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Islamic Trauma Healing: Integrating Faith and Empirically Supported Principles in a Community-Based Program

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Abstract

Access to adequate, much less state-of-the-art, mental health care is a global problem. Natural disasters, civil war, and terrorist conflict have forcibly displaced millions of Muslims and have resulted in a remarkable level of individual and communitywide trauma exposure. As a result, many are at risk for posttraumatic stress and other trauma-related disorders. Many religiously oriented Muslims traditionally rely on Islamic principles and teachings, as well as their community, to cope with and address trauma-related distress. Islamic Trauma Healing is a six-session, lay-led group intervention developed within a Somali Muslim community that integrates evidence-based trauma-focused cognitive-behavioral therapy principles with cultural and religious practices aimed to enhance uptake and create an easily up-scalable intervention for a wide range of trauma. In sessions, narratives of prophets who have undergone trauma (e.g., Prophet Ayyub, faith during hard times) present Islamic principles and facilitate cognitive shifts. Group members spend individual time turning to Allah in dua (i.e., informal prayer), focused on exposure to trauma memories. Program themes arc across suffering to healing to growth following trauma. This paper describes the core theoretical principles and methods in the Islamic Trauma Healing program. We

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also describe leader perspectives and the program's train-the-trainer model, in which lay leaders are trained to further disseminate the program and allow Islamic Trauma Healing to be owned and sustained by the Muslim community.

Keywords

refugee; trauma; cognitive-behavioral therapy; Islam; lay leader; PTSD

An estimated 68.5 million people worldwide are displaced from their homes as a result of natural or manmade disasters (United Nations High Commissioner for Refugees [UNHCR], 2018). The UNHCR (2019) has advocated that the health and welfare of refugees and other people experiencing displacement must be a priority if the ethos of the 2030 Agenda for Sustainable Development vision for global peace and security is to be realized. Muslims represent one of the largest growing displaced subgroups due to protracted conflict in several countries, including Syria and Somalia. As of 2016, 46% of all refugees entering the United States were Muslim (N = 38,901; Pew Research Center, 2016). This represented the highest number of Muslim refugees entering the United States since these data first became available to the public in 2002. Trauma exposure in the country of origin and the process of fleeing, migrating, resettling, and adjusting to a host country increases risk of psychological and physical health concerns among Muslim refugees (Palinkas et al., 2003). Indeed, refugees from predominantly Muslim countries and war-torn regions, such as Syria, Myanmar, Somalia, Afghanistan, and Iraq, are at an increased risk for developing chronic mental health problems, including posttraumatic stress disorder (PTSD; Bhui et al., 2006; Dietrich et al., 2019; Karam et al., 2014). With this trauma burden and the global increase in Muslim refugees, the international community faces a significant challenge in identifying effective methods for addressing the mental health needs of those with a high degree of trauma exposure (Jaranson et al., 2004; Song et al., 2015).

For many people from these Muslim communities, faith greatly influences conceptualization of psychological health, emotional distress, and ultimately help-seeking behavior. This has become evident in refugee mental health where multiple barriers to health care access and utilization exist despite growth in the development of effective interventions for trauma-related psychopathology in the last 20 years. Barriers to utilization include differing explanatory models of illness, the insular nature of the communities, cultural idioms of distress that differ from the Western biomedical paradigm, lack of trauma-related concepts in the culture of origin, and stigma associated with mental illness (Im et al., 2017). Stigma represents a primary barrier to mental health service utilization within Muslim refugee communities. Somali culture, for example, views spiritual, religious, and traditional healing practices as first-line treatments for emotional distress (Bentley & Owens, 2008; Wolf et al., 2016). Terms like "mental illness" and "depression" are often stigmatized due to a traditional cultural dichotomization of mental health into categories of "sane" and "insane." These factors often prevent internationally displaced refugees from seeking mental health services upon resettlement. In a study of Somali and Congolese refugees in the United States, mental health concerns were reported to be primarily managed through social support

in the community or religiously based programs, with only 11.3% seeking care from a mental health professional (Piwowarczyk et al., 2014).

Given faith's centrality in understanding and coping with psychological distress, the primary source of relief is often through seeking counsel from the Imam, reliance on religious practices, and turning to Islamic principles (e.g., Ai et al., 2005). When treatment modalities are not consistent with one's worldview, access to and sustainability of services may decrease (e.g., Pratt et al., 2017). Therefore, it is important to develop evidence-based paradigms that align with the faith culture of Muslims. If faith and the Qur'an are central in the lives of Muslims, then integrating these components with psychological best practices for trauma-related sequelae may build a bridge toward effectively enhancing access to mental health care. In one published clinical case of a Somali patient with PTSD (Boynton et al., 2010), adherence to a Western biomedical psychiatric treatment plan presented a prominent barrier until the health care provider framed the patient's symptom experience within a culturally consistent and religiously formulated paradigm.

Integrating the faith perspective of the target population while delivering care via trained peers may help reduce stigma, as well as cultural and linguistic barriers. For example, in a nonrandomized study of a peer-delivered cognitive-behavioral therapy (CBT) protocol for Somali women in Minnesota ($N = 55$), mood and anxiety improved but perceived inconsistency with Islam was noted as a significant barrier to uptake (Pratt et al., 2017)—that is, a subset of participants expressed believing that faith should prevent Muslims from experiencing stressful feelings. Therefore, focusing on topics such as stress and its effects may prevent some religiously oriented Muslims from fully engaging in the intervention unless the faith perspective becomes the orienting backdrop for these discussions. These findings underscore the need for religious congruence in order for interventions to be considered acceptable for religiously oriented Muslims. Several questions emerge about how to inform the development of effective interventions aimed at enhancing services for Muslims, including (a) Can evidence-based practices from trauma-focused psychotherapies be integrated with fundamental Islamic principles in order to optimize interventions for Muslim refugees? and (b) Is it feasible for such interventions to be delivered in a cost-effective and self-sustaining model that extends potential utilization?

Islamic Trauma Healing, aimed at reducing trauma-related psychological distress among Muslims, was developed to address the aforementioned questions. The manualized group-based program is lay led and provided through mosques. With a focus on integrating empirically supported PTSD treatment components with religious principles, such a program may help with stigma reduction and therapeutic engagement, both of which are critical in decreasing trauma-related distress. Islamic Trauma Healing was developed collaboratively with Somali community members and input of Islamic leaders and scholars. To be scalable and reduce stigma associated with help seeking, the program is delivered in mosques and formal diagnostic labels are not used. Moreover, the program does not require extensive expertise or training. Islamic Trauma Healing's evidence-based components are derived from prolonged exposure and cognitive therapy. In the program's group sessions, narratives of prophets who have experienced trauma (e.g., Prophet Ayyub, faith during hard times) facilitate cognitive shifts through Islamic principles. Using a graduated imaginal exposure

approach, group members also spend time turning to Allah in dua (i.e., informal prayer) specifically focusing on trauma memories. Program themes arc from addressing suffering to healing to growth following trauma. Table 1 conveys the progression of weekly themes and provides an outline of basic intervention elements covered in each session. The program's key components, prophet narratives, and time in dua with Allah, are well aligned with Islamic faith. Lay leaders must have knowledge of the Qur'an but need no prior training in mental health. Leader training is brief, delivered in two 4-hour sessions, emphasizing discussion leading skills. To facilitate sustainability and reduce reliance on credentialed mental health providers, the program uses a train-the-trainer model. It also builds in components of posttraumatic growth and reconciliation through community building and shifting content that highlights forgiveness and giving thanks to Allah over the course of the program.

Pilot data on perceived need for trauma healing, symptom outcomes, and results of a focus group conducted with participants at the end of their participation in the program has been published elsewhere (Zoellner et al., 2018). Somali community members with varied trauma histories endorsed a strong perceived need for and interest in the program. Group participants reported a strong match with the Islamic faith for the intervention and experienced substantial symptom reduction (PTSD, depression, somatic symptoms) and increases in well-being after 6 weeks with large effects from the pre- to postgroup ($g = 0.76–3.22$). Qualitative analyses of the focus group showed that group participants identified common themes of connection to community, role of Islam, and growth as being central to the program. The current paper extends beyond description of the early pilot data by providing an overview of the program, discussing the underlying theoretical rationale, and highlighting methods used to integrate Islamic and cognitive-behavioral principles that can potentially inform approaches to extending trauma-focused interventions to individuals from Muslim communities. In the remainder of this paper, we provide lay-leader perspectives on the program with an eye toward sustainability and capacity building for effective implementation, upscaling, and broad dissemination.

