forced behavioral intervention		observations, and questionnaires; patchwork case study (Jensen and Rodgers, 2001) and thematic content analysis (Hoepfl, 1997)
22	Liebling and Kiziri-Mayengo, 2002	Ugandan	Uganda	War violence (e.g., witnessing murders, rape, torture), structural violence (e.g., disease, poverty)	237 adult women	To investigate the long-term psychological effects resulting from traumatic experiences during the civil war some 13 years after the end of the war, to discuss implications for treatment based on these findings, and to make suggestions about how to address women's needs	PTSD, DSO, idioms	Mixed method: surveys and semi-structured interviews; content analysis (Creswell, 2013)
23	Michalopoulos et al., 2017	Zambian	Kafue Flatlands, Zambia	IPV; forced sex; assault; robberies; accidents; imprisonment; structural violence	Interviews: 20 adult women; focus group: 12 adult women	To explore (1) the extent and types of trauma exposure among female fish traders in Zambia, (2) trauma symptoms experienced as a result of psychosocial stressors and trauma, and (3) the relationship between trauma/migrant-related stressors, mental health problems, and HIV sexual risk behavior	PTSD, DSO, idioms	Semi-structured interviews and focus group discussion; template analysis (Braun and Clarke, 2006; Crabtree and Miller, 1999)
24	Mootz et al. (2019)	Ugandan	Teso, Northeast Uganda	Armed conflicts; IPV; structural violence	15 adult women	To understand mental health outcomes of IPV in conflict-affected communities	DSO, idioms	Mixed method: surveys, rapid ethnography (Bolton and Tang, 2004), and in-depth interviews; grounded theory method
25	Morgan et al. (2020)	Congolese	DRC	War violence and torture; rape; beatings; imprisonment	13 couples (F = 11, M = 9) participating to torture-surviving couple group	To increase awareness of couples' experiences after surviving torture and war trauma in the DRC; endorse the idea that healing from life-changing, violent trauma is possible and may be especially effective in relational contexts	PTSD, DSO, idioms	Semi-structured interviews; critical ethnography (Madison, 2005) and domain analysis (Spradley, 1979; McCurdy et al., 2005)
26	Mtiya-Thimla and Van der Merwe, 2021	South African	Bloemfontein, South Africa	Physical and sexual abuses by known and unknown perpetrator	15 older adults (60–80 yo)	To explore the experiences of abused older persons in resource-poor settings. Main question was 'What themes can be identified when exploring the experiences of abused	PTSD, DSO	Semi-structured interviews; Thematic Analysis (Braun and Clarke, 2006)

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Table 3 (*continued*)

Study ID	Author	Cultural Group	Study Location	Type of violence Exposure	Sample (n=)	Purpose	Study Category	Methods
						older persons regarding the abuse and associated trauma?'		
27	Mukamana and Brysiewicz (2008)	Rwandan	Rwanda	War violence; genocide; rape	7 adult women	To explore the lived experience of women who were raped during the 1994 genocide in Rwanda	DSO	Semi-structured interviews; phenomenological analysis (Colaizzi, 1978)
28	Nkosi and van der Wath, 2012	South African	Gauteng, South Africa	IPV	10 adult women	To explore and describe the mental health effects of domestic violence, as experienced by women utilizing a mobile primary health care clinic in low socio-economic area in Gauteng	PTSD, DSO	Semi-structured interviews; content analysis (Tesch in Creswell, 2009)
29	Olufadewa et al., 2022	Nigerian, IDPs	IDPs camp in Abuja, Nigeria	War violence; structural factors;	56 young	To explore young IDPs' mental health experiences, psychosocial support, and challenges in accessing mental healthcare. The findings from this study will inform public mental health policy and programs	PTSD, DSO, idioms	In-depth interviews and focus group; thematic analysis (Guest et al., 2012)
30	Omigbodun et al., 2022	Izzi, Nigerian	Ebonyi state, Nigeria	FGM/C	38 women (18–60yo, rural = 17, urban = 21)	To explore what is the psychological experiences surrounding FGM/C in women across the life cycle in the Izzi rural and urban communities of Southeast Nigeria	PTSD, DSO	Interviews based on adapted MINI; Thematic content analysis (Green, 2018)
31	Padmanabhanunni and Edwards, 2016	South African	Rhodes University, South Africa	Repeated childhood sexual abuses; sexual assault during early adolescence and adulthood (i.e., rape)	9 adult women	To examine the range of different experiences evoked and, in particular, to focus on experiences of healing and re-traumatization lived by raped women taking part in the *Silent protest*	PTSD, DSO	Semi-structured interviews; case narrative and phenomenological analysis (Smith and Osborn, 2003)
32	Patel et al. (2020)	Central African	Bangui, Central African Republic	Armed groups violence; ongoing conflicts; witnessing death of loved ones	26 adults (F = 10, M = 16)	To explore psychosocial response to ongoing violent conflict in Central African Republic, and to provide a deeper, locally informed perspective on mental health needs	PTSD, DSO	Focus group discussions; grounded theory (Glaser and Strauss, 1967)
33	Schultz and Lien, 2014	Migrants from Gambia, Somalia, and two neighboring countries	Gambia and Norway	FGM/C	33 adult women: 5 mothers, 15 circumcised women, and 13 circumcisers	To explore and analyze the psychological care provided for girls undergoing the ritual of FGM/C, and to describe the common belief system underlying the provision of care in Gambia	PTSD, DSO	In-depth interviews: grounded theory (No specific methodology mentioned)
34	Scott et al. (2017)	Congolese	Bukavu, DRC	Sexual violence-related pregnancies (SVRPs); ongoing conflicts; structural violence	55 adult women (38 mothers and 17 who had terminated the pregnancy)	To describe emotional responses, needs, and psychosocial outcomes among this	DSO	Mixed methods triangulation design: semi-structured interviews; thematic analysis (No specific

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Table 3 (*continued*)

Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
						subgroup of sexual violence survivors to inform future interventions		methodology mentioned)
35	Shannon et al. (2015)	Data extracted for Somali and Oromo (Ethiopian) refugees	USA	War violence (e.g., being forced to flee their homes, imprisonment, torture, witnessing killings, rape, physical injuries); violence in refugee camps; structural violence	54 adults (27 Oromo and 27 Somali)	To explore common and culturally grounded conceptions of the mental health effects of political conflict through the voices of newly arrived refugees to the United States	PTSD, DSO	Focus group interviews; thematic categorization (Spradley, 1979)
36	Shumba et al., 2017	Ugandan	Kabalagala slums in Kampala, Uganda	IPV; structural violence	48 adult women	To explore IPV experiences and women's health needs in Kabalagala slums in Kampala and recommends practical interventions for improving access to quality health and other supportive services in Uganda	PTSD, DSO, idioms	In-depth interviews; thematic content analysis (Green and Thorogood, 2009)
37	Song et al., 2014	Burundian	Provinces of Cibitoke, Kamenge, Kinama, and Sorerezo, Burundi	War violence; structural violence (e.g., political and social stigma)	25 former child soldier parents (F = 8, M = 17) and 15 civilian parents (F = 7, M = 8)	To examine if and how trauma from former child solider parents is passed to their children. Questions focused on prewar childhood, rebel war experience, postwar experience, and specific questions related to parent–child relationships	PTSD, DSO	Semi-structured interviews, focus group discussions, and observation; grounded theory analysis (Glaser and Strauss, 1967) and comparison of emerging data for observation and focus group (Barnes, 1996)
38	Tankink (2004)	Banyankore, Ugandan	Mbarara district, Uganda	War violence (e.g., murders, disappearances, imprisonment, consiracy of silence, rape); structural violence	63 adults (F = 35, M = 28); 9 key informants (health workers and medical students)	To discuss the question of 'disclosure or silence' of traumatic experiences, by analyzing the socio-cultural code of silence in southwest Uganda	PTSD, DSO	In-depth semi-structured interviews and focus group discussions; (No specific methodology mentioned)
39	Tenaw et al. (2022)	Ethiopian	North Wollo and Wagihmera zones, Northeast Ethiopia	Conflict-related sexual violence (i.e., rape); structural violence	23 adult women (19–30yo)	To understand and describe raped women's experiences during the armed conflict in northeast Ethiopia to improve health services and their access for the abused survivors	PTSD, DSO	In-depth interviews; thematic analysis (No specific methodology mentioned)
40	van der Kolk et al., 2005; 2015	South African	Cape Town, South Africa	IPV (i.e., sexual, physical, and emotional violence)	19 adult women	To explore experiences of chronic trauma, shame, and psychopathology with South African women survivors of IPV living in a shelter	PTSD, DSO	Semi-structured interviews; narrative analysis, categorical content analysis (Lieblich, Tuval-Mashiach, and Zilber, 1998)
41	Vloeberghs et al., 2012	Migrants from Somalia, Sudan, Eritrea, Ethiopia, and Sierra Leone	Netherlands	FGM/C	66 adult women	To generate empirically based conclusions about the impact of migration on long-term psychosocial consequences of FGM/C and to identify the problems faced by these victims	PTSD, DSO	Mixed methods (Creswell, 2009); questionnaires and in-depth interviews; grounded theory – triangulation (Hammersley and Atkinson, 1983)

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Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
						for providers to be able to offer better health services		
42	Watt et al. (2017)	South African	Phillipi, South Africa	Multiple sexual abuse during childhood and/or adulthood; IPV (e.g., physical and emotional abuses); structural violence	15 adult women	To clarify the HIV care needs of HIV-infected women with sexual trauma histories and inform locally relevant interventions in this setting, particularly as trauma-informed treatments have not been systematically integrated into HIV care services in most low-resource settings	PTSD, DSO	In-depth semi-structured interviews; memos analysis (Birks, Chapman & Francis, 2008)
43	White et al. (2020)	Sudanese refugees	Melbourne, Australia	War violence (e.g., torture, rape, genocide); displacement	12 adults (F = 5, M = 7)	To contrast Holocaust survivors and Sudanese refugees understandings of trauma and their experiences of living after trauma, in order to explore further which is not captured in the current PTSD criteria, in turn to contribute to appropriate interventions for refugees and others who have survived violence, displacement and associated traumatic events	PTSD, DSO, idioms	Semi-structured interviews; descriptive phenomenological analysis (Giorgi, 2009)
44	Woldetsadik et al. (2022)	Ugandan	Paper, Lira, and Gulu districts, Northern Uganda	Conflict-related sexual violence (i.e., forced marriage, rape, forced pregnancy); abduction; structural violence	30 adult women (23–60yo)	To assess the persisting impact of conflict-related sexual violence on the health and social well-being of Ugandan women survivors from their own perspectives in order to inform policy and improve health services	PTSD, DSO	In-depth interviews; modified grounded theory model (Charmaz, 2006; Glaser and Strauss, 2017)
45	Zamperini et al., 2017	Rwandan	Butare, Kigali, and Nyanza cities, Rwanda	War violence; genocidal rape conducting to unwanted pregnancy	20 mothers and 20 children (F = 12, M = 8)	To investigate and discuss the theme of memory and reconciliation policy in the Rwanda post-genocide context by integrating a macro perspective (politics of memory) with a micro perspective (well-being and psychological distress of mothers and children born after the collective rapes occurred during the genocide)	DSO	Narrative interviews (Sparkers, 2005) and participant observation (Denov and Piolanti, 2019); content analysis (Braun and Clarke, 2006)
46	Zietz et al., 2022	Tanzanian	Dar es Salaam, Tanzania	Childhood exposure to adversity (e.g., orphan, not living with parents, no parental affection); structural violence	24 men at high-risk of perpetrating IPV	To qualitatively examine, among high-risk men in Dar es Salaam, how different adverse experiences in childhood affect use of interpersonal violence as an adult.	DSO	In-depth interviews; narrative analysis – categorizing analysis (Maxwell and Miller, 2008)

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Table 3 (*continued*)

Study ID	*Author*	*Cultural Group*	*Study Location*	*Type of violence Exposure*	*Sample (n=)*	*Purpose*	*Study Category*	*Methods*
						We are particularly interested in protective experiences or environments for these participants		
47	Zunner et al. (2015)	Kenyan	Kisumu County, Kenya	GBV	61 adults: 43 female patients, and 18 key informants (F = 7, M = 11; community health workers, healthcare providers, and members of the clinic's community advisory board)	To conduct a mental health care needs assessment of HIV+GBV+ women served by the Kenya Medical Research Institute in order to adapt a scalable, capacity building mental health treatment for HIV+GBV+ women at the same site	PTSD, DSO	In-depth structured interviews and focus group discussions; grounded theory (Strauss, 1990)

Note: Find the references list for the included articles and their methods in the Appendix A.

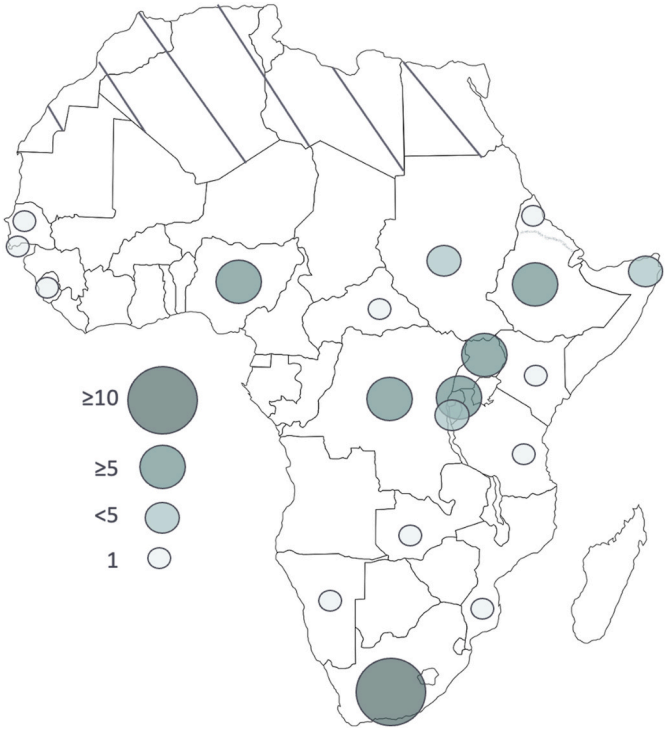

Fig. 2. Map representing samples' origin from included studies.

consequences. For example, while the traumatic nature of genital mutilation is generally unquestioned from a Western perspective, in communities where the practice has been culturally ingrained for ages, the stigma attached to not being circumcised appears to be even more distressing than the mutilation itself. This however does not prevent the women from experiencing negative physical and psychological consequences in the aftermath (30,33,41). Another study conducted in Nigeria (10) emphasized the role of religious beliefs on the severity of PTSD symptoms and general functional adjustment. Depending on the meaning attached to the experience, e.g., part of their destiny, punishment or evil spirit, individuals were developing more or less severe symptoms influencing their ability to function properly.

