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Development and Efficacy of Family CORE-Based Program on The Trauma Symptoms Among Family Members of Victims of Drug-Related Violence

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ABSTRACT: The illicit drug trade is a persistent global threat often met with punitive measures that leave behind a trail of psychological trauma for the families of victims. In the Philippines, the intense anti-drug campaign between 2016 and 2018 resulted in thousands of deaths and arrests. While rehabilitation programs for drug users are prevalent, there is a severe scarcity of restorative interventions for their family members—those who witness or survive the sudden arrest, kidnapping, torture, or killing of loved ones. This study aimed to address this gap by developing and testing the efficacy of the Family CoRe-based intervention program specifically designed to alleviate trauma symptoms in this vulnerable population. The research utilized an exploratory sequential mixed-methods design. Phase I involved qualitative exploration through focus group discussions with community leaders and in-depth interviews with nine family members of victims in Taguig City. This phase identified six core themes: disbelief, depression (encompassing helplessness, guilt, and emotional pain), anxiety-arousal/fear, anger, intrusive experiences, and defensive avoidance. These themes served as the foundation for the "Family CoRe" program, an acronym reflecting its theoretical integration of Cognitive Behavior Therapy (CBT) and Reality Therapy. The resulting intervention consists of seven modules delivered over nine sessions, facilitated in a small group format. In Phase II, the program's efficacy was tested using a one-group pretest-posttest single-subject design. Due to COVID-19 pandemic constraints, five participants completed this phase. The Trauma Symptoms Inventory-2 (TSI-2) was utilized to measure psychological distress across four primary factors: Self-Disturbance (SELF), Post-traumatic Stress (TRAUMA), Externalization (EXT), and Somatization (SOMA). Quantitative data were analyzed using IBM SPSS, with Hedge's *g* employed to calculate effect size and correct for bias inherent in small sample sizes. Results indicated that participants initially presented with clinically elevated T-scores, with the TRAUMA factor being the most prominent ($M = 64.80$). Specifically, Anxious Arousal (AA) and Defensive Avoidance (DA) recorded the highest baseline means ($M = 19.33$), followed by Depression, Somatic Preoccupations, and Intrusive Experiences. Following the implementation, post-test scores revealed a substantial decrease across all trauma domains. The TRAUMA factor mean dropped significantly to 17.6, while SELF decreased from 46.40 to 12.40, EXT from 32.20 to 16.20, and SOMA from 19 to 5.4.

The study concludes that the Family CoRe-based program is a feasible and effective restorative approach. CBT-informed components successfully targeted maladaptive appraisals and hypervigilance, while Reality Therapy empowered participants to restore agency and re-engage in daily routines. These results suggest that the program provides measurable relief for families experiencing violent bereavement. However, given the pilot

nature of this study, further validation through true experimental designs with larger cohorts is recommended to ensure long-term sustainability

1. INTRODUCTION

The Global and National Crisis of Illicit Drugs. The illicit drug trade remains a persistent global threat, resisting even the most stringent law enforcement measures. In the Philippines, this issue reached a critical point in 2015, with an estimated 1.8 million substance dependents, the majority of whom were users of crystal methamphetamine, or "shabu". This epidemic prompted an unprecedented and intense government campaign against illegal drugs starting in July 2016. While the campaign led to over 1.3 million individuals surrendering for rehabilitation, it also resulted in significant violence. Between 2016 and 2018, police operations accounted for 4,354 deaths, while non-police or vigilante operations were presumed to have caused an additional 2,290 deaths. In the National Capital Region (NCR) alone, killings were nearly evenly split between police (49%) and non-police (51%) operations.

The Hidden Victims: Families and Psychological Trauma. While much of the public and academic discourse focuses on the "drug personalities" or the substance abusers themselves, a profound and often overlooked crisis exists among their families. Family members are frequently witnesses to, or survivors of, the sudden arrest, kidnapping, torture, or killing of their loved ones. Expert accounts have documented that these experiences lead to severe psychological distress, including post-traumatic stress, chronic fear, and social isolation. In Taguig City—which ranks 10th in the NCR for drug-related deaths—initial environmental scanning revealed that 55.55% of victims in the study area were kidnapped, tortured, and killed. These families are left to navigate a landscape of "violent bereavement" complicated by social stigma and ongoing community-level uncertainty.