Underlying Theoretical Principles of Islamic Trauma Healing

Islamic Trauma Healing was designed as an integration of empirically supported principles of evidence-based PTSD treatments, Islamic principles, and promotion of community reconciliation. The program has the potential to provide a low-cost, self-sustaining model of a faith-based intervention that addresses the psychological wounds of trauma and promotes community reconciliation for Muslim communities.

Trauma-Focused Cognitive-Behavioral Principles

Several well-done meta-analyses (Cusack et al., 2016; Kline et al., 2017; Powers et al., 2010; Watts et al., 2013) have demonstrated the efficacy of trauma-focused CBT in reducing trauma-related psychopathology, with evidence of long-term persistence of gains. Efficacy of these interventions has been replicated across multiple randomized controlled trials, including refugees and individuals in sub-Saharan Africa (e.g., Foa et al., 2005; Hall et al., 2014; Hensel-Dittman et al., 2011; Neuner et al., 2008; Resick et al., 2002; Schnurr et al.,

2007; Weiss et al., 2015). However, these interventions are often conducted individually and/or use providers that have received extensive training in CBT techniques (e.g., doctoral-level psychologists; 2-week training for lay providers [Bass et al., 2013], 6-week lay-leader training [Neuner et al., 2008]). In contrast, lay-leader training in the Islamic Trauma Healing program is brief (two 4-hour training sessions) and focuses on discussion-leading skills. Table 2 summarizes prior approaches to training and delivering individual and group-based trauma interventions in low- and middle-income country settings. Robust reviews of the mechanisms of trauma-focused cognitive-behavioral treatments can be found elsewhere (e.g., Cooper, Clifton, et al., 2017; Kar, 2011).

Shifting Trauma-Related Unhelpful Beliefs—Unhelpful trauma-related beliefs about oneself (e.g., “I am weak,” “I could have stopped it”), others (e.g., “No one can be trusted”), and the world (e.g., “The world is a dangerous place”) have a prominent role in key theoretical models of trauma-related psychopathology (Ehlers & Clark, 2000; Foa et al., 2006). In trauma-exposed individuals, negative appraisals about the traumatic event are theorized to evoke chronic fear-related symptoms, which may subsequently maintain maladaptive patterns (Cooper et al., 2015; Ehlers & Clark, 2000). The interplay between negative beliefs and PTSD symptoms has been characterized as a “vicious cycle” leading to sustained posttraumatic distress over time (Shahar et al., 2013).

Negative beliefs substantially reduce following successful treatment of PTSD (Foa & Rauch, 2004; Hagenaars et al., 2010; Kleim et al., 2013; Nacasch et al., 2015; Resick et al., 2002; Taylor et al., 2003; Zoellner et al., 2011). Further, reduction in negative beliefs precedes symptom improvement in psychotherapy, suggesting that shifts in trauma-related beliefs may be a mechanism of change in psychological interventions for PTSD (e.g., Cooper, Zoellner, et al., 2017; Kleim et al., 2013; McLean et al., 2015; Øktedalen et al., 2015; Schumm et al., 2015; Zalta et al., 2014). While research on shifts in beliefs following trauma exposure in either refugee or Islamic communities is virtually nonexistent, there is some evidence to suggest that unhelpful posttraumatic cognitions are associated with trauma exposure (Hussain & Bhushan, 2009) and PTSD symptoms (Berzengi et al., 2017) in these populations.

In Islamic Trauma Healing, shifting of trauma-related unhelpful beliefs is targeted through discussion of common reactions to trauma, reviewing and discussing the lives of Islamic prophets, and during individual time in turning to Allah in dua about the trauma.

Reducing Trauma-Related Avoidance—Persistent avoidance of trauma-related memories and associated stimuli in the absence of actual danger is theorized to represent a dysfunctional fear response following a traumatic event (e.g., Foa et al., 2006; Foa & Kozak, 1986). Avoidance is characterized by excessive or overgeneralized responses (e.g., hyperarousal) to trauma-related stimuli and inaccurate associations between stimuli and responses (e.g., negative trauma-related beliefs; Foa & Kozak, 1986). It is thought to prevent new inhibitory learning (Craske et al., 2008, 2014), and is often viewed as negatively reinforced by reductions in fear and distress, which subsequently promote further avoidance, maintaining symptomatology (Pittig et al., 2018).

Avoidance is well documented following trauma in Muslim refugee samples (e.g., Ai et al., 2002; Momartin et al., 2003; Onyut et al., 2009). Avoidance can provide short-term relief from trauma-related distress, but in the long term, contributes to intrusive thoughts, nightmares, and flashbacks (Brewin et al., 2010; Williams et al., 2007). Avoidance is also a central predictor of poorer functioning and PTSD symptoms following trauma (e.g., Plumb et al., 2004; Shenk et al., 2012). Unhelpful avoidance is typically targeted across trauma-focused therapies through exposure techniques, such as imaginal exposure to the trauma memory and in vivo exposure to safe but avoided stimuli (e.g., Foa et al., 2007), written accounts of the traumatic event in cognitive processing therapy (e.g., Resick & Schnicke, 1996), and addressing unhelpful negative beliefs through hypothesis testing (e.g., Ehlers et al., 2005).

In Islamic Trauma Healing, avoidance is targeted through shared discussion of the experience and effects of trauma, understanding common reactions to trauma, and through imaginal exposure to the trauma memory through individual time turning to Allah in dua about the trauma.

Community and Islamic Focus

Addressing **s**ocial connectedness and perceived alignment with one's religion may be particularly relevant in the acceptability and uptake of mental health interventions in Muslim communities.

Building Community and Social Connectedness—Perceived social support, or lack thereof, is strongly implicated in adjustment following trauma exposure (Brewin et al., 2000; Ozer et al., 2003), with a large body of literature suggesting that lower levels of social support are associated with more severe PTSD symptoms (e.g., Galea et al., 2002; Hobfoll et al., 2006; Kaniasty & Norris, 1993; King et al., 1998; Martz et al., 2010; Thompson et al., 2000).

Social connectedness, or belongingness, may be particularly relevant in refugee and religious communities. Whereas the broader social support literature has focused primarily on perceived deficits in resources received from the social environment, connectedness may capture more of the relational component. Social connectedness has cognitive, behavioral, and interpersonal dimensions (Lee & Robbins, 1998) with potential implications in the refugee experience. Refugee migration, resettlement, and readjustment into a host country places refugees at risk for social fragmentation and adverse social interactions predictive of psychological distress (Carswell et al., 2011; Palinkas et al., 2003). In the early stages of displacement, many refugees experience forced separation from loved ones as part of the migration process and that separation often persists for years. Notably, "worries about family back home" has been found to be the most frequently endorsed moderate to very serious postmigration stressor experienced in the past year by refugees (e.g., reported by 48.3% of participants; Bentley & Dolezal, 2018).

Many Muslim refugee communities experience community-level trauma and multiple layers of social loss that may influence the sense of connectedness and, by extension, psychological distress (Silove, 2013). For example, the protracted civil war in Somalia has

led to pervasive clan-based discord that may influence a person's experience as he or she integrates into a postresettlement community and encounters experiences of being viewed as an "other," even by individuals from his or her own country of origin—that is, the backdrop of premigration sociopolitical conditions may contribute to social divides in the host country and serve to partially maintain posttraumatic symptoms within postresettlement communities (Bentley et al., 2011). This potential for within-group fragmentation occurs within the broader landscape of risk for marginalization and discrimination by members of the host country (Bäärnhielm et al., 2017). As a result, community-based psychological interventions in the postmigration setting may be most effective if they explicitly focus on social connectedness and belonging as a therapeutic mechanism of interest.

In Islamic Trauma Healing, social connectedness and community building is targeted in multiple ways. First, the groups are conducted within the community at local mosques with the supports of Imams. Second, leaders in the community serve as lay leaders of the program with separate groups for men and women, allowing for better connection and open discussion among leaders and members. Third, important community practices are observed, such as time for shared tea and snacks before or after the groups. Fourth, the groups allow for shared discussion of prophet narratives that explore themes of the trauma exposure and common reactions to trauma, as well as forgiveness, community building, and reconciliation with one another in the final sessions.

