STUDY PROTOCOL: Islamic Trauma Healing in Somaliland
August 5, 2018
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Study Design

We will conduct an active intervention only, *Islamic Trauma Healing*, pre-post design (*N* = 20) for men and women in Somaliland, East Africa, who have experienced at least one traumatic event and perceive a need for trauma healing, as evidenced by re-experiencing or avoidance of trauma reminders. Lay leader training will be outside country. Six-session men's and women's groups will be conducted by lay leaders in mosques. Feasibility will be evaluated via symptom reduction, dropout, participant satisfaction, and focus group feedback.

Inclusion and Exclusion Criteria

Men and women with trauma exposure and trauma-related avoidance or reexperiencing will participate in the study. Inclusion and exclusion criteria were carefully selected to help individuals self-identify as needing the program while also not conducting formal diagnostic measures that could stigmatize or alienate potential group members. Specifically, if the groups become known as groups for "patients" or for the "insane," many individuals in need of help will not participate. Concrete, behaviorally obvious inclusion criteria where chosen to facilitate lay leader and self-referral. DSM-5 definition of trauma exposure allows for a variety of events including witnessing or experiencing "life threatening events." Two behavioral symptoms of PTSD were chosen, specifically avoidance and re-experiencing symptoms, that are common, readily recognized, often easily linked to trauma exposure; and accordingly, easy for individuals to identify.

Table 1. Broad and Generalizable Criteria

Inclusion:

- Experienced a DSM-5 trauma at least 12 weeks ago
- Report current re-experiencing or avoidance symptoms
- Islamic faith
- 18-65 year of age

Exclusion:

- Immediate suicide risk, with intent or plan
- Cannot understand consent/visible cognitive impairment

Potential participants will self-identify as needing trauma healing. We chose not to use formal PTSD and depression interview diagnostic measures for several reasons. Somali refugees may not identify or report many of the symptoms associated with a Western conceptualization of PTSD and depression (Bentley et al., 2011). Further, in line with dimensional models of psychopathology, subthreshold PTSD symptoms are also common, often unremitting, and impairing and also warrant intervention (Bergman et al., 2016). By not requiring a DSM-5 diagnosis of PTSD, a broader conceptualization of post-trauma reactions and associated phenotypes is in line with RDoC Negative Valence Systems and a better match with current thought on the wide range of long-term psychopathology following trauma exposure (Kozak & Cuthbert, 2016, Broman-Fulks et al., 2006).

Participants will be of the Islamic faith, as the intervention will be conducted in mosques and uses tenets of the Islamic faith to promote trauma healing. Participants will be expected to not be visibly cognitively impaired. Individuals with current suicidal intent or plan will be excluded and provided appropriate referrals. See Table 1 for Inclusion/Exclusion criteria.

Islahul Qulub: Islamic Trauma Healing

Several years of iterative, collaborative development work with the Somali community have guided the content and format of the Islamic Trauma Healing program. A manual for the program was developed (Lang, Zoellner, Graham, Marks, & Feeny, 2016), and a local Imam carefully reviewed the content of the manual. Focus group feedback from lay leaders and group members was also utilized in revisions. The program was designed for groups of 5-7 members, with two to three lay leaders of the same gender. The program is structured so that the lay leader training, comprised of two 4-hour trainings, focuses on teaching lay leaders the skills of discussion leading, with the manual content providing more of the direct therapeutic work. That is, the lay leaders are not explicitly taught how to be psychotherapists or how to do cognitive behavioral therapy specifically. The manual contains an introduction to trauma healing, including a description of types of trauma exposure and common reactions, as well as Islamic principles related to trauma healing. Session-by-session content is clearly spelled out in the manual. Each session includes time for community building rituals (e.g., sharing tea and light refreshments), spiritual preparation using a brief supplication written by the local Imam, prophet narratives relevant to trauma healing, and a brief closing supplication also written by the Imam. In the first session, a rationale for the program, common reactions to trauma, and a breathing relaxation exercise are

described. Starting in the second session and continuing through the last session, turning to Allah in dua about the trauma is conducted. In the last session, group members are encouraged to organize a closing event at which certificates of program completion are given.

The program is 6 sessions long. This duration is in line with evidence that very brief or shortened protocols (e.g., four 30 min sessions) can substantially reduce PTSD symptoms (Cicrang et al., 2011; van Minnen & Foa, 2006). Key components of the program are prophet narratives aimed at targeting trauma-related beliefs, and talking to Allah, aimed at targeting trauma memories.

Prophet Narratives and Group Discussion. Prophet narratives are brief synopses of a particular prophet's life, including Qur'an verses. Cognitive restructuring-related group questions follow the narrative, mirroring the theme for the session. Prophet narrative content and questions shift from the presence and purpose of suffering to healing and reconciliation for oneself, others, and the larger community. These include: Session 1, Faith During Hard Times Prophet Job (Ayyub); Session 2, Trials Build Strength Prophet Joseph (Yusuf); Session 3, Overcoming Fear Prophet Moses (Muses); Session 4, Redemption of Self and Others Prophet Jonah (Yoonus); Session 5, Faith, Courage, and Hope for the Future Prophet Abraham (Ibraheem); and Session 6, Reconciliation Prophet Muhammad [peace be upon him]. Prophet narratives are read aloud (5-10 mins) by the group leaders. Following each narrative are questions to facilitate a group discussion related to the theme. The themes form an arch, moving from suffering to healing to growth following trauma. Many people of the Islamic faith are accustomed to talking about prophet stories, making this well aligned with their faith and would not be considered 'unusual' by group members or others hearing about the group.