3.4. PTSD symptoms

Thirty-six studies reported symptoms of PTSD as defined in the ICD-11, i.e., intrusions, persistent perceptions of heightened current threat, and avoidance. Frequencies for each symptom cluster can be found in Table 4.

Twenty-three studies (64 %) described symptoms of intrusions such as recurrent nightmares with trauma content (4,7,9,13,14,18,22,23,26,31,35,37,38,41,42,44), vivid flashbacks of traumatic scenes (5,8,10,14,22,25,26,29,31,33,35,37,44), and current physical sensations of the past event (4,26,30,31). These manifestations were triggered by external and internal elements directly related or not to the trauma such as a person, a location, physical pain, thinking a lot, HIV diagnosis and treatment, or insults and stigma from the community. Multiple consequences were reported including lack of concentration and memory problems (9,10,33,35), rumination and stress (13,42,43), confusion and disorientation (8,13,29), anger (5,14), avoidance (4,30,31,42,43), sleep disturbances (26,42), hyperarousal (31,39), withdrawal and tension in relationships (25,37), and difficulty to function normally (33,41). In two contexts, Mozambique and Uganda, participants explained they did not believe their nightmares were related to past trauma. For the Mozambican women interrogated, nightmares were the results of the war spirits 'gamba' that possessed their bodies and from their perspective there was no direct link with their past experiences (13). On the other hand, Ugandan participants argued that their nightmares were related to their difficult economic situation saying: "I can't sleep at night and I suffer from nightmares. You have to be rich to forget your experiences" (p.10) (38).

Persistent perception of heightened current threat was described in 20 studies (56 %). Participants expressed worries, nervousness, and stress (2,4,9,16,20,26,41,47), feeling unsafe (2,4,6,22,26,29,36,41) and being scared of reoccurrence (10,16,26,39), which led them to constant vigilance and exaggerated startle responses. Women from Uganda also described hearing voices: "I hear people calling me … I feel people are

Table 4
PTSD symptom cluster frequency (N = 36).

Symptom Cluster	Frequency (%)
Intrusions	23 (64 %)
Persistent perceptions of heightened current threat	20 (56 %)
Avoidance	13 (36 %)

Note: Frequencies were calculated based on total number of studies reporting PTSD symptoms (i.e., 36).

looking at me through the holes of my mud hut" (p.556) (22). Physical signs, e.g., heart palpitations, diarrhea, tightness in the chest, and tremors were associated with hypervigilance. Participants reported negative impact on their relationships as parents (3,37) or couples (41) because their constant vigilance was impacting their ability to trust others. Some people also narrated sleep disturbances (20,26,28,39) and limitations in their movements and activities (10,26). An important aspect that was highlighted in a few studies was the difficulty for participants to distinguish between appropriate and exaggerated appraisal of threat (6,9,29). Indeed, some contexts such as refugee camps, dangerous neighborhoods or IPV can conduct individuals to appraise their environment as dangerous and to be more vigilant which can be considered as an adaptative response.

Avoidance was reported in 13 studies (36 %). Three studies mentioned the avoidance of external elements, e.g., objects, locations, persons, or political activities (4,30,35), whereas eleven samples reported avoiding thoughts or emotions related to trauma (6,9,10,19,23,31,35,38,41–43), e.g., by staying busy or distracted. Other studies (6,19,35) mentioned the use of substances, usually alcohol, to avoid trauma-related distress. Avoidance was sometimes described as an acknowledged coping strategy to deal with distress (6,38,43). For example, interviewed Sudanese refugees considered thinking about the past as a distressing experience that could worsen their state; "you drive yourself crazy because you're mentally processing things … you're stressing yourself." (42, p.2243). In the Banyankore society in Uganda (38), people were taught to suppress their emotions or at least to keep them inside. Participants thus explained how suppression of thoughts and emotions related to painful events was normative protecting themselves and others from burden. In another study in South Africa, some women reported having kept their rape secret because of shame, fear of blame, and the desire to shield their loved ones from emotional strain (31). However, their strategy of avoidance was compromised by frequent triggers, resulting in substantial distress and numerous psychological symptoms.

3.5. DSO symptoms

45 articles reported on DSO symptoms as defined in the ICD-11, i.e., affect dysregulation, negative self-concept, and disturbed interpersonal relationships. Frequencies and descriptions of reported manifestations for each symptom cluster are presented in Table 5.

3.5.1. Affect dysregulation

A total of 37 articles reported affect dysregulation symptoms (82 %). Thirty studies reported difficulties in managing anger, which was the most commonly reported affect dysregulation symptom (2,3,5,6,11,14–19,21-26,29–31,33-35,37,38,41,42,44,46,47). Anger was expressed in various ways, including being easily angry, sudden outbursts, constant anger, irritability, and difficulties to control it. Sometimes, people also described mixed feelings including anger and other emotions which were difficult to distinguish from one another (26, 34,41). The target of the anger varied, with some directing it towards the aggressor (2,3,25,33, 42), themselves (34,41), the political system (35,38), or cultural traditions (41). In some cases, the anger was more general and had no particular target (30,31,34,37,44,47). Traumatic past experiences, e.g., abuses, losses, and their memory (11,14,19,24,30,34), unexpressed feelings (17,22,31), ongoing frustrations including injustice, loss of wealth, poor living conditions experienced in their current situation (11,14,16,23,24,26,33,38,46) and daily hassles (6,11,15,46) were all cited as triggers for anger. As this person expressed: "any small thing makes someone boil like water on fire" (11, p.12), some participants were especially prone to high emotional sensitivity and were unable to control their outbursts even when triggered by minor events. Two studies mentioned the difficulty to calm down after overwhelming emotions, conducting people to binge eating (21) or leaving for days to avoid hurting others (22). Numerous other consequences were mentioned, the most frequent being aggression toward others (6,11,15,16,19,22,24,29,35,37,46,47). Some parents reported "[anger] caused them to become more reactive with their children and manifested in new or increased levels of hitting their children as well as yelling at them" (6, p.5), severely damaging their relationship. Other persons dealt with their anger by drinking too much (11), crying (11,22), isolating themselves (11,16,19,22,37), suicidal thoughts or attempts (11,22,24), or by suppressing their emotions (31). In one study, Oromo refugees (Ethiopia) reported that expressing anger was more acceptable than showing sadness, causing them to select their emotions deliberately (35).

A persistent and profound feeling of sadness was also identified as a manifestation of affect dysregulation in 16 studies (2,3,11,15–17,19,28,29,31,34–36,41,43,47). Out of the 16 articles, eleven were presenting testimonies from women only and five were based on mixed samples of refugees or internally displaced persons. Sadness and sorrow were linked to past experiences such as trauma (2,11,17,19,28,29,31,34–36,41) or losses (11,15,16,29,35,41), but also to their actual situation, i.e., not having access to employment or food (3,17). Some refugees living in camps reported sorrow when thinking about their future (11) – "staying in Kakuma [refugee camp in Kenya] seems unbearable but going back to our country is another hell, we can't take it'"(p.14). Sadness manifested through crying (2,3,15–17,28,34–36), a tendency to be quieter and isolate oneself (11,37,47), as well as suicidal thoughts (17). In one study (47), women from Kenya explained that sadness was associated with impairment of daily functioning such as working and connecting with others.

Numbness was only reported in six articles describing it as the inability to feel any emotions (7,15,18,31,37) or to "taste the life […] to taste the joy" (43). All articles but one (43) mentioned past traumatic experiences as being directly linked to their numbness. Participants

Table 5
DSO symptom cluster frequency (N = 45).