Centrality of the Islamic Faith—Religious practices represent a primary avenue for connectedness with others but also connectedness to Allah. Religiously minded Muslim refugees rely on private prayer as a primary coping strategy following war trauma (Ai et al., 2005). Indeed, among Muslims, positive religious coping, such as the use of prayer, has been associated with lower PTSD symptom severity, while negative religious coping has been related to higher PTSD symptom severity (Aflakseir & Coleman, 2009; Leaman & Gee, 2011). Yet, engaging in religious practices, such as going to the mosque for organized gatherings and spending individual time in private prayer or reading scripture, may not fully buffer symptom expression (Bentley et al., 2014). Indeed, the relationship between trauma and religiosity as experienced by Muslim communities appears both reciprocal and complex (Abu-Raiya & Pargament, 2011; Berzengi et al., 2017). Premorbid beliefs, coping behavior, utilization of psychosocial resources, and severity of symptoms all appear to influence reactions to traumatic life events (Berzengi et al., 2017). These themes also become evident when considering the broader literature based on nonrefugee samples, where findings indicate trauma exposure and symptoms of PTSD can influence one's sense of connection with God and the process of meaning making (Falsetti et al., 2003; Fontana & Rosenheck, 2004; ter Kuile & Ehring, 2014). Utilization of even high levels of unstructured religious coping behaviors, therefore, may not yield full therapeutic benefit if underlying psychological mechanisms driving the distress remain unaddressed (Bentley et al., 2014).

Although religious practice may not in and of itself reduce trauma-related psychopathology, Islamic leaders and community members are highly motivated to improve care for those suffering. As such, their important role in community and spiritual connection puts them in an ideal position for program implementation. In the Islamic Trauma Healing program, centrality of faith is targeted through conducting the groups at local mosques, using faith

leaders to be lay leaders of the program, incorporating opening and closing supplications from the local Imam, using verses from the Qur'an within the prophet narratives, studying and discussing the lives of the prophets explicitly who have undergone suffering and trauma, and individual time in each session turning to Allah in dua about trauma and discussing this experience within the groups. Further, the Islamic content has been carefully vetted and focuses on central tenets that are not likely to spur sectarian divisiveness.

Addressing Stigma and Reconciliation

Reduction of Stigma—Within Muslim cultures, mental disorders can be viewed as a test or punishment from Allah, an expiation for sins, "kader" or destiny, supernaturally related (e.g., Iblees, jinns), and Allah as the ultimate doctor (Ciftci et al., 2013). In Somalia, mental disorders are viewed as being indicative of weak-mindedness, fear, and hopelessness (Bentley & Owens, 2008). As a result, individuals with mental illness are stigmatized, discriminated against, and often socially isolated. Individuals with severe mental illness (e.g., psychotic symptoms), referred to as *waali*, which translates to "crazy" (Carroll, 2004), are frequently chained up, caged, or imprisoned (Kivelenge, 2015), and are often precluded societal activities, such as marriage and employment (Cavallera et al., 2016; Reggi, 2013). Such stigma has implications for the ways in which psychological disorders are defined in Somali culture and represents a substantial barrier to mental health care utilization—for example, people who exhibit psychological distress without behavioral disturbances, such as depressive and anxiety symptoms, are not recognized as having a problem requiring professional intervention (Guerin et al., 2004; Ryan, 2008).

Similarly, although it is acknowledged that previous experiences, such as trauma, can impact current functioning and emotional state, these problems are typically resolved within the family or through religious and spiritual healing (Bentley & Owens, 2008; Cavallera et al., 2016). This is in part related to a lack of knowledge about mental health services available for posttraumatic symptoms, but it is also largely due to the understanding of the etiology of such symptoms (i.e., attributed to spiritual factors or "God's will" or other stressors rather than the trauma; Guerin et al., 2004; Reggi, 2013), as well as the perceived stigma and shame associated with mental illness.

In the Islamic Trauma Healing program, to reduce stigma, trauma is framed as something experienced by many in the community. The effects of trauma are normalized through discussions of common reactions to trauma, the common experience of trauma in the lives of the prophets, and by individual time focusing on turning to Allah in dua about the trauma. There is no discussion of mental disorders, treatment, or structured disclosure of personal trauma history in the groups themselves. Further, conducting separate male and female groups, according to Islamic norms, allows for more open discussions of gender-specific violence if the subject arises. Similarly, holding the groups in mosques in the community with the support of Imams destigmatizes participating in the program, and is viewed very differently from seeking mental health care through formal channels.

Reconciliation and Posttraumatic Growth—Programs attempting to reduce the impact of trauma at the individual and community levels may be more impactful if they also

address reconciliation and growth. Societies exposed to civil war and political violence often remain fragmented for years or decades following resolution of the conflict. Reconciliation programs have previously demonstrated helpfulness in promoting healing at a societal level, especially in facilitating forgiveness toward prior perpetrators of political violence and feelings of connectedness toward others in the community, but they appear to worsen psychological well-being (Cilliers et al., 2016). These mixed findings suggest that reconciliation alone is not sufficient to address trauma-related sequelae, but may be an important component.

Trauma-focused treatments often also seek to help the individual make meaning of his or her experience(s) and identify ways in which the person has become stronger as a result of his or her trauma, and there is strong evidence suggesting that PTSD treatments are effective at increasing posttraumatic growth (Hagenaars et al., 2010; Lee et al., 2017), including among refugees (Hijazi et al., 2014). Additionally, qualitative findings among women who survived the Rwandan genocide suggest that women who sought both freedom and reconciliation reported the greatest posttraumatic growth (Williamson, 2014). Pursuing reconciliation and societal healing may therefore facilitate posttraumatic growth, as may individually processing one's traumatic experience(s). Therefore, combining an individual and communal emphasis on healing may have more positive psychological benefit than either component individually.

In the Islamic Trauma Healing program, reconciliation and posttraumatic growth are targeted in a temporal arc that shifts content over the course of group sessions, with later sessions shifting to redemption of self and others, hope for the future, and ultimately thanksgiving to Allah and reconciliation with one another. Specific prophet narratives and the content of the individual time in dua parallel these themes.

Lay Led, Train-the-Trainers

Sustainable interventions are those that can continue to be delivered in the population at risk with capacity built in to support delivery (Chambers et al., 2013). Indeed, these types of models of mental health care are essential, especially in areas where disease burden is high and few providers are available. The train-the-trainer model seeks to build capacity for health service access by shifting tasks from professionally trained health care professionals to lay members of the community with the end goal being that established lay leaders will facilitate training new lay leaders. Dissemination models that rely on the ongoing involvement of experts and close supervision are expensive and difficult to sustain. A train-the-trainer model reduces expert involvement, lowers costs, increases local knowledge, and becomes self-sustaining, facilitating the widespread uptake of an intervention (Jacob et al., 2014).

There have been several successful train-the-trainer models implemented for various PTSD treatments, including in Israel, following 9/11, within the U.S. Department of Veteran Affairs, and with Rwandan survivors of the genocide (Cahill et al., 2006; Eftekhari et al., 2013; Jacob et al., 2014). Refer to Table 2 for a summary of previous approaches to trauma-focused mental health task shifting and associated training demand. In sub-Saharan Africa, where need is high and capacity low, a recent review identified community ownership and

mobilization as crucial facilitators of sustainability (Iwelunmor et al., 2016). Therefore, community-based programs, such as Islamic Trauma Healing, that utilize train-the-trainer methods may be particularly well suited to addressing stigma and service accessibility issues.

The training protocol for lay leaders in Islamic Trauma Healing is novel in various ways that are all in support of sustainability. First, lay leaders need no mental health experience; instead, they need "a heart for healing," knowledge of the Qur'an, and to be respected in their community. Second, unlike other training models in PTSD (e.g., Bass et al., 2013; Neuner et al., 2008), the training is purposely brief, over 2 days with about 8 hours of direct instruction and role plays. This means it can be conducted over a weekend and would be feasible for those who have family or work demands during the week. It also means that the lead time to start to run groups is short. In our work in Somalia, for example, we trained leaders over one weekend and they started groups in the community mosques within 3 weeks (Zoellner et al., 2018). The training is aimed at teaching the leaders how to *facilitate discussion*, not how to be a psychotherapist. Thus, the manual does the "heavy lifting" of the psychotherapeutic work and parts are designed to be read aloud by the leaders (e.g., the Prophet stories), followed by discussion with a set of questions aimed to highlight the central themes. The training model shifts from training cognitive-behavioral lay counselors to training how to facilitate groups, allowing for a dramatic reduction of training burden and broader ease for upscaling.

Islamic Trauma Healing Program

The Islamic Trauma Healing program was collaboratively created over several years by a team of clinical psychologists, a member of the local Somali refugee community, and community feedback (Zoellner et al., 2018). The format and content of the program were developed iteratively with careful community review, including content from a local Imam and a university-based Islamic scholar, as well as focus group feedback from lay leaders and group members. The program contains six sessions, with each session lasting approximately 2 hours. This duration is in line with evidence that brief or shortened protocols (e.g., four 30-min sessions; six 50-min sessions) can substantially reduce PTSD and other trauma-related symptoms (Cigrang et al., 2011; van Minnen & Foa, 2006; Zoellner et al., 2017). The program was designed for groups of five to seven members, with men's and women's groups run separately in accordance with cultural norms. Two lay leaders of the same gender facilitate each group. The manual provides scripts, instructions, and guidelines for thematic priorities of each session. Each session includes time for community-building rituals (e.g., sharing tea and snacks), spiritual preparation using a brief supplication written by the local Imam, prophet narratives and discussion questions relevant to trauma healing, time spent turning to Allah in dua, and a brief closing supplication also written by the Imam.