The Research Gap and Restorative Need Despite the scale of this violence, a significant gap exists in restorative interventions. Current community-based programs primarily emphasize the rehabilitation of the substance-dependent individual, leaving the affected family members without structured psychological support. There is a noted scarcity of published research and evidence-based programs specifically designed to alleviate trauma symptoms in this population. While general interventions like the Trauma Response Team (TRT) or family therapy have been used for broad community trauma, there is no specialized framework that integrates cognitive processing with the restoration of life functioning for those affected by drug-related violence.

Theoretical Framework: The Family CoRe-Based Program This study addresses this gap through the development of the Family CoRe-based Intervention Program. The program is theoretically anchored in Cognitive Behavior Therapy (CBT) and Reality Therapy.

- **CBT** is utilized to target the cognitive-affective processes of trauma, such as maladaptive appraisals, hypervigilance, and persistent fear.
- **Reality Therapy** (the "Re" in CoRe) focuses on helping participants manage their behavior and meet psychological needs—specifically belongingness and freedom—which are often shattered by sudden loss or state-led violence. By combining these approaches, the intervention aims to move participants from a state of "defensive avoidance" and "immobilizing grief" toward active agency and restored role functioning.

The Present Study: Inspired by the researcher's background in police advisory and community psychology, this study seeks to provide a restorative model for the wider community. The primary objectives are to:

1. Develop and implement the Family CoRe-based intervention program for family members of victims of drug-related violence.
2. Determine the significant differences in trauma symptoms—including Anxious Arousal, Depression, and Intrusive Experiences—using the Trauma Symptoms Inventory-2 (TSI-2).

Evaluate the efficacy of the program in providing measurable relief to this vulnerable population

2. MATERIALS AND METHODS

To evaluate the efficacy of the developed intervention, this study employed a robust methodological framework designed to capture both the qualitative depth of participant experiences and the quantitative measurement of symptom reduction.

2.1. Research Design

The study utilized an exploratory sequential mixed-methods design. This approach began with an initial qualitative phase (Phase I) to explore the trauma symptoms and needs of the family members, which served as the foundation for developing the Family CoRe-based intervention program. This was followed by a quantitative phase (Phase II) to test the program's efficacy. For the experimental component, a one-group pretest-posttest single-subject design was employed to determine significant changes in the participants' trauma levels following the intervention.

2.2. Study Site and Participants

The research was conducted in Taguig City, one of the major urban centers in the National Capital Region. Using a single-stage sampling procedure, nine participants were initially selected for the qualitative needs' analysis and program development phase.

- **Demographics:** The initial group was predominantly female (89%), with ages ranging from middle-aged (51–57 years) to retirement age (60–73 years). All participants were Catholic.
- **Attrition:** Due to the severe constraints of the COVID-19 pandemic and enhanced community quarantine, only five participants remained for the Phase II experimental implementation and post-testing.
- **Victim Background:** The family members reported that their loved ones had been randomly arrested/detained (44.44%), killed (33.33%), or kidnapped and tortured (22.22%).

2.3. Instrumentation and Data Measures

The study utilized both researcher-developed and standardized tools:

- **Qualitative Tools:** Semi-structured interview guides were used for Focus Group Discussions (FGDs) with community leaders (barangay chairpersons and team leaders) and for in-depth, one-on-one interviews to construct the participants' narratives.
- **Standardized Measure:** The Trauma Symptoms Inventory-2 (TSI-2) was the primary quantitative instrument. It assesses a broad range of psychological symptoms across four factors: Self-Disturbance (SELF), Post-traumatic Stress (TRAUMA), Externalization (EXT), and Somatization (SOMA). The TSI-2 includes 12 clinical scales and 12 subscales, providing a comprehensive assessment of trauma-related distress.

2.4. Data Collection Procedure

The procedure was divided into two distinct phases:

- **Phase I (Program Development):** Involved an extensive literature review, theoretical anchoring in CBT and Reality Therapy, FGDs with informants, clinical psychological assessments, and the creation of a preliminary intervention draft. This draft underwent **expert evaluation** by registered psychologists before finalization.
- **Phase II (Experimentation):** Consisted of the implementation of the **nine-session program**, followed by a post-test using the TSI-2 to measure symptom alleviation.

