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Review

How is trauma-related distress experienced and expressed in populations from the Greater Middle East and North Africa? A systematic review of qualitative literature

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ABSTRACT

The Greater MENA region has high rates of political, social, and structural violence exposure, however there is a discrepancy in reported rates of PTSD in comparison with other areas of the world. This may be due to cultural variations in the conceptualization and expression of traumatic stress. More generally, there has been ongoing tension between theories of universality versus cultural variance in mental health. Quantitative evidence shows that similar symptoms emerge in the aftermath of trauma across cultures. At the same time, a growing body of evidence indicates the integral role of culture in shaping the etiology and phenomenology of mental disorders. Research exploring local narratives of individuals exposed to violence within the Greater MENA region is increasing, but no review has summarized findings of this body of research yet. This systematic review aimed to critically examine qualitative literature investigating how PTSD, CPTSD, any other forms of culturally-acknowledged trauma-related distress are experienced and expressed among people living in the Greater MENA region. Results covered CCD, culturally normalized symptoms of distress, PTSD, and CPTSD symptoms. Main symptom clusters of PTSD and CPTSD were endorsed with variations on particular symptom expressions. Studies provided sociocultural norms guiding such symptom expressions and highlighted the importance of structural factors in maintaining and perpetuating traumatic distress. The discussion section situates these findings within broader literature to deepen our understanding, and thus provide practical and research recommendations for more comprehensive and culturally-relevant understanding, diagnosis, and treatment of traumatic stress with the Greater MENA region.

1. Introduction

For years, the Greater Middle East and North Africa (MENA) region has been witnessing prolonged situations of violence and humanitarian emergencies. The Greater MENA region includes Arab countries, in addition to Afghanistan, Iran, and Turkey (Carothes and Ottoway, 2004). More than half of the 89.3 million forcibly displaced individuals worldwide originate from the Greater MENA region due to political persecution, armed conflicts, human rights violations, and social unrests (UNHCR, 2022; Wachter et al., 2018). Most refugees in Greater MENA are either internally displaced (ID) or spend years displaced in neighboring low- or middle-income countries (LMICs). Only a small percentage is permanently resettled in high-income countries (HICs) (UNHCR, 2022). Those who are resettled still face considerable post-migration living difficulties (Li et al., 2016).

Given the intricate history of colonialism and imperialism in the Greater MENA region, many countries in the area face structural challenges, including issues like unemployment, limited education, and limited access to essential services. The region exhibits significant inequalities related to factors such as rural/urban areas, gender, ethnic minorities, etcetera (Krishnan et al., 2016). Almost 60% of populations are exposed to poverty and vulnerability (Khouri, 2019). Such conditions in settings of political violence or social unrest are generally associated with other forms of interpersonal violence (Boxer et al., 2013). Accordingly, reports show that refugee or ID camps have elevated rates of violence and militarization (Reed et al., 2012). The

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region also has a high prevalence of other forms of violence in both general population and refugee settings, for instance gender-based violence (GBV) (Boxer et al., 2013; Green et al., 2022; UNICEF, 2021).

This heavy violence exposure puts a mental burden on individuals and communities. Reports indicate a higher prevalence of common mental disorders (CMD) such as depression and anxiety (GBD, E. M. R. M. H. C, 2015) in this region compared to other parts of the world. Simultaneously, World Mental Health Surveys found a moderate lifetime prevalence for post-traumatic stress disorder (PTSD) in two MENA countries (i.e., 3.4% for Lebanon and 2.5% for Iraq). These rates were lower than the mean PTSD lifetime prevalence in HICs (5%) (Koenen et al., 2017). This difference raises questions regarding the reliability and applicability of the PTSD diagnosis among populations affected by high exposure to violence in the Greater MENA region.

1.1. Culture and traumatic stress: current state of the literature

There is an ongoing debate about "universality" versus "cultural variance" in the phenomenology and etiology of mental disorders in general (Antić, 2021; Kleinman, 1987), and PTSD in particular (Bracken et al., 1995; Droždek et al., 2012). On the one hand, researchers have worked toward identifying key symptoms that may occur in response to traumatic exposure cross-culturally. In its most recent edition, the International Classification of Diseases (ICD-11) (WHO, 2018) presents two "sibling disorders" in this domain: PTSD and complex PTSD (CPTSD). PTSD includes three symptom clusters: intrusions (i.e., re-experiencing trauma in the present), avoidance of traumatic reminders, and an enhanced sense of threat and hypervigilance. CPTSD is a newly introduced disorder which was developed to establish the pervasive psychological disturbances emerging from prolonged, extreme, recurrent, and often inescapable traumatic experiences, such as interpersonal trauma, child abuse, political violence, torture (Brewin et al., 2017). CPTSD was first introduced by Judith Herman in 1992 (Herman, 1992). Then later in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994), the diagnosis of *disorders of extreme stress not otherwise specified* (DESNOS) was introduced. In 2018, building upon both previous diagnostic concepts, the ICD-11 introduced the current CPTSD diagnosis, which entails meetings all the PTSD diagnostic criteria, in addition to three other symptom clusters described as *disturbances in self-organization* (DSO): affective dysregulation, negative self-concept, and disturbances in interpersonal relationships (Maercker et al., 2013). Since the conceptualization of CPTSD diagnostic criteria, tens of studies confirming the factorial structure of the CPTSD diagnosis in clinical and non-clinical samples across diverse cultural settings have been published (Brewin et al., 2017).

On the other hand, scholars like Arthur Kleinman (1987) criticize the assumption of universal diagnostic categories for mental health difficulties, including trauma-related ones, without considering the variations in cultural, and historical contexts. While scholars like Derek Summerfield (1999) question the exclusion of sociopolitical determinants of mental health, such as poverty, inequality, and ongoing violence, from trauma models, highlighting their impact on variations in trauma conceptualization and symptoms across different contexts. In recent years, and in response to this critique, there has been a growing body of qualitative research on phenomenological responses to trauma exposure in non-Western contexts (Kohrt et al., 2014; Michalopoulos et al., 2020; Rasmussen et al., 2014). Such studies provide evidence for *cultural concepts of distress* (CCD), entailing idioms of distress, explanatory models (i.e., causal attributions), and beliefs concerning treatment options. Through this type of qualitative research, scholars have been able to identify culture-specific symptoms and forms of distress across different cultural groups (Hinton and Lewis-Fernández, 2010; Rasmussen et al., 2014).

1.2. Culture and traumatic stress: in search of a dialectic approach to diagnosis and treatment

In response to this ongoing debate, we use in this review a dialectic approach that was based on a proposition by de Jong et al. (2005). They conducted a study on the equivalence of diagnostic criteria for DESNOS—the predecessor diagnosis of CPTSD in DSM-IV—across three post-conflict populations. Using the Structured Interview for DESNOS – SIDES (Pelcovitz et al., 1997), they found that certain aspects of the DESNOS diagnostic criteria were not stable across study samples, and that certain features were less prevalent than among Western samples. Based on their results, the authors suggested defining three types of symptoms: (a) core symptoms that are the same across cultures, (b) symptoms that are unique to a culture but reflect universal underlying problems, and (c) expressions of culture-specific processes that have specific symptoms, which include CCD.

Empirical findings in domains of other mental disorders, such as depression, anxiety, and prolonged grief disorder (PGD), indicate that using culturally invariant symptoms along with culture-specific symptoms (types [b] and [c]) enhances the validity of screening instruments (Hinton et al., 2018; Killikelly et al., 2020). Similarly, studies on the MENA region (e.g., Miller et al., 2006) show that these populations present PTSD symptoms along with other symptoms or CCD that are more salient and pertinent in their cultural context.

This research is yet to be done for CPTSD. Currently, there are two validated assessment tools to diagnose PTSD and CPTSD according to ICD-11 diagnostic criteria: the International Trauma Questionnaire (ITQ) (Cloitre et al., 2018) and the International Trauma Interview (ITI) (Roberts et al., 2018), which is the clinician-administered interview version of the ITQ. Originally, the ITQ included 28 items derived from the new diagnostic criteria (Cloitre et al., 2018). To follow the same guiding principles as ICD-11 (which is to maximize the clinical utility and international applicability through a focus on culturally invariant core diagnostic clusters; (WHO, 2018), researchers used results from endorsement rates, discrimination, and clinical relevance of symptoms in a British sample to reduce the ITQ's final validated version to 12 items (i.e., two items per symptom category). While the final ITQ has been tested in various cultural contexts, what remains to be done is examining possible symptom variations (type [b] and [c] symptoms) across cultural groups to determine if its accuracy can be enhanced.

Exploring cultural variation in CPTSD symptom-expression is crucial for understanding the disorder, as DSO symptoms are shaped by cultural norms (Heim et al., 2022). In their conceptual review on cultural variation in CPTSD symptomatology, Heim et al. (2022) found that psychological processes like emotion regulation, expression, self-concept, and interpersonal relationships vary considerably across cultures, suggesting that DSO symptoms will also vary accordingly. However, evidence on these cultural aspects of the DSO remains limited, partly due to the "novelty" of this diagnostic category. Currently, most literature focusing on cultural variations in traumatic-stress has primarily centered on PTSD and relevant CCD. One review (Michalopoulos et al., 2020) identified symptom-overlaps with CPTSD, urging future investigators to comprehend these symptoms in diverse cultural contexts.

Also, to our knowledge, no existing reviews offered detailed qualitative descriptions of trauma-related presentations or phenomenology in the sociocultural context of the Greater MENA region. Recent reviews covering adult trauma-related disorders in the region have either looked at conceptualizations of trauma and the diagnosis of traumatic stress (Hosny et al., 2023) or at prevalence rates (Al-ghzawi et al., 2014; Amawi et al., 2014). Our present review assessed the impact of cultural and structural factors on all three types ([a]–[c]) of trauma-related symptoms, with a particular focus on the DSO symptoms due to their novelty. We aimed at providing a thick description to contextualize different forms of distress in this region. The results can hopefully be used in treatment planning and adaptation (Heim and Kohrt, 2019).

1.3. Cultural and structural aspects in PTSD and CPTSD

Culture is a dynamic value system, a set of beliefs, practices, and ways of life which are constantly interacting with other contextual factors (Lewis-Fernández and Kleinman, 1995; Napier et al., 2014). Culture is introduced and instilled during early stages of life through "cultural scripts" (Chentsova-Dutton and Maercker, 2019; Kleinman, 1987). *Cultural scripts* are sequences of shared perceptions, cognitions, emotions, and behaviors that are causally interlinked. They include both mental representations (e.g., beliefs, values, meanings, expectations) and observable, structured practices (e.g., consensually understood behaviors). Cultural scripts are integral to understanding "normativity" and "deviance," which are needed to comprehend psychological functioning (Chentsova-Dutton and Maercker, 2019). By comparing socially approved, normative ways of thinking, feeling, and behaving versus socially undesired or "deviant" ways, including presentations of mental disorders, we can explore cultural understandings of pathology and symptom presentations (Chentsova-Dutton and Ryder, 2020).

Intersectional theories of trauma propose that culture is distinct yet deeply intertwined with structural factors such as social status, income, discrimination, or political oppression (Bryant-Davis, 2019). Traumatic exposure and distress are embedded within other forms of social, economic, and political inequalities (Bryant-Davis, 2019; Summerfield, 1999). Such persistent difficulties and inequalities emerge from a complex interplay of colonial and historical legacies, economic policies, cultural biases, institutional practices, and geopolitical factors (Farmer, 2004). Various terms from different disciplines have been used interchangeably, including social suffering (Kleinman, 1997), structural violence (Farmer, 2004), or structural factors or social determinants of mental health (Holmes et al., 2020) to describe these systemic daily-life challenges that can have a direct and detrimental impact on mental health outcomes.

Evidence demonstrates strong correlations between socioeconomic factors (e.g., financial and housing security), social and interpersonal factors (e.g., separation from family, perceived discrimination), and mental health outcomes and functioning (Porter and Haslam, 2005; Priebe et al., 2010). Studies across various cross-cultural contexts also reveal that traumatized individuals or communities often find themselves trapped in a continuous cycle of violence and distress in which a particular "index trauma" is not the sole source of traumatization, but the threat of revictimization in both public and private spheres is a continuous stressor (Kira, 2010; Straker, 1990). Yet, so far, there is a lack of reviews incorporating key sociocultural and structural factors surrounding trauma-related distress.

There is also a growing acknowledgement that such contextual factors shape the meanings attached to traumatic events (Mattar, 2010; Ventevogel and Faiz, 2018). As, Gilmoor et al. (2019) explained:

> Of course, culture has implications for what can be considered a traumatic event to begin with. If PTSD is considered a normal reaction to abnormal situations, how does it manifest in situations where violence or other potentially traumatizing events become the norm? (Gilmoor et al., 2019, p. 21, p. 21)

What is perceived as traumatic determines the degree of impact and the interpretation of responses as normal or pathological (Afana et al., 2010). This holistic understanding contributes to providing more accurate trauma models and responsive treatments (Holmes et al., 2020; Summerfield, 1999).

2. Review aims

For our review we examined the qualitative literature investigating how PTSD, CPTSD, and any other forms of culturally acknowledged trauma-related distress are experienced and expressed by populations in the Greater MENA region. To achieve this aim, our review focused on i) phenomenological descriptions of trauma-related distress in the Greater MENA region, with a particular focus on the DSO, ii) cultural scripts, cognitions, or perceived consequences related to peri- and post-trauma-related distress, and iii) surrounding structural factors influencing or exacerbating such distress.

Table 1
Search concepts and keywords.

Search terms
Search concept 1: Countries of the MENA region Algeria/ Algerian/ Bahrain/ Bahraini/ Comoros/ Djibouti/ Egypt/ Egyptian/ Iraq/ Iraqi/ Jordan/ Jordanian/ Kuwait/ Kuwaiti/ Lebanon/ Lebanese/ Libya/ Libyan/ Mauritania/ Mauritanian/ Morocco/ Moroccan/ Oman/ Omani/ Palestine/ Palestinian/ Gaza/ "West Bank"/ Qatar/ Qatari/ Saudi Arabia/ Saudi Arabian/ Somalia/ Somali/ Sudan/ Sudanese/ Syria/ Syrian/ Tunisia/ Tunisian/ United Arab Emirates/ Emirati/ Yemen/ Yemeni/ Iran/ Irani/ Turkey/ Turkish/ Afghanistan/ Afghani/ Pakistan/ Pakistani
Search concept 2: Methodology Qualitative/ mixed methods/ ethno*/ emic/ cultur*/ anthro*
Search concept 3: Distress mental health/ PTSD/ Complex-PTSD/ C-PTSD/ complex posttraumatic stress disorder/ disturbances in self-organization/ affect dysregulation/ emotional dysregulation/ shame/ guilt/ self-worth/ self-esteem/ self-concept/ dissociation/ identity/ possession/ "borderline personality disorder"/ BPD/ "borderline traits"/ psychological distress/ psychological symptom/ psychological dysfunction/ emotional distress/ psychiatric symptom/ psychiatric condition/ disrupted relationships/ interpersonal/ social support/ family support/ resilient/ resilience/ protective/ adaption/ cultural concepts of distress/ idioms of distress/ explanatory models/ culture-bound/ folk illness
Search concepts 4: Traumatic exposure violence/ war/ trauma/ trauma*/ political violence/ abuse/ torture/ sexual abuse/ child abuse/ disaster/ conflict/ refugee/ refugees

3. Method

This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Checklist and Guidelines (Page et al., 2021). The study protocol was registered on PROSPERO 2021: CRD42021267422.

3.1. Search strategy

A systematic search of 12 databases was completed. Nine databases for English language articles were searched: PsycINFO, PsycARTICLES, Web of Science, PubMed, Scopus, Pilots, MEDLINE, AnthroSource, and Anthropology Plus. In addition, three databases for Arabic literature were included: Al Manhal, Dar Al Mandumah, and the Arab Citation Index. Searches were conducted between June to August 2021 for studies published in English or Arabic until then and re-run in October 2022 for additional studies published during this period. The search strategy consisted of keywords and *medical subject headings* (i.e., controlled and hierarchically organized vocabulary used to index

Table 2
SPIDER inclusion criteria.

SPIDER	
Sample	Adult (18 or over) populations from the following countries: Afghanistan, Algeria, Bahrain, Comoros, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine (Gaza & West Bank), Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, Turkey, United Arab Emirates, Yemen
Phenomenon of interest	Experiences or symptoms of traumatic stress; PTSD; complex PTSD; or looking at cultural understanding of trauma-related distress
Design	Peer reviewed, empirical studies applying qualitative data collection methods (e.g., semi-structured interviews, focus group discussions ethnographies, among others)
Evaluation (outcome)	Affective, cognitive, behavioral, and interpersonal symptoms related to trauma, as well as cultural or structural factors contributing to these symptoms
Research type	Qualitative research

biomedical and health-related information to facilitate searching process in PubMed and MEDLINE databases) for four search concepts. Corresponding keywords are presented in Table 1. Boolean phrases were adapted accordingly for each database; a sample of exact terms and adaptations is provided in our appendices. Additional hand searches complemented electronic searches.

3.2. Study selection

The Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool was used to inform our search strategy and define our inclusion criteria. The SPIDER tool is suited for systematic reviews of qualitative studies (Cooke et al., 2012). Table 2 contains our inclusion criteria based on the SPIDER tool. All the samples in the included studies either must have had experienced a traumatic event or series of events or have been a mental health professional (MHP) or health professional or caregiver working closely with individuals who had experienced such event(s). Studies had to be conducted among samples from the identified 25 countries. We excluded nonempirical, conceptual, and review articles, as well as non-peer-reviewed publications such as protocols, dissertations, and book chapters. Studies with indirect exposure to violence or secondary traumatic exposure were also excluded.

Screening and selection were facilitated by Covidence systematic review software (Harrison et al., 2020). A pilot screening phase was conducted to ensure adherence to inclusion and exclusion criteria for the 200 articles. Four coders (MB, NH, and two student assistants) screened all titles and abstracts. Conflicts were resolved through consensus discussions, with a senior author (EH) acting as arbiter in rare cases. Full texts were reviewed when abstracts lacked sufficient information for eligibility verification. Two coders independently reviewed full texts and the same consensus approach was used to resolve discrepancies. All Arabic articles were screened by one reviewer (NH), given that she was the only Arabic speaker on the team. A total of 10,891 references, including duplicates, were retrieved (see Fig. 1).

3.3. Data extraction & synthesis

The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) framework (Tong et al., 2012) was followed and used as a guide in determining the method of analysis for the 47 selected studies (see ENTREQ Checklist in the appendices). Our review adopted a “critical realist” epistemological approach in that we used a hybrid approach between framework synthesis (Brunton et al., 2020) and thematic synthesis (Thomas and Harden, 2008). The aim was to provide a systematic and comprehensive account of culturally salient post-traumatic symptoms, with a particular focus on DSO. An initial framework analysis was used to organize accounts of symptoms and relevant cultural information related to PTSD and CPTSD. We then used an inductive approach to further analyze included studies to extract more detailed data on symptom presentations and relevant cultural information. In articles presenting CCD or other categories of distress other than PTSD and CPTSD (i.e., “normalized or habituated” responses), a thematic synthesis was used to develop an inductive coding frame. Data extraction and synthesis were facilitated by NVivo 12.

Initially, the following descriptive information was extracted from each article: year of publication, country of fieldwork, ethnic background, gender, type of violence exposure, study purpose, methodological design, and method of analysis. Thereafter, relevant information was extracted by coding the results sections in original papers. Descriptive themes emerged after an initial round of line-by-line thematic coding and multiple triangulation meetings (Thomas and Harden, 2008). Coding was iterative and completed by one author (NH), and triangulation meetings included other authors. These meetings addressed similarities and differences between codes and initial descriptive themes to develop them into analytical themes.

Due to heterogeneous study aims of included articles and a lack of

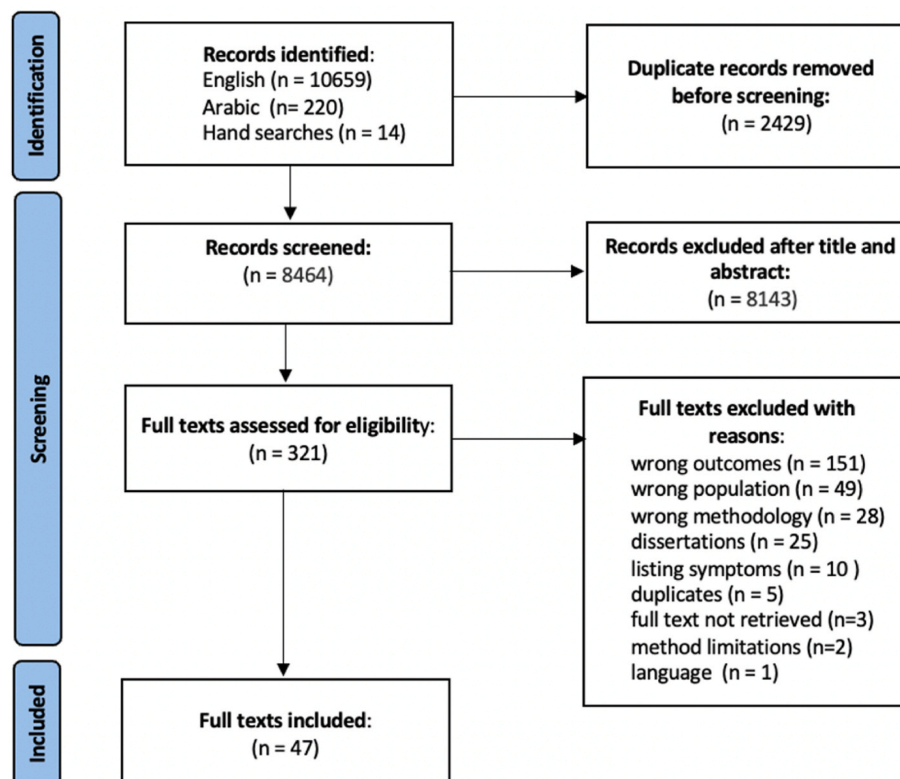

Fig. 1. PRISMA flow chart
Adapted from Page et al. (2021).

consistency in the type of information and depth of analysis provided, only themes relevant for our review (i.e., distress presentations of post-traumatic symptoms and relevant structural and cultural information) were coded. Based on these themes, extraction templates were created for symptoms of PTSD, CPTSD, CCD, or other forms of distress. This extraction frame was used on 20% of the data by another coder, and intercoder reliability was calculated; their agreement was excellent using Cohen's *k* (0.91).

After completing the data extraction, we coded symptom frequencies. We started with the main symptom clusters provided in the ICD-11. We coded all relevant symptoms mentioned in original studies. Symptoms with the same or similar meanings were clustered together under one code (e.g., feeling distant from others, feeling isolated from others, not feeling understood by others). At other times, when multiple features were related to one single symptom, all of them were coded under one code. For example, features such as erased personality, identity confusion, and not feeling like a man/woman were all coded under "identity difficulties." All such coding decisions were discussed in triangulation meetings. Frequencies of all other reported symptoms outside of the main ICD-11 PTSD and CPTSD diagnostic categories were coded separately.

3.4. Reasons for exclusion

Reasons for excluding full texts included wrong outcomes (e.g., focus on explanatory models or help-seeking behaviors without symptom presentations), wrong populations (e.g., children or outside the MENA region), lack of trauma exposure (e.g., burnout in professionals), non-trauma specific distress (e.g., exclusively describing anxiety symptoms), wrong methodology or methodological limitations, listing symptoms without phenomenological descriptions, duplicates, dissertations, and language. Articles describing features of DSO but without exposure to prolonged trauma were excluded, as symptoms of DSO can also appear in other mental disorders.

3.5. Quality appraisal

The quality of included studies was assessed using the Consolidated Criteria for Reporting Qualitative Studies (COREQ) (Tong et al., 2007). Two reviewers (MB, NH) independently assessed the quality of 20% of the included studies; their agreement was excellent using Cohen's *k* (0.83). The remaining studies were appraised by one author (NH). A scoring system was created, assigning 1 point to each of the 32 COREQ items. The aim of quality appraisal was not a priori to exclude studies but to assess methodological quality, highlight overall weaknesses and strengths, and prioritize higher quality studies in the analysis. However, the research team agreed post hoc to exclude articles scoring below 5 points due to substantive methodological inadequacies.

4. Results

4.1. General description

We included 47 peer-reviewed studies published between 1993 and 2022. The studies reported on samples originating from Afghanistan (*n*=2), Egypt (*n*=1), Iran (*n*=4), Iraq (Arabs, Kurds, Yazidis, and multiple ethnicities) (*n*=7), Jordan (*n*=1), Lebanon (n=2), Palestine (*n*=6), Turkey (*n*=5), Somalia (*n*=8), Sudan (*n*=1), Syria (*n*=6), and mixed samples from the region (*n*=4). Included studies examined individuals who had experienced either one or more of the following types of traumatic exposure: interpersonal violence (including intimate partner violence [IPV], GBV, sexual violence [SV], childhood abuse, minority prosecution); war violence; political violence (e.g., witnessing violence, torture, bombings); and natural disasters. Most studies examined samples exposed to more than one type of violence or trauma. Descriptive information and study identification numbers ("study ID") are provided in Table 3, which will be used in the presentation of results.

Thirteen studies had only female participants and 34 had mixed samples. Five studies included perspectives from stakeholders such as MHPs, health professionals, and policy makers. The remaining studies incorporated lay individuals or community samples. Data were collected through individual interviews and/or focus groups. Apart from two mixed-methods studies, all studies were strictly qualitative. Methodological approaches used in the original studies are listed in Table 3.

Studies were categorized based on the phenomenology they reported on. The following four categories were created: "normalized or habituated" responses to trauma (*n*=8), CCD (*n*=11), PTSD symptoms (*n*=21), and CPTSD or DSO symptoms (*n*=29). The same study was included in more than one category if more than one type of symptom group was presented. Detailed findings are presented in the corresponding results sections below. For a full list of included studies and detailed symptom descriptions and key cultural concepts per study, refer to our appendices.

4.2. Quality appraisal

The included papers were critically appraised using the COREQ (Tong et al., 2007). Most qualitative studies demonstrated moderate to high levels of methodological standards, with scores ranging from 15 to 27 (out of 32) points. Two studies were removed for scoring below 5 points. Four studies were not assessed using the COREQ, as they were complete ethnographies. Our appendices contain a quality appraisal table for included studies.

4.3. "Normalized or habituated" responses

The first category of articles was acknowledged and "normalized" responses to traumatic events. In these studies, participants and then study authors did not describe stress responses as a pathological reaction but rather as a habituated form of distress in response to extreme and enduring violent conditions and structural difficulties. Studies in this category had been conducted in Palestine (*n*=5) (1, 7, 12, 19, 31), Syrian refugee camps (*n*=2) (23, 42), South of Lebanon (*n*=1) (29). The common feature in these articles was the continuous nature of the violence. Distress was perceived to be mainly caused and maintained by protracted structural difficulties (i.e., a lack of fulfillment of basic needs, discrimination, siege, daily violence exposure). Various terms (e.g., social suffering, structural violence, organized violence, protracted political/social/economic/institutional violence or stressors) have been used in different articles to describe prolonged day-to-day difficulties. This illustrative quote from study (23) shows a participant's view of their distress:

> They described it as a collective experience since "everyone is tired." They did not perceive themselves as suffering from mental illness, which they viewed as an internal dysfunction within the person, or "craziness." Rather, they perceived their mental health problems as being the result of external stress. (p. 856)

In terms of phenomenology, two articles focused on the concept of *sudme*, literally translated as "shock or trauma," or a form of crisis caused by violent events (1, 42). According to these studies, the severity and transience of emotional and behavioral responses to sudme vary depending on the type of traumatic event.

Other studies described a more existential form of distress, which entails feelings of *permanent damage done to the psyche*, or "broken morale," and corresponding emotional and psychological exhaustion (7, 19, 31). Such symptoms were perceived to be more pertinent and common than specific PTSD or depression symptoms and caused poorer functioning. All but one of these studies reported different forms of a pervasive sense of hopelessness. Two studies described a constant pessimistic and hopeless cognitive style (12, 31), and another described depressive symptoms, helplessness, and suicidal tendencies (29).

Table 3
Descriptive study information (N = 47).