The program was developed for adults who practice Islam. For the program to be broadly adopted and not stigmatizing, we chose to normalize trauma exposure and its common reactions. Accordingly, the program clearly notes that it is for "trauma healing" and asks potential participants to self-refer, having experienced some type of trauma. Standardized diagnostic interviews or clinical severity cutoffs were not incorporated to reduce the risk of

stigmatization, allow a range of participants, and remove any burden of training clinical assessors. Further, the use of clinical interviews was not deemed a necessary or feasible component for the long-term implementation of this program.

Session Structure

Key components of the program include prophet narratives and turning to Allah in dua about trauma, targeting trauma-related beliefs, and avoidance of trauma memories. In the first session, a rationale for the program, common reactions to trauma, and a breathing relaxation exercise are described. Prophet narratives and subsequent discussion of the narratives begin in the first session and continue through the last session. Starting in the second session and continuing through the last session, imaginal exposure to the trauma memory or memories are conducted by having participants individually turn to Allah in dua. In the last session, group members are encouraged to organize a closing event at which certificates of program completion are given. Importantly, sessions and embedded components follow specific themes that form an arc, moving from suffering to healing to growth following trauma. Session themes and prophets discussed across sessions are as follows: Session 1, Faith During Hard Times—Prophet Ayyub (Job); Session 2, Trials Build Strength—Prophet Yusuf (Joseph); Session 3, Overcoming Fear—Prophet Musa (Moses); Session 4, Redemption of Self and Others—Prophet Yoonus (Jonah); Session 5, Faith, Courage, and Hope for the Future—Prophet Ibraheem (Abraham); and Session 6, Reconciliation—Prophet Muhammad (peace be upon him).

Common Reactions to Trauma and Breathing Exercise—In Session 1, common reactions are discussed and a rationale for the program is provided. The leaders describe that part of healing is in understanding what happens to people after they have been through traumatic experiences, like war, violence, natural disasters, loss of friends and family, or rape. Common reactions (e.g., fear, mistrust, avoidance) are described and normalized. Group members learn that these reactions are neither good nor bad; they are what is normal for people who have experienced traumatic events. A rationale for turning to Allah in dua about one’s trauma is provided, explaining to the group members that remembering what happened in a safe place, turning to Allah, will help to put traumatic memories in the past and allow healing. In line with Islamic tenets, Allah is described as all knowing, benevolent, comforting, and nonjudgmental. The first session also contains a 10-min breathing exercise to assist with trauma-related coping and facilitating engagement in other elements of the program (e.g., turning to Allah in dua). A rationale is provided differentiating diaphragmatic breathing from distressed breathing. Consistent with somatic interpretations of distress common in many cultures, including the Somali culture (Bentley et al., 2011), the rationale focuses on physical indicators of distress (e.g., “When we feel afraid or upset, we sometimes start breathing faster and more deeply. Instead of being calming, this can make our body feel like it is afraid. At these times, we need to slow down our breathing and take in less air”). Group members are then instructed on how to conduct slow, repeated diaphragmatic breathing while saying a calming mantra, “Yaa Allah,” helping to align the practice with the Islamic perspective. The breathing exercise is then used at the end of each individual time in dua prior to returning to the group discussion.

Prophet Narratives and Group Discussion—Prophet narratives and related discussion questions are intended to be culturally and religiously appropriate, active treatment components that address and restructure maladaptive, trauma-related beliefs and avoidance. Prophet narratives are brief synopses of a particular prophet's life, including verses from the Qur'an. Following prophet narratives, group discussion questions are posed that are in line with the theme for the session, and time for discussion is allotted. The lives of the prophets are well-known by religiously attuned Muslims. Each narrative focuses on the trials and traumas endured by the prophet. The prophet narrative is read aloud during the group session and is followed by specific questions designed to challenge unhelpful appraisals. Group members are first asked to think through the prophets' experiences and reactions, then reflect on their own experiences and think about what they may be able to learn from the prophets' reactions. Prophet narratives are read aloud (5–10 min) by the group leaders and specific discussion questions guide group discussion during each session.

Figure 1 provides an example of a prophet narrative for Session 3, Overcoming Fear (Musa). Following this narrative are questions to facilitate a group discussion related to building strength following trials. After discussion of the prophet narrative, the group leader provides a summary of key trauma-healing concepts from the session using prompts in the manual.

Turning to Allah in Dua and Discussion—From Sessions 2 through 6, group members are asked to spend time in individual dua, turning to Allah about their trauma. Of note, the term "prayer" in Islamic practice often has a more specific meaning, referring to the specific call to prayer fives time per day. "Dua," in contrast, is a more inclusive term including a more individual, personalized form of prayer. The term "turning to Allah" is often used to describe this time of individual prayer. Conceptually, this time serves as an adapted form of imaginal exposure to the trauma memory or memories. Turning to Allah about personal experiences, including the experience of trauma, has been intuitive for lay leaders and group members.

Mirroring session themes and other components of sessions, the content of turning to Allah 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, thanking or praising Allah for the lessons learned from the experience. In the first session, group leaders provide a rationale for turning to Allah about traumatic experiences. Participants are told that by remembering what happened in a safe place, turning to Allah can help put painful memories in the past and allow His healing. Allah is described as all knowing, benevolent, and nonjudgmental, and that He already knows what happened to them. By turning to Allah repeatedly about what happened instead of pushing the memory away, trauma-related anxiety, fear, and sadness ought to decrease over time.

In the second and third sessions, group members focus on the entire trauma memory, conveying what happened to Allah and what they thought and felt at the time. In the second session, this rationale is repeated, including an example of physical versus mental wounds (i.e., trauma can cause both physical and invisible wounds that need healing), instructions about how to select a trauma memory, and an example dua. They are instructed to focus on just one experience that is the most distressing to them and to pick a starting point, just

before they felt like they were in danger. Then, they are instructed to tell Allah what happened, moment by moment, and to include thoughts that occurred (e.g., “I can’t find a way to escape”) and feelings they experienced (“I’m so scared”). Turning to Allah is conducted individually for approximately 15–20 min. Group members are instructed to raise a hand if they would like assistance from a group leader. Group leaders are taught to monitor the time in dua, looking and intervening for group members who seem too distressed or too distant from the memory while turning to Allah. Caring and compassionate responses are encouraged and outlined in the manual such as, “It’s okay, these memories cannot hurt you. Allah is here with you.”

The specific focus of time turning to Allah shifts throughout the program. In Sessions 2 and 3, group members focus on the entire trauma memory, conveying what happened to Allah and what they thought and felt at the time (see Figure 2). In Sessions 4 and 5, turning to Allah shifts to a focus on the most difficult parts of the memory, places in the memory where they would like to hide from themselves or from Allah. In Session 6, which focuses on growth and reconciliation, turning to Allah again shifts to an emphasis on positive things that Allah has provided related to the trauma, thanking and praising Allah for the experience of what he or she has learned through the trauma, and looking toward the future. This focus on positive meaning making is facilitated by asking group members to think about what they have learned about themselves, others, and Allah because of their traumatic experiences and how they will use this in the future for themselves and their community.

Following individual time in dua, the group leader uses the breathing exercise to refocus group members for group discussion and then facilitates questions around the experience of turning to Allah in dua. Group members are encouraged to talk in the group about their experience while turning to Allah but reminded that they do not need to share their traumatic experience(s) with the group. Questions focus on the shift in experience over time turning to Allah in dua, mirror the themes of the specific session, and often incorporate the perspective of the prophet or a theme discussed earlier. Example questions include “How are you thinking differently about others?”; “What is the role of forgiveness … redemption of self? Others?”; and “How does this relate to lessons we’ve learned from Yoonus?” As group members share, common themes emerge through discussion. This is intended to promote cognitive restructuring of unhelpful trauma-related beliefs and foster social connectedness among group members.

Fidelity and Clinical Supervision—During lay-leader training, the importance of and requirements for clinical supervision are clearly presented. Time spent in clinical supervision (20–60 min/week, depending on number of group members and number of groups) focuses on fidelity monitoring, working with the group leaders to foster skills related to discussion leading, and addressing any emergent issues. Clinical supervision was designed to be straightforward and easily implemented either in person or remotely to increase program scalability and sustainability. Indeed, supervision has successfully been conducted both in person in the United States and remotely via WhatsApp with group leaders in Somalia.