Symptom Cluster	Frequency (%)
Affect dysregulation	
Anger[b, c, d]	30 (67 %)
Constant sadness[d]	16 (36 %)
Agression[c]	12 (27 %)
Unusual crying[c]	10 (22 %)
Numbness[a, b]	**6 (13 %)**
Risky behaviors[b, c, d]	4 (9 %)
Difficulty to calm down[a, b, c]	**2 (4 %)**
Negative self-concept	
Shame[b, c, d]	19 (43 %)
Guilt[b, c, d]	17 (38 %)
Worthlessness[a, b]	**14 (31 %)**
Helplessness[c, d]	13 (29 %)
Loss of identity[d]	8 (18 %)
Self-hatred[d]	7 (16 %)
Permanently damaged[c]	4 (9 %)
Feeling like a failure[a, b]	**1 (2 %)**
Disturbed relationships	
Social withdrawal[b, c, d]	15 (33 %)
Difficulty in relationships[a, b, c, d]	**14 (31 %)**
Mistrust[c, d]	14 (31 %)
Feeling distant[a, b, c, d]	**13 (29 %)**
Negative feelings	10 (22 %)
Conflicts[c]	2 (4 %)
Altered system of meaning	
Hopelessness[c, d]	17 (38 %)
Change in values[c, d]	6 (13 %)
Lack of life meaning[c]	5 (11 %)

Note: Frequencies were calculated based on total number of studies reporting DSO symptoms (i.e., 45).
[a] **Items from the latest version of ITQ** (Cloitre et al., 2018).
[b] Items from the original version of ITQ (Cloitre et al., 2018).
[c] Items from the SIDES (Pelcovitz et al., 1997).
[d] Symptoms present in the very first conceptualization of complex trauma (Herman, 1992).

reported strong and lasting consequences of numbness on the relationships with their family (7,15,37). "Things that have happened to me have taken away all the love that I had … I don't feel any special emotion for them [husband and daughter]" (7, p.816). One woman, who described avoiding thinking about the child sexual abuse she had endured, and usually suppressing her emotions, explained alternating "between being severely triggered and feeling emotionally numb" (31, p.822).

Finally, self-harm and risky behaviors were mentioned in four articles (12,21,23,44). One participant (12) described engaging in self-harm as a way to feel alive: "People say pain reflects who you truly are and it keeps me awake to know that I am here! I hurt myself for that joy of knowing that I am here and the pain keeps me alive" (p.6). Others mentioned thoughts about hurting themselves without acting out (21,44). One study (23) described sexual risky behaviors, i.e., having unprotected sex with multiple partners, as a self-destructive behavior which enabled women to forget about their traumatic experiences but put them at greater risk of contracting HIV.

Some articles mentioned normative emotional regulation strategies such as suppression and masking of emotions. For instance, within the Oromo community (Ethiopia), certain emotions are deemed more acceptable than others, leading individuals to mask the primary emotion (e.g., sadness) with a seconday emotion (e.g., anger) (35). Some participants also reported masking their emotional state by maintaining a constant smile on their face (40). Futhermore, a participant from Uganda explained that in their community, people learn to remain silent about their emotions only allowing themselves to express them in certain contexts (e.g., church) (38). "My culture has not given me permission to express my emotions. […] They encouraged me to suppress them." (p.9).

3.5.2. Negative self-concept

Overall, 34 studies portrayed features of negative self-concept (76 %) with shame and guilt being the most frequent manifestations described (respectively 42 % and 38 %). In addition to shame (1,2,3,8,11,16,18,21,25,27,31,34,36,39–42), other terms such as humiliation (2,11,27,40), embarrassment (2,16,26,36,40,41), and loss of dignity and respect (26,27) were used. In some cases, shame was intrinsically linked to feelings of guilt (1,31,36,41,42), worthlessness (27,42), failure (25), self-hatred (31,42), and feelings of rejection and isolation (21,34,40,41). Mostly, participants reported that feelings of shame were directly related to IPV, FGM/C, and/or sexual abuse experienced, and that fear of social judgement was very present. "I feel really ashamed, I think if people found out they wouldn't really look at me in the same way. They'd look at me like it's my fault, that I'm not pure and I don't want people to think of me in a disgusting way" (31, p.823). Indeed, in some cases, social stigma was well and truly displayed: "My family has lost respect on me. I am no longer consulted for anything that is happening in my family. It's worse with the community – they act as if I do not exist." (26, p.233), letting people alone and not providing support. Due to internalized stigma, some individuals exhibited shame towards themselves, e.g., because of their sexual orientation (1) or HIV status (42). As a result, participants tended to keep their experience secret, which prevented them from receiving any medical or legal help and, in case of IPV, delaying the decision to leave the partner. "They could not afford to seek healthcare due to self-stigma and perceived stigma by others. They stayed home and endured the pain first hand until they were healed, keeping their experiences a secret." (36, p.11). Non-disclosure often resulted in participants isolating from their family and/or community, further depriving them of necessary support. Other participants who were forced to flee their homes (i.e., refugees or internally displaced persons) experienced shame regarding their current circumstances, which included their financial instability, unemployment, and lack of property, which made them feel dependent on others (11,16).

Guilt was reported in 17 studies being described as regrets for past decisions and behaviors (1,11), but also for being alive (3), self-blame about trauma (2,7–9,21,25,26,28,31,36, 40,42), as well as guilt about one's responses after trauma such as non-disclosure (30) or binge eating to cope with overwhelming emotions (21). In context such as DRC or Rwanda, rape was used as a weapon in conflicts and as a mean to destroy communities, particularly through cultural stigma. "A few men expressed rage that their wives had 'allowed' soldiers to rape them, saying things like, 'She's a military wife now.' Most women believed it was their own fault that they had been violated" (26, p.1136). As a result of internalized cultural norms and values, coupled with reproach from others, victims often assumed the responsibility for their abuse and its consequences on the family and/or community, leading to a strong feeling of guilt. This feeling was also present in women who were victims of IPV and questioned why they remained in such relationships for prolonged periods, enduring the abuse without taking action. Self-blame was sometimes coupled with feeling of self-hatred or self-disgust (7,12,26,31,36,40,42) related to the abuse and its consequences.

Fourteen articles reported on low self-esteem and worthlessness (2–4,11,13,14,21,26,27, 36,39,40,42,47). Those feelings were described using terms such as feeling useless, inferior, being nothing, zero, unimportant, having low confidence and self-worth. These negative perceptions of oneself were pervasive and directly linked to the traumatic experience, e.g., in the case of IPV – "He (partner) made me feel I am lower than the dirt on the ground. Worthless. I will also never be good enough." (40, 2014, p.203). In other cases, a lack of access to basic needs contributed to a diminished sense of self-worth (11,14). It is noteworthy that the sense of inferiority reported was not felt in comparison to a particular individual or group, but rather a pervasive feeling that affected how the individuals perceived themselves in general. Some participants also reported feeling useless because of their loss of identity as a woman through different abuses targeting their bodies (3,19,27,42). For example, a woman who was sterilized by force explained "no longer feeling useful […] I am no longer a real women" (3, p.341) because she lost her ability to give birth which was described as being an essential value and assigned role in the Namibian culture. The loss of virginity through abuse was also closely linked to the loss of identity within the Rwandan cultural context (27). Feelings of dehumanization were also mentioned, with individuals feeling "abnormal" (41) and less than a person (28,40) leading them to believe they deserved what happened to them (18,28). Other people expressed feeling permanently damaged since the traumatic experience (8,21,25,31).

