Global Scientific JOURNALS
GSJ: Volume 14, Issue 4, April 2026, Online: ISSN 2320-9186
www.globalscientificjournal.com

A CONTEXT-SPECIFIC CULTURALLY SENSITIVE CONFLICT TRAUMA (CSeCT) SCALE: AN EXPLORATORY-SEQUENTIAL DESIGN

LOURDES CELSO – ALCAZAREN
PROFERIA S. PORALAN, PhD
UNIVERSITY OF IMMACULATE CONCEPTION

Abstract

This study developed and validated the Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale to assess trauma among armed conflict survivors in the Bangsamoro Autonomous Region in Muslim Mindanao. An exploratory-sequential mixed-methods design was employed to enable an in-depth understanding of the trauma experiences of the participants. In-depth interviews (IDI) and focus group discussions (FGD) were used to generate six core domains of trauma, such as hyperarousal and persistent fear, intrusive distress and cognitive disruption, functional physiological impact, relational trust and social disruption, faith-anchored meaning and spiritual regulation, and coping behaviors, reflecting participants' lived experiences.

In the quantitative phase, Exploratory Factor Analysis (EFA) was used, yielding a four-factor structure consisting of Intrusive Distress and Functional Impairment, Faith-Anchored Coping, Hyperarousal, and Interpersonal Distrust, with internal consistency (α = .888; 95% CI: .859–.918). Confirmatory Factor Analysis (CFA) supported the four-factor model, indicating strong factor loadings and excellent model fit. Integration of qualitative and quantitative findings highlighted the multidimensional nature of conflict-related trauma, encompassing psychological, physiological, social, and spiritual dimensions.

The validated CSeCT Scale offers a reliable and contextually grounded instrument for assessing trauma in conflict-affected populations. It has important implications for the development of culturally sensitive psychosocial interventions, community-based support initiatives, and policy formulation. The study underscores the value of integrating qualitative insights with psychometric validation to capture culturally specific expressions of trauma and inform evidence-based, contextually responsive mental health strategies.

INTRODUCTION

Trauma is a psychological and emotional response to overwhelming stress, leaving individuals feeling helpless and unsafe (APA, 2013). It weakens the sense of identity and makes it hard to understand and manage emotions (American Psychological Association, 2013). The APA (2022) further describes trauma as a strong emotional reaction to life-threatening events such as conflict, accidents, sexual assault, or natural disasters. Similarly, the World Health Organization (2023) highlights that trauma happens to an individual who experiences an overwhelming event, affecting one's capacity to process or deal with emotions. This shows that trauma is not just about external events, but a deeply personal experience that can have a lasting impact on a person's mental and emotional well-being.

Globally, trauma is a significant public health concern both for individuals and society (Magruder, K.M. et al., 2017). The Adverse Childhood Experiences (ACE) of Felitti et al. (1998) shows that there is a strong link between early trauma and mental and physical health issues in adulthood. While Kirmayer et al. (2011) argued that cultural beliefs influence how distress is understood, labelled, and managed. With this, the concept of trauma in Western countries did not capture the experiences of community-based or spiritually oriented societies. Studies in African communities highlight the role of community support, rituals, and spirituality as integral to healing trauma, suggesting that recovery is more collective than individual experiences (Wessels, 2009).

National studies show that emotional distress and trauma are real, measurable, and prevalent across diverse Filipino groups, including students, survivors, adolescents, and soldiers (Magruder, K. M., et al. 2017). Fajarito and De Guzman (2017) recognized the risk factor of posttraumatic stress disorder (PTSD) among Filipino soldiers as trauma effects differ on individual resilience, exposure, and social support. Meanwhile, Boyle et al. (2019) identified that trauma symptoms among Filipino boys caused by rituals and non-therapeutic medical procedures, even if they are culturally accepted practices, can cause psychological distress when considered as painful or coercive.

Furthermore, Martin (2018) explained that trauma as a collective cultural phenomenon in his study on “Martial Law as Philippine Trauma: Group Culture, the Sacred and Impunity”. Historical and ethnographic analysis, Martin argued that the martial law era created a shared psychological impact, that trauma can be transmitted socially and culturally through shared memory and intergenerational narratives.

Despite several studies on trauma, research gaps remain unaddressed. Studies on trauma in the Philippines used Western-based assessment tools that may not fully capture the culture-embedded nature of trauma experiences. However, only a few developed indigenous or culturally adapted instruments that reflect Filipino worldviews, spirituality, and relational

values in understanding distress and recovery. Additionally, existing studies focus on urban or disaster-affected areas, with limited attention to students' psychosocial experiences in BARMM. Students' emotional reactions and coping methods may differ because of cultural values, shared resilience, and faith-based practices that influence how they handle and view trauma. With this, the researcher aims to address the urgent need for culturally relevant psychological assessment tools in education, in line with Sustainable Development Goal (SDG) 3, which focuses on promoting health and well-being, especially mental health. The development of a Context-Specific Culturally Sensitive Trauma (CSeCT) Scale will provide a valid and reliable assessment tool for trauma that reflects the cultural realities, beliefs, and coping practices of BARMM students. This research will help promote inclusive, fair, and culturally responsive mental health services in the Philippine settings, supporting well-being and resilience in line with SDG 3 goals.

The researcher will submit the developed and validated trauma assessment tool to the recognized academic journals. Furthermore, seminar-workshops will be organized on trauma assessment awareness and promoting trauma-informed practices to the professionals dealing with trauma-affected individuals. The findings will be presented at local and international research forums to increase awareness and trauma preparedness, particularly among mental health practitioners.

Research Questions

The study aims to develop and validate a Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale using an exploratory-sequential design. It seeks to create a meaningful, reliable, and valid instrument that captures how individuals from armed conflict–affected communities experience, express, and cope with trauma shaped by their cultural beliefs and lived realities. Specifically, the study seeks to answer the following research questions:

1. How do college students describe their experience of trauma in an armed conflict environment?
2. What are the underlying dimensions of trauma?
3. Do the dimensions of traumatizing experience exhibit parsimonious fit?
4. Based on the analysis of the results, what measurement tool is suitable for assessing the trauma among students in an armed conflict environment?
5. Does the result utilizing the tool realize what is intended to measure in terms of the difference between groupings of variables included in the title?

6. In what way do quantitative results generalize the qualitative findings?

METHODS

Mixed methods research was an approach that combines both qualitative and quantitative data in a single study or across multiple studies on the same topic (Creswell & Clark, 2017; Terrel, 2012). According to Creswell and Clark (2017), mixed-methods designs were used in scale development and validation to ensure both theoretical rigor and psychometric evidence, drawing on the strengths of both approaches. The qualitative phase helps identify the constructs to be measured based on the lived experiences of the target populations, ensuring content validity (DeVellis, 2016). Meanwhile, the quantitative phase tests the psychometric properties of the scale, confirming its construct validity and completing the overall refinement of the scale (Creswell & Clark, 2017). Using mixed methods allows researchers to capture the complexity of a phenomenon, ensuring that the developed scale is not only statistically reliable but also meaningful and relevant.

This research employed an exploratory-sequential approach, a mixed-methods research design, and an integration of qualitative and quantitative methods to achieve a deeper exploration of armed conflict trauma experiences of the respondents. According to Creswell and Plano Clark (2018), the exploratory-sequential mixed methods start with the collection and analysis of qualitative data that serve as the foundation in identifying themes, patterns, and variables. This process involves Focus Group Discussion (FGD) with the participants having direct and indirect experiences of armed conflict. The qualitative findings was the basis for generating culturally sensitive items that reflect manifestations of trauma. The themes was translated in a measurable items for preliminary development of a Context-Specific Culturally Sensitive Trauma (CSecT) Scale, and tested in a sample populations with direct and indirect armed conflict exposure. Ensuring that the scale is theoretical sound, and rooted from socio-cultural and historical realities on armed conflict affected communities that will enhance the validity, relevance and practical utility of the tool. This tool was potential for both policy and practice in post-conflict mental health interventions.

The quantitative phase of this study employed the rigorous dimensions of trauma identified during the qualitative phase. Data gathered through structured survey questionnaire that captured the multidimensional aspects of armed conflict trauma. Statistical procedure was established for the psychometric properties of the (CSeCT) Scale (DeVellis, 2017; Boating et al., 2018). Exploratory Factor Analysis (EFA) was utilized to uncover the underlying factor structure of the instrument by examining how various questionnaire items group together to form distinct factors or dimensions. With this, the researcher determined prior knowledge about the data's structure

and explores patterns or relationships between variables without pre-determined hypotheses about the factor structure, which accurately captures the key constructs related to trauma. Reliability analysis, specifically through the application of Cronbach's alpha, was used to evaluate the internal consistency of the instrument in order to determine whether the items within each scale or subscale are interrelated, indicates whether measures the same underlying construct. Ensuring function cohesively as a group, enhance the reliability and overall quality of the instrument. This was crucial in establishing the reliability of the factors accurately represent the underlying structure of the data and align with the theoretical framework of the study.

RESULTS

Profile of the Participants

Presented in Table 1.1 was the profile of the respondents. A total of twenty-four participants, fifteen involved in In-Depth interviews (IDI), and nine for Focus Group Discussions (FGD). Participants were grouped by

Table 1.1

Profile of the Participants

Code	Year Level	Age	Location
In-Depth Interviews			
IDI-A1	4	23	Marawi City
IDI-A2	1	18	Marawi City
IDI-A3	2	20	Marawi City
IDI-A4	3	21	Marawi City
IDI-A5	1	18	Marawi City
IDI-B1	3	22	Maguindanao
IDI-B2	2	21	Maguindanao
IDI-B3	4	24	Maguindanao
IDI-B4	2	21	Maguindanao
IDI-B5	1	19	Maguindanao
IDI-C1	3	24	Cotabato City
IDI-C2	4	25	Cotabato City
IDI-C3	2	20	Cotabato City
IDI-C4	1	19	Cotabato City
IDI-C5	4	25	Cotabato City
Focus Group discussions			
FGD-A1	2	21	Marawi City
FGD-A2	2	21	Marawi City
FGD-A3	1	18	Marawi City

FGD-B1	1	18	Maguindanao
FGD-B2	2	20	Maguindanao
FGD-B3	2	21	Maguindanao
FGD-C1	2	20	Cotabato City
FGD-C2	2	19	Cotabato City
FGD-C3	2	20	Cotabato City

university location. To protect the identities of the participants, codes were assigned based on university location, IDI-A and FGD-A for Marawi City, IDI-B and FGD-B for Maguindanao, and IDI-C and FGD-C for Cotabato City.

The table 1.1 was the profile of the twenty-four participants in this study, where six participants coming from first year, eleven from second year, three from third year and 4 from fourth year level ages from 18 to 25 years old. Cotabato City group had older participants, which ages ranges 19 to 25 years old.

This descriptive presentation provided a diverse participant base on their ages, academic levels, and location that captured rich insights into individual experiences, shared perspectives, and group dynamics, enhancing the comprehensiveness and credibility of the data.

Descriptions of the Lived Experiences

Participants in Armed Conflict Area

Presented in Table 1.2 the six essential themes generated from narratives of the participants and from in-depth interviews and focus group discussions which includes: hyperarousal and persistent fear; intrusive distress and cognitive disruption; functional and physiological impact; relational trust and social disruption; faith-anchored meaning and spiritual regulation; and coping behaviors, highlighting the raw questionnaires items of the study.

Hyperarousal and Persistent Fear. Participants described their experiences during and after the armed conflict as marked by a constant fear, alertness, and intense emotional and physical reactions. Many participants shared that loud sounds, such as gunfire and explosions, and even ordinary sounds, could trigger their reactions, causing them to panic or become suddenly alert. This sound served as a powerful reminder of the conflict, reliving their fear. These responses indicate a heightened state of physiological and psychological alertness, commonly associated with hyperarousal, a condition in which participants become easily startled,

Table 1.2

Descriptions of Lived Experiences of the Participants on Armed Conflict Area

Essential Themes	Raw Questionnaire Items

Hyperarousal and Persistent Fear	I easily become frightened when I hear sudden loud sounds
	My body reacts strongly when I am reminded of past conflict
	I feel tense even in situations that seem safe.
	I quickly panic when something reminds me of gunfire.
	I remain alert because I worry violence might happen again.
	Loud noises still make me feel unsafe.
Intrusive Distress and Cognitive Disruption	Memories of the conflict suddenly come back to my mind.
	I sometimes blank out when I remember the conflict.
	I have difficulty concentrating because of past events
	I feel mentally overwhelmed when thinking about the conflict.
	Thoughts about the conflict interfere with my daily thinking.
	I overthink about possible dangers around me.
Functional and Physiological Impact	I avoid going out because I do not feel safe
	My sleep has been disturbed since the conflict.
	I sometimes lose my appetite when I feel afraid.
	The conflict affected my ability to focus on my studies or work.
	My body becomes tense when I recall the conflict.
	I feel physically exhausted because of stress related to the conflict.
Relational Trust and Social Disruption	I find it hard to trust unfamiliar people.
	I feel uneasy when strangers enter our community.
	I sometimes withdraw from social interactions
	My relationships with others changed after the conflict.
	I prefer to stay close only to people I deeply trust.
	I became more cautious in dealing with other people.
Faith-Anchored and Spiritual Regulation .	My faith in Allah/God became stronger after the conflict.
	Prayer helps calm my fears related to the conflict.
	I entrust my worries to Allah/God when I feel afraid.
	My religious beliefs give me hope despite what happened
	Spiritual practices help me manage painful memories.
	My faith helps me continue moving forward.
Coping Behaviors	I keep myself busy to avoid thinking about the conflict.
	Talking with family or friends helps reduce my fear.
	I try to suppress memories of the conflict.
	Spending time with others makes me feel safer.
	I focus on positive activities to help myself recover.
	I try to convince myself to move on from what happened.

remain constantly vigilant, and become emotionally reactive to potential threats even in safe environments.

The participants also exhibited persistent fear manifested as continuous worry, nervousness, and emotional distress. Some participants found it difficult to sleep, concentrate, or feel at ease, and were preoccupied with the possibilities of recurring conflict. The combination of hyperarousal and persistent fear suggests that participants have not fully regained a sense of safety, as their experiences during the conflict. These reactions stem from the exposure to armed conflict, where unpredictable violence conditioned them to remain constantly alert for danger.

During the In-Depth Interviews (IDI) and Focus Group Discussions (FGD), the participants shared that:

> *I easily panic or trigger po every time po na nakakarining po ako ng nahuhulog or ginugulat po ako. (FGD-A1)*
>
> I easily panic or get triggered whenever I hear something falling or when I am suddenly startled
>
> *Grabe yung takot na nararamdaman ko that time since I was still young. Paulit-ulit na sabog ng bombs and guns."* (IDI-A1)
>
> Intense fear at that time because I was still young,
> The explosions of bombs and gunfire keep happening
> Repeatedly.
>
> *Kahit konting putok lang umiiyak na ako, Naranasan ko po hirap, kawalan ng lakas, kawalan ng gana.* (IDI-A3)
>
> Even just a small gunshot would make me cry.
> I experienced hardship, weakness, and
> loss of motivation
>
> *Hanggang ngayon pag nakakarinig ako ng putok nandoon pa rin yung takot na baka maulit na naman yung nangyari.* (FGD-A3)
>
> Even now, whenever I hear a loud sound, the fear is still there…. might happened again.
>
> *kasagsagan ng putukan po ay nasa bahay po kami and we don't given a time to go in safe place*. (FGD-A1)
>
> During gunfire,were at home and were not given time to go to a safe place.

The hyperarousal and persistent fear theme emphasized the impact of violence among the participants. It reflected the pervasive state of heightened alertness, startle responses, sleep disturbances, and emotional reactivity experienced by the survivors, particularly those who are repeatedly exposed to threats and instability. The theme emphasized how prolonged exposure to armed conflict disrupts the sense of safety, which will lead to anxiety, vigilance, and even fear in non-threatening situations. The integration of trauma-informed perspectives with culturally sensitive interventions addresses not only distress but also rebuilds trust, restores emotional regulation, and fosters resilience, which are essential for psychological healing and promote long-term well-being and sustainable peace.

Intrusive Distress and Cognitive Disruption. The second theme reflected how the memories of armed conflict interrupted their daily functioning, affecting their ability to focus. Participants shared that they would experience moments of blanking out and become mentally absent which reflect how their attention disrupted when intrusive memories surface, being pulled back into past experiences which interferes their concentration which triggers when hearing loud sounds would intensify their experiences by bringing back memories associated with the conflict, these sudden memories of the participants described as mentally overwhelmed when thinking about the conflicts. These thoughts were often persistent and difficult to control, affecting emotional state and sense of safety.