Following each group session, lay leaders complete a fidelity session checklist, with behaviorally specific descriptions of key components of a given session. Group leaders check “yes/no” as to whether or not they covered the specific component (e.g., “Asked questions about Prophet Ibraheem”), and then record approximately how many minutes they spent with group members on that particular component. These checklists are included in the program manual. Clinical supervisors review these checklists after each session. Use of these checklists allows for consistent monitoring of how closely group leaders are adhering to the manual, ensures comprehensive records are kept in the case of remote supervision, and serves as a platform for discussion with and feedback to group leaders when supervisors notice a drift from protocol.

Other aspects of supervision are scaffolded over time, initially focusing on helping group leaders not be lecturers or teachers but rather supportive discussion leaders, and later on helping group leaders to notice and address trauma-related avoidance and unhelpful trauma-related beliefs among group members—for example, a supervisor working after the second session to improve discussion leading and active listening skills with group leaders in Somaliland said over WhatsApp, “This is great that you all are getting members to talk. As we move to next sessions, you want to continue to decrease the time you talk and do the active listening skills we learned. Make sense?” In a later session, a group leader brought up issues related to avoidance during the session, saying that a group member “was avoiding [thinking] or even encounter[ing] [anything] that may make her remember” her trauma and that she was “still afraid.” The supervisor provided words of support and reminded the group leader of the importance of approaching trauma-related memories, saying that, “fear is often why people avoid, and turning to Allah [about the trauma] helps address that fear.” Supervision is typically focused on key session elements and allows for ongoing support of and skill refinement for lay leaders. After completing the initial training and successfully leading a group for six sessions, with clinical supervision, group leaders receive a certificate of training.

Safety Procedures—As part of the initial session, group members learn that information shared in the groups should be treated as confidential and is not to be shared outside of group meetings. Examples are provided and this is repeated each session, helping to address a potential tendency to share others’ comments or traumatic experiences and reinforce the importance of respecting others’ privacy in groups. This repetition is particularly important where culturally it is common to spread information across social connections.

Group members are also instructed about the limitations of confidentiality and obligations about the reporting of elder abuse, child abuse, suicidality, and homicidality. Group leaders are trained to recognize these potential safety risks and trained to follow the safety protocol in the manual. As part of leader training, examples of who is appropriate and not appropriate for trauma-healing groups is discussed, including discussing individuals who are actively suicidal or have a recent history of a suicide attempt. The protocol highlights assessing, planning, and follow-up, and includes discussing any possible risks immediately with supervisors, handling any issues tactfully during groups, and responding in a caring manner over time. In cases of imminent risk, the safety protocol in the manual includes instructions and a toll-free, 24-hour, 7 day-a-week hotline to report such instances.

Lay-Leader Training

Lay leaders receive two 4-hour trainings for a total of approximately 6–8 total training hours. Training includes motivational stage setting, didactic and competence components (e.g., multiple role plays each day), breaks for salat (i.e., daily prayer times), and shared food with allowances for men and women to eat separately, if desired. Trainings, to date, have been provided in English with simultaneous translation by one of the lay leaders to the local language (e.g., Somali), where needed. Collectively, a shared mission statement is developed as well as shared, collaboratively generated ground rules for the training (e.g., respectful listening of others' perspectives, cell phones for emergencies only). Group leaders develop a mission statement that often includes elements such as "As Islamic leaders in our community, we are committed to doing what we can to help"; "Take what we learn to help our community"; "We use Islamic principles to heal the suffering from trauma"; and "Faith is some of the best medicine." Training follows the structure of the manual, discussing what is trauma, common reactions to trauma, rationale for the program, practice leading group discussions, breathing retraining, how to implement prophet narratives and time in dua, and time for strategic planning for next steps and potential barriers.

The focus of training is developing strong group facilitators. This starts with the selection of lay leaders who "have a heart for healing," are of the Islamic faith, and are respected in their faith community. No psychological or psychiatric training is needed by group leaders. Didactics focus on how to facilitate rather than "teach" a group discussion and emphasize that leaders need not to be experts in the Qur'an to facilitate a discussion on the life of a prophet. Specific questions regarding scripture interpretation are directed to the local Imam. Common techniques, such as asking clarifying questions and broadening the discussion to others, are emphasized. Sample discussions are modeled and practiced, with feedback. Similarly, group leaders are taught how to monitor the individual time of turning to Allah in dua, looking for signs of overengagement (e.g., scared, highly distressed) and underengagement (e.g., distracted, avoidant) with trauma memories, how reactions vary from tears to boredom, and when and how to intervene. When intervening, the general message is to be supportive, encouraging to turn to Allah about whatever a person is able to do, and that a range of reactions is normal. Group leaders are encouraged to remind group members that Allah knows about what has happened, He is present with them, and memories are not themselves dangerous. They are also encouraged to use the breathing technique with distressed group members to help modulate distress.

The training has built-in time for discussion of cross-cultural adaptation by lay leaders and supervisors to help address issues related to stigma and transferability of trauma-related concepts. Example discussions have focused on the cultural dichotomy between "sane" and "insane," with group leaders discussing the common practice of chaining the mentally ill in Somalia. This led to a discussion of behavioral examples of who would and would not be appropriate for trauma-healing groups (e.g., talking to self, yelling uncontrollably, recent suicide attempt, seeing things that are not there, behaviors that would be frightening to others in the group).

Another example of a discussion was around the term "trauma." The collective term "trauma," denoting a wide range of potentially traumatic events, does not translate well into

Somali. As a result, we had collaborative discussions aimed at clarifying and coming to a common understanding about what constitutes a traumatic event. Some examples, such as the drowning of a sister on a refugee boat or witnessing a friend die in a truck bomb, were easily identifiable by Somali members of the team. Other common, life-threatening events (e.g., drought/famine, cyclones) and witnessing of events (e.g., murder of a loved one) often were not identified by community partners as potentially traumatic. These discussions helped us to develop a shared understanding of the construct of trauma across cultural and linguistic lines, while better appreciating the pervasive impact of trauma on their community and, by extension, who may benefit most from the program.

The first cohort, supported by the original expert team, becomes responsible for leading the next two 4-hour training sessions following content they learned in the initial training. New lay leaders from the second cohort co-lead groups with an experienced lay leader from the first cohort. Experts remain as consultants. Handing over training to lay leaders not only increases financial sustainability but also enhances continuity and alignment with cultural practices (e.g., seeking help within the community) and increases dissemination (e.g., training can be conducted in Somali). It also increases community ownership of the program by allowing trainings to be provided by leaders within the community, as well as the potential viability and uptake of the program within a community. Although trained mental health providers could provide this intervention outside of mosques, faith is a critical component of the program and placement in mosques significantly solidifies this for group members. The success of the broader implementation model relies on both peers and institutions of faith to support the program and choose to implement it. Indeed, the support of local Imams has been critical for mosque members' willingness to participate in the program.

Lay-Leader Feedback and Perspectives

The perspective and feedback from group leaders has been integral in the continued development of the program. Universally, from the group leaders' perspective, the integration of Islamic principles to address the effects of trauma were the most attractive aspects of the program, noting that "stories of the prophets were my favorite," and that the most important part of the program was "the time spent in individual dua turning to Allah" about trauma; turning to Allah about trauma made intuitive sense and its healing value simple and straightforward. "I know Somalis go to the mosques, and they don't really take medications … this really resonates with Somalis because it's Islamic and because it deals with their specific problems." "I was amazed at how much commitment and how much knowledge they seemed to have … they were learning from [the prophet narratives] and had a good response to it." Many leaders noted that the integration of faith is "something that [Somalis] hold very dear," and indicated that they would highly recommend the program because of the program's foundation on Islamic principles. Similarly, another leader commented, "Even though I knew Islamically we're supposed to have patience and forgiveness, this is a new way of compiling … the Qur'anic perspective and the prophets and the psychological way."

Leaders also found the program's emphasis on healing, rather than on mental illness or psychopathology, to be beneficial: "I like to think of it in a sense that this is like emotional wellbeing, or emotional healing, or the emotional aspects of it that we are addressing versus the mental illness … we are not doing the mental illness aspect of it, rather it's the emotional piece we are dealing with from the traumatic experiences people have had." Group leaders also noted appreciation for the emphasis on community building, commenting on how beginning each meeting with tea and a supplication helped establish rapport within the group that then facilitated better, deeper discussions following reading prophet narratives. The groups not only provided support and solidarity in dealing with traumatic experiences but increased social connectedness between participants, and between group leaders and participants: "That is one way we establish relationships … through food and sharing, so that's an important aspect." Some group leaders noted, the importance of "Sitting together in [the] same place and sharing problems as well as solving [problems]." This was so much so that one group referred to the program as "sipping, sharing, and stories."