Feelings of helplessness were described in 13 articles (29 %). Those feelings were present during the abuse (8,15,30) and after because of the trauma itself (2,5,15,18,41,43), but also the environment surrounding the individuals, e.g., unsupportive relatives (31) or cultural norms normalizing violence against women (18,31,41). People also reported feeling powerless when their own governments were responsible for their sorrow (35,38,43) or did nothing to ensure justice (3,26). In the case of Oromo refugees (35), they stated that their mental health was directly influenced by the political situation in their home country and their feelings of helplessness related to it. Participants from Sudan (43) highlighted how the situation back home changed their self, leading them to feel helpless about their own situation in the resettlement country and undermining their ability to integrate (e.g., by learning the language or working). This loss of agency was also described by refugees in camps who could not make any progress or take any decisions to improve their situation (11).

3.5.3. Disturbed interpersonal relationships

Globally, 34 studies reported features of disturbed relationships (76 %). Social withdrawal, i.e., self-isolation or the actual avoidance of social gathering, was reported in 15 studies (1,4,11,14,16,19–22,26,34,37,41,45,47). Some people isolated themselves due to perceived stigma related to their past experiences but also their sexual orientation or HIV status (1,26,34,41,47). For others, the pervasive traumatic memories caused them to opt for solitude

(11,16,37,45), while others reported that they were now afraid of others (11,19) or that they lost interest in socializing (11,14,16,22). A minority referred directly to the avoidance of social or religious gatherings (1,11,16,47).

Fourteen studies mentioned difficulties in relationships which were either focused on the maintenance of previous relationships (13,15,22,25,37,41,44) or on the establishment of new ones (11,12,21,28,31,40,42). For the latter, people explained being afraid of being rejected by others and were considering relationships as being too painful or too risky, sometimes leading them to a lack of interest in intimate relationships (11,12,28,31,40). Due to early traumatic experiences, others described no healthy references in the way they were supposed to interact with others, leading to inappropriate behaviors from both sides (21). Regarding previous relationships, one study in Burundi (37) mentioned how parental practices were also affected with parents being easily angered and more eager to beat their children or, on the other hand, parents avoiding physical punishment due to their own traumatic experience. In both cases, their reactions were perceived to be deviant compared to expected parenting practices, making it difficult to maintain a healthy relationship.

Mistrust was portrayed in 14 studies. People expressed feelings of distrust towards the government back home (3,11,35,38), as well as the diaspora or community members (6,11,35), because they feared to be denounced if they said or did anything against their country – "Not only are people harmed, the whole of society is infected by distrust, veiled hatred and fear" (38, p.7). General mistrust of others was also reported (4,19,21,25,31,42,46), targeting men in case of past sexual abuses (8,19,31) and even affecting close relationships, i.e., family members, friends, or intimate partners (21,25,42,46) – "even if I am close to you, I do not trust you. I am always suspicious" (42, p. 3213). Living in distrust enhanced social withdrawal, emotional and social distance, as well as hypervigilance, and negative feelings toward others. Those feelings were portrayed in 10 studies including terms such as hate (12,15,32,38,47), resentment (38,44), and the desire to hurt others (2,19,22,23,32). Such feelings were addressed to the perpetrator of violence, e.g., partner in case of IPV or whistleblower neighbors in case of genocide, but could also be generally expressed. Increased conflicts and difficulties to solve them were also reported within couples (25) as well as within the community (16).

Thirteen samples described feeling distant from others by feeling alienated or different (14,21,22,25,28,31,40,47) leading to social distance (14,25,28,31,40), and feeling of isolation and lack of support (6,41). Fear of gossip, judgement and discrimination, as well as preserving the honor of the family name, were also cited as reasons to keep secret the abuse one suffered, worsening the distance between the victims and the community (6,12,41,44,47) – "I have to swallow everything inside and keep what happened to me inside, because what will the people say?" (6, p.5). Others mentioned feeling misunderstood (12,21,41,43,44) with the associated belief that "people who did not experience similar abuse wouldn't be able to truly empathize" (p.44, p.7).

3.5.4. Change in system of meaning

A total of 21 articles addressed changes in one's system of meanings (47 %). The most prominent feature was feelings of hopelessness which was described in 17 studies (3,4,7,11, 12,14,17,18,21–23,27,28,32,37,43,47). The loss of hope was related to their actual situation, e.g., living in an abusive relationship (18,28), having difficulties to fulfil basic needs (4,11,14, 17,37, 43), living with the aftermath of the traumatic experience (3,11,12,14,17,21,32,37,43,47), but also the way they perceived the future (4,7,22,23,27,43) – "'my future is still dark … I can't see it, no lights, not any.'" (43, p.2246). The uncertainty about their future was either linked to the still vivid perception that the traumatic experience could happen again no matter the context, or to the instability of their situation. Another frequent narrative was the inability to see a future for themselves because of the way the trauma has affected them, e.g., women who have been sterilized or are no longer virgin would not be able to get married because of the cultural expectation regarding gender-norms (e.g., 27), resulting in loss of life's meaning (7,18,26–28). Occasionally, those feelings gave rise to suicidal ideations or led to actual attempts (7,11,21,27,28,47) with people explaining "They will even prefer being dead than alive." (47, p.9).

Another interesting aspect that was reported in six studies was the change in the way the world or others were perceived. Participants revealed seeing the world as a dangerous place now and considered others as a potential threat – "He killed that part of me which was free to walk around and talk to people, now I have to be aware of people around me" (8, p. 15). Their fear was directly related to their traumatic experience; they could not help but think about their environment as dangerous. Participants from Central Africa (32) narrated that the violence and atrocities they have been through or witnessed had "destroyed [their] morality" (p.220). Those experiences provoked a desire for revenge, which was against their moral values and led them to a sense of being permanently and fundamentally changed.

3.6. Idioms of distress

Although the retrieved studies reporting on cultural concepts of distress are presented in a separate article (Bovey et al., 2024), it is noteworthy to highlight some meaningful expressions and metaphors reflecting local idiomatic interpretations that were used by participants to express trauma-related symptoms. Somatic metaphors related to the heart were used to express emotions such as anger, sadness, worries (14, 16,20,22–25,29,36,43) and sometimes the physical sensations were understood as the emotion itself – "heart paining is when my heart burns, and I feel like black ants are biting it. When my heart is paining, I cannot do anything because I just have to sleep on my chest" (24, p.7). Indicators of temperature were sometimes used to describe anger such as having fever, the heart burning or boiling (24). Thoughts, on the other hand, were often located in the mind or the head (14,20,23,24). A process of contamination between the heart (i.e., emotions) and the mind (i.e., thoughts), and vice-versa, was also described, which then impacted the body: "I was tortured in my mind and I developed anger and hate in my heart. That resulted into sweating and fast pumping of the heart" (23, p.9). When discussing the repercussions of trauma, participants expressed the lack of inner peace, e.g., "my soul is not in peace." (14, p. 628).

3.7. Other symptoms

Along with PTSD and DSO features, 43 studies also reported on other symptoms which do not fall under any of the categories presented yet. The most common additional manifestation of distress was suicidality, with 21 studies reporting it as a response to strong unpleasant emotions but also feelings of shame and hopelessness. Ideation were more frequently reported (N = 19) than attempts (N = 8). Participants who expressed such thoughts often explained they could not act on them because of their children or religious believes. Sleep disturbances were described in 18 studies as insomnia due to ruminations, fear of recurrence or nightmares, as well as multiple wakening through the night or excessive sleep. Studies also reported on depressive symptoms (N = 17), ruminations with the expression "thinking too much" being commonly used (N = 16), somatic symptoms (N = 15), concentration difficulties (N = 13), dissociative symptoms (N = 8), and grief (N = 4). See Table 6 for examples from the primary research and frequencies.