During the In-Depth Interviews and focus group discussions, the participants expressed that:

> *Naapektuhan po and aking pag aaral dahil sa experience na naranasan kona yon, like natutulala kana lang bigla. (IDI-A2)*
>
> My studies were affected by what I experienced, sometimes I would just suddenly mental block
>
> *minsan natutulala ako kapag naiisip ko yung dating nangyari. (IDI-A5)*
>
> Sometimes I find myself staring blankly when I remember what happened
>
> *hanggang ngayon dala-dala ko parin yong trauma lalo na pag may putok akong naririnig. (IDI-B2)*
>
> Until now I still feel trauma especially hearing loud gunshots *(IDI-B2)*

I become anxious easily and feel unsafe in stressful situations. (FGD-B1)

There are moments when I remember the events, and it makes me feel nervous or unsafe even if things are already calm.(FGD-C2)

This lived experiences become evident that participants are experiencing intrusive distress and cognitive disruption appear as psychological effects of armed conflict. This intrusive distress is reflected in the unwanted and recurring memories that suddenly appear in their minds, while cognitive disruption is seen in their difficulty concentrating, mental blanking, and reduced ability to stay focused in daily activities. The participant's intrusive memories interfere with academic performance, work productivity, relationships, and overall well-being. Participants' lived experiences affect their focus on daily routine activities. The theme highlights the persistence of intrusive memories and difficulty concentrating, showing how trauma continues to influence how they feel and function in their everyday lives.

*Functional and Physiological Impact***.** The third theme emerged from narratives of the participants, affecting their daily functioning, physical well-being, and quality of life. Participants reported avoiding going out due to fear; their basic routines, such as eating and sleeping, were disrupted, challenges being a student, particularly during displacement, and they were unable to relax because their bodies easily trembled. These impacts were evident in their daily routines, bodily reactions, and ability to carry out everyday activities.

The following was shared during the In-Depth Interviews and focus group discussions:

hindi kami pinapalabas sa bahay kasi baka daw may mangyari sa amin na masama. IDI-B1)

We were not allowed to leave the house because they said something bad might happen to us.

naranasan kong malimutan kumain for that situation I experience. (IDI-B3)

I experienced forgetting to eat because of the situation I went through.

nanginginig buong katawan like natatakot po talaga ako sa sobrang takot. (IDI-A2)

My whole body trembles because I am
so scared.

sa pag tulog ko is yung bigla-bigla kanalang nagigising sa kalagitnaan ng gabi. (IDI-A2)
I suddenly wake up in the middle of
the night. (FGD-B3)

When we evacuate our life get harder and my family members become traumatic, and also our studies got disturbed.

These themes highlight how the armed conflict affects the daily functioning and physical responses of the participants. These lived experiences show how armed conflict interferes pattern of functional and physiological impacts. These reactions suggest that their bodies and minds are influenced by past experiences, showing how trauma continues to shape their lives, and care for themselves even after the conflict.

*Relational Trust and Social Disruption***.** The fourth theme that emerged was the relational trust and social disruption that shaped from experiences of the participants during armed conflict. Participants described how experiences of armed conflict affect them and how they relate to others. Several participants expressed that after the conflict, they found it difficult to interact with people from outside the community, had limited interaction with others, and became more suspicious and cautious. These reactions among participants imply heightened vigilance in social situations, where unfamiliar individuals are perceived as potential sources of danger

Participants shared that:

For me I only trust now is only my family, relatives because of that expereince its so hard to trust other people.(IDI-A1)

naapektuhan yung interaction ko sa iba kasi dina masyado nakalalabas kasi andun yong takot na baka biglang magbarilan. (IDI-B2)

My interactions with others were affected because I have fear of going outside might gunfire suddenly happen.

madalas nagdududa kapag may mga taong dumadayo na hindi kilala. (FGD-B1)

I feel suspicious whenever unfamiliar
people come around.

This shows that the relational trust and functional disruption highlighted the impact of armed conflict on interpersonal relationships of the participants and on community cohesion. This was an indication that armed conflict lived experiences, displacement, and the loss of social networks strained family bonds and changed trust toward others, reshaping social dynamics, underscoring the significant role of trust in sustaining emotional stability.

*Faith-Anchored Meaning and Spiritual Regulation***.** The fifth essential theme underscores the role of faith and spiritual practices in helping armed conflict survivors face the challenges and disruptions. Participants described their experiences led them to deeply believe in their faith as a way of coping, brought them closer to Allah, and provided them with a sense of hope and safety, even during and after the most frightening moments. These lived experiences show that the participants not only endured the conflict but also sought meaning and emotional stability through spiritual beliefs and practices.

Participants shared that:

> *Mas nagtibay pa ang aking paniniwala sa ' Allah Taala. (IDI-C2)*
>
> My faith in Alah Ta'ala has become even stronger
>
> *Si Allah na bahala sa akin sa tuwing naiisip ko yong pangyayari na yon nagdarasal na lang ako*. (IDI-C3)
>
> I leave everything to Allah whenever I think about what happened, I am just praying
>
> *Mas napalapit pa kami sa Allah dahil sa gabay na binigay niya sa amin dahil nangyari sa amin noong araw ng bakbakan* .(IDI-C4)
>
> We become closer to Allah He gave guidance whatever happened during the conflict.
>
> *The conflict made me trust my faith more because it helped me feel hope and safety*. (FGD-B1)
>
> *The armed conflict strengthened my faith because I turned to prayer and reflection to feel safe and calm during those scary times.* (FGD-C2)

The faith-anchored meaning and spiritual regulation theme emphasized the importance of faith and spiritual practices in helping survivors of armed conflict find purpose, hope, and emotional stability. The findings revealed that the exposure to armed conflict survivors relies on prayer, religious beliefs, and spiritual reflection in order to manage fear, cope with loss, and strengthen resilience. From these lived experiences, was an evident that participants engaged in what can be understood as faith-anchored meaning and spiritual regulation. This demonstrates that the spiritual practices and beliefs provide a source of strength, comfort, and stability, helping them maintain hope and emotional balance in the face of adversity.

*Coping Behaviors***.** This sixth essential theme concerns how participants manage fear, distress, and disruptions to everyday activities arising from experiences of armed conflict. Participants expressed efforts to avoid or suppress distressing memories as a way to reduce emotional pain. Engaging in daily routines, hobbies, or school-related tasks helped them redirect their attention away from distressing memories, and talking to trusted individuals also provided emotional relief and a sense of safety.

Respondents shared that:

> *I tried my best to forget the experience and the feelings*. (IDI-A1)
>
> *And nililibang ko sarili ko and bonding with my family*. (IDI-A2)
>
> I keep myself happy and bond with my family
>
> *I coped by talking to people I trust, staying busy with school and hobbies, and trying to stay positive. I also spent time with my family and friends. (*FGD-B1)
>
> *Though communicating by individually and expressing my traumatic memories for my closeness friend and people that I know I can trust with my emotions*. (FGD-C3)

These narratives demonstrate that coping behaviour refered to the strategies used to regulate their emotions, reduce distress, and adapted challenging situations. This was an indication that the participants overcome fear by using such coping mechanisms and building resilience. This means that armed conflict survivors still stand up after the aftermath of the conflict and actively respond to it, using various strategies to regain emotional balance, maintain daily functioning, and rebuild a sense of stability in their lives.

Underlying Dimensions of Context-Specific

Culturally Sensitive Trauma Scale

Table 2.1 illustrates a 36-item core idea developed from the narratives of the participants during In-Depth interviews and focus group discussions. The core ideas underwent content validation to assess the adequacy of its items in measuring the intended constructs. Six experts, including two psychologists, two guidance counselors, one social worker, and one peace and development advocate, evaluated the tool. Each item was rated using a 4-point Likert scale: for relevance: (4=highly relevant, 3=quite relevant, 2=somewhat relevant, and 1=not relevant); for clarity: (4=very clear, 3=needs minor revision, 2=needs major revision, and 1=not clear), and for cultural appropriateness: (4=highly culturally appropriate, 3=acceptable but needs minor revision, 2=needs major revision, and 1=not culturally appropriate). The Item-Level Content Validity Index (I-CVI) and Scale-Level Content Validity (S-CVI/Ave) were computed to assess the adequacy of the instrument. The I-CVI value of .83 or higher is considered acceptable.

Table 2.1 showed that the majority of items achieved an I-CVI of 1.00, indicating unanimous agreement among expert validators on relevance and cultural appropriateness. Items that have minor clarity concerns but still exceeded the acceptable threshold of .88 for six validators. The Scale-Level Content Validity Index (S-CVI/average) ranges from .96 to .98, indicating that all items are accepted and had an excellent overall content validity. No items were removed; therefore, the instrument was suitable for pilot testing and further psychometric analyses, including Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) to determine whether the six factors function independently or cluster into broader domains. The finalized tool was administered to 200 identified survivors of armed conflict in the affected area in BARMM.

Table 2.1
Content Validity Index of the CSeCT Scale

Factor	Number of Items	I-CVI Range	Mean I-CVI	Interpretation
Hyperarousal and Persistent Fear	6	.80-1.00	.96	Excellent
Intrusive Distress And Cognitive Disruption	6	.80-1.00	.94	Excellent
Functional and Physiological				

Impact	6	.83-1.00	.95	Excellent
Relational Trust And Social Disruption	6	1.00	1.00	Excellent
Faith-Anchored Meaning and Spiritual Regulation	6	1.00	1.00	Excellent
Coping Behaviors	6	.83-1.00	.95	Excellent
Overall S-CVI	**36**	**--**	**.96-98**	**Excellent**

Note: I-CVI values were interpreted as follows: 0.83-1.00=Excellent; 0.66-0.82=Acceptable; Below 0.65=Needs Revision

Presented in Table 2.2, the checklist administered to 200 respondents who experienced armed conflict. It consisted of 4 sections: Informed Consent, a letter to the respondents, information and instructions, CSeCT items, and background information of the respondents. Respondents were instructed to read the purpose and directions before indicating their level of agreement with each item using a five-point Likert Scale: 5=Strongly Agree, 4=Agree, 3=Neutral, 2=Disagree, and 1=Strongly Disagree. The background information was provided by the respondents, such as school, age, gender, and place of origin. Respondents will also be asked to confirm that they had read and understood the privacy statements and voluntarily consented to the collection and secure use for research purposes only.

The core ideas of the scale items reflected manifestations of trauma-related reactions experienced from armed conflict and distressing events. These included being frightened by sudden loud sounds, intense physical reactions when recalling past conflict experiences, persistent tension in seemingly safe situations, rapid panic in response to gunfire, ongoing hypervigilance due to fears of violence, and feelings of insecurity triggered by loud noises. These indicators reflect traumatic experiences among participants.

The cognitive response items reflected how traumatic experiences influence the thought processes and mental functioning of the participants. These included the sudden flashbacks of the conflict, mental blank during distressing experiences, and trouble concentrating due to intrusive memories. The items experience mental overload, disruption of daily thought by conflict-related memories, and excessive concern toward

dangers, collectively reflecting cognitive disruptions with trauma-related exposure.

Table 2.2

Checklist for assessing the Development and Validation of CSeCT Scale

No.	CSeCT Items	Remarks
S1	I easily become frightened when I hear sudden loud sounds.	Retained
S2	My body reacts strongly when I am reminded of past conflict.	Retained
S3	I feel tense even in situations that seem safe.	Retained
S4	I quickly panic when something reminds me of gunfire.	Retained
S5	I remain alert because I worry violence might happen again.	Retained
S6	Loud noises still make me feel unsafe.	Retained
S7	Memories of the conflict suddenly come back to my mind.	Retained
S8	I sometimes blank out when I remember the conflict.	Retained
S9	I have difficulty concentrating because of past events.	Retained
S10	I feel mentally overwhelmed when thinking about the conflict.	Retained
S11	Thoughts about the conflict interfere with my daily thinking.	Retained
S12	I overthink about possible dangers around me.	Retained
S13	I avoid going out because I do not feel safe.	Retained
S14	My sleep has been disturbed since the conflict.	Retained
S15	I sometimes lose my appetite when I feel afraid.	Retained
S16	The conflict affected my ability to focus on my studies or work.	Retained
S17	My body becomes tense when I recall the conflict.	Retained
S18	I feel physically exhausted because of stress related to the conflict.	Retained
S19	I find it hard to trust unfamiliar people.	Retained
S20	I feel uneasy when strangers enter our community.	Retained
S21	I sometimes withdraw from social interactions.	Retained
S22	My relationships with others changed after the conflict.	Retained
S23	I prefer to stay close only to people I deeply trust.	Retained
S24	I became more cautious in dealing with other people.	Retained
S25	My faith in Allah/God became stronger after the conflict.	Retained
S26	Prayer helps calm my fears related to the conflict.	Retained
S27	I entrust my worries to Allah/God when I feel afraid.	Retained
S28	My religious beliefs give me hope despite what happened.	Retained
S29	Spiritual practices help me manage painful memories.	Retained
S30	My faith helps me continue moving forward.	Retained
S31	I keep myself busy to avoid thinking about the conflict.	Retained
S32	Talking with family or friends helps reduce my fear.	Retained
S33	I try to suppress memories of the conflict.	Retained

S34	Spending time with others makes me feel safer.	Retained
S35	I focus on positive activities to help myself recover.	Retained
S36	I try to convince myself to move on from what happened.	Retained

The traumatic experiences of the participants impacted physical well-being and daily functioning, such as staying indoors and avoiding outdoor activities for safety concerns, disrupted sleep, and loss of appetite because of fear. These was an indications that traumatic experiences affect the body and physical functioning, reflected in difficulties focusing on school and work, physical tension, and overall fatigue due to stress. Trusting unfamiliar people, social withdrawal, and altered personal relationships impacted their social functioning. In addition, reliance on faith and spiritual practices, including prayer and religious beliefs, was the sources of hope, emotional regulation, and resilience. Engagement in positive activities and seeking social support from family and friends were identified as strategies to manage fear and intrusive memories and to promote recovery. These indicators interplay with social, spiritual, and behavioural strategies in coping with conflict-related trauma.

Table 2.2 shows the result of the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett's Test of Sphericity.
Table 2.2 showed the adequacy of the sample and the suitability of the data for factor analysis were evaluated using the Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy. The KMO value was .949, which was considered excellent according to commonly accepted guidelines (values above .90 indicate superb sampling adequacy). These results suggested that the correlations among the variables are sufficiently compact and appropriate for factor analysis.

In addition, the individual KMO values for each item ranged from .907 to .972, all exceeding the recommended minimum threshold of .50, with most values falling within the .90 to .97 range, indicating very high sampling adequacy at the item level. These results demonstrated that each variable shared common variance with the other variables and contributed meaningfully to the underlying factor structure.
The KMO results indicated that the dataset meets the sampling adequacy assumption for exploratory factor analysis. Therefore, the correlation matrix was deemed suitable for factor extraction, supporting the validity of proceeding with the exploratory factor analysis reported in the previous results. An exploratory factor analysis (EFA) using JASP v. 95.4 was conducted to examine the factor structure of 36 items, using a Promax rotation. Results for the Chi-Square test of the instrument structure were statistically significant, $\chi^2(492) = 912.242$, $p < .001$, indicating that the correlation matrix was appropriate for factor extraction and items shared sufficient variance for factor analysis. The analysis yielded a four-factor solution based on the eigenvalue criterion. The unrotated eigenvalues indicated that Factor 1 had an eigenvalue of 16.75, Factor 2 had an

eigenvalue of 4.46, Factor 3 had an eigenvalue of 1.15, and Factor 4 had an eigenvalue of 0.75. Although the fourth factor had an eigenvalue below 1.00, it was retained based on theoretical considerations, interpretability, and contextually relevant factor structure.