Turning to Allah in Dua and Group Discussion. From sessions 2-6, participants are asked to spend time in individual prayer, turning to Allah about their trauma. Of note, the term 'prayer' is used illustratively, having varied meanings within Islamic practice, with the manual specifically using the term "turning to Allah in Dua." This prayer time is conceptualized as an adapted form of imaginal exposure to the trauma memory(ies). Muslims have a call to pray five times per day, and in our pilot work, talking with Allah about personal experiences, including the experience of trauma, is very intuitive. In the first session, group leaders provide a rationale for turning to Allah. In the second session, this rationale is repeated, including instructions about how to select a trauma memory, and an example is provided. Turning to Allah in Dua is conducted individually for approximately 15-20 min. Content of the dua shifts from simply recounting about what happened, turning to Allah about feelings and thoughts experienced during the trauma, to turning to Allah about the hardest parts, to finally thanking and praising Allah for the experience of what he or she has learned through the trauma and through talking about it. Following individual dua are questions to facilitate a group discussion related to the theme. Participants are encouraged to talk in the group about their experience while turning to Allah but not to directly share their traumatic experiences with the group during this time. This is intended to promote cognitive restructuring of negative trauma-related beliefs and foster social connectedness among group members. Similarly, the content of the turning to Allah in Dua forms an arc from initially approaching the trauma memory to approaching the hardest parts of the memory to at the end shifting the meaning of the memory to have positive or growth elements to it.

Pre- and Post-Intervention Measurement

The questionnaires have all been translated and back-translated from English to Somali, with audio versions in Somali. Questionnaires will be completed using a mobile device (e.g., tablet, smartphone) and headphones with Qualtrics Programming. Diagnostic interview measures are not included, due to cultural stigma associated getting any kind of formal diagnostic assessment (Aloud & Rathur, 2009). We want to avoid community members associating the group with PTSD, as we believe this will decrease interest. Diagnostic measures also have issues with sustainability; requiring additional training of lay assessors. Furthermore, we want to ensure that the intervention works for those with a range of symptoms, from mild to severe.

Main Outcome Measures

Psychopathology following trauma is assessed as dimensional and multifaceted, examining not only PTSD, but also depression, somatic symptoms, and functional well-being. Measures were selected to be minimal and efficient. Low literacy is a considerable issue; in our initial work, including audio of questions in

Somali reduced completion time and increased satisfaction.

PTSD Scale – Self-Report for DSM-5 (PS-SR-5; Foa et al., 2015). This measure provides a trauma screen and rates DSM-5 symptoms for the last 2 weeks, including functional impairment. This measure has good reliability and inter-rater reliability.

Patient Health Questionnaire-9 for depression symptoms (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The PHQ-9 is a self-report measure of depression symptoms with each question rated from 0-3. This measure demonstrates good discriminative validity (area under curve = 0.95) and correlates moderately to strongly with the SF-20 (Kroenke, Spitzer, & Williams, 2001).

Patient Health Questionnaire-15 for somatic symptoms (PHQ-15; Kroenke, Spitzer, & Williams, 2002). A brief, modified version of the PHQ-15 provides assessment of somatic symptoms (e.g., stomach pain, headaches, dizziness). This measure is included as a main outcome, given the likelihood of somatization of trauma-related symptoms (Bentley, Thoburn, Stewart, & Boynton, 2011).

WHO-5 Wellbeing Index (WHO-5; Bech, Olsen, Kjoller, & Rasmussen, 2003). This five-item measure assesses emotional well-being on a 0-5 scale over the past two weeks. It shows good convergence with the PHQ-9 and SF-12 (r = .55 - .69) and has good sensitivity and specificity (Hajos et al., 2013).

Client Services Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). This measure is included to assess acceptability of content and delivery. This well-validated questionnaire has been modified to contain 5 items, scored from 1 (*poor*) to 4 (*excellent*).

Focus Group Measurement

Qualitative interviews will cover these topics: (1) what was thought of the trauma healing program; (2) what was liked most about the program; (3) where the program needs improvement; (4) barriers for men and women to be involved in the program; and (5) lessons learned from the program. We will also use these focus groups to provide initial information for developing a local measure of functional capacity (e.g., Patterson & Mausbach, 2010). Focus groups with both leaders and members will be audiotaped and translated to English.

Data Analysis

Pre to post changes will assessed with descriptive rather than inferential statistics. We will compute percent dropout based on completing 4 or more group sessions. Pre- to post-group effect sizes (PS-SR-5, PHQ-9, PHQ-15, WHO-5) will be calculated using Hedges' unbiased g. We will also report CSQ mean, standard deviations, and range.

Qualitative data will be analyzed using NVivo 11 Pro (QSR International, Inc., 2015), with two raters independently analyzing written material and developing consensus. This information will be used for iterative development of the program and functional capacity measurement.