4. Discussion

This systematic review examined qualitative research that explores the experiences and manifestations of PTSD and CPTSD symptoms in the SSA region. Forty-seven studies using different samples have been

Table 6
Summary of other symptoms and their frequency (N = 43).

Symptoms	*Examples from the texts*	*Frequency (%)*
Suicidality	"it's better to die and rest" (24); "killing myself no, but I wish God can just take my life" (28); "contemplating suicide" (39)	21 (49 %)
Sleep disturbances	"excessive sleep and nightmares" (18); "an inability to sleep" (42); "poor sleep habits" (47)	18 (42 %)
Depressive symptoms	"feelings of depression" (1); "depression" (35), "depressed mood" (42)	17 (40 %)
Ruminations	"thinking too much" (16); "lots of thoughts" (24); "the person worrying too much […] it's like the mind is very far (47)	16 (37 %)
Somatic symptoms	"stomachaches and headaches" (7); "general body weakness" (13); "high blood pressure" (14); "heart attack […] the heart beating intensely" (20); "chronic pains" (21); "ulcers […] weakened system" (24); "hypertension" (36)	15 (35 %)
Concentration difficulties	"I can't think properly and I'm forgetful" (14); "trouble concentrating" (22); "I lost my attention" (39)	13 (30 %)
Dissociative symptoms	"Physically you might be present together with people but mentally you are totally not there" (3); "as if he looked at others through a glass wall" (21); "psychic numbing" (32)	8 (19 %)
Grief	"loss of their loved ones" (16); "symptoms of grief" (23)	4 (9 %)

Note: Features in the table were ranked by taking the product of their frequencies. Frequencies were calculated based on total number of studies reporting Other symptoms (i.e., 43).

identified. Only 19 out of 49 countries of SSA were represented in the selected literature. These findings reveal the lack of resources allocated to research in certain regions and the power dynamics at play. Although we have grouped all countries together, it is essential to keep in mind that each of them encompasses a variety of cultural groups, religions, and ethnicities. Thus, our results shed light on some groups, while they leave others in the dark. Additionally, none of the studies specifically focused on CPTSD and its symptoms. Consequently, the purpose and level of detail provided varied significantly among the studies.

4.1. Phenomenology of CPTSD in SSA region

Our findings confirmed the presence of PTSD symptoms and the three DSO clusters in the SSA region. However, manifestation of the DSO symptoms varied greatly from the ones that have been defined in the ITQ and ITI. Fig. 3 illustrates the constellation of symptoms per DSO cluster that have been reported by participants in the different studies. The closer to the center the more frequently they were mentioned. For affect dysregulation, results show that anger outbursts, constant sadness, and behavioral expressions such as aggression and unusual crying were more frequently reported than numbness or the difficulty to calm down. Similarly, for the self-concept, shame and guilt were slightly more prevalent compared to feeling worthless, and a multitude of other difficulties were mentioned. Feeling like a failure was only expressed once. Reported symptoms of disturbed relationships were closer to the ones used in the actual diagnostic tools (i.e., ITQ and ITI) with difficulties in relationships, social withdrawal, mistrust and feeling distant being almost equally endorsed by participants. Finally, an additional cluster emerged from our analysis – the alteration in the system of meaning – which was defined by hopelessness, changes in values and lack of life meaning. This indicator was part of the original conceptualization of CPTSD as a diagnosis criterion (Herman, 1992; Pelcovitz et al., 1997; van der Kolk et al., 2005) and adresses the exisential component of trauma. As for this additional cluster, most manifestations of DSO clusters found to be relevant in the context of SSA were also part of earlier conceptulisations of the disorder.

4.2. Insights from cultural scripts

Cultural scritps provide a framework to apprehend why certain manifestations appear to be more salient in the SSA region. The definition of functional emotion regulation, a valued sense of self, and optimal relationship patterns are all shaped by culture (Chentsova-Dutton and Ryder, 2020). Consequently, symptoms, which can be seen as deviant scripts, are intricately linked to normative scripts and can vary based on what is expected in a given-context. SSA countries tend to exhibit a collectivist orientation that emphasizes the importance of maintaining social harmony (Cheng et al., 2011; Eaton and Louw, 2000; Markus et al., 1997; Pelham et al., 2022; Triandis, 2015; Vignoles et al., 2016). Some authors also referred to *Ubuntu* or communalism as "African values of collective relatedness, interdependence, communality, group solidarity, and conformity" (Kpanake, 2018, p. 201). In this perspective, individuals' behaviors are shaped by norms and roles, with priority given to collective needs, the self being intrinsically related to the community (Etta et al., 2016; Schwartz et al., 2010). Moreover, "the self is not an entity that exists on its own, but only insofar as it connects the past to the future" (Markus et al., 1997, p. 43). In this conception, ancestors are fully part of the community as guardians of its obligations, norms and roles, and the person is defined by its place in the social chain linking past with present (Kpanake, 2018; Markus et al., 1997; Wissing et al., 2020).

One prevalent script that consistently arises in the selected articles is the concept of gender norms, which encompass prescribed roles, behaviors, and societal positions expected from individuals based on their gender. For instance, several articles reported a strong stigma surrounding sexual violence, primarily rooted in the perception of women as mothers and the emphasis placed on marriage and virginity (e.g., Denov and Piolanti, 2019; Morgan et al., 2020; Mukamana and Brysiewicz, 2008). Patriarchal norms were also described as contributing to the normalization of violence, as feminine participants often expressed a sense of futility and helplessness when it came to disclosing IPV or sexual abuse (e.g., Keynejad et al., 2023). Additionally, norms related to masculinity have been reported in relation to the prescribed norm of heterosexuality in Muslim societies (Alio et al., 2022). These norms related to gender, religion, status, and collectivism all influence cultural scripts related to emotions, to definitions of the self, and to relationships. The following sections will address each of them more thouroughly.

4.2.1. Emotion regulation

Our findings highlight two types of emotional regulation strategies prevalent in the context of SSA: suppression and masking of emotions. Both strategies are described as adaptative, aligning with the importance of situational adjustement rather than openly expressing emotions, which could potentially disrupt group harmony (Mesquita et al., 2014). Consequently, any uncontrolable expression of emotions, such as anger outbursts, aggression, constant sadness, or unusual crying, can all be considered deviant scripts, since the norm is to express emotions in a way that maintains social bonds or to suppress them. While difficulty in calming down may also be present in the SSA population, the very act of expressing uncontrolled emotions is already a significant violation of normative scripts probably making these symptoms more salient. Likewise, in the case of numbness, it is possible that this symptom has been reported less frequently due to its manifestation being more aligned with the normative cultural script, making it more difficult to identify for the individual and its entourage (Chentsova-Dutton and Ryder, 2020).

