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Institut de psychologie (IP)

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

Nadine Hosny [1], Marion Bovey [1], Felicia Dutray [2,3], Eva Heim[1]

[1] Institute of Psychology, University of Lausanne, Lausanne, Switzerland,[2]Appartenances, Consulation Psychothérapeutique pour Migrant-es, Lausanne, Switzerland, [3]Département de Psychiatrie, Centre Hospitalier Universitaire Vaudois (CHUV), Lausanne, Switzerland

Background

- A dialectic approach that combines universal core symptoms with culture-specific manifestations of trauma-related disorders i.e., PTSD, CPTSD is suggested by literature to enhance the validity of diagnosis (de Jong et.al, 2005).
- Particularly, for the new ICD-11 diagnosis of CPTSD, whose symptoms are heavily influenced by cultural norms (Heim et.al., 2022).

PTSD + DSO = CPTSD (WHO, 2018)

- Along with culture, structural factors (e.g., social status, inequalities) play a crucial role in shaping the meaning and impact of traumatic experiences, yet current literature lacks reviews that includes these key sociocultural information surrounding trauma-related distress (Drozdek et.al., 2012)

Aim

To critically examines qualitative literature investigating:

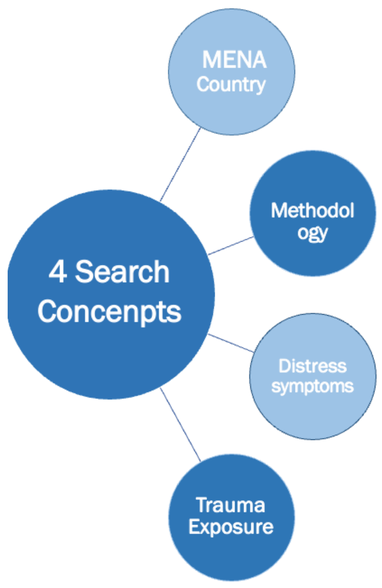
1. Presentations of trauma-related distress,
2. Relevant cultural scripts and surrounding structural factors exacerbating such distress in the Greater MENA.

Methodology

1

Search Strategy

- Review followed **PRISMA** guidelines
- Registered protocol on **PROSPERO**
- **9 English databases:** PsychInfo, PsycArticles, Web of Science, PubMed, Scopus, Pilots, Medline, Anthrosource, and Anthropology Plus
- **3 Arabic databases:** Al-Manhal, Al Mandumah, and Arab Citation Index
- Keywords & MeSH terms



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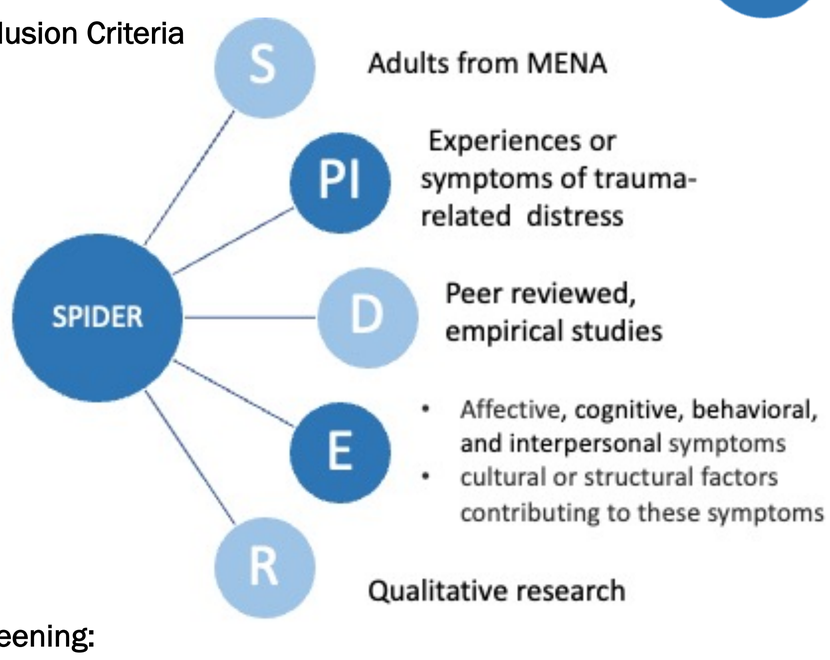
Inclusion Criteria



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Screening:

- All abstracts and full texts were screened by 2 Coders, using Covidence software

Extraction & Analysis:

- Thematic Synthesis (Thomas & Harden, 2008) & Frequency coding using NVIVO software

Quality Appraisal:

- COREQ (Tong et.al, 2007)

Results

Country

- Afghanistan (n=2)
- Iran (n=4)
- Iraq (multiple ethnicities) (n=6)
- Jordan (n=1)
- Lebanon (n=1)
- Palestine (n= 6)
- Pakistan (n=1)
- Turkey (n=5)
- Somalia (n=1)
- Syria (n=6)
- Mixed origin (n=4)

Gender

37 Studies

- Female only samples (n=13)
- Mixed samples (n=31)