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
1	Afana et al. (2010)	Palestinian	Gaza Strip, Palestine	War violence (e.g., loss of beloved person, property, or material possessions; witnessed killing or heard of murder of someone close; bombardments or house demolition)	Eight adults (F = 3, M = 5)	To investigate the social representations of trauma & ways in which trauma is defined (i.e., meanings assigned to trauma) & acted on (i.e., reactions or responses)	Normalized stress response + CCD	Ethnographic interviews with key informants; thematic analysis (Green and Thorogood, 2004)
2	Akça and Gençöz (2021)	Turkish	Turkey	IPV; including physical, verbal, & sexual abuse	Six adult women	To understand how women experience disgust during & after domestic violence, & how they try to cope with disgust evoking situations in this process	PTSD + DSO	Semi-structured interviews; seven interviews with each participant; interpretative phenomenological analysis (Smith and Osborn, 2003)
3	Al-Natour et al. (2019)	Syrians	Amman, Jordan	War violence; IPV	16 adult refugee women	To describe the lived experience of marital violence toward Syrian refugee women during the war in Syria	DSO	Semi-structured interviews; descriptive phenomenological research (Colaizzi, 1978)
4	Alessi et al. (2021)	LGBTQ refugees Syria (*n* = 9), Iran (*n* = 7), Iraq (*n* = 5), Lebanon (*n* = 2), Egypt (*n* = 3), Pakistan (*n* = 3), Jordan (*n* = 1), Palestine (*n* = 1), Somalia (*n* = 1), and excluded data: Tajikistan (*n* = 1), Chechenia (*n* = 1)	Vienna, Austria Amsterdam, Netherlands	Sexual violence; prosecution; war violence, additional victimization along migration pathways; displacement	32 adults (no gender information provided) (two excluded for geographical location)	To understand how refugees from Islamic societies who fled to Austria & the Netherlands describe & understand the shifts in their religious & LGBTQ identities from premigration to resettlement	DSO	Semi-structured interviews; thematic analysis (Braun & Clarke, 2006)
5	Alnabilsy et al. (2022)	Arab, Palestinian	Israel	Childhood abuse: physical, sexual, emotional abuse, neglect	20 adult women	To describe how experiences of abuse & exclusion experienced by young women in childhood & adolescence affect the construction of self-identity	DSO	Semi-structured interviews; thematic analysis (Braun & Clarke, 2006)
6	Bahadir-Yilmaz and Oz (2019)	Turkish	Giresun Province, Turkey	Interpersonal violence: physical, verbal/ psychological, & sexual violence	30 adult women	To explore abused Turkish women's experiences & perceptions regarding violence against women	DSO	Semi-structured interviews, descriptive approach; conceptual framework by Graneheim and Lundman (2004)
7	Barber et al. (2016)	Palestinian	Palestine (West Bank, East Jerusalem, & the Gaza Strip)	War violence; imprisonment; structural violence, (e.g., economic difficulties); prolonged protracted conflict/ violence	68 adult civilians & IDPs (F = 33, M = 35)	To identify and then develop & validate a quantitative measure of a new construct of mental suffering in the occupied Palestinian territory: feeling broken or destroyed	Normalized stress response	Group interviews; grounded theory (Corbin and Strauss, 1990)
8	Byrskog et al. (2014)	Somali	Sweden	War violence; interpersonal violence (e.g., whipping, beating, sexual harassment, rape, threats; IPV, including physical & sexual violence)	17 adult refugee women	To explore experiences & perceptions of war, violence & reproductive health before migration among Somali-born women in Sweden	CCD	Semi-structured individual interviews; thematic analysis (Braun & Clarke, 2006)

(*continued on next page*)

Table 3 (*continued*)

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
9	Carothes and Ottoway (2004)	Somali	United States	War violence (e.g., witnessing killing; death of a close family member, relative, or friend due to violence, hunger, or untreated infectious illnesses while in a refugee camp)	17 adult refugees (F = 9, M = 8)	To study how mental illness is understood, expressed, & treated among Somali refugees & how these factors influence use of health services for mental problems	CCD	Semi-structured interviews; grounded theory techniques (Corbin and Strauss, 1990; Crabtree and Miller, 1999)
10	Coffey et al. (2010)	Afghan, Iraqi, Iranian, or neighboring Middle Eastern countries	Australia	War violence, violence in refugee detention centers, (e.g., witnessing mass riots, fighting, acts of self-harm, suicide attempts, hunger strikes; aggression from officials, being subject to humiliating practices, beating, solitary confinement); traumatic separation from family	17 adult refugees (F = 1, M = 16)	To examine the experience of extended periods of immigration & detention from the perspective of previously detained asylum seekers, & identify the consequences of these experiences for life after release	PTSD + DSO	Semi-structured interviews: qualitative analysis (no specific methodology mentioned)
11	Cook et al. (2022)	Yazidi	Kurdistan, Northern Iraq	War violence, genocide; interpersonal violence (e.g., physical torture, sexual violence, psycho/verbal violence, witnessing murders, enslavement)	35 adults	To explore the shared experiences of the Yazidi who survived genocide	PTSD + DSO	Semi-structured interviews: qualitative analysis, emotion coding (Saldana, 2016)
12	Diab et al. (2022)	Palestinian	Gaza Strip, Palestine	War violence; imprisonment; structural violence, (e.g., economic difficulties); prolonged protracted conflict/ violence	30 MHPs: psychologists, social workers, psychiatric nurses, & psychiatrists (F = 10, M = 20)	To explore mental health providers' concerns about the most commonly occurring mental health problems, diagnoses, & psychological conditions among Gazan civilians who had been referred to community mental health centers for mental health services	Normalized stress response	Semi-structured interviews; thematic analysis (Braun & Clarke, 2006)
13	Einolf (2018)	Iraqi	Iraq	Political violence; interpersonal violence (e.g., sexual torture or rape in prison); prosecution due to religious sect	47 adults (F = 20, M = 27)	To answer the following questions: 1. What effects does sexual torture have on this sample of survivors? 2. In the absence of treatment, how does this sample of victims find meaning in their experiences? 3. Are there differences by gender?	DSO	In-depth interviews; categorical-content perspective analysis (Hiles and Čermák, 2008)
14	El Hajj (2022)	Lebanese	Beirut, Lebanon	Terrorist bomb attack	Eight adults (F = 5, M = 3)	To explore the psychological & physical reactions to the trauma experienced by Beirut blast survivors, as well as their coping strategies	PTSD	Semi-structured interviews, thematic analysis (Colaizzi, 1978)

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Table 3 (*continued*)

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
15	Erdener (2017)	Yazidi	Turkey	War violence; interpersonal violence (e.g., physical torture, sexual violence, psychological/verbal violence, witnessing murders, enslavement)	20 adult women; refugees	To show the strategies for coping with the post-war trauma of Yezidi refugee women who escaped from the Sinjar genocide	PTSD + DSO	Semi-structured interviews; grounded theory analysis (Corbin and Strauss, 1990)
16	Freh et al. (2013a)	Iraqi	Baghdad, Iraq	Bomb attack; witnessed or injured; prolonged exposure to war violence	11 adults (F = 5, M = 6)	To investigate how people who had experienced a potentially trauma-inducing event of being in a bomb attack made sense of the experience & attempted to cope with it	PTSD + DSO	Semi-structured interviews; interpretative phenomenological analysis (Smith and Osborn, 2003)
17	Freh et al. (2013b)	Iraqi	Baghdad, Iraq	Bomb attack; witnessed or injured; prolonged exposure to war violence	Nine adults (F = 5, M = 4)	To explore how people who have experienced a bomb attack in Iraq make sense of their experience & identify the ways in which they attempt to cope with this event	PTSD + DSO	Semi-structured interviews; interpretative phenomenological analysis (Smith and Osborn, 2003)
18	Gharacheh et al. (2020)	Iranian	Iran	IPV; physical, emotional abuse in women diagnosed with HIV	12 adult women with HIV	To explore the lived experience of domestic violence in HIV-infected women in Iran	PTSD + DSO	Semi-structured interviews; phenomenological analysis (van Manen, 1990)
19	Hammad and Tribe (2020)	Palestinian	Gaza Strip, Palestine	War violence; structural violence; protracted conflict/violence	Seven adults (F = 3, M = 4)	To explore impact of structural violence in the form of economic oppression (e.g., imposed situational poverty & restricted livelihood opportunities) on civilians living under military occupation & blockade in the Gaza Strip	Normalized stress response	Semi-structured interviews: thematic analysis (no specific methodology mentioned)
20	Im et al. (2017)	Somali	Nairobi, Kenya	War violence; forced migration, GBV; structural factors (e.g., chronic poverty, discrimination, an uncertain future, insecurity, fear of detainment & deportation)	15 stakeholders (F = 7, M = 8) FGD with 16 Somali refugee community members (F = 8, M = 8)	To explore a range of cultural idioms of distress among Somali refugees in urban Kenya to help care providers improve mental health communication & better serve this vulnerable population in a culturally responsive & sensitive manner	CCD	Semi-structured key informant interview & focus group interviews; template analysis method (King, 2004)
21	Johnsdotter et al. (2011)	Somali	Sweden	Civil war & migration	23 adult immigrants (F = 17, M = 6)	To discuss how certain culturally specific notions of mental health & disease may affect mental health-seeking behavior among Somali immigrants	CCD	Semi-structured interviews & focus group discussions; anthropological approach; naturalistic inquiry analysis (Lincoln and Guba, 1985)
22	Kaya (2021)	Syrian	Turkey	War violence; violence peri-migration; post migration structural difficulties &	16 adults (F = 6, M = 10)	To evaluate Syrian nursing students' experiences of being a foreigner before & after migration &	DSO	Semi-structured interviews; interpretative phenomenological

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Table 3 (*continued*)

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
				microaggressions (physical & verbal assaults)		throughout their university lives		analysis (Smith and Osborn, 2003)
23	Kerbage et al. (2020)	Health professionals & Syrian refugees	Lebanon	War violence; post migration structural violence & microaggressions (physical & verbal assaults)	60 health professionals or policy makers (F = 42, M = 18) 25 adult refugees (F = 18, M = 7)	To explore perceptions & experiences of policymakers, practitioners, & Syrians involved in mental health services at the individual-focused levels	Normalized stress response	Unstructured & in-depth interviews; thematic analysis (Braun & Clarke, 2006)
24	Korkmaz and Soygut (2022)	Turkish	Ankara, Turkey	Sexual violence during childhood or adulthood	Six adults	To examine the psychological symptoms in women who were sexually assaulted during childhood or adulthood by employing schema therapy	PTSD + DSO	In-depth interviews; qualitative narrative analysis (McLeod and Balamoutsou, 2001)
25	Lipson (1993)	Afghan	California, United States	War violence (e.g., imprisoned or tortured or having family members imprisoned, observing atrocities, losing family members, and fearing for their lives)	60 adult refugees (F = 32, M = 28)	To describe mental health problems & their antecedents experienced by Afghans in northern California, using the refugees' own words	PTSD + DSO	Ethnographic approach (no specific methodology mentioned)
26	Matthies-Boon (2018)	Egyptian	Cairo, Egypt	State violence, arrests, torture, physical violence (e.g., organized mass sexual assaults against women), systematic structural violence (e.g., life-threatening poverty)	40 (18–35 years old) Cairene activists (F = 15, M = 25)	To explore continuous traumatic stress (CTS) in post-revolution Egypt	PTSD + DSO	Ethnographic study
27	Mert and Aksoy (2018)	Turkish	Kocaeli, Turkey	CSA	23 adult women	To provide information on multidimensional long-term effects on the adult women from a low-income community in the city of Kocaeli, Turkey, who were exposed to childhood sexual abuse & how this abuse affected their lives	DSO	Semi-structured interviews; content analysis (Creswell, 2013)
28	Miller et al. (2006)	Afghan	Kabul, Afghanistan	Prolonged war violence (Soviets; U.S. Civil War); killings, torture, constant bombings, loss of family members; internal displacement, structural difficulties	324 adults (F = 162, M = 162) For qualitative interviews: 40 community members (F = 20, M = 20)	To identify local indicators of distress & develop the 22-item Afghan Symptom Checklist (ASCL)	PTSD + DSO + CCD	Mixed-method, interviews; semi-formal content analysis (no specific methodology mentioned); then factor analysis & validation of measure
29	Moghnieh (2021)	Lebanese	Lebanon	War violence, structural difficulties	No exact sample provided (anthropological fieldwork)	To explore how material conditions of war and aid have shaped the politics of trauma and *sumud* (steadfastness) in Lebanon	Normalized stress response	Ethnography
30	Mölsä et al. (2010)	Somali	Helsinki, Finland	Colonization and independence of Somalia, dictatorship, civil war violence, and	27 adults (F = 20, M = 7)	To examine how the conceptions, expressions, and treatment of mental distress are changing	CCD	Focus group interviews (design explained but no specific methodology mentioned)

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Table 3 (*continued*)

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
				exile/ forced migration		among Somalis living in Finland		
31	Nagamey et al. (2018)	Palestinian	Jerusalem & Qalandia refugee camps, Palestine	War violence, including daily crossing of an Israel Defense Forces (IDF) checkpoint to reach their schools or places of employment, exposure to violence from soldiers	20 adult IDPs (F = 10, M = 10)	To examine the mental experience & effects of Palestinian adults who pass daily at the Qalandia checkpoint	Normalized stress response	Semi-structured interviews; interpretative phenomenological analysis (Smith and Osborn, 2003)
32	Naghavi et al. (2019)	Iranian	Isfahan, Iran	Sexual IPV	10 adult women	To explore the effects of intimate partner sexual violence on women's sense of self-efficacy when it comes to speaking out against violence & seeking help	DSO	In-depth interviews; thematic analysis (Braun & Clarke, 2006)
33	Pinar and Sabuncu (2004)	Turkish	Izmit, Turkey	Natural disaster, (earthquake) over 7 months ago with aftershocks the following weeks	107 adults (F = 70, M = 37)	To explore long-term traumatic effects of the Marmara earthquake on survivors	PTSD	Focus groups, qualitative analysis (Crabtree and Miller, 1992)
34	Rasmussen et al. (2011)	Darfuri, Sudanese	Chad	War violence (being beaten, being shot, being burnt, limbs cut off, being bound, stabbing/cutting, suffocation or strangling, sexual violence, bombing, being chased, drowning, being kidnapped, and held captive); material loss of home and belongings; living in a refugee camp	Mixed sample of refugees: Imams, chiefs of blocks, aid and psychosocial workers, traditional healers, youth leaders, prominent women	To (GBD) describe Darfuri idioms of distress, (GBD) examine overlap in their measurement with PTSD and depression, and (3) examine the concurrent validity of these constructs vis á vis PTSD and depression	CCD	Quick ethnography (FGD, pile sorts) (Bolton and Tang, 2004), coding (Corbin and Strauss, 1990); surveys, statistical analysis of validity
35	Renner et al. (2020)	Syrian	Leipzig, Germany	War violence, peri-migration violence; resettlement difficulties	20 adult refugees (F = 4, M = 16)	To foster knowledge about the specific psychosocial needs of Syrian refugees in Germany	PTSD + DSO	Focus group discussions; content analysis (Kuckartz, 2012)
36	Riber (2017)	MENA region: Iraq (60%); Lebanon & Palestinian territories (30%); two participants from other countries	Denmark	Interpersonal violence (one or more types of child abuse); war violence, (e.g., continuous war-related events like imprisonment, torture, persecution for religious/ political reasons, or served as soldiers)	43 adult refugees (F = 21, M = 22)	To identify trauma types over the life course among adult refugees & to explore their accounts of childhood maltreatment (not focusing on general PTSD symptoms, but rather on attachment & DSO symptoms	PTSD + DSO	Adult Attachment Interview (AAI) (George et al., 1996); qualitative content analysis (Kuckartz, 2014)
37	Rometsch et al. (2020)	Care providers of female Yazidi refugees from northern Iraq	Germany	War violence (e.g., kidnapped by IS, tortured, witnessing killings); "loss-trauma" of missing family members & discrimination against minorities	84 care providers	To describe the views & experiences of professionals working with Yazidi refugees to assess the psychosomatic symptoms of this traumatized sample; to analyze working experiences to offer medical & psychotherapeutic provision & deduce helpful strategies	PTSD + DSO	Focus group discussions; qualitative content analysis (Mayring and Fenzl, 2014)
38	Shannon et al. (2015)	Somali (more participants from different ethnicities, but	Minnesota, United States (US)	War violence (e.g., forced evacuation, imprisonment, torture, witnessing	27 adult refugees (no gender distribution provided)	To explore common & culturally grounded conceptions of the mental health effects	PTSD + DSO	Focus group interviews; method of thematic