Table 2.2

Kaiser-Meyer-Olkin Test

		MSA
	Overall MSA	0.949
S1	I easily become frightened when I hear sudden loud sounds.	0.930
S10	I feel mentally overwhelmed when thinking about the conflict.	0.956
S11	Thoughts about the conflict interfere with my daily thinking.	0.962
S12	I overthink about possible dangers around me.	0.961
S13	I avoid going out because I do not feel safe.	0.949
S14	My sleep has been disturbed since the conflict.	0.953
S15	I sometimes lose my appetite when I feel afraid	0.951
S16	The conflict affected my ability to focus on my studies or work.	0.950
S17	My body becomes tense when I recall the conflict.	0.967
S18	I feel physically exhausted because of stress related to the conflict.	0.959
S19	I find it hard to trust unfamiliar people.	0.929
S2	My body reacts strongly when I am reminded of past conflict	0.950
S20	I feel uneasy when strangers enter our community	0.955
S21	I sometimes withdraw from social interactions.	0.960
S22	My relationships with others changed after the conflict.	0.967
S23	I prefer to stay close only to people I deeply trust.	0.914
S24	I became more cautious in dealing with other people	0.949
S25	My faith in Allah/God became stronger after the conflict.	0.921
S26	Prayer helps calm my fears related to the conflict.	0.927
S27	I entrust my worries to Allah/God when I feel afraid.	0.923
S28	My religious beliefs give me hope despite what happened.	0.954
S29	Spiritual practices help me manage painful memories.	0.963
S3	I feel tense even in situations that seem safe.	0.964
S30	My faith helps me continue moving forward.	0.929
S31	I keep myself busy to avoid thinking about the conflict.	0.950
S32	Talking with family or friends helps reduce my fear.	0.934
S33	I try to suppress memories of the conflict	0.970
S34	Spending time with others makes me feel safer.	0.943
S35	I focus on positive activities to help myself recover.	0.927
S36	I try to convince myself to move on from what happened	0.965
S4	I quickly panic when something reminds me of gunfire.	0.956

S15	I sometimes lose my appetite when I feel afraid	0.959
S6	Loud noises still make me feel unsafe.	0.907
S7	Memories of the conflict suddenly come back to my mind	0.958
S8	I sometimes blank out when I remember the conflict.	0.972
S9	I have difficulty concentrating because of past events	0.953

Summary of Kaiser-Meyer-Olkin Measure

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.949
Bartlett's Test of Sphericity	Approx. Chi-Square	912.242
	Df	492
	Sig.	< .001

Table 2.3 presents the communalities of the context-specific, culturally sensitive trauma items extracted using Principal Axis Factoring (PAF). The values indicated the proportion of variance in each item explained by the extracted factors. Initial values represented the total variance of each item before extraction, while extraction values showed the variance accounted for by the retained factors.

The communalities showed that each trauma-related item was represented by the factors extracted using Principal Axis Factoring (PAF). Items had moderate to high extraction values, ranging from **.**501 to .813, suggesting that the retained factors adequately accounted for a substantial proportion of the variance in most items. Several items, such as S14 (0.813), S27 (0.782), S11 (0.765), and S28 (0.754)**,** exhibit particularly high communalities, indicating that these items are strongly represented by the underlying factor structure. This suggested that these indicators are closely aligned with the latent constructs of the instrument. However, few items displayd relatively lower communalities, including S36 (0.371), S24 (0.470), and S3 (0.497). These values suggest that a smaller proportion of their variance was explained by the extracted factors. Although these

Table 2.3.

Commonalities

Item No.	Scale Items	Extraction
S1	I easily become frightened when I hear sudden loud sounds.	.584
S2	My body reacts strongly when I am reminded of past conflict.	.596
S3	I feel tense even in situations that seem safe.	.497
S4	I quickly panic when something reminds me of gunfire.	.568
S5	I remain alert because I worry that violence might happen again.	.501
S6	Loud noises still make me feel unsafe.	.563

S7	Memories of the conflict suddenly come back to my mind.	.610
S8	I sometimes blank out when I remember the conflict.	.705
S9	I have difficulty concentrating because of past events.	.727
S10	I feel mentally overwhelmed when thinking about the conflict.	.736
S11	Thoughts about the conflict interfere with my daily thinking.	.765
S12	I overthink about possible dangers around me.	.554
S13	I avoid going out because I do not feel safe.	.685
S14	My sleep has been disturbed since the conflict.	.813
S15	I sometimes lose my appetite when I feel afraid.	.700
S16	The conflict affected my ability to focus on my studies or work.	.696
S17	My body becomes tense when I recall the conflict.	.726
S18	I feel physically exhausted because of stress related to the conflict.	.580
S19	I find it hard to trust unfamiliar people.	.583
S20	I feel uneasy when strangers enter our community.	.675
S21	I sometimes withdraw from social interactions.	.563
S22	My relationships with others changed after the conflict.	.531
S23	I prefer to stay close only to people I deeply trust.	.531
S24	I became more cautious in dealing with other people.	.470
S25	My faith in Allah/God became stronger after the conflict.	.734
S26	Prayer helps calm my fears related to the conflict.	.730
S27	I entrust my worries to Allah/God when I feel afraid.	.782
S28	My religious beliefs give me hope despite what happened.	.754
S29	Spiritual practices help me manage painful memories.	.711
S30	My faith helps me continue moving forward.	.720
S31	I keep myself busy to avoid thinking about the conflict.	.652
S32	Talking with family or friends helps reduce my fear.	.623
S33	I try to suppress memories of the conflict.	.663
S34	Spending time with others makes me feel safer.	.700
S35	I focus on positive activities to help myself recover.	.702
S36	I try to convince myself to move on from what happened.	.371

Extraction Method: Principal Axis Factoring

values fall slightly below the commonly recommended threshold of 0.50**,** they may still be retained because theoretically grounded and contextually relevant.

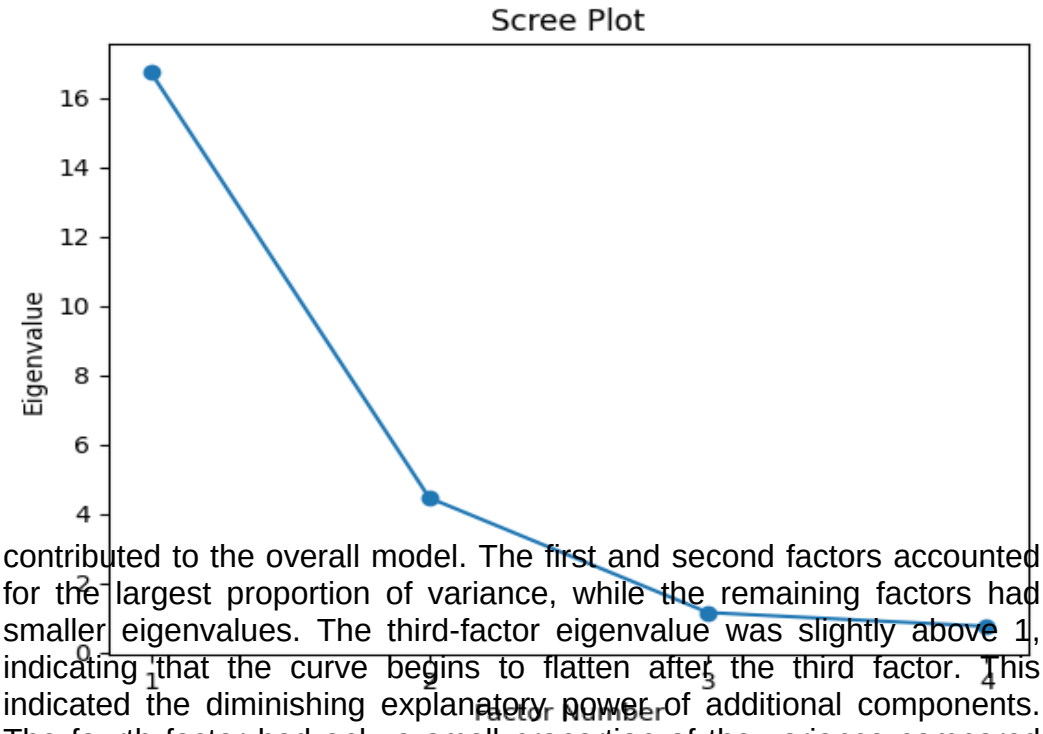
The communalities indicated that the extracted four-factor solution provided an adequate representation of the dataset variance, supporting the suitability of the retained factors for explaining the underlying dimensions of the instrument, which produced a reliable and meaningful

solution for identifying the underlying emotional, cognitive, physiological, social, and spiritual responses to trauma.

The Figure 4 showed the scree plot showed the distribution of eigenvalues across the extracted factors for the Armed Conflict Trauma Response Scale. The scree plot was commonly used in exploratory factor analysis to determine the optimal number of factors to retain based on the pattern of eigenvalues.

The scree plot displayed the eigenvalues associated with each extracted factor in descending order. As shown in Figure 4, there was a steep decline from Factor 1 to Factor 2**,** followed by a more gradual decrease from Factor 2 to Factor 3, after which the curve began to level off. This pattern indicated the "elbow" point of the scree plot**;** factors

Figure 5
Scree Plot



contributed to the overall model. The first and second factors accounted for the largest proportion of variance, while the remaining factors had smaller eigenvalues. The third-factor eigenvalue was slightly above 1, indicating that the curve begins to flatten after the third factor. This indicated the diminishing explanatory power of additional components. The fourth factor had only a small proportion of the variance compared with the first and second factors.

The scree plot displayed the eigenvalues associated with each extracted factor in descending order. As shown in Figure 4, there was a steep decline from Factor 1 to Factor 2**,** followed by a more gradual decrease from Factor 2 to Factor 3, after which the curve began to level off. This pattern indicated the "elbow" point of the scree plot**;** factors contributed to the overall model. The first and second factors accounted

for the largest proportion of variance, while the remaining factors had smaller eigenvalues. The third-factor eigenvalue was slightly above 1, indicating that the curve begins to flatten after the third factor. This indicated the diminishing explanatory power of additional components. The fourth factor had only a small proportion of the variance compared with the first and second factors.

The scree plot showed empirical support for the four-factor structure of trauma responses associated with armed conflict exposure. This was an indication that the dimensions of trauma, such as intrusive distress and functional impairment, faith-anchored coping and social regulation, hyperarousal and trauma reactivity, and interpersonal distrust and community were manifestations of trauma. The four-factor structure offered a meaningful framework for understanding the multidimensional nature of trauma experiences among individuals exposed to armed conflict and supported the development of the scale.

Table 2.4 presented the pattern matrix obtained using the Principal Axis Factoring (PAF) extraction method with Promax rotation and Kaiser normalization converging iterations.

Table 2.5

Factor Loadings					
	Factor 1	Factor 2	Factor 3	Factor 4	Uniqueness
S14. My sleep has been disturbed since the conflict.	0.998				0.187
S15. I sometimes lose my appetite when I feel afraid	0.927				0.300
S9. I have difficulty concentrating because of past events	0.919				0.273
S10. I feel mentally overwhelmed when thinking about the conflict.	0.864				0.264
S17. My body becomes tense when I recall the conflict.	0.860				0.274
S16. The conflict affected my ability to focus on my studies or work.	0.851				0.304
S13. I avoid going out because I do not feel safe.	0.849				0.315
S11. Thoughts about the conflict interfere with my daily thinking.	0.804				0.235
S8. I sometimes blank out when I remember the conflict.	0.678				0.295
S21. I sometimes withdraw from social interactions.	0.610				0.437
S18. I feel physically exhausted because of stress related to the conflict.	0.604				0.420
S22. My relationships with others changed	0.600				0.467

after the conflict.					
S12. I overthink about possible dangers around me.	0.599				0.446
S26. Prayer helps calm my fears related to the conflict.		0.929			0.270
S27. I entrust my worries to Allah/God when I feel afraid.		0.928			0.218
S28. My religious beliefs give me hope despite what happened.		0.912			0.246
S25. My faith in Allah/God became stronger after the conflict.		0.907			0.266
S29. Spiritual practices help me manage painful memories.		0.883			0.289
S30. My faith helps me continue moving forward.		0.812			0.280
S35. I focus on positive activities to help myself recover.		0.790			0.298
S34. Spending time with others makes me feel safer.		0.771			0.300
S31. I keep myself busy to avoid thinking about the conflict.		0.691			0.348
S32. Talking with family or friends helps reduce my fear.		0.674			0.377
S33. I try to suppress memories of the conflict.		0.619			0.337
S36. I try to convince myself to move on from what happened		0.549			0.629
S24. I became more cautious in dealing with other people		0.442			0.530
S23. I prefer to stay close only to people I deeply trust.		0.423		0.417	0.469
S1. I easily become frightened when I hear sudden loud sounds.			0.831		0.416
S2. My body reacts strongly when I am reminded of past conflict			0.680		0.404
S4. I quickly panic when something reminds me of gunfire.			0.631		0.432
S6. Loud noises still make me feel unsafe.			0.605		0.437
S5. I remain alert because I worry that violence might happen again.			0.596		0.499
S7. Memories of the conflict suddenly come back to my mind			0.466		0.390
S3. I feel tense even in situations that seem safe.			0.404		0.503
S20. I feel uneasy when strangers enter our community				0.556	0.325
S19. I find it hard to trust unfamiliar people.				0.521	0.417

Extraction Method: Principal Axis Factoring; Rotation Method: Promax with Kaiser Normalization; Rotation converged in 10 iterations

Table 2.4 shows the four identified factors that explain the underlying structure of the 36-item context-specific culturally sensitive conflict trauma scale. Each factor represented the dimension of trauma responses of the participants exposed to armed conflict. The items were

retained based on the minimum factor loading threshold of .40**,** which is the recommended cut-off for interpretation in social science research. However, Item 23 exhibited cross-loading on multiple factors, warranting its removal from the scale.

Factor 1, the Intrusive Distress and Functional Impairment, comprises 13 items that reflect psychological, cognitive, and functional difficulties following armed conflict. This factor has a very strong loading, ranging from .599 to .998**,** indicating that these items are highly representative of the underlying construct. The strongest indicators are S14 (0.998), S15 (0.927), S9 (0.919), S10 (0.864), S17 (0.860), and S16 (0.851)**.** This shows that these items highlight traumatic experiences related to armed conflict, which may disrupt daily functioning, emotional regulation, and cognitive processing. Additional items such as S13 (0.849), S11 (0.804), S8 (0.678), S21 (0.610), S18 (0.604), S22 (0.600), and S12 (0.599) further capture the persistent psychological strain and behavioral withdrawal associated with conflict-related trauma. This emphasizes that this factor reflects the intrusive nature of trauma symptoms that interfere with the life and emotional well-being of the respondents**.**

Factor 2, Faith-Anchored Coping and Social Regulation, comprises 13 items. These items emphasize prayer, trust in Allah/God, spiritual beliefs, positive activities, and interpersonal support to regulate distress and maintain hope. This factor reflects strong to very strong loadings, ranging from **.**423 to .929. The items have strong indicators, including S26 (0.929), S27 (0.928), S28 (0.912), S25 (0.907), S29 (0.883), and S30 (0.812). This shows that faith and spiritual practices play an important role in coping with trauma-related stress**.** Some of the items contributing to the factor include S35 (0.790), S34 (0.771), S31 (0.691), S32 (0.674), S33 (0.619), and S36 (0.549)**,** which reflect behavioral coping strategies such as engaging in positive activities, seeking social support, and consciously attempting to move forward from traumatic experiences. Additional items, including S24 (0.442), also contributed to this factor, capturing aspects of interpersonal caution and selective trust following conflict exposure. Together, these items illustrate how faith, spirituality, and social interaction served as protective coping mechanisms in trauma recovery**.**

Factor 3, labelled as Hyperarousal and Trauma Reactivity, comprised seven items that expressed heightened emotional and physiological responses triggered by re-experiencing past conflict. These items capture lived experiences such as being startled by loud sounds, feeling unsafe even in calm environments, and experiencing**.** Factor loadings ranged from .404 to .831, indicating moderate to strong associations between the items and the construct. The items include S1 (0.831), S2 (0.680), S4 (0.631), S6 (0.605), and S5 (0.596), which had the

strongest indicator**.** This reflects physiological and emotional hyperarousal associated with trauma**.** Another contributing item was S7 (0.466), which reflects sudden recollection of traumatic memories, and S3 (0.404), which describes persistent tension even in situations that appear safe. These items reflect the respondents' sensitivity and fear responses that persist after prolonged exposure to armed conflict**.**

Factor 4, the Interpersonal Distrust and Community Vigilance**,** comprises two items that describe changes in social trust and perceptions of safety following conflict in their community. This captures feelings of uneasiness with unfamiliar individuals and difficulty trusting people outside the group**.** Items S19 (0.521) and S20 (0.556) showed moderate but meaningful loadings**,** suggesting that they represent a distinct dimension, grounded theoretically and contextually in the social and relational consequences of trauma. This factor reflects how exposure to conflict can heighten vigilance and caution in interpersonal relationships, shaping how individuals perceive safety and trust within their community.