As with any group, the primary intervention focus is on the group members. However, Islamic Trauma Healing is not led by traditional mental health professionals, but rather by individuals within the community. Several group leaders were present during the civil war, famine, and ongoing conflict or were resettled refugees with a history of traumatic experiences during migration or in Somalia. Leaders often reported significant healing and changes within themselves as a result of leading groups. "Going through the prophet stories and finding how it resonates with me in my life … and to be able to connect to something, to really connect with it, was amazing." The group leaders intimated that they found themselves integrating different techniques into their own lives: "Even though when times were hard I prayed and talked to Allah, I never actually took the time to go into detail about what happened. I continue to use that technique." Leaders were able to draw parallels between the narratives they were discussing in groups and their own personal experiences; one leader observed "the prophets are the best people, and what I tell myself is if the prophets went through all of this hardship and got tested in this way, what about me?" Similarly, another leader stated that "Musa was forced to leave some country and … Prophet Mohammed [peace be upon Him] has similar experiences to those that [Somalis] are having now."

Consistently, the most common criticism or changes for the future, highlight the perceived need for this type of program in the community and its expansion. Leaders have routinely mentioned the need "to emphasize more trainings to the leaders encouraging expansion of the program" and "a lot of people who want to take part in the next training." Further, both in the United States and Somalia, group leaders and group members have highlighted the importance of "establish managing offices," reflecting a legitimacy and permanence of the program in their community.

Discussion

Given high levels of trauma exposure in refugee communities (Dietrich et al., 2019; Karam et al., 2014), severe mental health burden (Bhui et al., 2006), lack of access to standard approaches, and lack of acceptability of such approaches for religiously oriented Muslims

(Boynton et al., 2010), the need for an integrated approach focused on healing psychological wounds of trauma and rebuilding relationships following devastating civil conflict has long been apparent. Islamic Trauma Healing has the potential to meet an immense, unmet need by providing empirically supported trauma-related mental health programming for segments of U.S. Islamic refugees residing in the United States and larger Islamic community who do not seek standard mental health care or do not have access to these treatments. To improve accessibility and reduce stigma, the program embeds the Islamic faith, both in content and provision, within mosques and utilizes the collectivist culture in providing care in peer-led groups. Islamic Trauma Healing also shifts the model of training away from the traditional focus on teaching CBT skills to training lay leaders in facilitating group discussions and being supportive peers, dramatically reducing training time and providing a practical pathway toward broad dissemination and implementation.

Islamic Trauma Healing has been carefully developed over many years and in close collaboration with Somali community members and faith leaders. The development process involved many iterations of the original program, including careful input from the Imam, members of the mosque, lay group leaders, and group participants. The iterative and collaborative process provided opportunities to identify and resolve potential barriers to successful implementation (e.g., assessment methods, description of prayer, supervision procedures). The development process focused on promoting broad uptake across sects and mainline Qur'anic interpretations within Islam—for example, prophet stories included in the manual were carefully chosen with attention to those that are well-known and that illustrate accessible trauma-healing themes. Narratives were also selected to ensure a logical progression that follows extant trauma treatment protocols and culminates in reconciliation through the story of Prophet Muhammad (peace be upon him).

The previously published pilot data suggests that Islamic Trauma Healing is feasible and acceptable to both men and women of Islamic faith, both in the U.S. Somali community (Zoellner et al., 2018) and in Somalia (Zoellner et al., 2019). Further, it provides preliminary evidence that Islamic Trauma Healing reduced psychological distress and increased functioning. The promising preliminary results of the U.S.-based pilot study, ongoing domestic randomized controlled trial (Zoellner, 2018), and a feasibility trial in Somalia set the stage for larger-scale investigation of the efficacy of the program and the ability to effectively disseminate Islamic Trauma Healing utilizing the train-the-trainer's framework. One important next step is understanding putative psychological mechanisms of change, as this is key to the successful adaptation of trauma-related treatment within an Islamic community. The program is designed to target unhelpful trauma-related beliefs through discussion of Prophet narratives, trauma-related avoidance through imaginal exposure via turning to Allah in dua, and social support and connectedness to the community and with Allah via traditional rituals like tea and snacks in one's community mosque. The synthesis of these mechanisms of change, in conjunction with the community-based delivery model, provides a unique pathway to mental health service utilization among refugees experiencing extensive trauma burden but limited access to culturally aligned programming.

Importantly, the Islamic Trauma Healing program attempts to address two other common barriers to mental health service utilization: lack of trained human resources and stigma.

Lack of mental health providers has been a substantial practical barrier to scaling up mental health interventions, particularly in low-income countries. As a result, we utilize a train-the-trainers model for disseminating Islamic Trauma Healing that ultimately will reduce expert involvement, lower costs, increase local knowledge, and enhance sustainability. Such a training model yields an important means through which to facilitate widespread uptake of an intervention (Jacobs et al., 2014). In many Muslim communities, stigma has also been recognized as a considerable barrier to the access of mental health care (Bentley & Owens, 2008; Boynton at al., 2010). Islamic Trauma Healing addresses this systematically by using lay leaders who are members of the community, delivering groups within mosques, having the support of Imams, and emphasizing healing as opposed to pathology.

The Islamic Trauma Healing program has the potential to provide a low-cost, self-sustaining model of a faith-based intervention that addresses the psychological wounds of trauma and promotes community reconciliation for Muslim communities. Consistent with clinical best practices, with more evidence of efficacy, Islamic Trauma Healing could be adapted more broadly for other war and refugee populations and Muslim communities around the world. Further work is needed to evaluate the potential utility and specific required adaptations of the program to meet the needs of individuals located in midmigration contexts, such as refugee camp environments. Adaptation via online provision is also possible. However, the program was designed with built-in adaptability; its orientation toward community building through shared culturally aligned foods, opening with supplication, and attention to commonly known Islamic stories that attend to trauma themes are not unique to Somali culture but rather are practices that are commonly shared in multiple cultures that have also experienced war and community violence.

There are several limitations to consider given the current developmental stage of the Islamic Trauma Healing program. The randomized controlled trial in the United States is underway, so empirical support for the program remains preliminary, though preliminary effect sizes benchmark well with individual psychotherapy for PTSD (e.g., Cusack et al., 2016). Completion of the randomized controlled trial will be essential in understanding the program's efficacy and mechanisms of action. Although there is strong theoretical and empirical justification for focusing on avoidance and negative beliefs, the other purported mechanisms of action remain largely unknown (e.g., social connectedness, centrality of faith). We have not yet measured potential effects of the program on systems influential to trauma and mental health in the population of interest (e.g., mosque, increased discussion of trauma in the community, reduced stigma). The length of this relatively brief program, and therefore dosing of active mechanisms, may not be fully optimized—however, there has been some precedent in the existing literature for trauma interventions in the four- to six-session range in global mental health settings (see Neuner et al., 2004, 2010). Although the program was collaboratively built around Islamic narratives and principles believed to be broadly transferable to practitioners of the Muslim faith, the ability to generalize from the pilot work with Somalis to other Muslim populations also remains unclear. There are many cultures within the Muslim community, and the Islamic Trauma Healing program must be adapted to particular cultural and community contexts—for example, the community-building and spiritual preparation practices need to be adjusted to fit the unique customs of the community that adopts the program. Such an approach will aid in incorporating the

richness and complexity of intersectionality within Muslim communities. Finally, though the train-the-trainer model has been effective in other contexts (Baron, 2006; Thornicroft et al., 2012), the effectiveness of disseminating this program through this process has not been evaluated.

In conclusion, if progress is to be made on the goals outlined in the United Nations' 2030 Agenda for Sustainable Development, international efforts to promote the physical and mental welfare of refugees and other displaced people must emerge as a priority. Islamic Trauma Healing represents a new model for the process of global mental health intervention development. This low-cost and easily upscalable program was collaboratively developed and tested to address the needs of a local community, and then expanded to international contexts with a plan for broad dissemination extending to trauma-exposed Muslim communities. The Sustainable Development Goals outlined by the United Nations state that the international community must "resolve to take further effective measures and actions … to remove obstacles and constraints, strengthen support and meet the special needs of people living in areas affected by complex humanitarian emergencies and in areas affected by terrorism" (UNHCR, 2019). Given the burden of trauma and associated distress experienced by displaced persons, mental health professions can play a central role in these efforts. Focusing on collaborative development and rigorous empirical testing of community-based and culturally aligned programs built on sustainable delivery models is in line with international initiatives aimed at promoting wellness among trauma-exposed members of often marginalized refugee groups.