2.5. Ethical Considerations

The study was reviewed and ethically approved by the **University of Santo Tomas (UST) Manila Ethics Review Committee (ERC)**. All participants were assured of anonymity and confidentiality. Furthermore, the implementation strictly adhered to risk-based public health standards for **COVID-19 mitigation**, and participants provided explicit consent for intervention sessions conducted during the pandemic.

3. RESULTS AND DISCUSSION

3.1 Preliminary Analysis

The results of this study are presented in two phases: the qualitative development of the intervention program and the quantitative evaluation of its efficacy.

For Phase I

3.1. The components of the Family CoRe-based intervention program among the family members of victims of drug-related violence

For Phase II :

3.2. The significant difference between the pre- and post-test mean scores of the participants on trauma symptoms as measured by the Trauma Symptoms Inventory- 2

3.3. The efficacy of the program using TSI-2 as post-test, noting the significant change from the initial clinical assessment (pre-test) and after the implementation of the Family CoRe-based intervention program.

PHASE I:

3.1. The Components of Family CoRe- based Intervention Program on Trauma Symptoms Among the Family Members of Victims of Drug- related Violence

The Family-CoRe-based Intervention Program is a seven-module psychological intervention program based on the data outcome of this study to alleviate the trauma symptoms among the selected family members of victims of drug-related violence.

Table 1 describes the components of the program. It includes the title, number of sessions, number of modules, therapeutic intervention used, activities, objectives, and required materials.

Table 1 The Components of Family CoRe- based Intervention Program

Components	Description
The Title	Family CoRe- Based Intervention Program
Session	9 sessions including the orientation and the closing
Modules	7 Modules
Therapeutic Intervention	Family Therapy, CBT and Reality Therapy
Activities	10 Worksheets
Objectives	To alleviate Trauma Symptoms
Materials Needed	PowerPoint Presentations and Worksheets

It is a seven (7) modular intervention with nine sessions, seven of which are intended for modules 1-7. Due to community quarantine, the sessions were administered once a week ; the duration is designed to be 1-2 hours and facilitated in a small group with 5 members.

The entire program is named as “Family CoRe-based Intervention Program” as it is derived from the results and analysis of the earlier stages of program development founded on the two evidence-based therapies namely : Cognitive- behavior Therapy,

and Reality Therapy. Cognitive Behavior Therapy believes that behaviors are shaped by thoughts and feelings based on the notion that psychological problems emerge because of the way people's thoughts, feelings, and behaviors are interpreted or evaluated (Tull, 2018). Reality Therapy assists people in managing behavior in deciding on new and difficult choices in life. Helping people meet their psychological needs such as belongingness and freedom is the goal of reality therapy (Sharf, 2012).

Issues and concerns were explored and identified through the FGDs conducted with the informants (barangay chairpersons & team leaders). Common responses were as follows :

"Masaya sila at nakulong dahil adik, pasaway, sakit sa ulo; maraming hindi nawawala sa sistema ng pamilya ang droga dahil ito ang source of income nila. Dine-deny ng ina ang labat. Maging ang mga apo ay nagiging biktima na rin ng ipinagbabawal na gamot; may kinalaman sa koneksyon. Isang pinakamalaking pamamaraan ng pusher kaya hindi ito natatakot na magpabalik-balik sa bisyo."

("They were happy knowing that they were arrested because they are addicted, uncontrollable, a pain in the head ; most of them couldn't get rid of the system because it's their source of income. The mother denies all of it. Even the grandchildren are already victims of prohibited drugs ; connection has something to do about it. It's the biggest source of the pushers that's why they are not afraid of doing some illegal activities/ vice all over again.")

Phase I findings revealed six core qualitative themes that characterize the psychological distress of family members: (1) Disbelief; (2) Depression (helplessness, guilt, and pain); (3) Anxiety-Arousal/Fear; (4) Anger; (5) Intrusive Experiences; and (6) Defensive Avoidance. These themes formed the conceptual basis for the Family CoRe-based Intervention Program, which integrates Cognitive Behavior Therapy (CBT) and Reality Therapy.

The finalized program consists of seven modules delivered over nine sessions. Each session is designed to last 1–2 hours and is facilitated in a small group format. Due to community quarantine constraints, the implementation was intensified to three sessions per week while maintaining the core therapeutic components.