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Table 3 (*continued*)

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
		data extracted for the Somali sample)		killing, rape, physical injury, separation from children); post displacement difficulties (e.g., violence in camp)		of political conflict through the voices of newly arrived refugees to the US		categorization (Spradley, 1979)
39	Shoeb et al. (2007)	Iraqi	Michigan, US	War violence after American invasion or pre-invasion; violence of living under Saddam Hussein's oppressive & violent rule; religious prosecution (including imprisonment, torture, & other violations); violence during flight; displacement	60 adult refugees (F = 30, M = 30)	To explore the experiences of an Iraqi refugee population to adapt the Harvard Trauma Questionnaire for use in Iraq	CCD	Mixed methods, ethnographic narrative interviews; grounded theory (Miles & Huberman, 1984; Rubin and Rubin, 2005)
40	Shoqirat et al. (2019)	Jordanian	Amman, Jordan	IPV : physical, sexual, & psychological	10 adult women	To understand the experience of IPV & related consequences among married Jordanian women	DSO	Semi-structured interviews; thematic analysis (Riessman, 2008)
41	Timraz et al. (2019)	Arab American; countries of origin were Lebanon, Iraq, Morocco, Saudi Arabia	US	CSA, ranged from 5 to 15 years	10 adult women; immigrants lived in the US 2–56 years	To explore CSA characteristics, social support, & Arabic culture as antecedent factors of coping with CSA; (GBD) to explore the coping processes employed by female Arab American CSA survivors; (3) to explore CSA long-term psychological outcomes	PTSD + DSO	Individual semi-structured interviews; qualitative content analysis (Elo and Kyngäs, 2008; Hsieh and Shannon, 2005)
42	Wells et al. (2018)	Syrian	Jordan	War violence; displacement; threats to safety in host country (e.g., physical, or sexual abuse), or structural violence (e.g., inadequate housing, exploitation, & financial strain)	29 psychosocial professionals, working in psychosocial organizations supporting the Syrian refugee community (no gender distribution provided)	To develop the applicability of the ecological model to the perceived needs & wellbeing of Syrian refugees living in Jordan	Normalized stress response	Semi-structured interviews; grounded theory analysis (Charmaz, 2014; Corbin and Strauss, 1990)
43	Yaghoubirad et al. (2021)	Iranian	Tehran, Iran	Persecution and minority discrimination: interpersonal violence (e.g., physically, or sexually abused, bullied, neglected, or left by one or both parents) or structural violence (e.g., by state institutions or community)	14 adult transwomen	To learn more about the predisposing psychological factors & prevalent manifestations in Iranian female transgender individuals, as well as the approach of Iranian society & culture in confronting this phenomenon through the perspectives of transgender women	DSO	Semi-structured interviews; grounded theory analysis (Corbin and Strauss, 1990)
44	Zarowsky (1997)	Somali	Eastern Ethiopia	Displacement-related distress, war violence (e.g., drought, threat by soldiers of government, dispossession, injustice, poverty, & poor living conditions)	Adult refugees & returnees No exact sample provided (anthropological fieldwork)	To present an overview of the "refugee experience" of Somali populations, focusing on interactions with relief & development, the story of community, a	CCD	Ethnography

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Table 3 (*continued*)

Study ID	Author	Cultural group	Study location	Type of violence exposure	Sample (*n*)	Purpose	Study category	Methods
						discussion of Somali emotion words		
45	Zarowsky (2004)	Somali	Hurso, Dire Dawa, & the Aware refugee camps, Ethiopia	War violence, displacement, confiscation of farmlands & displacement to refugee camps; repatriated without their land years later	Adult refugees & returnees No exact sample provided (anthropological fieldwork)	To contribute to the understanding of emotion, suffering, & trauma in different cultural & sociopolitical contexts, & to explore some of the narratives of dispossession & rhetoric of emotion in Ethiopian Somali communities	CCD	Ethnography
46	Zbidat et al. (2020)	Syrian	Germany	War violence (e.g., detention & imprisonment; threats of death, separation of family, traumatic deaths, or illnesses of loved ones); absence of basic necessities under IS rule, post resettlement structural difficulties; interpersonal physical or psychological violence in their families	16 adult refugees (F = 8, M = 8)	To analyze the representations of trauma, self-reported complaints, indications of somatization, & coping strategies among a refugee population	PTSD + DSO	Individual semi-structured interviews; qualitative content analysis (Mayring and Fenzl, 2014)
47	Zeighami et al. (2021)	Iranian	Kerman, Iran	Interpersonal violence; verbal & physical sexual harassment/ violence	22 nurses (F = 22, M = 4)	To investigate the effects of sexual harassment in the workplace on Iranian nurses	PTSD + DSO	Individual semi-structured interviews; qualitative content analysis (Graneheim and Lundman, 2004)

Note. The level of detail provided is dependent on the level of detail presented in each article. Each study has been given an “ID” to be used in all results. IPV: intimate partner violence. IDP: internally displaced person. CSA: childhood sexual abuse. PTSD: post-traumatic stress disorder. DSO: disturbances in self-organization.

Symptoms were attributed to a loss of control over daily structural factors, daily violence of military occupation, or the ongoing possibility of war reignition (12, 29, 31). In two studies, both MHPs and lay individuals reported that patients do not understand symptoms (e.g., sleep problems, numbness, substance use) as specific to certain disorders (e.g., depression, PTSD), despite their severity. They viewed these symptoms as part of an overall response to extreme living conditions and more severe mental health difficulties (12, 23). Studies also pointed out reasons for an absence or lack of recognition of trauma symptoms, for example the gendered reality of viewing trauma as a form of weakness or emasculating, or a reduction of collective political struggle, or valorizing endurance in religion and culture (1, 7, 29, 42).

Four studies highlighted the concept of *karama*, translated as dignity. Karama is a key cultural concept affecting identity, family, and social standing. Studies reported that humiliation or “broken dignity” was a main cause of distress (12, 19, 31, 42). Broken dignity can result from the inability to uphold cultural roles, norms, and values, or the inability to lead a “normal” life due to violence exposure and structural barriers. This situation was perceived to result in feelings of vulnerability, entrapment, negative self-appraisals, nihility, shame, and eventually rage. Studies reported on such permanent feelings of easily triggered rage and by consequence increased family or interpersonal violence (10, 17, 31, 42). Prolonged violence exposure was also connected with loss of personal and communal values, social resources, and deteriorated relationships (12, 31). Four studies also presented distress as a cumulative model, where negative feelings and distress accumulated over time, due to *daght*, translated as psychological stress, pressure, or tension (1, 12, 23, 42). Daght is a form of mental suffering caused by violence exposure and the build-up of internal and external (social) pressure from structural difficulties.

Finally, two articles mentioned coping strategies for distress in situations, such as emotional suppression normalized by the community, avoiding daily triggers, and dissociation during recurrent violence exposure (1, 31). Although these strategies are listed as symptoms of CPTSD in ICD-11, they were normalized in these sociocultural contexts as ways of enduring continuous and communal traumatic exposure. While not all studies reported symptom severity or impaired functioning, certain studies highlighted that distress, though not pathologized, was still perceived as severe and burdensome to overall wellbeing and functioning (1, 7, 23, 29, 31).

4.4. CCD and idioms of distress

Eleven studies presented CCD, that is, culture-specific idioms of distress and syndromes. Seven studies included Somali samples (8–9, 20–21, 30, 44–45). Studies placed distress on a continuum ranging from milder symptoms of “everyday sadness” to more severe syndromes of “madness” (9, 20–21, 30, 45). Idioms representing milder levels of distress were related to everyday structural difficulties or displacement (e.g., *nayid jab, murrug, buufis, wareer*) (8–9, 20–21, 30, 44–45), while idioms of moderate levels of distress were centered around effects of violence exposure (e.g., *argegah, buqsanaan, marrora dilla,’ qaracan)* (20, 44–45). A more serious category of distress included psychotic and dissociative features (e.g., *waali, jinn, zar)* that were attributed to either

Table 4
Summary of CCD (N = 11).

Cultural syndrome or idiom	Description	Study ID
Ethnicity: Somali (n = 7)		
argegah	• Transient state following sudden shock and subsequent physical and behavioral reactions; includes vomiting and temporary inability to act in response to a spectrum of events ranging from (e.g.) waking from a nightmare to seeing the murder of one's relatives	41, 42
buqsanaan	• Derived from a Somali word to express "jammed mind," like acute anxiety or a panic attack; emotional state or condition when one is distressed; physical and interpersonal symptoms include isolation, change in behavior; a reaction to sudden and severe stressors or crises (daily life or traumatic event); the cure is to remove the stressor	20
buufi	• Derived from a Somali word meaning "to withhold breath," ranges from anxiety-like symptoms, obsession with certain desires (e.g., leaving the country), to unsettledness or tenseness or paranoia (more severe form), feelings of worthlessness; caused by the civil war and devastating clan conflicts tearing apart former social networks and poor living conditions; may also happen due to post-migration living difficulties or failing social roles; a state that is not pathologized, but also not normalized; and the only relief pathway is for a person to leave the situation in Somalia or get a desired outcome (e.g., reunification with family, resettlement)	8, 20, 21
gini or *jinn*	• Used to express that someone is possessed by a jinni—an evil spirit. It is the most stigmatizing category of symptoms, which include becoming "mentally unfit," appearing "unconscious" or, alternatively, "afraid, mad, or unnatural"; similar psychotic symptoms to Waali syndrome, in addition to other intense fears, bad dreams, disorientation, and, occasionally, violent behavior toward others; appearing outwardly nervous or stressed or having inner voices talking to them; caused by supernatural beings; resolved through religious practices	9, 20, 28
marrora dilla'	• Anguish caused by a sudden overwhelming loss of something precious and characterized by rage, perceived powerlessness, and uncontrolled behavior ranging from weeping to violence to madness	41, 42
muruug	• A syndrome ranging from "everyday" sadness, stress, or disappointments to a more serious depression that could cause physical illness or "craziness"; caused by the shock and trauma of war or sadness over something that is out of one's control. Symptoms include loss of appetite, crying, lack of interest in social activity; PTSD: poor sleep, having flashbacks, other somatic symptoms (e.g., headache, trembling, fever or feeling hot, and hair loss). In more everyday contexts it presents as having trouble and "feeling low,'' being in a state of worry; can manifest in mundane situations, such as financial difficulties; can be resolved through religious coping and social support	9, 20, 21
nervooso	• Feelings of irritability, impatience, resentment, or tiredness, or having little energy, sometimes also the loss of interest or pleasure	28
niyed jab	• A state of being demoralized, hopeless, dejected, literally "will-broken" or having a "broken mind and heart"	28, 41, 42
qaracan	• A state associated with traumatic events ("something unexpected happened to you"), derived from the word shock or trauma in Somali; symptoms are similar to PTSD; it is considered a (severe) mental state; symptoms manifest physically, psychologically, religiously, and socially (e.g., lowered religious and social functioning, self-neglect, developing extremist thoughts)	20
wareer	• A state of thinking/anxiety/dizziness/confusion caused either by a febrile illness (e.g., delirium) or by life problems; it is worry to the point of distraction, much stronger than ordinary worry	41, 42
waali/walily	• A severe and stigmatizing state, the person is described as "crazy," "mentally unfit," "nervous," and "mad"; includes psychotic symptoms (e.g., "talking nonsense" or mumbling unintelligibly, not talking at all, or "behaving outrageously," like wandering through the streets aimlessly or without clothes on, taking off one's clothes in public, and dressing inappropriately; violent beating or screaming at someone else randomly and unpredictably); considered "madness" subsequent to physical illness, or biomedical illness, or with no known reason; "sent by God," or caused by jinn; it has three possible sequelae: recovery, niyed jab, or incurable "madness"; can be resolved by biomedical care	9, 20, 21
welwel	• Constant worries and anxious cognitions and behaviors, a more stable form of an anxiety disorder. Symptoms include anxiety, feeling uneasy, worrying constantly, being suspicious of others, fearing others, and crying; caused by a perceived inability to fulfill one's social responsibilities due to a lack of resources (e.g., financial problems); needs to be resolved before it develops into "waali" and is incurable	20
zar or *wadodo*	• A form of spirit possession encompassing depressive and intense somatic symptoms that is closer to the idea of depression at other times and can include more severe symptoms like violent behavior, hearing voices, shouting, crying, and suicide attempts; resolved through religious practices	28, 41
Ethnicity: Palestinian (*n* = 1)		
assabiah	• Derived from the word *asab*, or nerves; nervousness, anxious feelings, or jitteriness; includes being nervous, emotional, short-tempered, volatile, anxious, angry, enraged, aggressive, or displaced anger on others, and having poor impulse control	1
araq	• Interruptions in or inability to sleep. The term is used when a person thinks of their unknown and insecure future accompanied by physical symptoms such as headache and low appetite	1
azmah nafseya	• Psychological crisis because of the continuous environmental stressors experienced: "When you pass through a series of issues such as the lack of electricity, no work, being unable to meet your children's needs, living in fear, and being unable to move, you feel stuck and keep thinking of ways to overcome it"	1
dagt nafsi	• Arabic word for "psychological pressure," described as repetitive and cumulative daily stressors felt as overwhelming and that hinder daily activities	1
fajiah	• Literal translation "tragedy": caused mainly by the loss of a loved one or exposure to a distressing event and/or a grievous situation; can include confusion, shouting, crying loudly; the individual may lose consciousness or run out into the street "like a mad person"; is sometimes characterized by silence, tears, and a temporary inability to speak	1
khaufa	• Commonly used expression when a person is unexpectedly exposed to something frightening; associated with various physical symptoms such as knee joint pain, headache, fever, decreased appetite, and general fatigue	1