The uniqueness values ranged from .187 to .629, indicating that most items accounted for a substantial proportion of their variance by the extracted factors. This means that the EFA results indicate the instrument has a multidimensional structure with four underlying factors, with most items exhibiting strong factor loadings and acceptable communalities. These results provide evidence that supports the construct validity of the scale, which justifies proceeding with confirmatory factor analysis (CFA) for future validation.

The final factor solution, yielding 35 items, were retained because each item had a factor loading of .40 or higher, which met the accepted threshold for inclusion in exploratory factor analysis. The four-factor structure implies that the CSeCT Scale captures the multidimensional nature of trauma responses to armed conflict. These four factors include intrusive distress and functional impairment, faith-anchored coping, hyperarousal, and interpersonal distrust**.** These factors represent how respondents psychologically, socially, and spiritually respond to conflict-related traumatic experiences.

Table 2.5

Factor Characteristics

The factor characteristics table showed the eigenvalues, percentage of variance explained, and the cumulative variance for both the unrotated and rotated factor solutions derived from the exploratory factor analysis of the Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale.

The table showed four factors in the unrotated solutions. Factor 1 had an eigenvalue of 16.746, accounting for 46.5% of the total variance and indicating the strongest factor in the scale. Factor 2 had an eigenvalue of 4.457, meaning 12.4 % of the total variance, Factor 3 had an eigenvalue of 1.149, explaining 3.2% of the total variance, and Factor 4 had an eigenvalue of 0.752, accounting for 2.1% of the variance. The four factors accounted for 64.2% of the total variance, indicating that they explained most of the variation in the responses.

After rotation, the total cumulative variance of the four factors remained the same at 64.2% of the total variance, indicating that the four-factor structure adequately represents the data. Specifically, Factor 1 contributed 27.1%, Factor 2 shared 23.0%, Factor 3 explained 9.5%, and Factor 4 accounted for 4.6% of the total variance. This means that the variance was distributed across the four factors.

Table 2.6

Factor Characteristics

	Unrotated solution			Rotated solution		
	Eigenvalue	Proportion var.	Cumulative	SumSq. Loadings	Proportion var.	Cumulative
Factor 1	16.746	0.465	0.465	9.749	0.271	0.271
Factor 2	4.457	0.124	0.589	8.268	0.230	0.500
Factor 3	1.149	0.032	0.621	3.423	0.095	0.596
Factor 4	0.752	0.021	0.642	1.664	0.046	0.642

The rotated factor loadings indicated that the items loaded strongly on their respective factors. For Factor 1, items S14, S15, S9, S10, S17, S16, S13, S11, S8, S21, S18, S22, and S12 demonstrated loadings ranging from .599 to .998. Factor 2 included items S26, S27, S28, S25, S29, S30, S35, S34, S31, S32, S33, S36, and S24 with loadings ranging from .423 to .929. Factor 3 consisted of items S1, S2, S4, S6, S5, S7, and S3 with factor loadings between .404 and .831. Finally, Factor 4 was defined by items S20 and S19, with loadings of .556 and .521, respectively. This indicates that the factor structure supports the four-factor solution, which captures the multidimensional nature of trauma responses in conflict-affected populations.

Presented in Table 2.6 the Factor Correlation Matrix, which examines the interrelationship of the identified factors. The factor correlation matrix showed positive relationships among the four factors of the Context-Specific Culturally Sensitive Conflict Trauma (CSeCT)**,** indicating that the trauma response dimensions were related but distinct constructs. The correlations ranged from .379 to .686**,** showing low to moderate relationships among the factors, which were still retained because they were theoretical and contextually relevant.

The first factor, Intrusive Distress and Functional Impairment, had the strongest relationship with the third factor, Hyperarousal (r = .686)**,** suggested that individuals who experienced intrusive memories, difficulty concentrating, and disruptions in daily functioning are also likely to show strong emotional and physical reactions to reminders of the conflict, such as fear, tension, and increased alertness.

The first factor also showed a moderate correlation with the second factor, Faith-Anchored Coping (r = .499)**,** indicating that individuals who experience distress may rely on faith, prayer, and support from family or friends to help manage their emotions and cope with painful memories. In addition, the first factor had a moderate relationship with the fourth factor, Interpersonal Distrust (r = .407)**,** suggesting that people experiencing psychological distress may also become more cautious or less trusting of others after conflict. The second factor, Faith-Anchored Coping, also showed moderate relationships with the other factors, including Hyperarousal (r = .476) and Interpersonal Distrust (r = .393)**,** indicating that while spiritual coping help individuals manage trauma, they are still connected to the emotional and physiological reactions caused by conflict experiences. Meanwhile, the third factor, Hyperarousal, showed a low-to-moderate relationship with Interpersonal Distrust (r = .379)**,** suggesting

Table 2.7

Factor Correlation Matrix

Factor	1	2	3	4
1. Intrusive Distress and Functional Impairment	1.000	.499	.686	.407
2. Faith-Anchored Coping	.499	1.000	.476	.393
3. Hyperarousal	.686	.476	1.000	.379
4. Interpersonal Distrust	.407	.393	.379	1.000

Extraction Method: Principal Axis Factoring; Rotation Method: Promax with Kaiser Normalization.

that individuals who frequently experience fear and heightened alertness may also become more cautious and watchful in their interactions with others in the community.

The use of Principal Axis Factoring (PAF) with Promax rotation and Kaiser normalization allows the scale factors to be related to each other. The results show that trauma responses are multidimensional but interconnected**,** including emotional distress, physical reactions, coping strategies, and social adjustment closely related and influence one another. These findings indicated that the CSeCT scale measures several aspects connected with the trauma experience of the respondents. This

means that the importance of addressing psychological, social, and spiritual dimensions supports trauma-informed support and interventions.

Factor Structure of the Questionnaire on CSeCT Scale

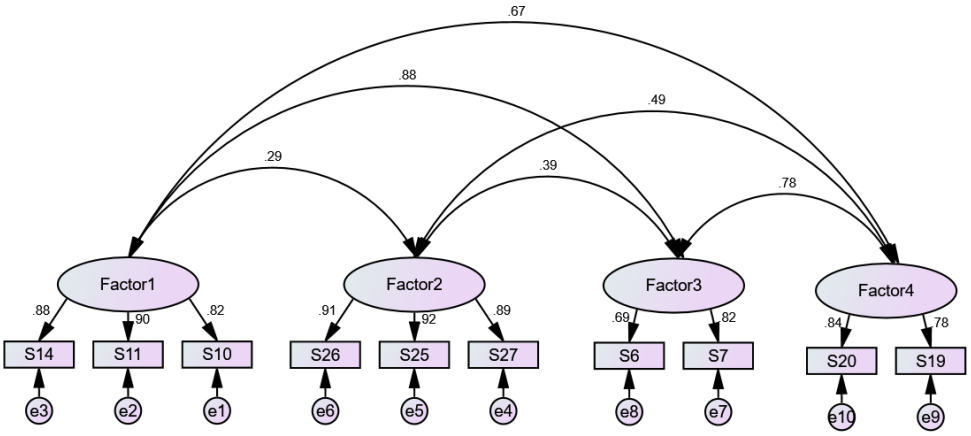
A Confirmatory Factor Analysis (CFA) was employed to assess and validate the factor structure of the CSeCT scale among students who experienced armed conflict. The 35-item scale was administered to 84 participants from State Universities whose communities had been affected by armed conflict. The purpose was to verify whether the items in the scale measure different aspects of trauma.

The Confirmatory Factor Analysis (CFA) model of the Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale, explained the 10 items were grouped and renamed into four factors, and the relationships between the four latent factors and their respective observed indicators.

Factor 1 Intrusive Distress and Functional Impairment was represented by three indicators: S14, S11, and S10 with strong standardized loadings of .88, .90, and .82, respectively. This means that the item values exceed the commonly accepted threshold of .60, implying that the items strongly represent experiences such as intrusive memories, emotional distress, and disruption in daily functioning are central manifestations of trauma responses among individuals exposed to conflict.

Factor 2 Faith-Anchored Coping includes S26, S25, and S27, with very strong loadings of **.**91, .92, and .89, respectively. This indicated that the items strongly represented the construct, demonstrating that reliance on faith, prayer, and spiritual belief systems plays a significant role in coping with the psychological consequences of armed conflict. The strength of these loadings suggested that faith-based coping mechanisms are a highly coherent dimension within the scale.

Figure 6
Best-Fit Model of CSeCT Scale



Factor 3 Hyperarousal includes two indicators, S6 and S7, with loadings of .69 and .82, respectively. Although S6 has a slightly lower loading compared to other items, it still exceeds the acceptable threshold and remained a meaningful indicator of trauma-related hyperarousal. These items captured physiological and emotional responses such as heightened vigilance, startle reactions, and sensitivity to environmental triggers following exposure to conflict.

Factor 4 Interpersonal Distrust was represented by S20 and S19, with strong loadings of .84 and .78, respectively. These values suggested that the items effectively measure the construct, reflecting how individuals may develop increased caution, distrust, or vigilance in social interactions following traumatic experiences related to armed conflict.

The covariances among the four latent factors indicated a meaningful relationships between different dimensions of trauma response. For instance, the relatively strong covariance between Factor 1 and Factor 2 (.88) suggests that individuals experiencing intrusive distress may also rely heavily on faith-based coping mechanisms. Moderate covariances among other factors (e.g., .49, .39, and .67) indicated that while the constructs were related aspects of trauma responses, they remained conceptually distinct dimensions within the multidimensional model.

The CFA results supported the structural validity of the four-factor CSeCT model, demonstrating that the items load strongly on their intended factors and tthe latent constructs were meaningfully related yet distinct. This confirmed that the scale effectively captures multiple dimensions of trauma responses in conflict-affected populations, including intrusive distress, faith-based coping, hyperarousal, and interpersonal vigilance, suitable for measuring the manifestation of trauma among students who experienced armed conflict.

Table 3.1 showed the Standardized Regression Weights (SRWs) of the four-factor (CSeCT) scale model. The SRWs presented a strong relationship between each item and reflect how well each item measures its underlying factor. All examined factor loadings were statistically significant at $p < .001$. Indicating that each item played an important role in measuring its factor, which contributed to the overall scale.

Table 3.1 revealed that Factor 1, Intrusive Distress and Functional Impairment, had standardized loadings ranging from .824 to .900, indicating a very strong relationship with the factor and clearly measuring the aspect of trauma. Among the items, S11 (β = .900) had the highest loading, indicating the most representative indicator of intrusive distress and the functional disruptions associated with conflict-related events. S14 (β = .881) and S10 (β = .824**)**, also showed strong relationships with the factor, reflecting the presence of intrusive thoughts, emotional distress, and cognitive disturbances. All factor loadings under Factor 1 exceeded the recommended threshold of .60, indicating a strong measure of the same construct and providing strong evidence of convergent validity.

Factor 2, Faith-Anchored Coping the standardized loadings range from **.**886 to .919. This reflected the very strong relationship between the items and the underlying coping construct. S25 (β = .919) had the highest loading, indicating the strongest item of faith-based coping and spiritual reliance or social resources in handling trauma. Similarly, S26 (β = .910) and S27 (β = .886) exhibited strong loadings, respectively, which reinforced the importance of spirituality and supportive interpersonal relationships in regulating emotional responses after the armed conflict. These high loadings revealed that the items strongly represented the convergent validity of the factors.

Table 3.1

Standard Regression Weights of the Four-Factor CSeCT Model

Latent Construct			Estimate	p-values
S10	<---	Factor1	.824	***
S11	<---	Factor1	.900	***
S14	<---	Factor1	.881	***
S27	<---	Factor2	.886	***
S25	<---	Factor2	.919	***
S26	<---	Factor2	.910	***
S7	<---	Factor3	.818	***
S6	<---	Factor3	.694	***
S19	<---	Factor4	.781	***
S20	<---	Factor4	.837	***

*Note: p-value *** = p<.001*

Moreover, Factor 3, Hyperarousal had strong standardized loadings ranging from .694 to .818. Item S7 (β = .818) had the highest loading, highlighting its importance as an indicator of physiological and emotional hyperarousal commonly associated with trauma exposure. S6 (β = .694), while slightly lower, still exceeded the acceptable threshold of .60, meaning that the item remained a meaningful indicator of trauma symptoms such as heightened vigilance, tension, or emotional sensitivity.

Furthermore, Factor 4, Interpersonal Distrust had strong standardized loadings ranging from .781 to .837. This showed the strong relationship between the items and the latent construct. Among them, S20 (β = .837) reflected the highest loading, suggesting that this item was the most representative indicator. S19 (β = .781) also showed a strong relationship with the factor items reflected how individual manage emotional responses and gradually after experiencing conflict-related stress.

The standardized regression weights demonstrated strong convergent validity for the CSeCT measurement model. All retained items exceeded the commonly recommended loading threshold of .60, indicating that the indicators were reliable representations of their respective latent constructs. These findings provided empirical support for the four-factor structure of the CSeCT, capturing key dimensions of trauma responses among individuals affected by armed conflict, including intrusive distress and functional impairment, faith-anchored coping, hyperarousal, and relational trust. Consequently, the scale appears to be a psychometrically sound instrument for assessing multidimensional trauma responses in conflict-affected populations.

Table 3.2 presented the fit indices for the four-factor Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) scale**,** used to evaluate how well the proposed model represents the observed data. The model fit was assessed using both absolute and incremental (or comparative) fit indices, each serving a complementary purpose in evaluating model adequacy.

Absolute fit indices evaluated the overall agreement between the hypothesized model and the data. The CMIN/DF (χ^2/df) value of 1.482 in a confirmatory factor analysis (CFA) indicated that the measurement model consisting of four latent factors was acceptable. Results indicated an excellent fit between the hypothesized model and the observed data across multiple indices: $X^2(29) = 42.98$, $p = .05$, Goodness-of-Fit Index (*GFI*) = .96, Normed Fit Index (*NFI*) = .97, Tucker-Lewis Index (*TLI*) = .98, Comparative Fit Index (*CFI*) = .99, and Root Mean Square Error of Approximation (*RMSEA*) = .05. Although the chi-square was statistically significant ($p < .05$), the ratio of chi-square to degrees of freedom (X^2/df) of 1.482 fell well within the recommended threshold of less than 3.0, and the

remaining absolute and incremental indices exceeded the standard cutoff of .90, confirming fitness of the model.

The model was defined by four latent constructs: Factor 1 (S10, S11, S14); Factor 2 (S27, S25, S26); Factor 3 (S7, S6); and Factor 4 (S19, S20). All standardized regression weights (factor loadings) were statistically significant (p <.001) and ranged from .694 to .919. Specifically, Factor 1 was strongly defined by S11 (β = .900), S14 (β = .881), and S10 (β = .824). Factor 2 showed the highest loadings with S25 (β = .919), S26 (β = .910), and S27 (β = .886). Factor 3 was represented by S7 (β = .818) and S6 (β = .694), while Factor 4 was defined by S20 (β = .837) and S19 (β = .781). These high loadings indicated that the observed items are strong indicators of their respective latent constructs.

Table 3.2
Model Fit Summary of the Four-Factor CSeCT Model

Fit Indices		Criteria for Acceptable Fit	Obtained Value	Interpretation
Absolute Fit Indices	CMIN/DF (x^2/df)	≤ 3.00 (good fit)	1.482	Good Fit
	GFI	≥ 0.90 (good fit)	.96	Excellent Fit
	RMSEA	≤ 0.05 (close fit) ≤ 0.08 (acceptable)	.05	Acceptable Fit
	PCLOSE	≥ 0.05 (acceptable)	.05	Close Fit supported
Incremental or Comparative Fit Indices	NFI	≥ 0.90 (good fit)	.97	Excellent Fit
	TLI	≥ 0.90 (good fit)	.98	Excellent Fit
	CFI	≥ 0.95 (good fit)	.99	Excellent Fit

The model fit indices provided strong evidence that the CSeCT scale is a valid and reliable measure of trauma-related constructs. The results showed that the indicators demonstrated good convergent validity, capture multiple aspects of trauma responses, such as intrusive distress, hyperarousal, faith-based coping, and interpersonal distrust. This means that the scale was suitable for both research and applied assessment in conflict-affected populations, supporting the multidimensional framework of trauma responses.