Another interesting aspect that emerges from the data was the embodied expression of emotions. Many participants used somatic metaphors to describe their emotional state such as "pain in the heart" (e.g., Morgan et al., 2020, p. 1137), "crying in your heart" (e.g., White et al., 2020, p. 2244), "heart attack" (e.g., Koegler et al., 2019, p. 366), "having nerves" (e.g., Kagee, 2004b, p. 628), and also described a range of somatic symptoms as signs of their distress. It would be simplistic and inaccurate to interpret these somatic symptoms merely as consequences

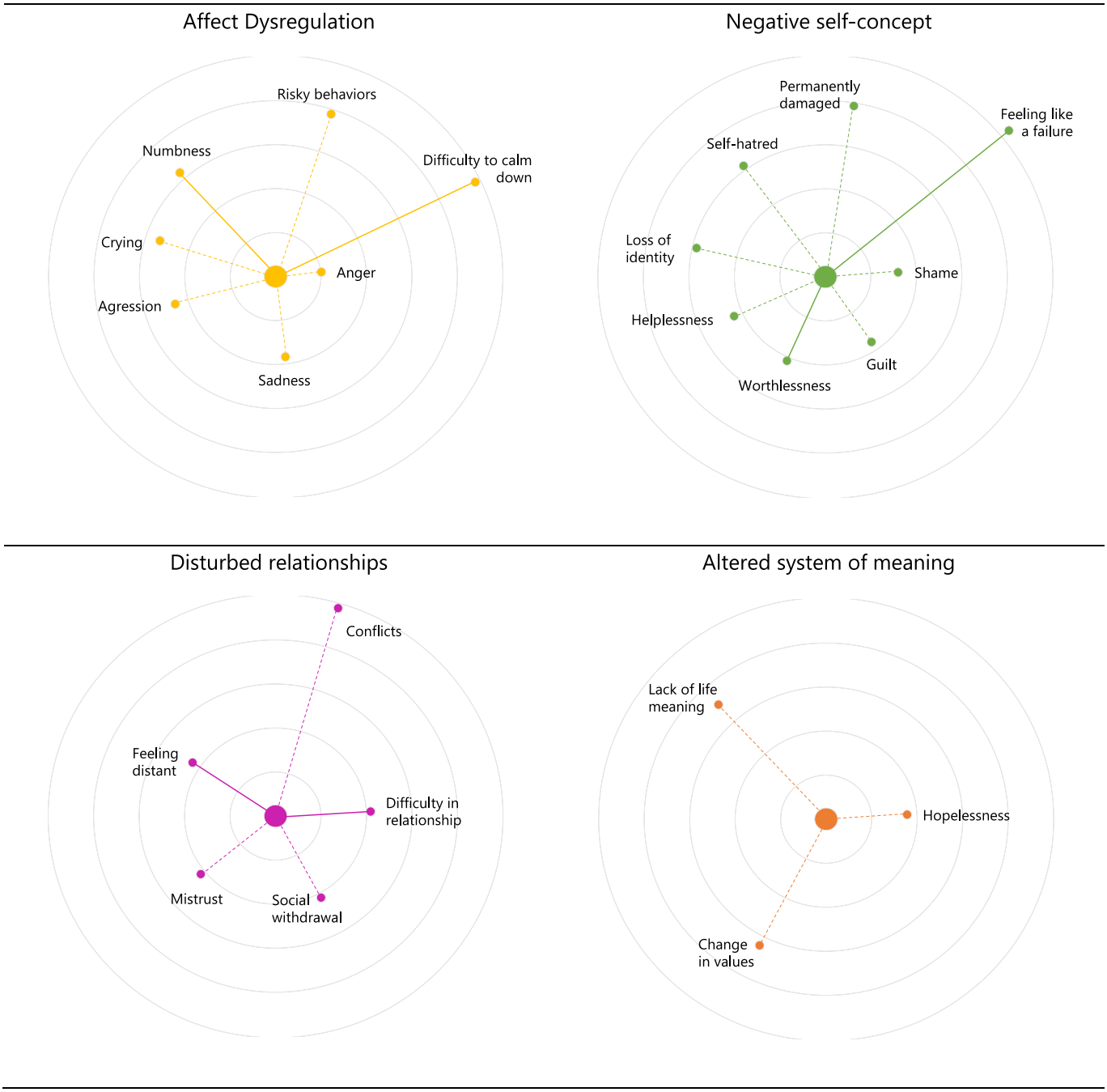

Fig. 3. Constellation of symptoms per cluster. N**ote:** The closer the symptoms are to the center, the more frequent they are. Solid lines indicate core symptoms from the latest version of ITQ and dashed lines indicate additional symptoms.

of emotional suppression strategies prevalent in the SSA context (Dzokoto, 2010). Instead, these findings underscore the inextricable link between the body and the mind in the conceptualization of the person in SSA (Kirmayer et al., 1998; Mbaegbu, 2016; Musana, 2018), emphasizing the diverse ways in which emotions are experienced and expressed in various contexts.

4.2.2. Self-concept

In our review, shame and guilt emerged as the most frequently described features of negative self-concept. These emotions are considered socially engaging, i.e., they play a role in maintaining group harmony and motivate the individual to restore it when it has been disrupted (Kitayama et al., 2006). Shame was predominantly reported following IPV or sexual abuses, which violate cultural scripts pertaining to women, their body and the associated virtues such as virginity and creating life. Moreover, shame was frequently associated with the fear of social judgement and emerged as the primary reason for non-disclosure of traumatic experiences. For example, Ethiopian women who experienced IPV were very reticent to "divulge secrets" due to shame associated with violating social norms of spousal unity (Keynejad et al., 2023,

p. 6). Shame and fear of judgement are known to inhibit the propensy to share emotional experiences socially (Rimé, 2005) and increase the tendency to mask symptoms (Chentsova-Dutton and Ryder, 2020). Some participants described being stuck between the impossibility for disclosure and the distress related to keeping the secret: "You become scared of telling people what happened to you, because you fear that they will judge you. […] What's killing you inside is the fact that the more you don't talk about it, the more it haunts you" (Watt et al., 2017, p. 3213).

Those who did disclose their experiences, voluntarily or involuntarily, often faced stigma from their own community or family, in addition to internalized stigma such as self-blame and guilt, resulting in rejection and exclusion (e.g., Kahn & Denov, 2022; Tenaw et al., 2022; Woldetsadik et al., 2022). Another relevant feature described was the loss of identity caused by the traumatic experience. Indeed, as Nsamenang and Lamb (1994, cited in Markus et al. (1997) state: "human offspring need other humans to attain full selfhood: A sense of self cannot be attained without reference to the broader community" (p.42). Aligned with this perception, many women defined themselves through their assigned roles as wifes and mothers. When trauma deprived them of these possibilities, e.g., through forced sterilization or rape, women reported losing their sense of belonging, feeling useless and hopeless (e.g., Bakare and Gentz, 2020; Knettel et al., 2019; Mukamana and Brysiewicz, 2008). Worthlessness was not really defined as a lack of self-esteem but more reflected the evaluation of the self in relation to others and the ability to fulfill ascribed roles (e.g., Horn, 2010; Igreja et al., 2006; Zunner et al., 2015). Therefore, social emotions such as shame and guilt, along with the sense of identity and worthlessness as community members, may be more relevant in capturing the impact of traumatic experiences on the interdependent self, as opposed to attributes strictly related to the independent self such as self-esteem or feeling like a failure.

4.2.3. Relationships

Both feelings of detachment from others and actual withdrawal from social interactions have been reported. This holds significant emotional importance within a cultural context in which the definition of a human being resides intrinsically in its affiliation to the community and its participation in activities that give a sense of belonging (Wissing et al., 2020). The concept of the interpersonal loop, proposed by Chentsova--Dutton and Ryder (2019), provides a framework for understanding the development and maintenance of symptoms following a traumatic experience, incorporating cultural scripts. This model illustrates a self-perpetuating cycle that involves the traumatic experience and resulting symptoms (1), leading to the fear of judgment or stigma if the trauma is disclosed (2), a feeling of shame related to the violation of cultural scripts (3), subsequent social withdrawal (4), and a lack of support and potential reproach from the community (5), which can further exacerbate the symptoms. This vicious cycle that has the potential to amplify distress and maintain the negative impact of the initial traumatic experience, was partly described in several articles included in this review (e.g., Mtiya-Thimla and Van der Merwe, 2021; Scott et al., 2017; Zunner et al., 2015). In addition, two articles examining Sudanese and Ethiopian samples shed light on normative cultural scripts that highlight the expectation of social support being offered by others rather than actively sought out by individuals themselves (Tenaw et al., 2022; White et al., 2020). This aligns with the values of communalism, where "mutual help is a widespread trait of social life" (Etta et al., 2016, p. 306). However, the presence of the interpersonal loop increases the risk for individuals experiencing trauma-related distress to withdraw from their community, ultimately depriving themselves of the inherent social support available to them.