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Table 4 (*continued*)

Cultural syndrome or idiom	Description	Study ID
musiba	• Literal translation "calamity"; caused by traumatic exposure and leaves permanent and durable scars; the psychological pain is continuous and persistent; symptoms include sadness, unhappiness, and crying, especially if triggered by a reminder of the traumatic event	
qalaq	• Described as being anxious or apprehensive, a state of fear of the future and of the unknown	
sadma	• Literal translation "shock"; distress after experiencing an acute traumatic event; facial expressions of surprise or fear; the person appears distracted or confused, experiences brief convulsions that immediately resolve, cries, or faints and falls to the floor; the somatic symptoms can include headache, tremors, sweating, redness in the eyes, and chest pain	
Ethnicity: Iraqi ($n = 1$)		
asabi	• Derived from the word *asab*, or "nerves," which describes a condition of irritability, nervousness, a lack of patience, and anger outbursts in interpersonal relationships; usually the person wants to be left alone	35
dayeg	• Encompasses rumination, poor concentration, lack of initiative, boredom, sleep problems, tiredness, and somatic complaints (e.g., headache, backache, muscle aches, heart palpitations, breathlessness, dizziness, choking sensation, lump in throat, butterflies in stomach, numbness, and/or poor appetite); can be associated with problems of daily living, difficulties of uprootedness, feelings of insecurity due to disrupted relationships and uncertainty about one's future, or interpersonal conflict	35
nafsak deeyega or *makhnouk*	• A feeling of constriction in the chest and a choking sensation; the chest is felt to be too tightly "filled" with unpleasant feelings to accommodate the inspiration of air; unable to take a deep breath, the person can feel short of breath and sighs repeatedly; used to describe tension associated with daily hardships (poverty, political repression, etc.); difficulties of uprootedness; feelings of insecurity due to disrupted relationships; uncertainty about one's worth, position, and future; can stem from interpersonal conflict; at times is used to describe experiences of panic	35 35
nafseetak ta'abana	• Derived from the word, *el-nafs*, meaning "psyche," which encompasses at different times body, behavior, affect, or conduct; it means that a person's soul is tired; it covers a wide range of undifferentiated anxiety and depressive symptoms	35
qalbak maqboud	• A sensation of the heart being squeezed, often connected with feelings of sadness, dysphoria, or anxiety, stemming from problems of daily living, insecurity about the future, uprootedness, family illness, death, or sorcery; differentiated from somatic symptoms, instead it is a subtle form of talk about affect rooted in traditional understandings and metaphors of the body. In this instance the heart (*qalb*) is treated as the subject of emotional experience and a symbol of the true essence of the person	35
Ethnicity: Afghan ($n = 1$)		27
asabi	• Feeling nervous or highly stressed; people with high levels of asabi were described as overwhelmed by major life stressors such as poverty, domestic violence, and single parenting	
fishar -bala- an	• An expression of "high blood pressure" which is not an actual somatic manifestation but an internal state of emotional pressure and agitation	27
fisha-e- payin	• An expression of "low blood pressure" which is not an actual somatic manifestation but an internal state of low energy and motivation	27
jigar khun	• A form of sadness that includes grief following interpersonal loss but that may also be a reaction to any deeply disappointing or painful experience; used to describe the emotional reaction of people who had lost family members during the war	27
Ethnicity: Darfuri ($n = 1$)		
hozn	• Caused by social and material losses, symptoms can include hopelessness, melancholy, loneliness, crying uncontrollably, irritability or outburst of anger, thinking too much, flashbacks, recurrent intrusive thoughts, recurrent nightmares, physiological reactivity at cues, palpitations, headaches, difficulty falling asleep, lack of appetite, forgetfulness, survivor guilt, or being tormented by demons	32
majnun	• A more severe syndrome with causes that involve a spiritual problem; symptoms include arguing with family, getting into frequent arguments, doing things others consider foolish, talking in ways others cannot understand, physical aggression, talking when one is alone, experiencing a "hot heart," walking around too much, difficulty concentrating, feeling worthless, diminished pleasure, inability to recall parts of event, thinking of one's ending life, and feeling distant from others or emotionally numb	32

Note. The level of detail provided here is based on the depth of information in the original articles.

spirit possession (9, 20, 30, 41), family history, or unknown causes (9, 20–21). Studies also reported that if milder distress exacerbates or is not well managed, it can turn into more severe conditions. A study on a Darfuri sample presented the same continuum model progressing from milder sequelae (e.g., *hozn)* to more severe distress (e.g., *majnun),* which may include psychotic-like symptoms (34).

Three other studies investigating samples from Palestine (GBD), Iraq (39), and Afghanistan (28) presented idioms of distress. The idiom *asabi* or as*abiyya*, which encompasses states of nervousness and irritability, was found across the three studies (1, 28, 39). Two additional idioms were found among Iraqi and Palestinian samples (i.e., *azma nafseya* and *nafseetak ta'abana*), both of which encompass psychological crises and fatigue due to mental exhaustion from stressors.

Studies 1, 8, 34, 44, and 45 attributed distress to traumatic events, broken social bonds, daily life stressors, collective suffering, and an inability to fulfill social roles. Descriptions of all CCD are provided in Table 4.

4.5. PTSD symptoms

Overall, 21 studies described PTSD symptoms as defined by ICD-11 (i.e., intrusion, avoidance, and hypervigilance). Thirteen studies

Table 5
PTSD symptom cluster frequency (N = 21).

Symptom cluster	Frequency (%)
Re-experiencing or intrusion	13 (62%)
Avoidance	13 (62%)
Hypervigilance or arousal	17 (81%)

Note. For detailed descriptions of symptoms refer to section 3.5. Features in the table were ranked by tabulating the product of their frequencies, which were calculated based on the total number of studies reporting PTSD symptoms (i.e., 21).

(62%) reported symptoms that corresponded with the intrusion symptom cluster, which included nightmares and associated sleep problems, as well as flashbacks of traumatic events. Two studies (36, 40) reported that content of intrusive memories included traumatic memories from childhood (e.g., being beaten by parents) which were triggered by exposure to war. Other studies reported intrusive and repetitive thoughts about homeland and families in a displaced sample (2, 35). Intrusion presentations encompassed constant preoccupation with details of the traumatic incident, sensitivity to reminders about traumatic incidents (10, 41), or difficulty forgetting details (11, 38). Symptom frequencies can be found in Table 5.

In terms of avoidance symptoms, 13 studies (62%) described avoiding triggers such as the place of the traumatic event, news from home, media, contact with men (if abuser was a man), contact with other refugees, crowded places, being alone, or other forms of behavioral avoidance (e.g., political activity) (15–17, 24, 33, 35, 38, 46). Studies also reported on mental mechanisms such as evading or suppressing thoughts about a traumatic event, with activities such as prayer, study, or work (10, 14, 41, 46). Two other studies reported that participants had resorted to maladaptive patters such as self-harm, drugs, or oversleeping (17, 41). Four studies reported short- or long-term memory loss or difficulty remembering (10, 14, 28, 38). Emotional detachment or numbing were presented as a form of avoidance (14, 33). Other studies described the emotion of disgust or sexual aversion as a form of avoidance in samples who had experienced sexual abuse (2, 24).

Table 6
DSO symptom frequency (N = 29).

Symptom	Frequency (%)
Affect dysregulation	
Anger[b,c]	16 (55%)
Aggression[c]	11 (38%)
Numbness[a]	**10 (34%)**
Suicidality[c]	9 (31%)
Pervasive sadness, emotional pain	7 (24%)
Self-harm[c]	4 (14%)
Intense emotional outbursts[b,c] (mood swings, sudden, multiple, mixed emotions)	4 (14%)
Constant crying	3 (10%)
Negative self-concept	
Guilt, self-blame[b,c]	20 (68%)
Worthlessness, low self-esteem[a]	**18 (62%)**
Shame[b,c]	13 (45%)
Helplessness, powerlessness[c]	11 (38%)
Permanently broken or damaged[c]	9 (31%)
Identity difficulties	6 (20%)
Incompetence[a]	**3 (10%)**
Self-disgust, self-hatred	3 (10%)
Interpersonal difficulties	
Social withdrawal[b,c] (i.e., behavioral avoidance of social activities or self-isolation)	12 (41%)
Mistrust[a]	**12 (41%)**
Negative feelings toward others (e.g., bitterness, repressed anger, hatred)	10 (34%)
Difficulties being close to others[a]	**8 (27%)**
Feeling isolated, distant from others[a]	**8 (27%)**
Interpersonal conflict[c]	4 (14%)
Social inadequacies (difficulties in social situations)	3 (10%)
Changes in systems of meaning	
Hopelessness, pessimism[c]	12 (41%)
Change in previous values/perspectives regarding self or the world[c]	6 (20%)

Note. For detailed descriptions of symptoms refer to section 3.6. Features in the table were ranked by tabulating the product of their frequencies, which were calculated based on the total number of studies reporting DSO symptoms (i.e., 29).

[a] **Bold** indicates items in the final ITQ or final six DSO items.

[b] Items available in ITQ's original 16 DSO items (Cloitre et al., 2018).

[c] Items available in SIDES (Pelcovitz et al., 1997).

As for hypervigilance, 17 studies (81%) reported symptoms such as fright, constant fear, being easily startled, insecurity, feelings of constant stress or worry over "little things," and fluctuating states of nervousness (10–11, 14, 16–18, 24, 28, 33, 35–38, 46–47). Several studies used terms related to "anxiety" to describe constant arousal (e.g., 10, 17, 37). Two studies reported sleep problems associated with a lack of security (33, 35). Hyperarousal was also associated with a lack of concentration, an inability to learn new skills, or forgetfulness (10, 14, 33). In situations of prolonged violence, symptoms of arousal or a sense of threat persisted due to the continuous nature of a stressor and its presence in their daily lives (e.g., IPV [18] or worry over life conditions and repatriation [10]). Two studies reported participants' preoccupation with death or the possibility of dying after the traumatic event (16, 33).

4.6. CPTSD symptoms

Overall, 29 studies reported on one or more DSO presentations in populations having experienced prolonged or repetitive exposure to traumatic events. Symptom frequencies can be found in Table 6.

4.6.1. Affect dysregulation

In total, 23 studies revealed affect dysregulation symptoms. The most common symptom was anger regulation difficulties, reported in 16 studies (55%) (3, 6, 10, 13, 15, 17, 22, 26, 28, 35, 37, 38, 41, 46–47). Some of these studies described the intensity and nature of anger as constant and intense (22, 28, 37). Anger was described as a form of rage (3, 47), as explosive in nature ("insides that will explode" on p. 689 in source 6), emotional intolerance (16), and in terms of increased irritability, excitability, impatience, and unpredictability (10, 26, 38, 40). A common reported underlying cognition was a belief that the inflicted damages were irreversible (e.g., "my whole life has been ruined" on p. 8 in source 37). Studies also reported several anger sequalae, including short temper, temper tantrums, hostility, increased aggression, and constant dissatisfaction (3, 6, 10, 15, 17, 26, 28, 35, 37–38, 46). Four studies (14%) reported that in episodes of anger, participants engaged in hitting their children or spouses (3, 13, 28, 38), or other forms of violent outbursts (38). Two studies mentioned that family members had noticed changes in participants' behaviors and general state, for instance becoming quick-tempered, very angry, or abusive (3, 46).

Eleven studies (32%) reported on states of numbness (10, 13, 16, 22, 25–26, 35, 38, 40, 46). These states were described as, emotional withdrawal from life and the sensation of being "dead on the inside" (13); emotional detachment from everything and everyone (16); or the inability to enjoy activities that were previously enjoyed and/or positive in general (10, 25, 35). Two studies reported that numbness was stemming from prolonged states of despair and hopelessness, and/or the numerous losses endured. Participants attributed these reasons as to why they believed that no event could ever have any effect on them anymore (18, 46).

Another nine studies (31%) reported suicidality due to extreme affective distress. Of those, seven described suicidal behaviors (4, 6, 18, 27, 32, 40–41) and two described ideation (10, 13). Seven studies (24%) described overall states of pervasive sadness or emotional pain, pain in the heart, or emotional devastation (3, 11, 15, 25, 28, 38). Three studies (10%) also reported cyclical patterns of crying in which participants cried almost constantly without external triggers (15, 25, 28). Four studies (14%) reported on extreme emotional outbursts and mood swings that included a combination of emotions such as anger and sadness. Such outbursts were characterized as severe, sudden, and at times prolonged, including laughing, crying, and simultaneous screaming (13, 15, 17, 25). Four studies (14%) reported self-harm behaviors (e.g., self- beating or hitting their head against walls) in states of elevated distress (13, 18, 28, 41).

Seven studies addressed suppression as an emotion-regulation strategy (3, 10, 22, 24, 35–37). At times, suppression was mandated by cultural scripts, like avoiding an abusive husband, suppressing

emotions due to a cultural emphasis of keeping violence within the family, or accepting and enduring violence as a part of the cultural expectations toward women (e.g.,3). Other times, participants described masking their emotions from family members to protect them from further suffering or burden (e.g., 10). Other studies reported active suppression of any positive emotion due to feelings of survivor's guilt or guilt in general (e.g., guilt from experiencing positive emotions after abuse) (10, 24–25, 37). Finally, in a sample of survivors of child abuse, the participants reported that as children they had been left without affect-regulation strategies or emotional confirmation. They explained that, consequently, they still suffered from major difficulties in explaining, expressing, or processing emotions as adults. Hence, they resorted to emotion suppression (36).

4.6.2. *Negative self-concept*

Twenty-seven studies addressed negative changes in self-concept with varying degrees of depth. These changes included feelings of shame, self-blame, low self-esteem, guilt, and feelings of "permanent damage." The most frequently endorsed symptoms were guilt and self-blame (20 studies, 68%). Participants reported internalizing blame and internalizing accusations of perpetrators. By consequence, they saw themselves as the reason for violence, or deserving of it (2, 5–6, 24, 28, 32, 43). In other contexts, self-blame was associated with not protecting oneself or with not enduring torture, accompanied by intense regret and guilt (13, 33, 36, 41, 47). Guilt, however, was mostly associated with the lack of meeting obligations with loved ones. Examples included guilt resulting from separation from family (e.g., leaving them in Syria) and the inability to remove family from danger (10, 46), or guilt for not providing a better life to their children (10, 15). Several other studies described forms of survivor's guilt in which participants felt both guilty and ashamed from living or experiencing any positive emotions because family members had died. At other times they reported feeling responsible for the death of family members (10–11, 16, 25, 35, 37).