Table 4 presented the reliability analysis of the four-factor structure of the Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale. Cronbach's alpha was used to evaluate the internal consistency of the items within each factor. In general, a Cronbach's alpha coefficient of **.**70 or higher means the reliability is acceptable, .80 or above indicates

good reliability, and .90 or higher shows excellent internal consistency among the items in the scale.

The internal consistency of the four-factor Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale was tested using both Coefficient α (Cronbach's alpha) and Coefficient ω (McDonald's omega). The two coefficient measures were commonly used to check the reliability of a scales. The Cronbach's alpha implies the consistency of the items measuring the same concept, with McDonald's omega (ω) gave more precise estimate of reliability when factor loadings vary across items.

The results showed an excellent scale internal consistency. Cronbach's α was 0.888 (95% CI: 0.859–0.918). This indicated that the values exceed the recommended level of 0.70 used for social science research. This was an indication that the items in the four-factor model were highly correlated and reliably measure the concepts they were intended to measure.

The narrow confidence intervals for both reliability coefficients showed that the results were precise and stable. This implied that the four factors of the CSeCT scale, including intrusive distress and functional impairment, faith-anchored coping, hyperarousal, and interpersonal distrust, reliably measure the multidimensional responses to conflict-related trauma.

Table 4

Reliability Test of the Four-Factor CSeCT Model

			95% CI	
Coefficient	Estimate	Std. Error	Lower	Upper
Coefficient ω	0.887	0.012	0.863	0.910
Coefficient α	0.888	0.015	0.859	0.918

The CSeCT Scale showed that the instrument was suitable for research, assessment, and practical application in conflict-affected populations. The high internal consistency also supported the instrument's construct validity, showing that the scores reflect differences in trauma-related experiences rather than measurement error.

Measurement Tool Suitable for Assessing the CSeCT

Table 5 presented the central outcome of the study: the finalized 10-item Context-Specific Culturally Sensitive Armed Conflict Trauma (CSeCT) Scale, developed based on qualitative findings undegone factor analysis results.

The CSeCT scale comprised of four distinct factors. Three items assessed *Intrusive Distress and Functional Impairment*, which captures disturbing thoughts or memories and difficulties in daily functioning. Another three items that measured *Faith-Anchored Coping*, indicating that individuals in conflict-affected areas used faith-anchored to cope with trauma. The *Hyperarousal* had two items that described the strong stress reaction and heightened alertness after the conflict exposure. Two additional items capture *Interpersonal Distrust*, which reflect feelings of distrust and caution toward other individuals in the community.

Respondents rated each statement the level of agreement using a 5-point Likert scale, ranging from Strongly Agree to Strongly Disagree. The participants' responses format reflected the degree of reaction or coping response related to the armed conflict. The use of the Likert scale provided a systematic psychometric structure for measuring the intensity of trauma-related experiences, emotional reactions, faith-based coping, and social perceptions in conflict-affected situations.

Presented in Tables 1.1 and 1.2, the scale were developed through In-Depth-ended interviews and focus group discussions. The responses of the participants were analyzed thematically to identify common themes that reflect experiences of conflict-related stress and coping strategies. Stories and experiences gathered from participants from conflict-affected communities were carefully analyzed to generate common themes and patterns. These themes were used for generating the initial pool of items reflecting psychological distress, trauma reactions, faith-based coping, and interpersonal vigilance toward others associated with experiences of armed conflict. These essential themes and core ideas, which emerged from the interviews, were translated into questionnaire items that accurately emerged from lived experiences of the participants.

Table 5
The CSeCT Scale

FACTOR 1. Intrusive Distress and Functional Impairment	
S10	I feel mentally overwhelmed when thinking about the conflict.
S11	Thoughts about the conflict interfere with my daily thinking
S14	My sleep has been disturbed since the conflict.
FACTOR 2. Faith-Anchored Coping and Social Regulation	
S27	I entrust my worries to Allah/God when I feel afraid
S25	My faith in Allah/God became stronger after the conflict.
S26	Prayer helps calm my fears related to the conflict.
FACTOR 3. Hyperarousal and Trauma Reactivity	
S7	Memories of the conflict suddenly come back to my mind.
S6	Loud noises still make me feel unsafe/
FACTOR 4. Interpersonal Distrust and Community Vigilance	
S19	I find it hard to trust unfamiliar people
S20	I feel uneasy when strangers enter our community.

Furthermore, to ensure clarity and comprehensibility, initial items underwent content validity testing by six experts. Following this process, the researcher employs Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) to examine the underlying factor structure of the scale and establish construct validity. The results supported a four-factor model which includes intrusive distress and functional impairment, faith-anchored coping, hyperarousal, and interpersonal distrust, respectively. The model demonstrated good fit, showing that the structure represented the observed data.

On the other hand, the Instrument was also tested to reliability using Cronbach's alpha to assess the internal consistency of the identified four factors. Based on the results, items in the four-factor model were highly correlated and reliably measure what they are intended to measure. The scale implied strong factor loadings, theoretical relevance, and conceptual importance in trauma literature, ensuring the instrument captured the trauma-related experiences and coping strategies among individuals living in conflict-affected communities.

Intrusive Distress and Functional Impairment. The first factor showed psychological and functional difficulties when recalling or thinking about the armed conflict. It includes intrusive thoughts, constant safety-related worries, and emotional stress affecting daily functioning. The items captured experiences such as feeling overwhelmed when recalling the conflict, overthinking possible dangers, avoiding certain places due to fear, and experiencing physical drained from prolonged stress. These factors revealed that conflict exposure can disrupt emotional stability and daily functioning.

*Faith-Anchored Coping***.** The second factor reflected that faith and spirituality help individuals cope with the effects of armed conflict. It showed that many individuals relied on their belief in Allah/God to handle fear, worry, and emotional distress. The items showed participants strengthening their faith and entrusting their worries to Allah/God through prayer. This emphasized that hope came from religious beliefs, and they used their faith as a source of strength to keep moving forward. Moreover, this factor also showed that faith helps people manage their emotions and stay positive during difficult times. This factor highlights that faith and spirituality were important ways of coping with resources, developing resilience, keeping hope, and managing their emotions after experiencing armed conflict.

Hyperarousal. The third factor showed that people who experience armed conflict become very alert and quickly startled. The responses of the participants occurred because the body and mind remained on high alert as a protective reaction to previously threatening situations. This factor indicated that exposure to conflict can led to strong emotional and physical reactions, increased vigilance, and strong physiological reactions to environmental triggers that remind individuals of past danger. These reactions showed as sudden fear, tension, or discomfort when something unexpected happen. This factor implied that hyperarousal is a common response to trauma, leaving a lasting effects on sense of safety and emotional well-being of every individual.

*Interpersonal Distrust***.** The fourth factor reflected the social and relational impact of living in a conflict-affected environment. It highlights the difficulty individuals in trusting unfamiliar people and the tendency to remain alert to potential threats in their community. This heightened vigilance often develops as a protective response to past experiences of danger or trauma. This factor emphasized how conflict can influence social interactions, leading individuals to be cautious, suspicious, or guarded in their relationships with others. It also showed the ongoing effort to monitor surroundings to maintain safety. This factor captured on how exposure to conflict shapes trust, social engagement, and community awareness, reflecting both protective behaviors and the challenges of rebuilding social confidence.

The Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale was well-designed instrument for assessing trauma responses, coping strategies, and social vigilance among individuals affected by armed conflict. The four factors provided a comprehensive framework that captures intrusive distress, faith-based coping, hyperarousal, and interpersonal vigilance, offering a holistic understanding of how conflict impacted psychological, emotional, and social functioning. This tool can be applied across different communities to identify patterns of trauma and

resilience, as well as to compare experiences in varied conflict-affected settings. Regular use of the CSeCT can inform mental health programs, community support initiatives, and intervention planning, helping practitioners develop targeted strategies to address stress, strengthen coping resources, and promote safety and well-being. The results may also guide training for counselors, social workers, and faith-based support providers, ensuring that interventions are responsive to the specific needs of those living in conflict-affected areas. Future research can explore cross-validation and longitudinal studies to confirm the scale's reliability and applicability across diverse populations. Additionally, integrating the CSeCT Scale into digital platforms could enhance accessibility, allow for real-time monitoring, and support programs aimed for improving resilience, community cohesion, and psychosocial recovery in regions impacted by conflict.

Data Integration of the Salient
Qualitative Quantitative Findings

Presented in this section the integration of qualitative and quantitative findings from the two phases of the study. The purpose of this integration was to show how the themes identified from narratives of participants, supported and validated through empirical quantitative analysis. By linking the results from both approaches, the study provided a comprehensive understanding of trauma responses, coping mechanisms, and social vigilance among individuals affected by armed conflict. The integration demonstrated the relationship between the thematic patterns from the qualitative phase and the factor structure derived from the quantitative phase, reinforcing the rigor and validity of the developed Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale.

A mixed-methods exploratory sequential design was employed to develop and validate the (CSeCT) Scale, ensuring that the scale reflected both lived experiences and measurable constructs of armed conflict trauma and coping strategies. Presented in table 7 the joint display of the qualitative and quantitative findings, showing how the statistical results supported the themes generated from narratives of the participants. The matrix highlighted the main focus areas, qualitative insights, quantitative evidence, and integrated interpretations, illustrating a clear connection between narratives of the participants, and the empirically validated factor structure.

The integration of qualitative and quantitative findings demonstrated how the CSeCT scale was systematically developed to capture trauma responses among individuals affected by armed conflict.

The qualitative phase initially identified six major themes reflecting the lived experiences of the participants, including hyperarousal, intrusive distress, functional disruption, relational trust issues, faith-based meaning, and coping behaviors. These themes were formed the conceptual basis for the initial 36-item instrument. Through exploratory factor analysis, several items from different qualitative themes clustered together, revealing underlying relationships among trauma experiences. As a result, the items were reorganized into four broader dimensions: Intrusive Distress and Functional Impairment, Faith-Anchored Coping, Hyperarousal, and Interpersonal Distrust.

Table 7

Joint Display on the Salient Features of Qualitative and Quantitative Data

Focal Points	Qualitative Findings	Quantitative Findings	Nature of Data Integration
Identifying Key Themes (Research Questions 1 & 2)		By employing Factor Analysis	
	Theme 1 – Hyperarousal and Persistent Fear *with 6 items*	A total of 13 fell on Factor 1. These were 14, 15, 9, 10, 17, 16, 13, 11, 8, 21, 18, 22, and 12. The items 1, 2, 3, 4, 5, and 6 were placed in Factor 3. Merging three themes into 1 factor and renamed to Intrusive Distress and Functional Impairment	Building Confirmation
	Theme 2 – Intrusive Distress and Cognitive Disruption *with 6 items*	A total of 14 items fell to Factor 2. The items were 26, 27, 28, 25, 29, 30, 35, 34, 31, 32, 33, 36, 24, and 23. Items from different factors were placed in factor 2. Merging items from two factors for theme 2, and was renamed to Faith-Anchored Coping and Social Regulation.	Building Confirmation
	Theme 3 – Functional	A total of 7 items fell to	Building

	and Physiological Impact *with 6 items* Theme 4 – Relational Trust and Social Disruption *with 6 items* Theme 5 – Faith Anchored Meaning and Spiritual Regulation *with 6 items* Theme 6 – Coping Behaviors *with 6 items*	factor 3. The items were 1, 2, 4, 6, 5, 7, and 3. Items from factor 1 merged in Factor 3, and was renamed to Hyperarousal & Trauma Reactivity. A total of 2 items fell to factor 4. The items were 20 and 19, from factor 5 and were renamed Interpersonal Distrust Items from factor 5 were placed in factor 2.Items were 25, 26, 26, 28, 29, 30. Items in Factor 6 were placed in factor 2. Items were 31, 32, 33, 34, 35, and 36.	Confirmation Building Confirmation
Factor Structure (Research Question 3)	 Theme 1 - Intrusive Distress and Functional Impairment (*3 items were retained out of 13 statements)* Theme 2 - Faith-Anchored Coping (*3 items were retained out of 14)* Theme 3 - Hyperarousal *(2 items were retained out of 7 items)* Theme 4 - Interpersonal Distrust (*retained the 2 items)*	Items with conventional threshold .40 or higher were retained during the EFA. Subsequently, the Cronbach's alpha was .888 (95% CI: .859 - .918 which exceed the conventional benchmark of .70. Factor 1 - Intrusive Distress and Functional Impairment S10 - .824 S11 - .900 S14 - .881 Factor 2 - Faith-Anchored Coping S27 - .886 S25 - .919 S26 - .910 Factor 3 - Hyperarousal S7 - .818 S6 - .694 Factor 4 - Interpersonal Distrust S19 - .781 S20 - .837	 Building Confirmation Building Confirmation Building Confirmation Building Confirmation
Application of the	The four core themes	The newly developed scale	Building

Newly Developed Measurement Tool for Research Questions 4 and 5	served as the foundation for developing the newly created scale.	was utilized, achieving its intended purpose by administering a research survey assessing trauma responses among individuals affected by armed conflict	Confirmation
Generalization of Qualitative Findings for Research Question 6	The qualitative findings produced the four key themes, which served as the basis for developing the CSeCT scale and were further refined and validated through factor analysis.	The qualitative findings were typically context-specific and not readily generalizable to other settings; the subsequent research survey using the CSeCT scale provided sufficient empirical evidence to support the assumptions regarding armed conflict–related trauma responses. The quantitative results from the CSeCT scale, developed from qualitative insights, further demonstrated that the identified trauma-related constructs are applicable to similar populations exposed to armed conflict, thereby strengthening the potential generalizability of the findings to comparable contexts.	Building Confirmation

The quantitative findings further validated this structure. Items with factor loadings of .40 and above were retained during the exploratory phase. Subsequent confirmatory factor analysis refined the scale to 10 items across four factors, with standardized loadings ranging from .694 to .919, providing strong evidence of convergent validity. These results confirmed that the retained items demonstrated strong internal consistency (Cronbach's $\alpha = .888$), indicating high reliability, effectively represent the multidimensional nature of trauma responses associated with armed conflict.

The convergence of qualitative insights and quantitative validation strengthens the credibility of the CSeCT scale. The qualitative findings were typically context-specific, the statistical supported. The data indicates that the identified constructs were applicable to similar populations exposed to armed conflict. This integration of methods not only enhances the psychometric soundness of the scale but also demonstrates its potential utility for future research, trauma assessment, and intervention planning in conflict-affected communities

DISCUSSIONS

Descriptions of the Lived Experiences of the Participants on Armed Conflict

The lived experiences of the participants generated six themes related to armed conflict experiences, which include: hyperarousal and persistent fear, intrusive distress and cognitive disruption, functional and physiological impact, relational trust and social disruption, faith-anchored meaning and spiritual regulation, and coping behaviors. These themes served as the basis for the development of the scale that captures the lived experiences of the participants. This section explores the assumptions and personal experiences of how people react to conflict, the factors that shape participants' responses, and the critical factors that affect psychological well-being, coping, and social functioning in these contexts.

Hyperarousal and Persistent Fear. Hyperarousal and persistent fear are widely recognized as core psychological responses among individuals exposed to armed conflict. Based on American Psychological Association (APA, 2022), trauma is a psychological and emotional response to events that overwhelm an individual's ability to cope. This narrative involves hyperarousal, illustrated by fear, heightened alertness, and a traumatic experiences (APA, 2020). Prolonged exposure of the participants to armed conflict experienced persistent fear, unstable interpersonal relationships, and negative self-awareness (Herman, 1992). Similarly, Courtois (2005) states that repeated experience of armed conflict has prolonged effects on emotional, cognitive, and social functioning. Participants who experienced major traumatic events, such as war, displacement, and societal disruption, are susceptible to intense trauma (APA, 2019). Several studies show a high prevalence of Post-Traumatic Stress Disorder (PTSD), depression, and anxiety, among refugees and displaced individuals revealing both hyperarousal (e.g., heightened vigilance, intrusive thoughts) and persistent fear (e.g., hearing loud sound quickly panic and feel unsafe) (Scholte et al., 2004; Hassan et al., 2018; Miller et al., 2018). As Fauerback et al. (2020) shows, that individuals differ the trauma responses, ranging from acute reactions marked by hyperarousal to resiliency adaptation over time.