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Highlights

- Muslim refugees are at increased risk for developing posttraumatic stress disorder
- Stigma and lack of culturally aligned interventions are substantial treatment barriers
- Islamic Trauma Healing is a manualized, mosque-based, lay-led group program
- The faith-based program integrates evidence-based practices and Islamic principles
- The embedded train-the-trainer approach promotes a low-cost, self-sustaining model

We will always have a time for community at the beginning, like we did today.

We will then read and discuss the life of one of the Prophets. Today, we are focusing on Musa and Overcoming Fear.

We will also spend time individually turning to Allah in Dua about our traumatic experiences. Today, we will focus on remembering how we felt and thought during the trauma.

These activities will work together to address unhelpful beliefs and avoidance related to your traumatic experiences and help heal ourselves and our community.

4. Prophetic Narration (20 min): Overcoming Fear

The Story of Prophet Musa

The life of the Prophet Musa teaches us about trusting Allah to help overcome our fears.

Pharaoh, the King of Egypt, was a tyrant who oppressed and enslaved the Children of Israel for a long time. Pharaoh heard the Israeli people speak of a prophecy or a vision that one of Israel's sons will dethrone the Pharaoh of Egypt. In other narrations, it was Pharaoh himself who had a vision that a son of the Children of Israel will overthrow him. He gathered his priests and magicians and asked them about his vision. They said, "This means a boy will be born of them and the Egyptian people will perish at his hands." To prevent such a dream from coming true, Pharaoh devised and implemented a policy of killing all the sons of the Children of

Israel. This murderous policy was carried out until experts of economics advised Pharaoh to spare the sons one year and slay them the following year. Prophet Musa was born in a year when the sons of the Children of Israel were murdered.

But Allah protected Musa. Allah had Musa's mother hide him in a basket and put it on the river. The river carried the basket to the Pharaoh's house where he was taken in. Musa grew up safe and strong in the Pharaoh's own house.

When Musa reached manhood, God made him a prophet and sent him to free the Children of Israel from the tyrant Pharaoh. Musa came to Pharaoh and demanded him to free the Children of Israel and to follow God's commands. Pharaoh, being an absolute tyrant and oppressor, refused to follow God's commands. God commanded Musa to face the tyrant Pharaoh and fear not, because God would be with him.

Musa said, *"O my Lord! Open for me my chest (grant me self-confidence, contentment, and boldness). And ease my task for me; and make loose the knot (the defect) from my tongue, (remove the incorrectness of my speech) that they understand my speech, and appoint for me a helper from my family, Aaron, my brother; increase my strength with him, and let him share my task, and we may glorify You much, and remember You much, Verily! You are of us Ever a Well-Seer."*

اذْهَبْ إِلَىٰ فِرْعَوْنَ إِنَّهُ طَغَىٰ (٢٤) قَالَ رَبِّ اشْرَحْ لِي صَدْرِي (٢٥)
وَيَسِّرْ لِي أَمْرِي (٢٦) وَاحْلُلْ عُقْدَةً مِّن لِّسَانِي (٢٧) يَفْقَهُوا قَوْلِي (٢٨)
وَاجْعَل لِّي وَزِيرًا مِّنْ أَهْلِي (٢٩) هَارُونَ أَخِي (٣٠) اشْدُدْ بِهِ أَزْرِي

(٣١) وَأَشْرِكْهُ فِي أَمْرِي (٣٢) كَيْ نُسَبِّحَكَ كَثِيرًا (٣٣) وَنَذْكُرَكَ كَثِيرًا (٣٤) إِنَّكَ كُنتَ بِنَا بَصِيرًا (٣٥)

"Go, both of you, to Pharaoh, verily, he has transgressed all bounds in disbelief and disobedience and behaved as an arrogant and as a tyrant. And speak to him mildly, perhaps he may accept admonition or fear Allah. Fear not, Verily! I am with you both, Hearing and Seeing. So go you both to him, and say: "Verily, we are Messengers of your Lord, so let the children of Israel go with us, and torment them not; indeed, we have come with a sign from your Lord! And peace will be upon him who follows the guidance!" (Qur'an 20:43-47).

اذْهَبَا إِلَىٰ فِرْعَوْنَ إِنَّهُ طَغَىٰ (٤٣) فَقُولَا لَهُ قَوْلًا لَّيِّنًا لَّعَلَّهُ يَتَذَكَّرُ أَوْ يَخْشَىٰ (٤٤) قَالَا رَبَّنَا إِنَّنَا نَخَافُ أَن يَفْرُطَ عَلَيْنَا أَوْ أَن يَطْغَىٰ (٤٥) قَالَ لَا تَخَافَا ۖ إِنَّنِي مَعَكُمَا أَسْمَعُ وَأَرَىٰ (٤٦) فَأْتِيَاهُ فَقُولَا إِنَّا رَسُولَا رَبِّكَ فَأَرْسِلْ مَعَنَا بَنِي إِسْرَائِيلَ وَلَا تُعَذِّبْهُمْ ۖ قَدْ جِئْنَاكَ بِآيَةٍ مِّن رَّبِّكَ ۖ وَالسَّلَامُ عَلَىٰ مَنِ اتَّبَعَ الْهُدَىٰ (٤٧)

When Pharaoh refused to free the Children of Israel, Musa called for his Lord, *"Our Lord! Destroy their wealth, and harden their hearts, so that they will not believe until they see the painful torment."*

The Good Lord decided to put an end to the abuse and oppression of the tyrant Pharaoh. God ordered Musa to depart from Egypt with the Children of Israel. In the darkness of night, Musa led his people towards the Red Sea in Exodus. Pharaoh and his chiefs mobilized a powerful army to pursue them. In the meantime, the Children of Israel were

afraid in facing the powerful Pharaoh. Yusha, Ibn Nun, exclaimed: *"In front of us is this impassable barrier, the sea, and behind us the enemy; surely death cannot be avoided!"* Musa replied, *I will wait for God's guidance,* and his words brought hope to his people. God's promise was fulfilled and God commanded Musa, *"Smite the sea with your staff!"* Musa did as he was told.

فَلَمَّا تَرَاءَى الْجَمْعَانِ قَالَ أَصْحَابُ مُوسَىٰ إِنَّا لَمُدْرَكُونَ (61) قَالَ كَلَّا ۖ إِنَّ مَعِيَ رَبِّي سَيَهْدِينِ (62) فَأَوْحَيْنَا إِلَىٰ مُوسَىٰ أَنِ اضْرِب بِّعَصَاكَ الْبَحْرَ ۖ فَانفَلَقَ فَكَانَ كُلُّ فِرْقٍ كَالطَّوْدِ الْعَظِيمِ (63) وَأَزْلَفْنَا ثَمَّ الْآخَرِينَ (64) وَأَنجَيْنَا مُوسَىٰ وَمَن مَّعَهُ أَجْمَعِينَ (65) ثُمَّ أَغْرَقْنَا الْآخَرِينَ (66) إِنَّ فِي ذَٰلِكَ لَآيَةً ۖ وَمَا كَانَ أَكْثَرُهُم مُّؤْمِنِينَ (67) وَإِنَّ رَبَّكَ لَهُوَ الْعَزِيزُ الرَّحِيمُ (68)

"Strike the sea with thy rod." So, it divided, and each separate part became like the huge, firm mass of a mountain. And We made the other party approach thither. We delivered Musa and all who were with him; but We drowned the others. Verily in this is a sign: but most of them do not believe. And verily thy Lord is He, the Exalted in Might, Most Merciful" (Qur'an 26:61-68).

Questions for Discussion:

- *What were circumstances in Musa's life or his mother's life where they had to overcome fear?*
- *What characteristics did Musa pray for to help him face his fears, such as the tyrant, etc.?*
- *What did Allah tell him about fear?*
- *What did Allah grant him?*
- *What does this tell us about fear?*

Summary of Prophet Musa: Overcoming Fear

Some things that are important for us to remember about Musa are that:

- *People are very resilient even in the face of abuse and oppression.*
- *Musa was afraid and sought Allah's help.*
- *At times when terrible suffering seems inevitable, Allah helps us to survive.*
- *Eventually, Allah will lead us to safety.*

Healing Help

A key part of leading a discussion involves showing that you are doing what is called "active listening" and being "encouraging" when someone says something good that reflects understanding of key ideas or productive shifts in how he or she is thinking about things.

One method is to be "*reflective,*" like a mirror, in what you say to someone after he or she answers a question. For example,

- *Yes, like you said, 'Allah helps us to survive.'*

Another method is to "*go deeper*" on a comment someone makes. This asks individuals in the group to think more about what the person has said. For example,

- *Yes, does anyone else want to say more about how Allah helps us survive?*

A final method is to "*validate*." This is really simple. For example,

- *Great point.*
- *I agree.*

When you hear someone in the group say something helpful, try to do one of these things.