To know the level of the participants' trauma symptoms, the Trauma Symptoms Inventory-2 was administered to the nine participants during the clinical assessment. Tables 2 and 3 show the different factors measured by the Trauma Symptoms Inventory-2.

Table 2 illustrates the different factors such as : Self-Disturbance (SELF), Post-traumatic Stress (TRAUMA), Externalization (EXT), and Somatization (SOMA).

Table 2 Difference Between the Factors Measured by Trauma Symptoms Inventory-2

Trauma Symptoms Inventory- 2 Factor								
Participant Number	Self T-score	Interpretation	Trauma T-score	Interpretation	Ext T-score	Interpretation	Soma T-score	Interpretation
1	80	CE	85	CE	69	CE	52	N
2	49	N	61	P	62	P	49	N
3	44	N	67	CE	58	N	44	N
4	47	N	71	CE	46	N	51	N
5	77	CE	84	CE	94	CE	74	CE
6	78	CE	80	CE	86	CE	74	CE
7	75	CE	81	CE	80	CE	76	CE
8	74	CE	70	CE	78	CE	67	CE
9	56	N	63	P	64	P	54	N

Legend : 0-59 N= Normal, 60-64 P= Problematic, 65 above CE- Clinically Elevated

Higher T scores indicate greater degrees of symptomatology. T scores from 0-59 are considered normal, T scores from 60-64 are considered problematic, having clinical implications, and those at or above 65 are considered clinically elevated, having clinical concerns (Biere, 2011). Results further show that the participants obtained mostly clinically elevated T-scores on posttraumatic stress (TRAUMA), followed by self-disturbance (SELF), and externalization (EXT), then somatization (SOMA). It is significant to note that TRAUMA factor items do not explicitly refer to a specific traumatic event. In the current study, the participants with family members being randomly arrested/detained, captured, kidnapped, tortured, and killed due to drug-related activities have elevated TRAUMA scores.

Table 3 Level of the Participants' Trauma Symptoms Inventory- 2 Clinical Scales

N= 9

Clinical Scales	M	SD
IE	16.56	4.10
AA	19.33	6.24
SOM	16.67	7.50
D	17.22	6.96
DA	19.33	4.33
IA	12.78	8.35
ANG	13.89	6.17
ISR	13.11	8.84
TRB	11.33	5.52
DIS	11.11	5.86

Legend : N= Number of participants, M= mean, SD= standard deviation IE= Intrusive Experiences, AA= Anxious Arousal, SOM= Somatic Preoccupations, D= Depression, DA=Defensive Avoidance, IA= Insecure Attachment, ANG= Anger, ISR= Impaired Self- Reference TRB=Tension Reduction Behavior, and DIS= Dissociation

Table 3 above illustrates the level of the participants' trauma symptoms in the Trauma Symptoms Inventory-2. Moreover, it shows that the participants obtained high mean scores on the following clinical scales, AA and Defensive Avoidance (DA) (M=19.33). The summary of clinical scales suggests that AA and DA obtained the highest mean score among the clinical scales under the factor TRAUMA, followed by D (M=17.22), SOM (M=16.67), IE (16.56), and ANG (M=13.89).

The **Anxiety- Arousal- Anxiety/Fear**. AA-A scores show how the **participants underwent symptoms of worry/fear linked with trauma exposure (Biere, 2011)**.

The following narratives reflect that the participants did not only fear for their own lives but also for the future of the grandchildren left under their care :

"Baka balikan po kami." (P1) ; "Ayaw kong mangyari sa akin...Sabi nila I ano raw... (report) ayaw ko baka kami balikan. Wala kaming lakas na anubin yun. (report) Maraming nagsasabi dapat ipa tulfo namin, nangunguna sa akin yung takot e... baka mamaya kami ang balikan. Hindi namin alam baka Kami ang gantiban."(P2); "Nangibabaw yung una takot dun sa pangyayari. Maaaring hindi kami lang, hindi lang anak

ko. Baka mamaya pati kami dahil hindi naka singil, baka kami naman ang bawian. Kung babawi naman ako, kami naman ang babalikan.” (P3); “Sa totoo lang parang takot akong makipag-usap sa inyo... mamaya e isa kang pakawala... baka may kinalaman ka sa gumawa kay J...