The family and social structures collapse due to conflict, which contributes to trauma reactivity; they may experience heightened anxiety, emotional instability, and social withdrawal (Sivananth, 2020; Karam et al., 2021). Labrador et al. (2013) defined stages of trauma, the initial exposure, a hyperarousal, including rapid heartbeat, sweating, and trembling, while later stages involve emotional destabilization, flashbacks, intrusive thoughts, and depression, representing trauma reactivity. Last stage

highlights coping and adaptation, the potential for recovery and resilience after armed conflict causing trauma.

Armed conflict experience can disrupts psychological and social functioning, representing both hyperarousal (e.g., hypervigilance, startle responses) and trauma reactivity (e.g., avoidance, emotional numbing) manifestations of PTSD, depression, anxiety, and somatic symptoms (Betancourt et al., 2017; Miller et al., 2016; Miller & Rasmussen, 2017; Abdullah et al., 2021). Crises in the Philippines such as the Marawi Siege triggered hyperarousal and trauma reactivity on affected individuals, they experienced flashbacks, nightmares, emotional withdrawal, and difficulty regulating daily life activities (Mordeno et al., 2019; Veloso, 2022; Mendoza et al., 2022; Ferolino et al., 2024). Note only civilians were affected but also military personnel and children were affected by armed conflict, and feel intense psychological stress, showing hyperarousal (heightened alertness, fear responses), and trauma reactivity (avoidance, depression, impaired social interactions) (E. Castro et al., 2001; Labadisos et al., 2020; Veloso et al., 2022).

Furthermore, community and cultural contexts affect how trauma is expressed, with Indigenous populations and displaced individual showing trauma reactivity through communal and intergenerational distress, social bonds disruption, and expressed culturally suffering (Merchant, 2020; Naidoo et al., 2024; Bryant-Davis, 2005). Intervention on trauma experiences, such as the Mental Health and Psychosocial Support (MHPSS), trauma-informed mind-body interventions, and Psychological First Aid (PFA), were used to reduce hyperarousal symptoms, such as anxiety and physiological stress, while reducing the trauma reactivity which includes avoidance, emotional numbing, and social withdrawal (Action Against Hunger, 2023; Cordisco Tsai, 2025; Luzano & Mordeno, 2024). The Community-based resilience programs and culturally sensitive trauma assessments aim both hyperarousal and trauma reactivity, for the recovery and functional reintegration in their daily life and into the society (Katatagani et al., 2016; University of the Philippines, 2024).

Armed conflict experience triggers the physiological and psychological responses, manifesting in hyperarousal and persistent fear. The sudden onset of traumatic events activates the fight-or-flight response of the body, which produces rapid heartbeat, sweating, dizziness, trembling, and other acute physical reactions. Individuals may also experience shock, disbelief, or emotional numbness as a defense mechanism (Labrador et al., 2013; APA, 2022). The CSeCT concept is supported by the communal trauma with social and cultural realities, particularly communities affected by war. (Mordeno et al., 2020; Mendoza et al., 2022).

Intrusive Distress and Cognitive Disruption. Intrusive distress is defined as traumatic experiences through flashbacks, nightmares, and re-experiencing traumatic events, frequently accompanied by elevated arousal and anxiety, according to participant narratives of armed conflict (Turner et al., 2018; Scholte et al., 2004). Meanwhile, trauma exposure, particularly in the context of armed conflict, had profound implications for functional impairment, affecting multiple domains of life for every individual. .As Herman (1992) contends, survivors of prolonged victimization frequently experience disruptions in relationships and emotion regulation, reflecting the long-term effects of trauma on daily functioning.

Based on the studies, trauma may arise from a single incident, such as an armed conflict, car accident, natural disaster, or from prolonged exposure to distressing circumstances, including abuse, neglect, or chronic illness, highlighting the overwhelming distress associated with traumatic events (APA, 2020). Survivors of prolonged experiences may struggle to build relationships and may develop negative perceptions, demonstrating impairments in self-concept (Herman, 1992). According to Courtois (2004), complex trauma has long-lasting effects that may occur at any time in any situation, an indication that distress significantly affects daily functioning. Mental health disorders are common among individuals affected by armed conflict, showing broader functional impairments based on psychiatric symptoms (Turner et al., 2018). For instance, Scholte et al. (2004) found that Posttraumatic Stress Disorder (PTSD), common symptoms among war-affected populations, 36.6% of Sudanese refugees exhibited PTSD and depression symptoms, direct evidence of intrusive distress and functional impairment. A study by Miller et al. (2018) revealed that Palestinian families exposed to decades of conflict had a 97.2% rate of exposure to at least six traumatic situations, causing a disruptive effect on daily functioning. These trauma symptoms differ across individuals, ranging from acute to resilient forms, highlighting differences in intrusive symptoms and functional outcomes (Fauerback et al., 2020).

The loss of a loved one and displacement resulting in emotional instability, increasing the level of anxiety, depression, and even substance abuse, may impair daily functioning (Karam et al., 2021). These symptoms can disrupt daily life, leading to emotional withdrawal, mistrust, and irritability (Labrador et al., 2013; APA). Armed conflict experience also contributes to different mental health issues, including PTSD, depression, anxiety, and somatic symptoms, reflecting direct impacts on psychological and behavioral functioning (Betancourt et al., 2013; Miller & Rasmussen, 2017). Cultures and beliefs facilitate how trauma is expressed, highlighting implications of culturally grounded coping strategies (Fernando, 2012).

In the Philippine context, trauma has a big impact on mental health, particularly Post-Traumatic Stress Disorder (PTSD), identified as the most common effects, such as nightmares, flashbacks, and severe anxiety that

affect daily life functioning (Mordeno et al., 2020; 2023). Armed conflict trauma can cause other mental health issues, such as sleep problems and nightmares, and disrupt focus, irritability, and fatigue, disrupting daily life functioning (Tuason et al., 2023). According to Edward et al (2021), emotional and psychological distress caused by trauma can decrease self-worth and life satisfaction, cause difficulty in maintaining personal, social, and professional relationships, impair decision-making, and disrupt overall functioning (Edward et al., 2021; Weintraub et al., (2016). This emotional numbness and concentration difficulties caused by trauma, if unnoticed, can trigger and elevate mental health issues (Philippine Daily Inquirer, 2022). Assessment tools like the PTSD Checklist for DSM-5 (PCL-5) and instruments such as the Self-Reporting Questionnaire (SRQ-20) or the Global Assessment of Functioning (GAF) may fail to fully differentiate between comorbid symptoms, potentially overlooking functional impairments related to unresolved trauma (Weathers et al., 2013; WHO, 1994). Existing assessment tools inadequately capture cultural differences in expressing trauma, may cause misdiagnosis and underestimating the consequences of complex trauma (Mordeno et al., 2023).

Evidence highlights that early and intermediate mental health interventions are critical in preventing intrusive distress and cognitive disrutions associated with trauma (Colizzi et al., 2020; Baughman et al., 2020; Przybylko et al., 2021). Public Mental Health Plus (PM+) is a community-based program that provides a structured approach to address both acute and ongoing mental health needs, mitigating cognitive disruptions and promoting psychological resilience (Luzano & Mordeno, 2024). These studies underscore the widespread impact of trauma on intrusive distress and cognitive disruption, captures the significance of culturally sensitive, context-specific assessment and intervention to support recovery and reintegration of the conflict-affected populations.

Functional and Physiological Impact. The results of this study illustrates that trauma in armed conflict extends beyond psychological distress, demonstrating significant disruptions across both functional and physiological domains. The functional impact of armed conflict trauma mainly impairs the capacity of individuals to engage in everyday life activities. Most of the participants shows complications in emotional regulation, interpersonal relationships, and function in everyday life activities, reflecting the pervasive influence of trauma on ability to function. Similarly with Mordeno et al. (2020), describes that who are experiencing trauma commonly manifesting intrusive symptoms and emotional dysregulation that disrupt daily functioning. According to Edward et al. (2021) and Weintraub et al. (2016), trauma disrupts personal, social, and occupational fields, limiting the ability of individuals to maintain relationships, decision-making, and accomplish everyday responsibilities. Furthermore, Miller et al. (2019) also emphasized that the effects of

trauma influence family systems and weaken community stability. These results imply that trauma is a socio-ecological context, affecting both individual functioning and well-being.

Based on physiological stance, the results imply that trauma is the response of the body system to threats. The increased alertness, persistent anxiety, and physical symptoms align with the findings of Labrador et al. (2013), showing that challenging situations trigger the fight-or-flight response. This reaction that manifest heartbeat, sweating, blanking and shaking, is a symptoms of physiological response. Based on the study of Turner et al. (2018) reveals that individuals exposed to armed conflict increase level of arousal and anxiety, which are the core components of the trauma. Prolonged experience to armed conflict will have long-term effects on health problem (Betancourt et al. 2013).

These findings demonstrate the multidimensional nature of trauma, which impacts both functional and physiological aspects. The disruption of everyday functioning, together with physiological arousal, proves how trauma affects individuals, compromising adaptation, maintaining relationships, and regulating both emotional and bodily responses. This is an indication that there is a need for comprehensive intervention programs that address the psychological symptoms and functional recovery for conflict-affected populations and the community.

Relational Trust and Social Disruption. The findings illustrates that the relational trust and social functioning greatly affect individuals who are exposed to armed conflict, showing both individual and common dimensions of trauma. Continued exposure to violence, displacement, and loss affects the personal psychological stability and the integrity of the family, the community, and the social networks. According to Miller et al. (2016) argued that armed conflict threaten social stability, commonal identity, and sense of belonging of every affected individual, which are the basis for relational trust. As Sivananth (2020) highlights, family disruption and social systems contribute to psychological distress, and loss of critical sources of emotional support and stability. Karam et al. (2021) found that experiences of displacement and bereavement strengthen vulnerability to emotional instability, mistrust, and social withdrawal, reinforcing the nature of trauma. These findings demonstrate how armed war trauma can lead to social disturbance and a breakdown in interpersonal trust. Restoring family ties, bolstering community cohesion, and promoting resilience all require comprehensive interventions.

Faith-Anchored Meaning and Spiritual Regulation. Individuals affected by trauma in conflict-affected areas often rely on various coping strategies to manage psychological distress. Some turn to faith-anchored coping, drawing on religious beliefs, spiritual practices, and cultural rituals

to foster hope, resilience, and meaning in the aftermath of traumatic experiences (e.g., the use of grief ceremonies and cultural education in Indigenous healing practices; Takini Network, Lakota, 2021). Trauma-Informed Mind-Body Practices interventions, which integrate meditation, mindfulness, and self-awareness, help the individual regulate emotional responses, lead to reduced symptoms of PTSD, and support long-term recovery (Cordisco Tsai, 2025). Faith-anchored coping also helps individuals navigate feelings of helplessness, anxiety, and depression, and provides emotional stability, during and after armed conflict or disasters experiences.

Social regulation and community-based interventions play significant role on trauma recovery, such as Psychological First Aid (PFA), school-based mental health programs, and Community-Based Trauma Care for Indigenous Peoples, underscore support, structured social interactions, and trained professionals help stabilize emotions, normalize experiences, and facilitate reintegration into daily life (Action Against Hunger, 2023; DepEd programs; University of the Philippines, 2024). Similarly, the group-based resilience programs and creative arts interventions foster coping mechanisms, peer networks, and adaptive strategies for children and adults facing trauma (Katatagani et al., 2016; Tejero et al., 2020; Castro et al., 2012). Social regulation includes family-focused programs such as sensitive parenting and family support initiatives that help caregivers understand the effects of trauma, which can improve communication and attachment, and ensure a supportive environment for recovery, particularly for children experiencing trauma (Save the Children Philippines). These social frameworks, with guidance from the community, social regulation supports for reintegration into their daily lives, emotional stability, and coping skills, alongside culturally grounded approaches, help individuals become resilient in the face of any uncertainty they encounter.

Effective interventions that recognize cultural and community contexts significantly shape coping, healing, and resilience in trauma-affected populations. Together, faith-anchored coping and social regulation represent pathways for trauma recovery: faith-based resilience, and emphasizes external, socially mediated support.

Culturally and spiritually approaches are important aspect for understanding trauma, and support recovery, particularly affected populations by armed conflict. In Indigenous communities, healing process through rituals, ceremonies, and storytelling, which restore both individual stability and social integration (AMA Journal of Ethics, 2021; Lakota, 2021). Therapeutic frameworks from Western countries acknowledges the significant role of integrating cultural and spiritual identities of the clients, highligthing trauma-informed care and cultural humility to enhance the

effectiveness of intervention (PMC, 2020; Ranjbar et al., 2020). This is an indication that aligning mental health interventions along with cultural, religious, and communal values with enhance coping mechanisms, improves therapy engagement, and supports adaptive social regulation (Johnson, 2022; Soto et al., 2018; Adebayo, 2024). These corresponding cultural practices support the CSeCT construct of Faith-Anchored Coping and Social Regulation, describing how faith, belief, ritual, and communal support as protective strategies that promote resilience, emotional stability, and collective recovery from armed conflict-affected populations.

Coping Behaviors. The present findings indicate that individuals exposed to armed conflict adopt a variety of coping behaviors to manage psychological distress and maintain functioning in the face of prolonged adversity. Coping strategies emerged as both individual and collective mechanisms that mitigate the impact of trauma, ranging from problem-focused strategies to emotion-focused approaches. Studies of Betancourt et al. (2017) illustrates that individual experienced armed conflict rely on culture as coping techniques, such as religious faith, seeking social support, and engaging in community-based rituals, which give them psychological relief and social connectedness. Similarly, studies by Fernando (2012) highlight that cultural and spiritual traditions influence how individuals express and process traumatic experiences, emphasizing the role of faith in meaning-making for resilience and recovery.

Mendoza et al. (2022) and Veloso et al. (2022) emphasize that coping behaviors among armed conflict-affected individuals used active engagement in routines, reliance on familial and peer networks, and psychological reframing of experiences to maintain resilience. So, as the Military personnel and social workers, their coping strategies involve institutional support, counseling services, and debriefing conducted by trained professionals, which safeguard them against cumulative impact and vicarious trauma (IDEAS/RePEc, 2021; ASEAN Social Work Journal, 2022). Herman (1992) emphasizes adaptive coping strategies for emotional stabilization, integrating traumatic experiences and narratives, and gradually regaining a sense of hope. This evidence suggests that coping behaviors to overcome trauma, emphasizing the significant role of culturally sensitive interventions, promote individual resilience and collective support structures.

Underlying Dimensions of Context-Specific Culturally Sensitive Conflict Trauma

The quantitative phase employs Exploratory Factor Analysis (EFA) to evaluate the structural validity, grounded in the qualitative foundations that support the CSeCT Scale development. This procedure sought to determine whether the items generated from the narratives of the

participants through in-depth interviews and focus group discussions truly represented the various dimensions of trauma responses among individuals exposed to armed conflict. By analyzing the 200 responses of the conflict-affected participants using a five-point Likert scale, the inter-relationships among the items and the factor loadings to identify the latent dimensions that cluster together. The EFA procedure used a systematic approach, starting with assessments of sampling adequacy and factorability, followed through factor extraction, rotation, and interpretation to ensure that the final structure was both statistically sound and theoretically significant. This rigorous analysis provided the empirical basis for a four-factor model of the CSeCT Scale, illustrating trauma responses of the participants are multidimensional, including intrusive distress and functional impairment, faith-anchored coping, hyperarousal, and interpersonal distrust.

The appropriateness of the dataset for factor analysis was determined using the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's Test of Sphericity. The results indicated that the dataset met the sampling adequacy and correlation matrix suitable for factor extraction (Nguyen & Duong, 2021). Communalities indicate that four-factor solution provides and adequate data representation, supporting the suitability of the retained factors contributed to the construct structure (Ling et al., 2024).

The Total Variance Explained and Scree Plot determined the retained factors. The results implies that the eigenvalues greater than one had a distinct inflection point indicating the ideal number of latent dimensions (Ma et al., 2024). This means that the four-factor solution represent the total variance, reflecting trauma and coping strategies dimensions.

The Principal Axis Factor (PAF) and Kaiser normalization analysis results were utilized to refine the factor structure. This shows that the shared variance among items exceeds the total variance that determine the psychological constructs of trauma varied, connected and often overlap (Burke et al., 2023). This clearly shows that the Pattern Matrix item loadings across the four factors, and Factor Correlation Matrix shows low-to-moderate correlations still retained due to theoretical and contextually important.

The Content Validation Index is a significant step for scale development (Morgado et al., 2017). Thorough qualitative grounding, combination of Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) provides sufficient item validation (Boateng et al., 2018; Erden et al., 2024; Zincirli et al., 2025). This process ensures the scale were contextually relevant and psychometrically strong.

The proposed CSeCT Scale demonstrates both statistical stable and theoretical and contextually important. The four factors: Intrusive Distress and Functional Impairment, Faith-Anchored Coping, Hyperarousal, and Interpersonal Distrust, capture the varied nature of trauma responses among participants who experienced armed conflict. This scale comprehensively captures the nature of trauma, includes emotional, cognitive, physiological, social, and spiritual consequences, supporting interventions in affected communities.

Intrusive Distress and Functional Impairment. The Intrusive Distress and Functional Impairment factor supported by literature which capture the psychological, cognitive, and physiological impact of trauma. According to Nguyen and Duong (2021) and Ling et al. (2024), trauma experiences emerged through intrusive memories, flashbacks that disrupt daily activities, social connectedness, and academic performance.

Similarly, studies of Ma et al. (2024) and Burke et al. (2023**)** have shown that the indicators of functional impairment, including cognitive overload, hypervigilance, and avoidance behaviors, are core components of trauma. Disrupted sleep patterns, heightened physiological tension, and inability to focus, which impacts both the mind and body associated with trauma (Boateng et al., 2018; Erden et al., 2024). Several studies confirmed that intrusive distress and functional impairment is multidimensional factor that support the concept of Context-specific and culturally sensitive scales use to assess armed conflict trauma symptoms.

Faith-Anchored Coping. The dimension demonstrating how spirituality promotes resilience in trauma-affected populations (Cañabate et al., 2024; Andresen et al., 2023; Leung et al., 2025). Individuals rely on spiritual beliefs, religious practices, and social support systems to regulate emotional distress and facilitate recovery. Entrusting all worries to Allah/God. Prayer and spiritual beliefs serve as the center of hope and coping strategies. Survivors engaging in these practices show enhanced emotional stability, reduced intrusive distress, and a strengthened sense of hope despite ongoing conflict (Fierro-Suero et al., 2022; Hao & Yang, 2022

The Faith-Anchored Coping is interrelated with Intrusive Distress and Functional Impairment. Through prayer and entrusting all worries to Allah/God, lessen the hyperarousal, intrusive thoughts, and functional disruptions due to armed conflict trauma (Franco et al., 2021; Slingerland et al., 2024). Engaging in spiritual practices fosters coping behaviors, enhances emotional regulation, and strengthens social bonds, thereby facilitating recovery from trauma (Cañabate et al., 2024; Leung et al., 2025).

Faith-Anchored Coping factor is a multidimensional construct integrating spirituality and proactive coping behaviors, represented in the CSeCT Scale core factor, and helps explain how individuals face the psychological, cognitive, and behavioral impacts of armed conflict trauma. The importance of a culturally sensitive scale, incorporating local social norms, community rituals, and faith-based practices, enhances resilience and recovery (Cohabite et al., 2024).

Hyperarousal. This dimension captures symptoms such as persistent tension, startle responses to loud sounds, panic reactions, hypervigilance, and constant alertness, highlighting the impact of trauma on both body and mind (Franco et al., 2021; Slingerland et al., 2024; Macías et al., 2021). Similarly, the state of alertness can disrupt daily functioning, impair concentration, and affect decision-making, illustrating physiological arousal and cognitive distress (Fierro-Suero et al., 2022; Wiium, 2021). These responses are often triggered by sensory cues such as gunfire, sudden loud noises, or reminders of conflict which elicit strong fear reactions and exacerbate cognitive strain (Hao & Yang, 2022; Leung et al., 2025).

The factor also emphasizes the psychological vulnerability of individuals exposed to armed conflict. Hyperarousal symptoms are associated with intrusive thoughts, difficulty focusing, and emotional overwhelm, which further perpetuate functional impairment if not address through coping mechanisms (Cañabate et al., 2024; Andresen et al., 2023). Hyperarousal represents a multidimensional construct encompassing both emotional and physiological dimensions of trauma, inclusion in CSeCT Scale capturing bodily and psychological reactivity of the participants, providing a basis for assessing the severity of trauma.

Interpersonal Distrust. The factor emphasizes the impact of trauma on community cohesion. Persistent mistrust and selective social engagement can hinder the rebuilding of social networks and collective resilience, which are critical in post-conflict recovery (Cañabate et al., 2024; Andresen et al., 2023). This will captures the social and relational consequences reflecting heightened caution, mistrust, and vigilance toward others within the community. Participants have difficulty trusting unfamiliar individuals, increased wariness in social interactions, and limited engagement to social networks (Franco et al., 2021; Andresen et al., 2023). Similarly, studies by Slingerland (2024) and Macias (2021) indicate that prolonged exposure to violence can recalibrate social perceptions, prompting protective strategies to mitigate perceived threats. As Hao and Yang (2022) state, individuals avoid unfamiliar spaces or social situations to maintain safety, demonstrating how trauma reshapes the behavior and cognition in relational settings (Fierro-Suero et al., 2022). These psychological symptoms occur

along with hyperarousal and intrusive distress, emphasizing the interconnectedness of social vigilance with other trauma dimensions (Leung et al., 2025; Wiium, 2021). Such vigilance manifests as hyper-awareness of social environments, frequent monitoring of potential risks, and cautious decision-making in interpersonal contexts.

Interpersonal Distrust represented a distinct but related dimension of trauma response, showing how armed conflict exposure influences social perception, interpersonal trust, and a vigilance in community contexts. The inclusion of this factor in the CSeCT Scale ensures that both relational and safety-oriented behaviors, supporting comprehensive assessment and context-specific psychosocial programming.

Factor Structure of the Questionnaire for Respondents' CSeCT Scale

The Confirmatory Factor Analysis (CFA) results support the validity of the CSeCT Scale that measure different nature of trauma responses. The four-factor model includes Intrusive Distress and Functional Impairment, Faith-Anchored Coping, Hyperarousal, and Interpersonal Distrust theoretically grounded aligns with psychometric finding capturing conflict related trauma (Franco et al., 2021; Andresen et al., 2023). Studies by Fierro-Suero et al. (2022) and Leung et al. (2025). This multidimensional frameworks validly represented using Confirmatory Factor Analysis (CFA) with standardized factor loadings and favorable fit indices.

CFA results confirmed that all items had a strong factor loadings and excellent model fit, an indication that the results captures trauma-exposed populations (Macías et al., 2021; Wiium, 2021). Item refinement, includes the removal of low-loading indicators and enhancing the model fit, following the standard in instrument validation (Hao & Yang, 2022; Cañabate et al., 2024). This process reveals that the values ranged from .78 to .85, reflecting the interrelatedness of the trauma dimensions but still preserving their distinctiveness. These findings aligned with Slingerland et al. (2024), who emphasizes that exposure to conflict linked to psychological and social responses that must be measured in a comprehensive framework.

The results reflects the complex nature of trauma responses and shaped the experiences of affected individuals. Fit indices, including PGFI, PNFI, and PCFI, indicated that the parsimonious fit model and explanatory (Leung et al., 2025; Andresen et al., 2023). Reliability testing confirmed the internal consistency, with Cronbach's alpha of $\alpha = .888$, parallel to other trauma assessment tools.

The validated CSeCT Scale is a reliable, well-established measure of trauma. Using a multidimensional approach to support assessment, intervention, and help evaluate the program, which contributes to research and practical application in mental health and the community for recovery.

Measuring Tool Suitable for Assessing the CSeCT Scale

Through qualitative narratives and thematic analysis, the CSeCT scale was developed, validated through Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA), and used to assess armed conflict-related trauma. The final scale consists of 10 items across four factors: Intrusive Distress and Functional Impairment has three items, Faith-Anchored Coping has three items, Hyperarousal has two, and Interpersonal Distrust has two items. The four factor represented by different aspect of trauma, showing psychological and social impacts of armed conflict exposure, representing the complex dimension of trauma.

Trauma interplay with beliefs, values, and social structures, underscoring the need for context-specific, culturally sensitive assessment to capture its complexity of trauma (Greene et al., 2020). This guided the development and validation of the four factors of the CSeCT Scale, which include Intrusive Distress and Functional Impairment and Hyperarousal, and reflect the lived experiences of conflict-affected populations. Items in these factors assess the recurring distress, functional disruption, and re-experiencing symptoms, showing strong factor loadings and communalities, aligning with culturally informed trauma experiences (Bovey, 2025). Hyperarousal items assess irritability, increases startle response, and sleep problems exhibited strong loadings and significantly explained of the total variance, supporting theoretical and physiological aspects of trauma as discussed in the IPV-ADAPT+ framework (Cordisco Tsai, 2025) and Healthcare Toolbox principles (Healthcare Toolbox, 2024).

Culturally grounded interventions in the Philippines further informed the content of the scale. Programs for the community by the University of the Philippines (UP, 2024), the trauma-informed mind-body interventions (Cordisco Tsai, 2025), and the Mental Health and Psychosocial Support framework for BARMM (Action Against Hunger, 2023) emphasizes the significance of addressing personal distress and socio-community impacts. As reflected the strong factor structure of Interpersonal Distrust and the correlations among factors. Lyons (2025) and the Culturagram (Congress, 1994) ensures the relevance, cultural validity, and cultural appropriateness of items across diverse Filipino communities, as shown by the EFA four-factor solution.

Global examples of scale adaptation supported the CSeCT validity structure. Research from Harvard Trauma Questionnaire (Mollica et al., 1992), CAPS adaptations for Latino populations (Rendon, 2015), UCLA PTSD-RI (Steinberg et al., 2004), and the Global Post Traumatic Stress Disorder Scale (Michalopoulos et al., 2025) highlighted that the culturally adapted instruments maintain reliability and validity across different contexts. The CFA results for the CSeCT Scale confirmed the model's stability and high to moderate internal consistency across factors, demonstrating psychometric properties similar to those of internationally validated trauma assessment tools.

Addressing common issues in trauma scale, like differentiating PTSD from co-occurring depression and anxiety (Weathers et al., 2013; Smith et al., 2017) and limitations of the tools like the SRQ-20 and GAF in capturing trauma details (WHO, 1994), the CSeCT Scale specifically measures conflict-related intrusive distress and functional impairment, hyperarousal, and social distrust. The integration of culturally sensitive, well-validated items ensures that the scale captures personal and community trauma dimensions, providing a comprehensive framework for assessment, intervention, and future research in Mindanao and similar Southeast Asian contexts.

Data Integration of the Salient Qualitative Quantitative Findings

The study employed an exploratory-sequential mixed-methods design to develop and validate the CSeCT Scale, a culturally sensitive instrument measuring trauma among individuals who have experienced armed conflict. Qualitative interviews and thematic analysis first identified six core domains of trauma: Hyperarousal and Persistent Fear, Intrusive Distress and Cognitive Disruption, Functional and Physiological Impact, Relational Trust and Social Disruption, Faith-Anchored Meaning and Spiritual Regulation, and Coping Behaviors. These contextually grounded themes reflected lived experiences of the participants, consistent with literature emphasizing the need for culturally sensitive trauma assessment frameworks (Greene et al., 2020; Bovey, 2025; Cordisco Tsai, 2025). Such qualitative grounding ensures the scale captures both socio-cultural and psychological dimensions of conflict-related trauma (Healthcare Toolbox, 2024; Lyons, 2025).

Following qualitative identification, Exploratory Factor Analysis refined and consolidated these themes into four empirically supported

factors. Intrusive Distress and Functional Impairment merged items from multiple initial themes, yielding strong loadings on factor one, confirming the empirical distinctiveness of distress and functional disruption (Mollica et al., 1992; Steinberg et al., 2004). Faith-Anchored Coping also emerged as a factor, validating the qualitative patterns of spiritual and social coping as key adaptive mechanisms (Cordisco Tsai, 2025; University of the Philippines, 2024). Hyperarousal formed a separate factor, aligning quantitative evidence with qualitative reports of physiological hyperarousal (Michalopoulos et al., 2025; Weathers et al., 2013). Interpersonal Distrust, reflecting relational and communal dimensions of trauma, linking social distrust to vigilance behaviors observed in conflict-affected populations (Action Against Hunger, 2023; Lyons, 2025). The internal consistency for the retained items was excellent, surpassing conventional benchmarks ($\alpha = .888$; 95% CI: .859–.918).

Confirmatory Factor Analysis supported the four-factor model, yielding strong factor loadings and high model fit indices, thereby confirming structural validity (Haddadian et al., 2024; Howard, 2023; Rogers, 2022). This integration of qualitative and quantitative phases demonstrated methodological rigor, wherein qualitative insights directly informed scale construction, while factor analyses validated the theoretical coherence of the constructs (Gogo & Musonda, 2022; Younas et al., 2020). The CSeCT Scale was subsequently applied to assess trauma responses among conflict-affected populations, capturing nuanced variations in distress, hyperarousal, faith-based coping, and social vigilance, thereby extending the empirical applicability of the qualitative findings (Hochwald et al., 2023; Nessle et al., 2023).

The development of the CSeCT Scale illustrates a rigorous, culturally sensitive instrument development process, in which qualitative insights shaped the factor structure, Exploratory Factor Analysis confirmed the latent dimensions, and Confirmatory Factor Analysis established structural robustness. The scale provided a reliable tool for measuring armed conflict–related trauma, and its integration of contextually grounded, faith-informed, and relational constructs supports to similar populations in Southeast Asia and other conflict-affected regions (Bovey, 2025; University of the Philippines, 2024; Cordisco Tsai, 2025).

Conclusions

The findings of this study confirmed that trauma is a psychological response to overwhelming or life-threatening experiences affecting emotional well-being, and major public health concern.

In the qualitative phase, twenty-four participants were involved. Fifteen participated in in-depth interviews, and nine participated in a focus group discussion. Participants described lived experiences during and after armed conflict in their community. They expressed constant fear, as shown by their easy startle response and feeling unsafe even in normal situations. Those experiences highlight intrusive memories such as flashbacks and difficulty concentrating, which disrupt their thinking, which affects their physical and daily functioning, including sleep problems, fatigue, and difficulty focusing on studies. Socially, participants struggle with trust and often withdraw from others, reflecting changes in relationships. Most of the participants rely on faith and spirituality to cope, finding hope and emotional stability. They used various coping strategies, includes avoidance and seeking social support, to manage their experiences. These shows how trauma individuals felt, manage and cope in challenging environments

Six underlying dimensions of trauma were emerged from the narratives of the participants such as: hyperarousal and persistent fear, a state of alertness and heightened sensitivity to threat, intrusive distress and cognitive disruption capture the recurring memories, mental overload, and difficulty to focus caused by trauma, functional and physiological impact is how trauma affects sleep, appetite, energy levels, and overall functioning, relational distrust and social disruption alters interpersonal relationships, leading to withdrawal and reduced trust, faith-anchored meaning and spiritual regulation highlights the role of spirituality and belief systems in managing distress and fostering hope, and coping behaviors used to deal with trauma, including avoidance, social support, and engagement in positive activities. These findings show that trauma is a multidimensional construct interconnected with psychological, social, physiological, spiritual, and behavioural aspects.

The dimensions of trauma exhibit parsimonious fit. The four-factor model explained 64.2 percent of the total variance, indicating that a small number of factors can effectively represent the complexity of trauma. The model was supported by an excellent KMO value of 0.949 and a significant Bartlett’s Test, confirming that the data were suitable for factor analysis. All items met the minimum loading threshold, shows that every item contributed to the construct. The variance distributed across the four factor which enhanced interpretability and balance. These confirmed that the model achieved parsimony by providing a simple, interpretable, and statistically multidimensional nature of trauma.

The Context-Specific Culturally Sensitive Conflict Trauma (CSeCT) Scale a ten-item instrument organized into four factors such as: Intrusive Distress and Functional Impairment, affects thoughts and emotions that disrupt daily life. Faith-Anchored Coping highlighted how individuals rely

on faith to overcome trauma, Hyperarousal reflects heightened alertness and physiological responses to stress, and Interpersonal Distrust represents caution and vigilance in social interactions.

The CSeCT scale demonstrated strong psychometric properties, Factor loading from .694 to .919, means the scale reliably measure their intended to measure. The model fit indices, such as CFI of .990 and RMSEA of .05, implies excellent fit. The reliability with Cronbach's Alpha at .888 , an indication that the scale is a reliable, valid, and culturally sensitive tool suitable for assessing complex dimension of trauma caused by armed conflict. This will guide both research and intervention planning in conflict-affected communities. The variables of this study grouped into four distinct strong factors. The model showed excellent fit and reliably measures the intended to measure of trauma among conflict-affected individuals.

The quantitative results generalized the qualitative findings by transforming the themes identified from narratives of the participants into measurable variables. The themes were validated through factor analysis, which showed that the items clustered into four factors consistent with the qualitative results. The strong factor loadings and good model fit indicated that these patterns were not limited to a few individuals but across the larger sample. The quantitative findings extend the qualitative insights by demonstrating that the lived experiences of trauma were systematic and generalizable. Therefore, the CSeCT scale was a validated, culturally grounded, multidimensional measure of conflict-affected trauma that provides a reliable tool for evidence-based assessment, intervention planning, and program evaluation, supporting targeted psychosocial support that addresses both intrapersonal and community-level needs. It also ensures its relevance for assessing conflict-related trauma in the Philippines and offers potential applicability in other Southeast Asian and conflict-affected populations.

Recommendations

In view of the conclusion of the study, the following are recommended:

Educational institutions should utilized the CSeCT scale as an assessment tool and implement trauma-informed and faith-sensitive support programs, such as counseling services, peer support, and resilience-building initiatives to address needs of the students.

Mental health practitioners and school counselors may utilize the CSeCT Scale as a screening tool to assess multidimensional trauma, allowing for more targeted and culturally responsive psychosocial interventions.

Policymakers and program developers are encouraged to utilize and integrate CSeCT Scale to mental health and psychosocial support programs to guide interventions and strengthen support systems in conflict-affected communities.

Future research should further validate the CSeCT Scale administer to a larger and more diverse samples, including non-student populations and other conflict-affected communities. Longitudinal studies are also recommended to assess the stability of trauma responses and the sensitivity of the scale.

Cross-cultural validation is encouraged to assess the scale's applicability in other regions, ensuring its adaptability and maintain cultural sensitivity.

References:

Abdullah et al., 2023. Review of patterns of experiences among civilians in conflict zones. Disarat Human and Social Sciences. https://doi.org/10.35516/hum.v50i4.5636

Abdullah, T., & Murshed, M. (2021). *The intergenerational impact of trauma in conflict-affected communities: A comprehensive review*. *Journal of Traumatic Stress, 34*(2), 290-298.

Action Against Hunger. (2023). *Mental health and psychosocial support (MHPSS) framework for BARMM*. Action Against Hunger. Retrieved from https://accioncontraelhambre.org

Ahmed, A.Y., Khider, H.E., & Albarbandi, R. (2025). Mental health consequences in populations exposed to war and violence: A global health crisis. *World Journal of Advanced Rech and Reviews*.

AMA Journal of Ethics. (2021). *What does it mean to heal historical trauma?*. American Medical Association. https://journalofethics.ama-assn.org/article/what-does-it-mean- heal-historical-trauma/2021-06

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Amsalem D, et.al., 2025. The effects of war-related experiences on mental health symptoms of individuals living in conflict zones: a longitudinal study. Sci Rep. 2025 Jan 6;15(1):889. doi: 10.1038/s41598-024-84410-3. PMID: 39762464; PMCID: PMC11704351.

Arnado, J. M. (2012). Armed conflict in the Philippine South: Unanticipated consequences of Christian migration since 1913. *Kasarinlan: Philippine Journal of Third World Studies, 27*(1–2), 33–70. Retrieved from https://animorepository.dlsu.edu.ph/faculty_research/11987

Bangsamoro Autonomous Region in Muslim Mindanao (BARMM). (2021). *How the Bangsamoro's own struggle influenced Philippine independence*. https://bangsamoro.gov.ph/news/latest-news/how- the-bangsamoros-own-struggle-influenced-philippine-independence/

Bendavid et al., 2021. The effects of armed conflict on the health of women and children.

https://doi.org/10.35516/hum.v50i4.5636

Betancourt, T. S., et al. (2015). Strengthening community-based mental health interventions in conflict-affected areas. *Lancet Psychiatry, 2*(5), 401-410.

Bhandari, P. (2024, October 1). *Ethical considerations in research Types & examples*. Scribbr. https://www.scribbr.com/methodology/research-ethics/

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best practices for developing and validating scales for health, social, and behavioral research: A primer. *Frontiers in Public Health, 6,* 149. https://doi.org/10.3389/fpubh.2018.00149

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). *The American Indian holocaust: Healing historical unresolved grief*. American Indian and Alaska Native Mental Health Research, 8(2), 56–78. https://doi.org/10.5820/aian.0802.1998.56

Brown, T. A. (2015). *Confirmatory factor analysis for applied research* (2nd ed.). Guilford Press.

Bryant, R. A., et.al., (2011). Trajectory of post- traumatic stress following traumatic injury: 6-year follow-up. *British Journal of Psychiatry, 198*(2), 98–103.

Bryant-Davis, T. (2019). *The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice*

guideline and intersectionality. Psychotherapy, 56(3), 400–408. https://doi.org/10.1037/pst0000241

Buchanan, T., et al. (2018). Gender and PTSD: Experiences of women in conflict zones. *Traumatology, 24*(2), 106-115.

Bueno, D. C. (2016). *Research ethics and principles in the Philippine context*. Manila: Rex Book Store.

Carpiniello, B. (2023). The mental health costs of armed conflicts—a review of systematic reviews conducted on refugees, asylum-seekers and people living in war zones. *International journal of environmental research and public health*, *20*(4), 2840.

Chavez, P., et al. (2020). Socioeconomic factors and mental health in conflict-affected populations. *Journal of Trauma & Dissociation, 21*(1), 72-85.

Child, D. (1990). *The essentials of factor analysis* (2nd ed.). Cassell Educational Limited.

Congress of the Philippines. (2012). *Data Privacy Act of 2012 (Republic Act No. 10173).* Official Gazette of the Republic ofPhilippines.https://www.officialgazette.gov.ph/2012/08/15republicc-act-no-10173/

Cordisco Tsai, L. (2025). *Trauma-informed mind-body interventions in Cebu*. ScienceDirect. Retrieved from https://www.sciencedirect.com

Costello, A. B., & Osborne, J. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research, and Evaluation, 10*(1), 1–9. https://doi.org/10.7275/jyj1-4868

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications.

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). Sage.

Datukali, . T. P. ., & Pangandaman, H. (2024). Effects of Psychosocial Intervention on the Level of Stress: A Pre-Experimental Research on School Children Who

Experienced Displacement in Marawi City, Philippines. *The Malaysian Journal of Nursing (MJN)*, *15*(4), 33-42. https://doi.org/10.31674/mjn.2024.v15i04.005

DeCoster, J. (1998). *Overview of factor analysis*. Retrieved from https://stat-help.com/notes.html

Department of Education (DepEd)**.** (n.d.). *School-based mental health programs*. Department of Education, Philippines. Retrieved from https://www.deped.gov.ph

DeVellis, R. F. (2017). *Scale development: Theory and applications* (4th ed.). SAGE Publications.

Ebardo, R. A., Peralta, J., & Ibonia, M. (2024). The impact of COVID-19 on psychological well-being: Exploring intrusion, hyperarousal, and avoidance among teachers in Marawi City. *Worldwide Journal of Multidisciplinary Research and Development, 10*(4), 72–81.

El Bizri, M., Langlois, E.V., Reid, A., & Khosla, R. (2025). Women and children first: Delivering solutions in conflict-affected settings. *PLOS Global Public Health, 5*. https://doi.org/10.1371/journal.pgph.0004084

Fabrigar, L. R., & Wegener, D. T. (2012). *Exploratory factor analysis*. Oxford University Press.

Fauerbach, J. A., Pulos, E., & Herbert, J. D. (2020). *The impact of posttraumatic stress disorder on trauma survivors: A review of recent research*. *Journal of Traumatic Stress, 33*(2), 194-202.

Frontiers. (2023). *Elements of cultural scripts of trauma sequelae among trauma victims in East Africa*. Frontiers in Psychology. https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2023.1206503/full

Garabiles, M.et al., 2023. A comparison of DSM-5 and ICD-11 models of PTSD: Measurement invariance and psychometric validation in Filipino trauma samples, Journal of Psychiatric Research, Volume 163, Pages 24-31, ISSN 0022-3956, https://doi.org/10.1016/j.jpsychires.2023.05.006.

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2019). *Multivariate data analysis* (8th ed.). Cengage Learning.

Hassan, G., et al. (2018). Mental health of refugees and internally displaced persons in conflict zones. *World Psychiatry, 17*(3), 398- 409.

Haynes, S. N., Richard, D. C. S., & Kubany, E. S. (1995). Content validity in psychological assessment: A functional approach to concepts and methods. *Psychological Assessment, 7*(3), 238– 247. https://doi.org/10.1037/1040-3590.7.3.238

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal, 6*(1), 1–55. https://doi.org/10.1080/10705519909540118

Johnson RJ, Antonaccio O, Botchkovar E, Hobfoll SE. War trauma and PTSD in Ukraine's civilian population: comparing urban-dwelling to internally displaced persons. Soc Psychiatry Psychiatry Epidemiol. 2022 Sep;57(9):1807-1816. doi: 10.1007/s00127-021-02176-9. Epub 2021 Oct 1. PMID: 34596712.

Kaiser, H. F. (1974). An index of factorial simplicity. *Psychometrika, 39*(1), 31–36. https://doi.org/10.1007/BF02291575

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing, 72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kanstrup M, et al., (2021). Reducing intrusive memories after trauma via a brief cognitive task intervention in the hospital emergency department: an exploratory pilot randomised controlled trial. Transl Psychiatry. 2021 Jan 11;11(1):30. doi: 10.1038/s41398-020-01124-6. PMID: 33431807; PMCID: MC7798383.

Karam, E. G., & Fayyad, J. (2021). *Mental health consequences of displacement and loss: A review of recent findings*. *Journal of Affective Disorders, 282*, 108-116.

Khoury, B., & Hakim-Larson, J. (2020). From refugees to immigrants: The role of psychology in the struggle for human rights. In N. S. Rubin & R. L. Flores (Eds.), *The Cambridge handbook of psychology and human right* (pp. 212–226).Cambridge University Press https://doi.org/10.1017/9781108348607.015

Kline, R. B. (2016). *Principles and practice of structural equation modeling* (4th ed.). Guilford Press.

Kline, R. B. (2016). *Principles and practice of structural equation modeling* (4th ed.). Guilford Press.

Kokori, E. et al., 2024, A mini-review on safeguarding global health amidst a “Pandemic” of armed conflicts. Medicine.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Luthar, S. S., et al. (2021). Resilience in conflict survivors: Role of community solidarity and social networks. *American Journal of Community Psychology, 67*(3-4), 397-408.

Miller KE, Rasmussen A. The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. Epidemiol Psychiatr Sci. 2017 Apr;26(2):129-138. doi: 10.1017/S2045796016000172. Epub 2016 Apr 4. PMID: 27040595; PMCID: PMC6998767.

Moreno-Chaparro, et al., (2022). Mental health consequences of armed conflicts in adults: an overview. *Actas espanolas de psiquiatria*, *50*(2), 68–91.

Mutuyimana, C., & Maercker, A. (2023). *Elements of cultural scripts of trauma sequelae among trauma victims in East Africa*. Frontiers in Psychology,14, 1206503. https://doi.org/10.3389/fpsyg.2023.1206503

Nela, A. (2024). Psychological Effects of Armed Conficts on Children. The Global Psychotherapists, Vol. 4, No. 1, pp. 132=138. DOI: 10:52982/lkj227

Nisa, Z. U., Talat, A., Khan, S. E., Elahi, A., & Ghazanfar, I. (2024). Navigating mental health challenges in conflict zones: a mixed method literature review. *Pakistan Journal of Humanities and Social Sciences*, *12*(3), 2629-2642.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1–13. https://doi.org/10.1177/1609406917733847

Oishi, M. (2016). Introduction: The ASEAN Way of Conflict Management Under Challenge. In: Oishi, M. (eds) Contemporary Conflicts in Southeast Asia. Asia in Transition, vol 3. Springer, Singapore.

https://doi.org/10.1007/978-981-10-0042-3_1

Pangandaman, T. A., Mala, A. M., & Raki-in, S. A. (2019). Perceived psychophysiological effects of Marawi Siege among internally displaced persons. *International Journal of Advanced Research, 7*(3), 993–1001.

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). SAGE Publications.

Peace for Asia. (2022). *On the way to autonomy: The Moros' decades-long struggle for self-determination in Mindanao*. https://peaceforasia.ch/on-the-way-to-autonomy-the-moros-decades-long-struggle-for-self-determination-in-mindanao/

Perez, J. C. (2019). Greed and grievances: A discursive study on the *Ethnic and Cultural Studies, 6*(3), 1–14. https://www.ejecs.org/index.php/JECS/article/view/254

Philippine Red Cross. (n.d.). *Psychological first aid (PFA) in disaster-affected communities*. Philippine Red Cross. Retrieved from https://www.redcross.org.ph

PMC. (2020). *Cultural humility in mental health practice*. National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC7011220

Pole, N. (2007). The psychophysiology of posttraumatic stress disorder: A meta-analysis. *Psychological Bulletin, 133*(5), 725 746.

Pro Peace. (n.d.). *Background*. Pro Peace. https://www.propeace.de/en/background

Quintero et al., 2016. Pastoralism development in the Sahel : a road to stability? https://doi.org/10.1596/24228

Ranjbar, N., & Ramaswamy, S. (2020). *Trauma-informed care and cultural humility in the mental health setting*. Psychiatric Services, 71(4), 345–348. https://doi.org/10.1176/appi.ps.20190027

Restrepo MT, Padilla-Medina D. Armed conflict exposure and mental health: examining the role of imperceptible violence. Med Confl Surviv. 2023 Sep;39(3):199-221. doi: 10.1080/13623699.2023.2222360. Epub 2023 Jun 16. PMID: 37325901.

Samuels, P. (2016). *Advice on exploratory factor analysis*. Birmingham City University. Retrieved from https://www.open- access.bcu.ac.uk/6076/

Sateemae, M. et al., 2022. Violence and traumatic exposures among islamic high school students in thailand's subnational conflict. Intervention 20(1):p 14-27, Jan–Jun 2022. | DOI: 10.4103/INTV.INTV_2_21

Save the Children Philippines. (n.d.). *Trauma-sensitive parenting and family support programs*. Save the Children Philippines. Retrieved from https://www.savethechildren.org.ph

Scholte, W. F., et al. (2004). PTSD in Sudanese refugee camps. *Journal of Refugee Studies, 17*(3), 313-323.

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry, 16*(2), 130–139.

Sivananth, A. (2020). Social and familial breakdown due to war: Impact on displaced populations. *International Journal of Social Psychiatry, 66*(5), 409-417.

Stovall-McClough, K. C., & Cloitre, M. (2006). Unresolved attachment, PTSD, and dissociation in women with childhood abuse histories. *Journal of Consulting and Clinical Psychology, 74*(2), 219

228. https://doi.org/10.1037/0022-006X.74.2.219

Subica, A. M. (2021). *Cultural trauma as a fundamental cause of health disparities*. Social Science & Medicine, 276, 113826. https://doi.org/10.1016/j.socscimed.2021.113826

Suhr, D. (2006, July). *Exploratory or confirmatory factor analysis?* SAS Users Group International Conference, San Francisco, CA, United States.

Tabachnick, B. G., & Fidell, L. S. (2019). *Using multivariate statistics* (7th ed.). Pearson.

Tejero, S. M., Mancia, A. P., & Padagas, R. A. (2021). Creative arts psychosocial interventions for conflict-affected children of the Marawi siege. *Journal of Psychological Studies, 8*(2), 41–58.

Thabet, A. A., & Vostanis, P. (2011). Impact of political violence and trauma in Gaza on children's mental health: A community- based study. *Arab Journal of Psychiatry, 22*(2), 71–82.

University of the Philippines. (2024). *Community-based trauma care for Indigenous peoples*. MedRxiv. Retrieved from https://www.medrxiv.org

van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. *Penguin Books*.

Williamson, V. & Murphy, D. 2025.Psychological consequences of global armed conflict. BMC Psychology.

Yehuda, R., et al. (2015). Epigenetic changes in the offspring of trauma survivors. *Translational Psychiatry, 5*(6), e530.

Yehuda, R., et al. (2018). *Intergenerational transmission of trauma effects: A review*. *Journal of Psychiatric Research, 103*, 87-93.