5. Review why and how to turn to Allah about trauma (5-10 min)

Now, we will have time for individually turning to Allah in Dua. As we talked about last week, this time will be a bit different than what you might be used to, as it will be about the traumatic experiences that happened to you.

As you do this, remember that Allah is all knowing. He already knows what has happened to you, knows your suffering, and knows your heart. Nothing you can say to Him will be shocking or surprising.

This time when we individually spend time with Allah about the trauma, we would like you to focus on more details of the experience you went through, including what you saw, heard, felt, smelled, or tasted. The idea is to remember some of the thoughts and feelings you had during the trauma.

Let me remind you of the example from last time, this time with me putting emphasis on how to focus on your own thoughts and feelings about what happened. [Be sure to emphasize the bolded words when reading the example.]

> *"Oh Allah, the most Gracious and most Merciful. I will now share my story with you, as I know you are loving and will help me with my suffering. I am walking home from work one day along a dirt road when a car pulls up beside me with three men inside. One of the men puts his head out of the window and asks me for directions into town. I am smiling, and* ***he looks friendly****. Suddenly, one of the other men opens the car door and pulls me inside and puts a gun to my head.* ***I am terrified, and my heart is racing. I am so***

> ***shocked.*** *I cry to you, "Oh Allah." I am staring straight ahead. The air is hot. We drive for what seems like forever* ***and I want to yell but I am too scared****. I see dry land for miles and* ***don't know where I am. I think I am far from the town or anyone who can help me.*** *The car suddenly stops and the man with the gun pushes me outside onto the ground. He kicks my back and demands that I give him everything I have. I cannot speak* ***because I am too afraid.*** *I feel more kicks on my back, legs, and head. The beating seems to go on forever.* ***I am afraid he is going to kill me.*** *He reaches into my pockets and pulls out my belongings. The next thing I remember is hearing their footsteps getting further away and the car door slamming. I am alone.* ***I give You thanks for being my protector. I am relieved that they have left and start to cry, I am in so much pain and do not know how to get back to town, to my family.*** *Oh Allah, you are most Gracious and know my memory and my pain."*

Does this make sense how this is different than just stating the facts of what happened to you to Allah?

The focus this time is on turning to Allah not just about what happened but your ***thoughts*** *in your head at the time and what you* ***felt****.*

6. Turning to Allah about the trauma (20 minutes)

Now, we are going to have you do the same thing.

- *For now, we are going to continue to focus on your most distressing trauma memory. This should be the same one you shared with Allah about last meeting.*
- *Like I said before, this time we want you to add in details about what you were thinking and feeling during the trauma, just like Musa shared his fears and concerns with Allah. So, you are not just sharing the facts that happened but your own experience during the trauma. Does this make sense?*
- *We will turn to Allah in Dua for 15-20 min. Everyone's story differs. You might need to repeat your story once, twice, or more. Try not to stop in the middle of the story. Even though it might be hard to continue, always go through until the end before starting again.*
- *Raise your hand if you would like assistance, and we will come over to you.*
- *I will let you know when it is time to return to the group to discuss what it was like together. Even though the memory may begin to feel very real, Allah knows that it happened in the past, and Allah is with you.*

Encourage the group to find separate spots for time with Allah and begin.

Allow 15-20 min to do this.

Carefully monitor individual time turning to Allah, assisting group members as they need it. See Chapter 5 for details on how to assist.

7. Breathing exercise and rejoining the group (5 min)

After individual time turning to Allah, call the group back together.

Let's go ahead and get back together as a group.
Before we get started, let's briefly do the breathing exercise again.

- *Take a normal breath in, 2, 3, 4, breathe out, Yaaa Allah.*
- *Take a normal breath in, 2, 3, 4, breathe out, Yaaa Allah.*
- *Take a normal breath in, 2, 3, 4, breathe out, Yaaa Allah.*

8. Reflection on turning to Allah (20 min)

As we talk together now, you do not need to share details of what happened to you. In fact, please do not share details about what happened. This is for you and Allah. We instead want to talk a bit about what it was like for you today during your time turning Allah about what happened to you.

Use these questions to begin discussion in the group

- *How did your time with Allah differ from the last meeting?*
- *How did it change turning to Allah to really focus on your experience during the trauma? That is, focusing on what you thought and felt?*
- *How does admitting our fears and concerns to Allah help with our healing?*
- *Did you learn anything about yourself or Allah today that you want to make sure you remember?*
- *How does this relate to Musa overcoming his fear?*

9. End of Session Spiritual Closing

Table 1

Islamic Trauma Healing: Session Outline and Intervention Arc

Prophet stories and thematic progression	Structure of weekly group meetings
Session 1: Faith During Hard Times (Prophet Ayyub)	• Community and spiritual preparation ○ Tea, incense, written opening supplication from local Imam
Session 2: Trials Build Strength (Prophet Yusuf)	• Psychoeducation and breathing (Session 1 only) ○ Privacy and confidentiality ○ Common reactions to trauma
Session 3: Overcoming Fear (Prophet Musa)	• Describe program (Session 1 only) ○ 6 weeks, 2 hours per week ○ Overview of weekly session structure
Session 4: Redemption of Self and Others (Prophet Yoonus)	• Prophet narratives and discussion (e.g., see Fig. 1)
Session 5: Faith, Courage, and Hope for the Future (Prophet Ibraheem)	• Turning to Allah about trauma in dua and discussion (e.g., see Fig. 2)
Session 6: Reconciliation (Prophet Muhammed صلى الله عليه وسلم)	• Closing supplication

Note. Themes shift across sessions from impact of trauma in one's life (Trials Build Strength: Yusuf) to promoting forgiveness and posttraumatic growth (Faith, Courage, and Hope for the Future: Ibraheem) and ultimately reconciliation with others (Reconciliation: Muhammad صلى الله عليه وسلم).

Table 2

Islamic Trauma Healing Training Model as Compared to Other Trauma-Focused Interventions Implemented in LMIC Contexts

Intervention	Country	Duration of training	Background of counselors	Individual or group format	Number of sessions	Supervision
Islamic Trauma Healing (ITH; Zoellner et al., 2019)	Somalia	6–8 hrs	Community and religious leaders with no prior mental health training	Group	6 weeklv sessions	30 min to 1 hr per week in-person or via WhatsApp with a U.S.- based psychologist using a fidelity checklist
Cognitive processing therapy (CPT; Bass et al., 2013; Kay sen et al., 2013)	Democratic Republic of Congo (DRC); Kurdistan region of Iraq	2 weeks (DRC); 8 days (Kurdistan)	In the DRC, assistants with years of case management and individual supportive counseling experience; at least 4 years of postprimaryschool education In Kurdistan, local community mental health workers with varied education	Group (DRC); individual (Kurdistan)	In the DRC, 1 individual session (1 hr) and 11 group sessions (2 hrs each) In Kurdistan, 12 weekly individual sessions, with a shorter period negotiated on a case- by-case basis	Tiered for both settings using an apprenticeship model (see Murray et al., 2011); weekly supervision conducted by a trained local provider and weekly consultation between the local supervisor and U.S.- based trainers; direct observation of sessions; fidelity checklist; duration of supervision meetings not reported
Common elements treatment approach (CETA; Murray et al., 2014; Weiss et al.. 2015)	Iraq; Thailand	2 weeks provided to lay counselors and supervisors simultaneously	In Iraq, health care providers (predominantly medics or nurses) with some prior counseling experience In Thailand, individuals interested in becoming counselors, with a subset having had prior counseling experience	Individual	Approximately 11 weekly sessions (range: 5—13)	Weekly supervision calls based on an apprenticeship model (see Murray et al., 2011); duration of supervision meetings not reported
Narrative cxposuic therapy (NET; Ertl et al., 2011; Jacob et al., 2014; Schaal et al., 2009)	Rwanda; Uganda	12 days (8 his/ day)	Local clinical psychologists with bachelor degree (Rwanda)	Group (Rwanda); individual (Uganda)	8 weekly sessions lasting fiom 90 to 150 min, with at least 3 days between sessions (Rwanda); 10 sessions lasting 90 min	90–120 min weekly individual supervision and 90–120 min of weekly group supervision by a German psychologist (Rwanda); supervision details not provided for Uganda study
Trauma-focused cognitive-behavioral therapy (TF-CBT; Murray et al., 2015; O'Donnell et al., 2014)	Tanzania; Zambia	10 days for / counselors and supervisors	Local counselors who had little to no mental health training background; at least high school educated	Group (Tanzania); a mix of child alone, caregiver (s) alone, and family members together (Zambia)	Average of 11 weekly sessions (range 8–23 sessions)	2–4 hrs per week between community supervisors and counselors and at least 2 hrs/week of contact between trainers and supervisors via Skype/phone/in person; fidelity checklist