Our findings also highlight the fundamental role of mistrust inherent to the SSA context and the types of traumatic experiences undergone. Mistrust was expressed towards the agressors, namely governments, partners, members of enemy ethnic groups but was also generalized to other people. We witness here a double movement; on one hand, the bond of trust is broken between the individuals and their aggressor, and on the other hand, the individuals distrust their own community. As Tankink (2004) emphazised, in certain contexts where your enemy was and remains your neighbor, there is a need for social healing because "the whole of society is infected by distrust, veiled hatred and fear" (p.7). In this example, as well as in other studies (e.g., Christie et al., 2020; Duma et al., 2007b; Horn, 2010; Watt et al., 2017), the feeling of mistrust goes alongside the change in the system of meaning, i.e., one's perception of the world and most precisely the community as a safe place has been replaced by hate and mistrust. Within the context of SSA, where communalism is the prevailing norm, the bonds within communities hold strong significance, serving as vital sources of support and healing. However, in many cases, trauma damages those bonds of the individual with his or her community or even the coherence of the group itself, amplifying the saliance of those symptoms. Without understanding normative scripts, it is impossible to fully apprehend the specific repercussions of this symptoms cluster on both the individual and the community.

4.3. Structural factors and their impact on the diagnosis formulation

Several structural factors were reported in the selected studies and different mechanisms of action were described. Poverty, low socioeconomic status, lack of education, lack of employment, lack of opportunities, lack of money, lack of food, loss of properties such as houses or lands, inability to fulfil basic needs of the family, unsafe environment, and discrimination were all commonly reported. Some additional aspects were depicted by individuals who had to flee their home (i.e., refugees or internally displaced persons) including poor conditions in refugee camps, disappointment regarding their situation, feeling of being stuck without knowing for how long, uncertainty, restriction of movements, injustice, insecurity, poor health facilities, family separation, family expectations, and their need to adapt to a new culture and language.

Most articles depicted structural factors as causes of CPTSD symptoms, independently or in addition to trauma (e.g., Denov and Piolanti, 2019; Hughes et al., 2021; Kohrt et al., 2014; Tankink, 2004). For instance, hopelessness was related to unemployment for South African former detainees (Kagee, 2004b), or to disillusion regarding migration and family separation for refugees in Kenya (Horn, 2010). Anger was described as both the results of traumatic experiences as well as ongoing frustrations about their current situation by refugees and IDs (e.g., Kaiser et al., 2020; Kandemiri, 2019; Shannon et al., 2015). In case of IPV, the fact that women were unable to provide for their family, often led them to stay in the abusive relationship, in addition to stigma and norms violation, worsening their situation and the risk of traumatic sequelae. Another article descibed how poverty compromised individuals ability to cope with stress and anger leading them to use alcohol and to be more sensitive and easily resorting to physical violence (Zietz et al., 2022). When asked about their main concerns in life, participants often mentionned structural factors ahead of mental health concerns (Kagee, 2004b; Mootz et al., 2019; Patel et al., 2020). Before individuals can even reflect on their mental well-being, structural factors and therefore basic needs must be adressed, as these are regarded as the root cause of their distress.

4.4. Implication for practice and future research directions

In a context such as in SSA countries, understanding how structural factors impact individuals' mental health, especially in relation to the emergence of symptoms associated with CPTSD, holds significant importance. The accurate diagnosis of CPTSD requires the ability to differentiate symptoms directly resulting from trauma from those induced by structural factors, as the presence of trauma-induced symptoms is a key criterion. Therefore, it is imperative to incorporate

structural factors into diagnostic tools to distinguish false positives from true positives and to develop appropriate treatment plans accordingly. Following the Lancet commission's suggestions (Patel et al., 2018), we propose the implementation of a staging approach with tailored care to improve cost-effectiveness and therapeutic outcomes. Specifically, if symptoms appear to be predominantly related to structural factors, a transdiagnostic approach could be considered to provide functional support. In cases of CPTSD, specialized treatment is recommended. However, in both scenarios, the social and political aspects of the distress should not be overlooked and calls for a holistic and multidisciplinary approach to provide comprehensive care.

Researchers increasingly emphasize the necessity to adapt mental health assessment interviews and questionnaires, as well as treatment to diverse cultural groups (e.g., Forehand and Kotchick, 1996; Hall et al., 2016; Heim et al., 2022). In accordance with ICD-11's guidelines of clinical utility and international applicability, and building on a proposal by De Jong et al. (2005) to combine universal and local modules to capture culture-specific expressions of extreme stress, we advocate for the creation and implementation of cultural modules as add-ons to the actual CPTSD diagnostic tools, i.e., ITQ and ITI. This approach has already been instigated for prolonged grief disorder (PGD) by Killikelly and Maercker (2023), with good results. Therefore, cultural modules should propose culture-specific symptoms reflecting core DSO clusters (e.g., in the SSA context, anger outburst, shame, guilt, mistrust) using local terms and systems of meaning related to emotions, relationships, and the self. They should also incorporate any culture-specific processes and related symptoms that diverge from Western nosology, e.g., the existential component of trauma or CCDs. In addition, it should also address important structural factors.

Findings of this systematic review are a first step and we can only emphasize the need for more emic research to gain deeper insight into local perceptions of trauma-related distress. Indeed, the identification of the three DSO clusters in the SSA context tells us nothing about how symptoms are understood, manifested, interpreted, and managed, nor does it shed light on their severity. The underlying cultural interpretation of the distress and its manifestation is crucial in constructing effective local modules. It is, moreover, a first step to reopen the dialogue on the cultural formulation of CPTSD and its assessment.

5. Conclusion

Trauma, as a concept, is not a fixed and universal entity; rather, it is a social construct that is intricately intertwined with the context of its time and cultural setting (Summerfield, 2001). Different cultures and histories shape the way individuals perceive and respond to adverse experiences and try to make sense of it. Yet, no matter the place or the time, trauma always intrudes in people's lives, disrupting their inner organization to varying degrees. What sets apart different cultural contexts is the use and acknowledgement of specific cultural scripts for expressing trauma-related distress. While we assume that PTSD and DSO clusters may be universal features, the way they are expressed and coped with is culturally defined. Hence, it is imperative to recognize and account for cultural and structural factors when diagnosing and treating CPTSD in diverse cultural settings. By integrating cultural and structural considerations into clinical practice and research, we can strive for more inclusive and effective approaches to support individuals impacted by trauma-related distress in diverse regions of the world.

CRediT authorship contribution statement

Marion Bovey: Conceptualization, Data curation, Formal analysis, Investigation, Visualization, Writing – original draft, Writing – review & editing. **Nadine Hosny:** Formal analysis, Investigation, Methodology, Writing – review & editing. **Felicia Dutray:** Validation, Writing – review & editing. **Eva Heim:** Conceptualization, Supervision, Validation, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmmh.2024.100298.

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