Shame was reported in 13 studies (45%). It was experienced on inter- and intra-personal levels. Participants reported that, at times, feelings of shame were associated with others' responses and at other times with breaking their own value system. In sexual minority groups (e.g., lesbian, gay, bisexual, transgender, and queer [LGBTQ]), shame was associated with internalized social scripts or religious doctrines, which made them view themselves as sinful, sick, deviant, or deserving of abuse (4, 43). In other samples, including female survivors of SV, women reported that they felt self-disgust or self-hatred in addition to shame (2, 41, 47). Other descriptions of shame included feeling undignified, humiliated, unwanted, "small in the eyes of society" (source 6, p. 689) and in their own eyes (6, 24, 32, 36).

The triggering of shame in loved ones or family was particularly observed in contexts of LGBTQ samples and SV (4, 6, 13, 24, 32, 43). Sexually abused women described their experience of fear of being shamed for: not protecting themselves, not taking action, breaking cultural codes of virginity, losing their honor, or ruining their family's reputation (13, 27, 41, 47). Some of these women did not experience feelings of internal shame or were aware that they should not be blamed, but they nevertheless feared shame within community settings.

Shame was also associated with feelings of humiliation, powerlessness, and embarrassment arising from contexts of abuse. Such feelings were reported to arise in contexts such as being exposed to prolonged IPV without escaping it (3, 32) or prolonged situations of deprivation, or detention (10), or racism and humiliation based on cultural identity (22).

Eighteen studies (62%) reported self-esteem difficulties such as low self-esteem (10, 22, 32, 41, 47), lack of self-confidence (5, 28, 40), constant feelings of inferiority (40), worthlessness (2, 5–6, 18, 22, 24, 33, 40–41, 47), or weakness (11, 16). Eleven studies (38%) also associated feelings of helplessness or loss of control over their lives with a negative self-concept (3, 5–6, 10, 18, 24, 26–27, 32, 38, 40). Other studies indicated negative feelings such as incompetence (2, 6, 10) or self-disgust and self-hatred (2, 41, 47). In studies where participants reported abuse in early life, they expressed that low self-confidence created problems in autonomy, where constant self-doubt and insecurity prevented them from pursuing or performing tasks independently (5–6, 36).

Nine studies (31%) reported that participants viewed themselves as being broken, damaged, defeated, or scarred. Such perceptions were characterized by the belief that trauma effects were irreversible, leaving no room for recovery (5–6, 10–11, 13, 18, 24, 33, 41). A negative self-regard was also connected to identity problems or a confused identity in relation to trauma (six studies, 20%), like self-suppression, the feeling of having an erased personality, not feeling like a man/woman, a lack of a sense of belonging, a lack of direction in life, feeling meaningless, or a sense of emptiness (5, 18, 26, 36–37, 40).

4.6.3. *Interpersonal difficulties*

Twenty-four studies portrayed features of interpersonal difficulties. Twelve of these studies illustrated different forms of emotional and social withdrawal from life and obligations (25, 35–36, 38, 40, 47), three reported on a general loss of interest and unwillingness to engage in interpersonal/intimate relationships (16–17, 36), and three revealed deliberate self-isolation, despite feelings of loneliness (6, 26, 40, 43). Two studies described this withdrawal to be outside of individuals' control (16–17). Examples of withdrawal behaviors included not engaging in conversations (25), not seeing anyone (28, 37), not attending social events (10, 25, 28), an inability to care for children (38), and problems in intimacy (16, 36). Eight studies reported having difficulties being close to others and problems in both forming new relationships and sustaining old ones in terms of quality and stability (e.g., 10, 16).

In samples describing feeling distant from others (eight studies, 27%), participants reported that their interpersonal difficulties were sustained by low levels of solidarity, a lack of social sharing/reciprocity, or a lack of empathy after trauma exposure (15–17, 41). In samples exposed to prolonged interpersonal violence, participants highlighted the connection between perceiving themselves as damaged/broken and their impaired ability to build long-term interpersonal relationships due to problems in personal boundaries and beliefs in their inability to protect themselves from others (5, 36, 40). Three samples (10%) also reported that violence exposure created self-perceived social inadequacies and anxiety, which affected their daily functioning (e.g., related to talking or walking in the street) (6, 10). Such interpersonal difficulties reinforced a negative self-image and constant hypervigilance, which according to two studies created a "vicious cycle" (6, 36).

In other studies, participants reported distancing themselves from others in fear that others would learn of their trauma history. In their view, such knowledge could have social repercussions or threats, like being re-abused or being further stigmatized (11, 27, 41). Several studies reported that participants viewed the disclosure of sexual abuse in close relationships (e.g., mothers, sisters, close friends) as being ineffective because it often resulted in "blaming the victim," social rejection, and disgrace (e.g., 2, 13, 41). In other studies, participants isolated themselves because they felt alien to others, as the latter would not understand their experiences (2, 22). Other reasons for isolation were overwhelming symptoms (e.g., constant rumination) affecting social abilities (10), or avoidance of getting engaged in relationships due to the fear of suffering personal and social losses again (28, 35).

Another salient feature of interpersonal difficulties was increased conflict. Studies highlighted increased arguments/conflict with family members or neighbors, along with increased overall hostility and aggression after trauma exposure (e.g., 16–17, 26, 28, 40). Elevated levels of aggression or hostility were not just related to dysregulation, but also to changed core beliefs in relation to oneself, others, and relationships, as well as changed values regarding justice in the community and with humanity in general (10–11, 15, 17, 26, 40). Twelve studies (41%) reported beliefs that society was dangerous, and that the

community was no longer safe, which led to apprehension of others, mistrust, and an inability to discern trustworthiness (4–5, 10, 15–17, 26–27, 32, 35–36, 41).

Ten studies (32%) reported on recurrent negative emotions toward others, such as bitterness, fear, hatred, and insecurity, particularly in torture victims or in minority communities (4, 6, 10–11, 13, 15, 24, 26, 41, 47). In contexts of minority prosecution, some studies reported that exposure to violence from the host community (in the case of refugees) or from surrounding other majority groups fortified participants' distrust and sense of betrayal, leading to communal responses, like becoming a self-enclosed society (10–11, 15, 22, 26, 35). In such groups, distrust of others extended into distrust of governments and service providers, such as health professionals or aid workers (10, 15). Anger and bitterness toward the family or community were mostly present in victims of childhood sexual abuse (6, 24, 27, 41) and in contexts where victims were not acknowledged (3, 5, 32, 40).

Contrary to most of the included studies, two reported a surge in participants' new relationships after leaving a context of abuse. The participants needed new relationships to both disconnect from their traumatized self and repair a distorted self-image. Such changes also included changing social environments so that they would be far from the people who knew about the abuse and limiting their relations with prior friends or family (2, 25). Finally, in two studies including survivors of war and displacement, participants reported that social support and integration were culturally acknowledged needs for recovery (35, 40).

4.6.4. New/old symptom cluster: changes in systems of meaning

We found that samples endorsed clinical features relevant to changes in systems of meaning or worldview, which were not included in any of the core ICD-11 symptom clusters of CPTSD or in the ITQ items. We struggled with coding such data within the DSO symptom cluster and reverted back to the SIDES (Pelcovitz et al., 1997), where this was included. In Table 6, we report on two relevant symptoms in this domain. Twelve studies (43%) included a sense of hopelessness/pessimism (5–6, 10, 16–18, 27–28, 32, 35, 37, 40), while six studies (20%) reported changed values or beliefs (e.g., a loss of meaning or negative view of the world and humanity) after trauma exposure (10–11, 15, 17, 26, 40).

4.7. Other trauma-relevant symptoms

Studies reporting on PTSD or CPTSD symptoms also described other relevant symptoms. In this section we review all the other symptoms that did not fall under the main diagnostic criteria for PTSD and CPTSD. The most common additional symptoms were sleep problems (n=12) and various forms of somatic symptoms (n=12). Studies also reported on varying dissociative symptoms (n=8), symptoms of rumination or "thinking too much" (n=8), or concentration and memory difficulties (n=8). Studies also reported symptoms of grief (n=5), sexual aversion (n=4), depressive symptoms (n=4), functioning difficulties (n=3), psychotic symptoms (n=2), and fatigue (n=1). Detailed descriptions of all symptoms and frequencies are provided in Table 7.

4.8. Structural factors

This section focuses on the relationship between structural or cultural factors and distress. Such information is concentrated in this section to synthesize how existing literature presents contextual information in which distress is embedded.

4.8.1. Type 1: relevant sociocultural information

First, certain articles provided crucial contextual information for understanding trauma-related distress in MENA contexts. Among these were studies including communities exposed to violence collectively, which offered a multidimensional understanding of mental health symptoms within a sociopolitical context where traumatic distress and related emotions, such as anger, are integral to the construction of collective or communal identity (1,7, 12, 29, 38, 44–45). These studies emphasized that the severity of emotional distress and suffering is linked to social strain and injustice rather than simply individual or private suffering. Therefore, the interpretation of private affliction was viewed in a wider context of sociopolitical trauma.

Two articles (25, 46) with Syrian and Afghan samples identified separation from family as a main trauma, viewed as a primary cause of distress on par with violence exposure. The participants expressed an inability to move forward in life with family members remaining in their homeland or elsewhere. A few other studies (e.g., 10, 24) also reported elevated distress due to separation.

4.8.2. Type 2: cycle of distress & structural/cultural factors

The second type of articles either focused on portraying cultural and structural information and their role in exacerbating distress or presented the bidirectional vicious cycle between structural factors and

Table 7
Summary of other trauma-related symptoms (N = 30).

Symptom	Description	Frequency (%)
Sleep problems	• Lack of sleep, difficulty falling asleep, and staying asleep; insomnia	12 (40%)
Somatic symptoms	• Pain, general aches ranging from dull to severe: sore arms and legs, neck soreness, a "heavy head" or constant headache/migraines, body pain, back aches, stomach/abdomen aches, pain related to specific torture experiences • Cardiovascular and pulmonary symptoms: feelings of cardiac arrest, increased blood pressure, chest pressure, or pain in the heart; fear of having a heart attack; shortness of breath, palpitations; high or low blood pressure • Appetite problems; loss of weight; nausea	12 (40%)
Dissociative symptoms	• Depersonalization, detachment, alienation from self, sudden loss of orientation, loss of consciousness/fainting; perceptual confusion, such as hearing voices; disengaging from conversations/not listening while others speak	8 (27%)
Rumination or *"thinking too much"*	• Worrying, circular thoughts, thinking that could not be controlled or turned off • The content of such thoughts included worries about one's family that one always thinks about, like the situation at home or events that took place or trauma over structural concerns (e.g., deportation during the temporary visa period)	8 (27%)
Concentration/memory difficulties	• Cognitive impairment in relation to memory and concentration • Short- or long-term memory loss	8 (27%)
Grief	• Feelings of grief over losses of homes or people and overwhelming and unresolved sadness	5 (17%)
Aversions	• Mostly sexual aversions, disgust, or being triggered by any sexual experience or content	4 (13%)
Depression	• Depressive symptoms or affect and low mood	4 (13%)
Functioning difficulties	• Difficulty functioning at home or work or acquiring new needed skills (e.g., caregiving, sustaining employment)	3 (10%)
Psychotic symptoms	• Talking to dead people, hearing voices, incomprehensible speech	2 (0.6%)
Fatigue	• Physical fatigue	1 (0.3%)

Note. Features in the table were ranked by tabulating the product of their frequencies, which were calculated based on the total number of studies reporting other symptoms (i.e., 30).

pathology. These articles demonstrated transactions between symptoms and the continuation/worsening of structural conditions and vice versa. Studies reported that victims of SV were stereotyped, and there was a lack of public social acknowledgement. Victims of any extramarital SV were regarded as not being “pure” and instead dirty and more prone to engage in sexual activity (4, 13, 24, 27, 32, 43). Such stereotypes have direct consequences like living in constant fear of being socially stigmatized (41), which can lead to increased feelings of insecurity, negative self-worth (4, 24, 27, 41, 43). Other social consequences of violence exposure, such as forced marriage to a perpetrator (27) and ruined or reduced marriage prospects due to the loss of virginity (13), impacted women’s loss of role in society and life-progression after trauma. This then cultivated and sustained feelings of worthlessness and ongoing distress.

Other studies (2–3, 5–6, 32, 40) revealed patriarchal cultural norms in which women endured violence and did not receive support from their social networks. Women reported suppressing emotions and staying in abusive marriages due to children and a lack of finances. The lack of economic or instrumental support from their families, combined with a fear of separating from family and friends, prevented them from leaving a distressing situation.

LGBTQ communities faced discrimination based on their sexual orientation or gender identity (4, 43). Diaspora communities were not a reliable source of support for them, even after immigration (4). Another study on transwomen addressed the effects of sociocultural factors, legislation, and medical system impediments on distress (43). Firm gender codes in Iranian social structure affected participants’ daily lives (e.g., expulsion from school due to identity), increasing their distress and vulnerability. Legal and medical obstacles during the “social freezing period” in which they could not take any jobs or come out publicly as trans until their gender-assignment surgery is documented led to financial difficulties and vulnerability to revictimization, symptom-worsening, and the creation of a vicious loop of compromised functioning. Other forms of structural violence, such as the lack of support from police and associated authorities, increased feelings of insecurity, distrust, negative self-regard, or suicidality.

Changes in gender responsibilities or roles were also an exacerbation factor of distress. One study argued that stressors, such as the loss of a social role , increased distress and further disrupted interpersonal functioning (42). In their sample, gender norms for men encouraged the refusal of external help. This in turn limited resources for the family, leading to increased distress for men (e.g., low self-worth, isolation, aggression) and family conflict. In these studies, distress and family conflict were described as having a direct bearing on interpersonal bonds, as self-worth is partly defined by intra- and extra-familial social affiliation.

In general, post-migration living difficulties such as employment, housing, language difficulties, asylum status, or lack of social support were presented in many studies as key to worsening psychological conditions (22,35,42,46). Other structural difficulties were also connected to anger outbursts and aggression. One study (28) found that parents in war zones may resort to inappropriate beatings due to high levels of stress related to unemployment, crime, lack of access to care, poor housing conditions, and terrorism. After such incidents, parents acknowledged the inappropriateness of their behavior and often expressed regret. Women in another study identified financial difficulties as a reason for conflict and violence between spouses (3,18).

A changed self-perception following trauma was also associated with structural difficulties (8, 22). These studies demonstrated that participants’ self-perception of diminished agency and powerlessness impaired their goal-directed behavior, like acquiring new languages or skills or sustaining study or work. This prevented them from improving living conditions and confirmed a sense of failure due to a perceived inability to reestablish their lives and their failure in their role as family protectors and providers. Such difficulties weakened participants’ sense of control over their future and their overall sense of dignity, which also fed into a loop of helplessness (8, 42). This increased overall distress and particularly rumination over structural concerns. Racism, microaggressions, and a lack of social support increased feelings of worthlessness and a negative self-image, shame, and feelings of isolation (22).

One study (26) described how, in the aftermath of a revolution, state violence (e.g., torture, arrests, clashes) to repress political reform and justice and worsening structural conditions created a cycle of continuous traumatic stress (CTS). Anger and frustration turned inward and outward, resulting in severed social bonds, a polarized society, and widespread social aggression. This further intensified individual symptoms such as avoidance, anger, feelings of alienation, mistrust, and hopelessness and created a cycle of compromised functioning.

5. Discussion

Our review included 47 studies presenting in-depth descriptions of ICD-11 PTSD, CPTSD, CCD, and “habituated” distress in the Greater MENA region. Findings revealed cultural nuances in the conceptualization, normalization versus pathologization, and symptom presentation of trauma-related distress. They also touched on the structural factors influencing or exacerbating such distress.

5.1. Context of trauma

Most included studies reported overlapping forms of violence (e.g., interpersonal and collective war/political violence). In addition, many studies showed that domains of violence often include public (e.g., state or institutions) and private (e.g., partner or family) spheres. Some of these studies addressed structural living conditions, like poverty or stigma, as a part of either their exposure to violence or the maintenance of cycles of violence (Coffey et al., 2010; Diab et al., 2022; Naghavi et al., 2019). Others studies established links between structural difficulties in daily life and elevated distress (Wells et al., 2018).

Structural conditions were mentioned in studies that focused on samples exposed to one form of violence (e.g., IPV), as well as in samples with overlapping violence domains, particularly childhood abuse and war violence. These studies revealed the known link between structural conditions and different forms of interpersonal violence, such as poverty, war, or domestic violence (e.g., Al-Natour et al., 2019; Miller et al., 2006). Another example was the concept of daght, or the buildup of pressure, which highlights the continuous strain placed on individuals and communities living with ongoing violence. In these studies, structural difficulties and direct violence exposure (e.g., killings or oppression) were conceptualized as part of an overarching trauma-distress model and could not be viewed separately (Afana et al., 2010; Kerbage et al., 2020; Wells et al., 2018).

Structural factors also impacted the perceived duration of trauma exposure. Some literature suggests that the failure of social systems “to contain, nurture, care for, and protect individuals, as in the case of the lack of assistance and compassion towards the victims of poverty, disease, natural catastrophe, social turmoil, economic crisis, violence, or war” (Hernández de Tubert, 2006, p. 152) is considered an “ongoing” social trauma. This (re)raises the question of whether the concept of “post-traumatic” (on which PTSD is based) is an adequate term in such contexts (Kira, 2010; Straker, 1990).

Another provided reason for perceiving trauma as ongoing was separation from family. Some accounts revealed ongoing grief and a sense of threat that were related to separation from family, and the separation itself was perceived as a current and continuous trauma (Zbidat et al., 2020). Some theoretical research has shown that primary relationships in interdependent cultures are instrumental in self-perception and identity (Jobson, 2009). For the interdependent (Markus and Kitayama, 1991) or relational (Joseph, 1994) self, the perceived boundaries of the self are not confined to the person but include family members and the community. Thus, the threat to the self is not limited to the person but is rather extended to those circles (Hosny

et al., 2023; Jobson, 2009). Therefore, in the MENA region, forcibly severed family relationships may cause more distress and have a more negative impact on PTSD and CPTSD symptoms (e.g., trauma memories, intrusions, self-perception) or mental health in general than elsewhere because social ties and institutions play a prominent role in people's functioning.

At an individual level, the subjective perspective on traumatic events (i.e., *what* is perceived as being traumatic) shapes the development of psychopathology, including symptom resolution or symptom interpretation (e.g., the normalization of distress) (Mattar, 2010). Afana (2012) stated:

> The fact that an Arab respondent in Western Sahara has endorsed the same symptom on a standard PTSD questionnaire as a U.S. respondent in West Los Angeles does not mean that they have the same experience, that they interpret it in the same way, or that the symptom has the same diagnostic meaning. (p. 2)

Our findings regarding how trauma was normalized in contexts of protracted violence along with other literature surface the issue of the cultural construction of trauma and the question of what should be considered a life-threatening event (Gilmoor et al., 2019). To address these issues on a research level we need to incorporate the social, historical, and structural context into investigations on the meaning of trauma in particular settings (Droždek et al., 2012; Ventevogel and Faiz, 2018).

In summary, there are multiple factors which affect the development of trauma-related psychopathology. We found it was caused and maintained by two factors: "trauma exposure" in the narrower sense (i.e., the exposure to extreme, life-threatening violence) and cultural and structural difficulties. The "weight" attributed to each element needs to be reassessed to understand the functional relationship between symptoms and trauma exposure, as required in the ITI. Such a "calibration" process is needed to avoid false positives in which symptoms are attributed to trauma exposure when they actually stem from structural difficulties. This distinction will allow us to differentiate between origins of distress, formulate a more attuned diagnosis, and guide accurate psychosocial interventions.

Our findings also help us conclude that there is a triad consisting of (a) trauma exposure (in the narrower sense) and its interpretation, (b) cultural and structural factors, and (c) symptoms of traumatic stress. In this triad, there might be a bidirectional relationship between symptoms and the social determinants; for example, trauma survivors may struggle to find or hold a job, stay married, or find (or keep) a place to live due to affect dysregulation and interpersonal difficulties. This can cause a *vicious cycle*, as difficulties with employment, housing, or relationships may aggravate DSO. As reported (see section 3.8.2), a few of the reviewed studies elaborated on cyclical or bidirectional relationships among these three factors (e.g., Coffey et al., 2010; Yaghoubirad et al., 2021). More research is needed on the dynamic of this triad for each of the symptoms separately.

5.2. Culture and traumatic stress: phenomenology

In line with the dialectic approach, we searched for universal, core symptoms provided in the ICD-11 (type [a]) as well as culture-specific PTSD or CPTSD manifestations (type [b]/[c]). Our findings confirmed that while the core diagnostic clusters for CPTSD (i.e., PTSD and DSO) were present, symptom variations emerged within each cluster.

The new CPTSD diagnosis in ICD-11 and the corresponding assessment tools include 12 core symptoms to maximize clinical utility. For this approach to succeed, it becomes essential to create and validate cultural modules to account for variations on the symptom-level across groups (Hinton et al., 2018; Killikelly et al., 2020). Table 5 in section 3.6 shows that the several DSO indicators in the ITQ were present in studies from the Greater MENA region. At the same time, other specific symptoms or indicators (e.g., shame and guilt) frequently mentioned could be added to such cultural modules. Meanwhile, some of the symptoms included in the ITQ were not widely endorsed in studies from this region (e.g., a sense of failure or an inability to calm down). Some of these items were present in the original 28-item ITQ, and others were included in the SIDES.

The only difference we found on the symptom cluster-level was the "changes in systems of meaning" symptoms, which we could not integrate into any DSO cluster. This suggests that culturally sensitive assessments of CPTSD should perhaps consider including an item or criterion assessing changes in systems of meanings, as done in the SIDES.

Regarding PTSD, we found no new symptom variations other than those which had been previously mentioned in other reviews (Michalopoulos et al., 2020; Rasmussen et al., 2014). Most symptoms reported in the "other trauma-related symptoms" category also appeared as additional common symptomatic presentations with stress-related disorders in either the ICD-11 or DSM-5. Consistent with other literature from the region, somatization was the most frequently reported among other relevant symptoms (Mellor et al., 2021). We also noted that ruminative thinking patterns otherwise labelled as "thinking too much" were prevalent in various cultural groups in our review (e.g., Coffey et al., 2010; Renner et al., 2020; Shannon et al., 2015). Such patterns were mostly concerned with worries over structural concerns, including asylum status, repatriation, income, or family safety. This is in line with findings of a review by Kaiser et al. (2015), who found that certain vulnerability factors (e.g., financial dependence, oppression, and compromised social status) were associated with thinking too much. Such fears or ruminative patterns need to be contextualized before being deemed as disproportionate or pathological, given the continued threat in participants' perspectives.

In samples who suffered from severe loss, either personal (e.g., home, financial means, status) or interpersonal (e.g., loved ones, community), features such as grief over losses along with overwhelming sadness were reported (e.g., Lipson, 1993; Rometsch et al., 2020). Such difficulties could overlap or be associated with PGD (Killikelly et al., 2018). They could also be relevant to pervasive sadness and emotional pain reported in the affect-dysregulation section. More research is warranted to both understand the role of grief and prolonged sadness in individuals presenting DSO features and clarify clinical distinctions and overlaps between both diagnostic categories.

Articles presenting what we called "normalized" trauma responses raised the issue of diagnosis and the continuum of mental health and mental disorders (Patel et al., 2018). For this continuum to be accurately understood, it needs to be viewed in a wider sociocultural context, as illness narratives are deeply intertwined with the social conditions in which adversity or trauma is faced. For instance, in contexts of ongoing trauma exposure, certain studies have rejected the pathologization of distress (e.g., Barber et al., 2016; Hammad and Tribe, 2020). Participants have expressed that the medicalization and diagnosis of their distress "labelled" them, diminished their agency, and undermined their sociopolitical circumstances and struggle for human rights (e.g., Barber et al., 2016; Diab et al., 2022). While these studies acknowledged distress and the burden of symptoms, they framed them as normative responses to a prolonged extraordinary situation (i.e., refugeehood or prolonged violence of settler-colonialism). This happened even though these normalized states of distress included features of CPTSD or DSO. See Fig. 2.

Over the course of time, inter- and intra-personal processes associated with prolonged exposure to trauma can be interpreted as adaptive or a normative response to a situation. This does not necessarily mean that certain behaviors are conceptually different from *symptomatic* (i.e., pathological) distress in other contexts. This raises the question of whether "normal" necessarily equates to "healthy." *What* is considered normal could be a maladaptive response that has become normalized due to a prolonged exposure to violence. However as "disability is largely determined by the social environment rather than simply by the impairments themselves" (Patel et al., 2018, p. 1564), these difficulties

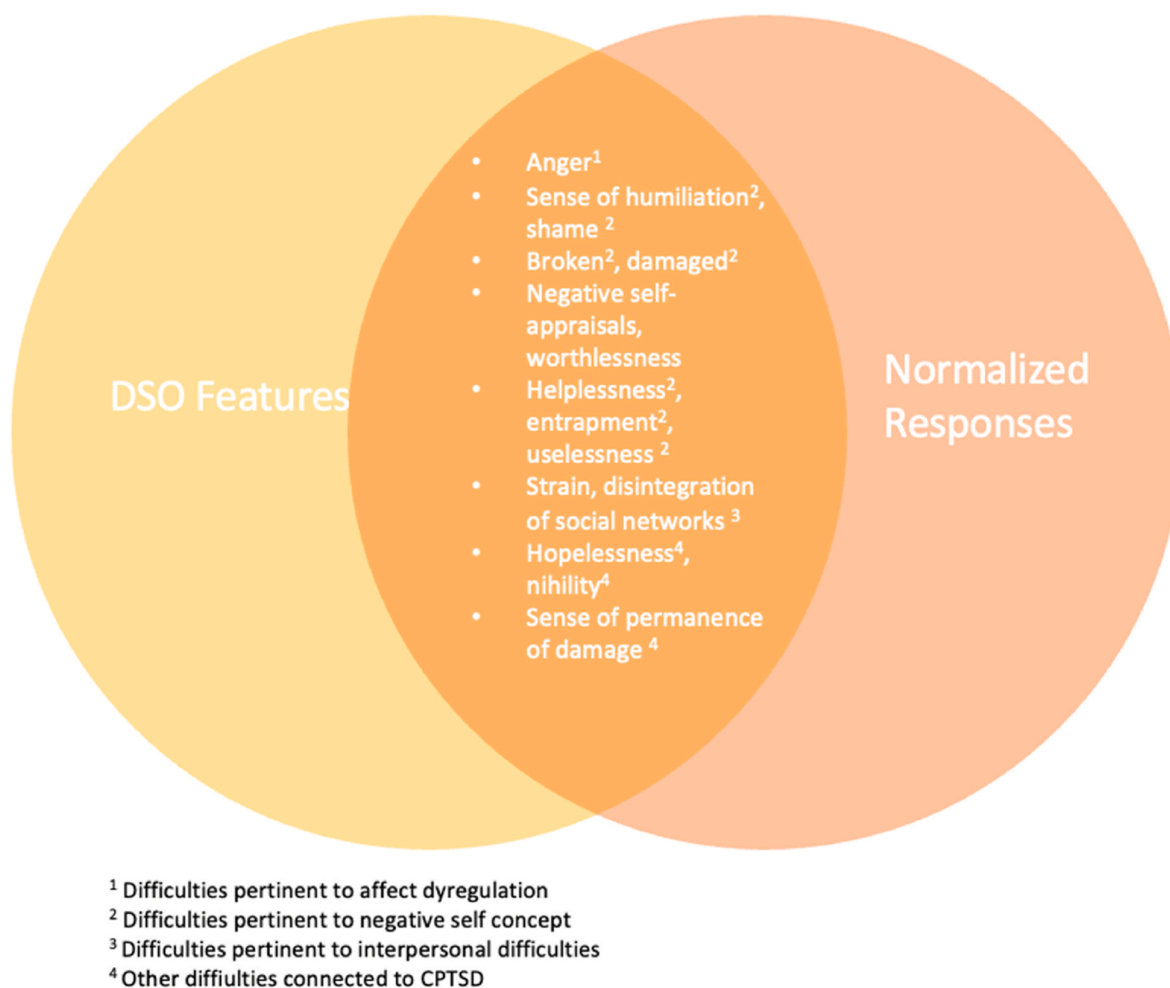

Fig. 2. Diagram of overlap between DSO and normalized cultural responses.

are normalized due to repetition and the collective nature of the ongoing traumatic situation (Ventevogel and Faiz, 2018). The assessment of functional impairment to understand severity and determine the PTSD and CPTSD diagnosis, as it is done in the ITI and ITQ, is therefore crucial to understanding all types of trauma-related distress. The extent to which individuals can perform their social role in their sociocultural context is key to determining impairment and disability caused by mental disorders. This may be the *only* means to ensure that diagnostic processes are context-sensitive and not based on culturally incongruent conceptual premises (Patel et al., 2018).