Violence

Most samples experienced **1<** types of vioelence

- **Interpersonal violence** (including IPV, GBV, childhood abuse)
- **War violence political violence** (e.g., witnessing violence, bombings, prosecution)
- Natural disasters

PTSD (n=20)

- Hypervigilance 80%
- Re-experiencing 65%
- Avoidance 60 %

Other Symptoms (n=30)

- Hopelessness 40%
- Somatic Symptoms 40 %
- Sleep Problems 40%
- Suicidality 30%
- Dissciotaive Symptoms 27%

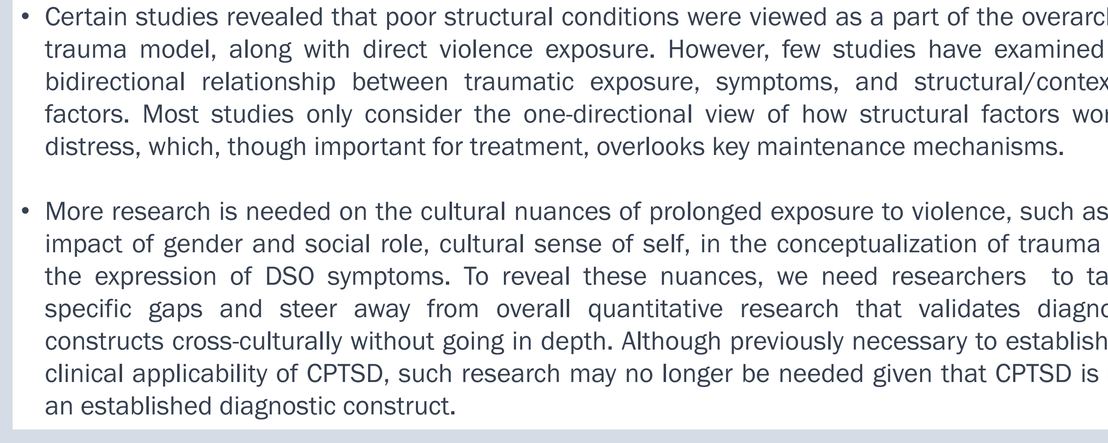
N.B: Top 5 reported symptoms that do not fall under the main diagnostic criteria for PTSD and CPTSD

Disturbances in Self-organization (n=28)

Affect Dyregulation	Negative Self-concept	Interpersonal Difficulties
Anger 53%	Guilt & Self-blame 71 %	Social Withdrawal 43%
Aggression 36%	***Worthlesness 64%***	***Mistrust 39%***
Numbness 32%	Shame 46 %	Negative emotions towards others 32%
Pervasive Sadness 25%	Helplessness 36%	***Difficulty being close to others 25%***
Emotional Outbursts 14%	Broken or Damaged 32%	***Feeling distant from others 25%***

- *N.B:* Top 5 reported symptoms within each of the DSO symptom cluster
- Symptoms in ***italics*** are the ones present in the final version International Trauma Questionnaires (ITQ), the validated assessment tool to diagnose CPTSD

Normalized Distress (n=7)



- These responses were not presented as a pathological reaction or psychological dysfunction, but rather as a normalized or habituated form of distress in response to extreme and enduring violent conditions, and structural difficulties. All of these studies were set in a protracted contexts of violence (e.g., Syrian refugee camps and Palestine).

Discussion

- Findings suggest that while the core diagnostic clusters for CPTSD were present, symptom variations emerged within each cluster, with some culture-specific symptoms (e.g., shame and guilt) frequently mentioned, and some symptoms in the ITQ (e.g., sense of failure) not widely endorsed in studies from the Greater MENA region (Cloitre et.al, 2018). Such symptoms could be added in culturally adapted version of the assessment.
- In contexts of ongoing trauma exposure, some studies reject pathologizing distress and label it as a normative response. These normalized states of distress may include features of CPTSD or DSO. Hence, the assessment of functional impairment to determine PTSD and CPTSD diagnosis is crucial, as it ensures that diagnostic processes are context-sensitive and not based on culturally-incongruent conceptual premises (Patel et.al., 2018; Ventvoge & Faiz,I 2018).

Research Directions:

- Certain studies revealed that poor structural conditions were viewed as a part of the overarching trauma model, along with direct violence exposure. However, few studies have examined the bidirectional relationship between traumatic exposure, symptoms, and structural/contextual factors. Most studies only consider the one-directional view of how structural factors worsen distress, which, though important for treatment, overlooks key maintenance mechanisms.
- More research is needed on the cultural nuances of prolonged exposure to violence, such as the impact of gender and social role, cultural sense of self, in the conceptualization of trauma and the expression of DSO symptoms. To reveal these nuances, we need researchers to target specific gaps and steer away from overall quantitative research that validates diagnostic constructs cross-culturally without going in depth. Although previously necessary to establish the clinical applicability of CPTSD, such research may no longer be needed given that CPTSD is now an established diagnostic construct.

References

For rerefrences please scan the QR code: