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EMPHNET's Research Digest

How is Trauma-related Distress Experienced and Expressed in Populations from the Greater Middle East and North Africa? A Systematic Review of Qualitative Literature

Introduction

The Greater Middle East and North Africa (MENA) region, encompassing Arab countries, Afghanistan, Iran, and Turkey, has faced prolonged violence and humanitarian crises. Over half of the 89.3 million displaced individuals globally come from this region due to political persecution, armed conflicts, and social unrest. The region's history of colonialism and imperialism has created structural problems like high unemployment, limited education, and restricted access to essential services. This, coupled with significant inequalities based on location, gender, and ethnicity, leaves nearly 60% of the population in poverty or vulnerable. Political violence and social unrest in the region are linked to high levels of interpersonal violence, including gender-based violence in refugee and displaced persons camps. The prevalence of mental health issues like depression and anxiety is higher compared to other regions.

A dialectic approach to diagnosis suggests three types of symptoms: universal core symptoms, culturally influenced symptoms reflecting universal issues, and culture-specific symptoms. Culture, intertwined with structural factors like social status and political oppression, shapes responses to trauma, which are embedded within broader socio-economic inequalities influencing mental health outcomes. Understanding these factors is essential for accurate trauma models and effective treatments.

This digest of a systematic review published in SSM Mental Health titled "How is trauma-related distress experienced and expressed in populations from the Greater Middle East and North Africa?", examines qualitative studies on post-traumatic stress disorder (PTSD), complex-PTSD (CPTSD) and other trauma-related distress in the Greater MENA region. The goal is to provide context-specific insights to improve treatment planning and adaptation.

Methods

The study followed the PRISMA guidelines and searched 12 databases. Using the Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool, qualitative studies on PTSD, CPTSD, and cultural understandings of trauma-related distress were selected. Data were synthesized using framework and thematic analysis, with Consolidated Criteria for Reporting Qualitative Studies (COREQ) used for quality appraisal.

Results

47 studies published between 1993 and 2022, from Afghanistan, Egypt, Iran, Palestine, Jordan, Lebanon, Turkey, Iraq, Somalia, Sudan, and Syria were included. Participants included individuals who experienced trauma and health

professionals, with data collected through interviews and focus groups.

Studies were categorized into: “normalized or habituated” responses to trauma, cultural concepts of distress (CCD), PTSD symptoms, and CPTSD or disturbances in self-organization (DSO) symptoms. Most studies demonstrated moderate to high methodological standards, with two excluded due to low COREQ scores.

Normalized or Habituated Responses were common in studies in Palestine, Syrian refugee camps, and South of Lebanon, where continuous violence and protracted structural difficulties led to distress being seen as habitual rather than pathological. Concepts like “shock”, “broken morale” and corresponding emotional and psychological exhaustion were prevalent. Symptoms were attributed to a loss of control over daily structural factors, daily violence of military occupation, or the ongoing possibility of war reignition. Additionally, studies reported that humiliation or “broken dignity” was a main cause of distress. Emotional suppression and avoidance were normalized as common coping strategies, even though these strategies are listed as symptoms of CPTSD in ICD-11.

CCD and Idioms of Distress were identified in eleven studies, presenting a continuum from everyday sadness to severe syndromes like madness. Idioms representing milder levels of distress were related to everyday structural difficulties or displacement while idioms of moderate levels of distress were centered around effects of violence exposure. Idioms of distress varied across regions, reflecting cultural perceptions of mental health issues. Studies attributed distress to traumatic events, broken social bonds, daily life stressors, collective suffering, and an inability to fulfill social roles.

PTSD Symptoms were described in 21 studies, featuring intrusion, avoidance, and hypervigilance. Common symptoms included nightmares, flashbacks, avoidance of triggers, and hyperarousal, with emotional detachment and numbing also noted. Content of intrusive memories included traumatic memories from childhood (e.g., being beaten by parents) which were triggered by exposure to war, or thoughts about homeland and displaced families. Hypervigilance was linked to constant fear and insecurity.

CPTSD Symptoms were prevalent across studies, revealing various patterns of DSO due to prolonged or repetitive trauma. Affect dysregulation was significant, particularly in anger management, leading to frequent and severe emotional outbursts or violent behavior. These responses were often connected to a belief in the permanent impact of trauma, fostering ongoing dissatisfaction and hostility. Emotional numbness, withdrawal, and suicidality were also prevalent, underlined by persistent sadness and cyclical crying.

Many individuals used suppression as an emotion-regulation strategy, influenced by cultural expectations and survivor’s guilt, particularly when confronting abusive situations. Negative self-perceptions were common, with participants internalizing guilt and low self-esteem, often exacerbated by abuse in early life. Interpersonal issues were also widespread, including withdrawal from relationships and heightened conflict within communities, driven by trust issues and altered core beliefs about safety.

Moreover, trauma often led to changes in personal values and a pessimistic outlook on life, indicating profound impacts on individuals’ worldview beyond traditional CPTSD symptomatology.

Other Trauma-related Symptoms included sleep pr-oblems, somatic symptoms, dissociation, rumination, and concentration difficulties. Structural and cultural factors, such as violence, family separation, and patriarchal norms, played significant roles in exacerbating distress, creating a cycle of continuous traumatic stress. Sociocultural and structural factors, such as vi-olence, separation from family, and patriarchal norms, played significant roles in exacerbating distress. Post-migration difficulties, discrimination, and economic hardships further intensified psychological conditions, creating a cycle of continuous traumatic stress.

Structural Factors and cultural factors significantly in-fluence trauma-related distress. Socio-political contexts, including collective violence and social strain, shape mental health symptoms. Family separation, especially in Syrian and Afghan samples, emerged as a major trauma source. Cultural stereotypes and social stigmatization, particularly toward sexual violence victims, exacerbated distress through social exclusion and internalized negative self-worth. Patriarchal norms and economic dependency often trapped women in abusive situations, worsening their mental health.

Post-migration challenges like unemployment and housing instability intensified psychological conditions, linking economic hardship to increased anger and family conflicts. Diminished agency and powerlessness following trauma led to a loop of helplessness and heightened distress.

Conclusion

The study concludes by emphasizing the necessity of understanding mental health within sociocultural contexts. It highlights the balance needed between universal diagnostic criteria and cultural variations to enhance clinical relevance. The research underscores that psychiatric observations must be interpreted within cultural norms to determine abnormal mental states.

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