5.3. *Cultural scripts: notions of normalcy and deviance*

In this section we highlight the most salient nuances in cultural scripts of normalcy and deviance (Chentsova-Dutton and Ryder, 2020) that are pertinent to samples from Greater MENA. These scripts guide notions of functioning, coping, and distress expression.

5.3.1. *Scripts of functioning*

In line with approaches of assessing functional impairment, we searched for cultural norms influencing the perceived degree of distress in the Greater MENA region. This evaluation occurred by comparing individual deviance in relation to cultural expectations. Participants in several studies (e.g., Coffey et al., 2010; Miller et al., 2006; Shannon et al., 2015) evaluated the degree of distress by individuals' behavior within either the community (i.e., participation in social life, fulfillment of obligations, respect shown to others) or the family (i.e., ability to fulfil roles, interact, and cooperate with members). In addition, observable features related to people's internal psychological state (i.e., irritability, aggression, control over emotions, mood, ability to use coping mechanisms rooted in cultural values) were also used to evaluate the degree of psychopathology.

5.3.2. *Affect regulation*

Issues related to normalcy and deviance also occurred in the domain of coping and regulation. The most frequently reported emotion-regulation mechanism was suppression. Suppression was generally used due to perceived cultural norms, for instance women's obligation to endure in domestic violence contexts (e.g., Al-Natour et al., 2019). Experimental and comparative studies in interdependent cultures found that habitual suppression in accordance with cultural norms was linked to less negative emotions compared to samples from independent cultures (Butler and Gross, 2009; Butler et al., 2007). This accentuates both the significance of cultural context in shaping regulation patterns and strategies and their impact on distress and psychological wellbeing (Tull and Aldao, 2015).

At other times, the suppression of positive emotions was described (e.g., Coffey et al., 2010). Returning to the interdependent or *relational self*, individuals in the Greater MENA may suppress positive emotions due to implicit cultural guidelines about cohesion and group wellbeing as well as the perceived cultural appropriateness of certain emotions. This includes feeling guilty for experiencing happiness or positive emotions when family or loved ones are not safe, as it may violate their perceived self-concept and social expectations (Schouten et al., 2020).

Another related process is disclosure. Emotion-regulation strategies have been shown to serve both intra-personal and cultural purposes (de Leersnyder et al., 2013), and patterns of disclosure also often seem to line-up with such cultural expectations (Dalgaard and Montgomery, 2015). Our review showed that in contexts where expression or disclosure was viewed to cause disruption to overall values (e.g., among sexual abuse victims), it was described as pointless or even harmful (e.g., Einolf, 2018). Samples in our review suppressed emotions or opted not to disclose difficulties to their social networks in fear of burdening others, losing face, and disturbing group cohesion (Kim et al., 2006). For example, Erdener (2017) found in a Yazidi sample the use of self-enclosure and avoidance of trauma as adaptive regulation strategies. These mechanisms may be viewed as pathological from a Western perspective, but in the context of ongoing traumatic experiences (e.g., prosecution, genocide) of this minority group, they could be seen as a communal form of emotional relief, a means of ensuring survival, or an adaptive strategy to reduce daily distress.

However, other studies found that participants expressed a need for disclosure and social acknowledgement (e.g., Naghavi et al., 2019). In these cases, women's lack of disclosure resulted in increased negative emotions, partly due to stigma or norms, but also because they received no social acknowledgement or support. Studies from other interdependent cultural groups similarly discovered that the inability to receive culturally acknowledged forms of social support (i.e., instrumental, belonging, appraisal) was associated with post-traumatic stress. (Hansford and Jobson, 2021). Thus, more research is needed on disclosure and victim acknowledgement in the Greater MENA region, as these processes seem to be relevant in the etiology of PTSD and CPTSD in general (Maercker and Horn, 2013).

5.3.3. *Self-concept*

It seems that the most pertinent features of negative self-concept in the Greater MENA were shame and guilt, which were related to the perception of failing to adhere to cultural scripts (e.g., for women in contexts of SV) (e.g., Einolf, 2018) or non-compliance with ascribed roles. For example, men reported more shame related to not maintaining their role or for shifting gender roles in displaced settings (Kerbage et al., 2020; Wells et al., 2018). Men's loss of their ascribed social role, and a loss of dignity, negatively influenced their ability to seek support. Women, however, as in other literature (e.g., Almakhamreh et al., 2020; Darychuk and Jackson, 2015), showed more adaptability by asking for and accepting more support without feeling shame.

Shame emerged as a multilayered and complex emotion in the region. It was evoked by situations that violated cultural codes of honor and dignity, such as feelings of inferiority or humiliation. Samples described that poor living conditions, or enduring violence for prolonged periods, induced feelings of inferiority, humiliation, and thus shame. "Feeling small" was used to describe shame associated with perceived inferiority, discrimination, or subordination in status and wealth (Fessler, 2004; TenHouten, 2016). Anger and shame frequently co-occurred in included studies, possibly because shame-triggering incidents violate honor codes, which threatens the social self and triggers dysregulated responses such as anger (Boiger et al., 2014).

Overall, there was a lack of consistency in how shame, guilt, and self-blame were understood and used in the literature from the Greater MENA region. These terms were often used interchangeably, referring to both internal and external processes, and they were associated with regret from harming oneself or others. This lack of consistency may stem from linguistic differences and variations in emotional experiences associated with these terms (de Groot et al., 2021). Further qualitative research is needed to gain a better understanding of the nuances of these emotions and their relationships with self-concepts in Greater MENA.

5.3.4. *Interpersonal difficulties*

Interpersonal difficulties were a major area of cultural dysfunction, consistent with literature emphasizing the importance of relationships and communal values in the region (Awad et al., 2021). Hence, functioning difficulties associated with personal detachment, severed relationships, or the loss of interest in relationships were widely noticed and reported. Social withdrawal was the most frequently endorsed symptom in the interpersonal difficulties cluster in our review. While other features of disturbed relationships (e.g., distance, loneliness) could be considered internal experiences, social withdrawal is an external and active behavior in which a person openly deviates from interdependent, reciprocated, and communal values. Thus, the cultural consequences for this symptom are more glaring and evident and acknowledged as functional impairment (Nickerson et al., 2016). Chentsova-;Dutton and Ryder (2019) used the term "interpersonal loops" to describe a cycle in which the inability to fulfill cultural roles or expectations in daily life impacts psychopathology, and vice versa. For instance, some participants expressed the importance of family cohesion in overcoming traumatic experiences yet still reported increased interpersonal tension that created dissonance and added to their psychological burden and guilt toward others. This further increased their distress and "fed" the loop (e.g., Renner et al., 2020; Wells et al., 2018).

5.4. *Implications for practice*

Several implications for practice can be drawn from our review. The Lancet Commission postulated that sustainable development and mental health go hand in hand (Patel et al., 2018). Similarly, multiple studies supported the incorporation of structural elements in treatments, especially if participants themselves identified mainly structural solutions to alleviate their distress (e.g., Kerbage et al., 2020). As an example, there was agreement across studies that women from different cultural groups in the Greater MENA region stayed in violent relationships or households due to multiple socioecological factors (see section 3.8.2) (Essaid et al., 2015; Gharaibeh and Oweis, 2009). There is a need for multi-systemic interventions that include policy, advocacy, and gender-inclusivity, in addition to psychosocial and clinical interventions.

Another recommendation emphasized in included studies was acknowledging political trauma in future psychosocial interventions (Afana et al., 2010; Shannon et al., 2015). As Drozdek and Wilson (2007) explained, when survivors seek help for their fears, shame, or guilt they expect interventions that include social justice and rehabilitation, whereas they often end up "only" receiving medication or protocolized treatments, which leave them feeling misunderstood and therefore unengaged. By including both sociocultural and structural factors and acknowledging traumatic contexts, tailored interventions can build individual and collective capacities to pursue social justice and facilitate both individual and communal healing (Karcher, 2017; Silove, 2013). In interventions in ongoing conflict settings, it is recommended to acknowledge collective and/or human rights issues (e.g., structural violence, oppression, poverty) as the root of distress to enhance engagement (Drozdek and Wilson, 2007; Giacaman, 2018). In such contexts, it is also pertinent to assess the inapplicability of "post" traumatic stress and its implications on symptoms and interventions. Such implications include adopting trauma models that consider distress recurrence in interpersonal and sociopolitical contexts (Behrouzan, 2015) and pursuing therapeutic goals such as 'realistic threat discrimination' that may be more congruent than complete symptom-resolution (Matthies-Boon, 2018).

In the light of our findings and related literature, we believe that notions of normalcy and deviance should be considered in future adaptations to culture-specific DSO features (e.g., unique versions of shame, guilt, centrality of family) (Chentsova-Dutton and Ryder, 2020). Increasingly integrative conceptualizations might enhance the clinical utility and accuracy of diagnostic tools and the acceptability and effectiveness of interventions.

5.5. Future research directions

Our review demonstrated the need for DSO-focused qualitative research. While there is a considerable and promising number of studies exist, most did not specifically focus on the phenomenology of consequences of prolonged exposure to violence. Therefore, further investigations are necessary to explore the DSO symptom experience and expression, and the culturally influenced intra- and inter-personal processes underlying the emergence, maintenance, and recovery of C-PTSD (Heim et al., 2022, p. 10). We need more researchers to specify and target study purposes within these particular gaps and steer away from "overall" quantitative research that aims to assess and validate diagnostic constructs as a whole cross-culturally, without going in depth. While the field previously needed to establish the clinical applicability of CPTSD, CPTSD has arguably already reached the status of an established diagnostic construct.

We also recommend more research on DSO features in samples exposed to collective or communal violence, as cultural meaning-making processes define traumatic responses (Maercker and Horn, 2013; Mutuyimana and Maercker, 2022). Our findings indicate that communal/collective or continuous trauma may have an impact on the conceptualization of trauma (i.e., processes of normalization versus pathologization) and trauma-related distress.

We also recommend incorporating structural and contextual elements in both quantitative and qualitative research. The studies that mostly incorporated structural elements as sociopolitical products inseparable from violence exposure were the ones that described normalization distress in prolonged settings of violence and social suffering (see section 3.3). Most studies have focused only on the one-directional perspective of how structural factors exacerbate distress, which while important for treatment planning miss salient features of maintenance mechanisms. Some literature shows that structural difficulties maintain and/or exacerbate traumatic stress symptoms (e.g., Miller and Rasmussen, 2010). The problem that remains is to differentiate between symptoms caused or maintained by structural difficulties and those resulting from violence exposure to effectively address them in diagnostic tools and interventions.

More research is needed on the impact of separation and collapsed social networks on psychopathology in the Greater MENA region to inform clinical practice. Overall, there is a lack of studies exploring self-concepts and selfhood from cultural clinical psychology perspectives. Our findings indicate that two key factors—social role and gender—are closely intertwined and pertinent to self-concepts. Further literature and conceptual frameworks are necessary to examine different dimensions of self-concepts in a clinically relevant manner.

More generally, trauma-related CCD were mostly reported in Somali samples, along with a few other samples from different locations in the Greater MENA region. We encountered three difficulties in finding more studies reporting CCD in the region: 1. Some of these CCD were addressed in dissertations or other non-peer-reviewed mediums; 2. Studies often listed idioms briefly or provided literal translations without explaining symptoms, explanatory models, or resolutions; and 3. Articles did not specifically aim to include trauma-related CCD and lacked focus on violence exposure. We need more in-depth peer-reviewed literature on CCD, as it would broaden our understanding of trauma-related distress in the field and situate it in cultural and sociopolitical realities of the region.

5.6. Limitations

Limitations of this review include a potentially incomplete identification of all relevant papers due to the restriction of searches to English and Arabic peer-reviewed literature, therewith possibly missing relevant studies in other languages. Another limitation is the heterogeneity of included studies that had varying study purposes, depth of symptom presentation, and reporting. Some symptoms may have been overlooked or excluded from interview guides or study purposes. However, given the exploratory nature of this review topic, such limitations were difficult to avoid.

The studies' samples were from war zones, resettled within MENA, or in HICs, potentially creating variations in accounts due to acculturation processes. Resettled individuals in HICs may have adopted host countries' strategies or been exposed to psychotherapeutic settings, confounding cultural information (de Leersnyder et al., 2013). In this sense, it is important to note that the cultural information presented is constantly changing during globalization. Nevertheless, this is the case in all cultural research, despite best efforts to present dominant norms and scripts, findings must continuously be interpreted with caution to avoid generalization and homogenization. Finally, since this is a qualitative and non-comparative study, we could not directly compare different cultural groups within the Greater MENA region to guide interventions for specific ethnic groups.

We acknowledge that by adopting this dialectic approach, we engage with two very different modes of knowledge (Rasmussen et al., 2011). We recognize the contrast between Western trauma psychology, and local trauma explanatory models. These distinct paradigms of knowledge, while seemingly at odds, are both very much needed to inform and complement the current landscape of humanitarian and psychosocial research and clinical settings.

6. Conclusion

In recent decades a critical mass of researchers has taken it upon themselves to investigate cultural variations in the etiology and phenomenology on mental disorders. Their works indicate that mental health cannot be understood without an *intersectional lens*, that is, without being situated within unique sociocultural contexts (Bryant--Davis, 2019). The state of the literature suggests the importance of adopting the dialectic of universality and culture variance. Disorder classifications should aim to include a limited number of core diagnostic symptoms to maximize the clinical utility and use of these diagnoses universally (Brewin et al., 2017). Concurrently, classifications should highlight the centrality of cultural variations in providing more inclusive and relevant diagnostic concepts and consequent interventions (Lewis-Fernández and Kirmayer, 2019).

De Jong et al. (2005) highlighted:

> Psychiatrists can be trained to make observations, but we cannot be sure that the observations are valid, that is, whether a patient does or does not have an abnormal mental state. […] The determination of whether these reports refer to an abnormal mental state is an interpretation. This interpretation is related to knowledge of the group's behavioral norms and what they consider as normal or deviant experiences or reactions. (p. 19)

With this review we aimed to contribute to an essential and necessary type of literature that deepens our understanding of the intricate relationships between culture, structural factors, and trauma-related distress. We sought to describe some of the scripts that guide and influence psychopathology in Greater MENA populations exposed to violence, thus hopefully providing a foundation for future theoretical and practice-oriented research. While significant progress has been made, there are still specific literature gaps that require attention, and the development of culturally and structurally relevant interventions remains an important task.

CRediT authorship contribution statement

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

Methodology, Validation, Writing – review & editing, Supervision.

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.

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Appendix A. Supplementary data

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