tinitignan kung ako ay magkakaso pa Takot ako, kabado ako.” (P4); “Ninerbyos po ako , biro nyo 4 yung apo ko Buntis pa sya nung kinulong sya.”) (P6); Sabi po sa akin “Ano baka gusto nyo isama ko kayo sa kulungan?” (P7)

(“We might experience a setback- revenge.” (P1); “I dread having it happen to me... They say:...something bad was done about him...and I don’t want a setback-revenge. Many say we should ask for help from Tulfo...I feel scared though...we might be harmed unjustly. We don’t know how we’ll taste their revenge.” (P2); “At first, fear set in due to the incident. Not just thinking of our family or child, ...we might all be asked to pay in some way. If I am going to do something, there’s no telling what might happen to us.” (P3); “Honestly, I’m kinda scared to be seen talking to you...you might be one of their men...you might be one of those involved...regarding J...looking for a way to implicate me. I’m scared, nervous.” (P4); “I got nervous, it’s no joke, 4 grandkids, and she was pregnant when they arrested and detained her.” (P6); Someone told me, “what! Do you want me to bring you with him? (in jail)” (P7). In the field of offender research, dehumanization is linked to social exclusivity and mistreatment through the perceptions of threat/s (Viki, et al., 2012 as cited in Labor, et al., 2017).

The **Defensive Avoidance (DA)** scale is the overall measure of emotional, cognitive, and behavioral avoidance. Findings show that the participants have efforts to remove or deny painful thoughts and memories that have become aware of. The participants' unwillingness to speak about and process every negative, trauma-connected experience is manifested through different activities. The subsequent were observed from the

participants :

(a) Having fun ; “Nililibang ko na lang po sarili ko.” (P1) (P2) (P6); “Minsan nanonood na lang ako ng TV para mawla-wala yung ano... para malibang.” (P4) (“I just console myself.”) (P1) (P2) (P6) ; “Sometimes, I watched TV and tried to make (the memory) go away...to feel entertained.”) (P4)

(b) Keeping oneself busy with household chores ; “Sa loob ng bahay kung ano-ano nang gawin... naglilinis.”(P6) (“In the house, I do whatever it takes, clean the house”) (P6)

(c) Working so hard ; “Minsan nagta trabaho ako... pinapagod ko ang sarili ko.”(P4) ; “Minsan po nagtitinda na lang ako ng sampaguita.” (P6) “Nagta trabaho po ako, kahit anong trabaho,naglalaba nangangalakal, o kaya po ay naglilinis ng bahay.” (P7). (“Sometimes I work and tire myself out...” (P4); “Sometimes I sell Sampaguita flowers”(P6); “I work at anything, work, work, work... in laundry or business/trade, or clean the house...” (P7).

(d) Taking care of grandchildren and other members of the family ; “Nag-aalaga ako ng apo.” (P1) (P3) ; ; “Bumabawi sa mga apo.” (P3) ; “Alagaan yung maliit, asikasuhin yung mga apo... hatid sundo sa school.” (P6). (“I take care of my grandkid.” (P1) (P3) ; “I do better through my grandchildren.” (P3) ; (“ take care of grandchildren and little stuff, take them to school and bring them home”) (P6).

(e) Doing rituals “Pag naalala ko, gaya nito (death anniversary) nagtitirik ako ng kandila.” (P1) ; “Dasal lang ako ng dasal sa Diyos... nalalampasan ko to dahil sa Panginoon.” (P2) (P4) (P8) ; “Iniisip ko na may Diyos, na may asawa ako.” (P3) ; “Nagdarasal na lang ako kay Lord... “bahala na kayo Lord pagod na ako e...Naging kapahingahan ko si Lord... nagbalik ako sa service sa church” (P8). (“When I recall, like this (death anniversary), I light a candle.” (P1) “I pray and pray to GOD... I survived throughout the ordeal because of the LORD.”) (P2) (P4) (P8) ; “I think of GOD and of my spouse.” (P3) ; (“I just pray to Lord and say : “Lord, it’s all up to You. I’m so tired ...HE is my Rest...I got revived/renewed in the service of His church”) (P8). High DA scores show triggered memories of a traumatic incident. It shows how people with DA scores have efforts to remove or deny painful thoughts and memories that have become aware of. Higher scores here may mean a smaller chance for the person/s to willingly talk about and process very negative, trauma- connected experiences for therapy or treatment (Biere, 2011). The participants’ unwillingness to talk about and process every negative, trauma-connected experience has been manifested. It was evident that the participants also obtained high scores on Defensive Avoidance (DA). Meaning, efforts to remove or deny painful thoughts and memories that have become aware of, were manifested. The participants avoid situations that remind or can lead to such things.

The **Depression (D)** Scale. This scale measures the extent to which the participants experienced depressed mood and cognition. As cited in the study of Hodgkinson & Prins (2011) perhaps the better term for depression is “melancholia” or deep gloom/sadness. It is useful to realize that clinical depression is different from daily feelings of mild depression or mood. Major

depression is seen in people of any age and background, it can be extremely weakening, and one can suffer from it for a very long time (Zarate, 2010). Table 3 also shows that the participants obtained a high score with a mean score of 17.22 and a standard deviation of 6.96. It reflects the participants' frequent feelings of sadness and unhappiness. Under Depression, feelings of helplessness, guilt, and emotional pain were manifested and observed :

a. Helplessness. As a reaction to the uncontrollable situation, an individual develops helplessness (Mohanty, et al., 2015). Helplessness is giving up hope over environmental events (Nuvvula, 2016). This has been expressed by participants 2, 6, and 7, wherein they both admitted that they had experienced being involved in illegal drug activities and had been arrested and put to jail for years. The participants felt that they were unable to try to do anything to assist the victims because they did not know where to go to and evoke help :

"Nung kinuha sya, hindi ko alam kung saan ako hihingi ng tulong, saan ako tatakbo... kabit saan ako pumunta walang tumutulong... para bang sarado labat mga kaibigan nya." (P1) ; "Hindi na namin alam kung saan sya babanapin... Sa labat ng prisinto binanap na namin sya, wala talaga, kabit saan wala talaga, kabit madaling araw... walang tulog basta makita lamang namin sya." (P2) ; "Wala akong asawa, wala akong pera, wala akong trabaho, tiniis ko po labat yun. Di ko maintindihan po, syempre nag-iisa ako wala akong katuwang sa bubay bakit nagkaganon ? Wala akong magawa nung kinuha sya... drugs e." (P6) ; "Dinamog po sya pero ayaw nila akong papasukin... gusto ko pong pumunta duon (police outpost) ... Syempre anak ko yun nabalitaan ko na binibugbog nila... magagawa koandyan na yan." (P7).

("When they kidnapped him, I didn't know where to get help, where I run to... everywhere I went, nobody dared to help... it seemed that all his friends weren't there." (P1) ; "We don't know where to find him... search until dawn in every precinct but we failed... we search everywhere until dawn... we didn't sleep just to see him." (P2) ; "I don't have a husband, I don't have money, I don't have work, I could not understand... I'm all-alone, why is it that this thing happened to me ? I couldn't do anything once they get her... due to drugs." (P6) ; "They arrested him and once I heard that they did hit him hard, of course he's my son. I wanted to see him but they didn't allow me to enter the police outpost") (P7). Illegal drug use/abuse can weaken healthy growth and family bonding to affect regulation. Now and then the results of maximum and current illegal drug use/abuse by a parent can estrange both parent and child. A long-term separation of parent and child can have a negative, great impact on a child. He/she will not be able to become close to anyone, as a regulate affect, and it can cause hyper-arousal or numbing as a trauma response. Usually at great risk, possibly developing drug abuse/illegal drug use problems or so on. (Lander, et al., 2013). Sorrenti, et al. (2019) investigated the presence of learned helplessness in the development of anxiety and depression (internalizing problems) ; anger and aggressive behavior (externalizing problem).

b. Guilt. It is perceived as an uncomfortable negative experience that an individual does not want to remember (Rebega, et al., 2013). In the current study, guilt was described as maladaptive. Upon knowing about the sudden arrest and death of their family members due to involvement in illegal drugs, the participants expressed their feelings of guilt because of :

(1) Inability to sense that their children were involved in illegal drugs

(using, selling, pushing) as seen in the following responses: "Hindi ko alam kung ano na nangyayari sa kanila kasi nagtitinda ako ng Sampaguita." (P6) ; "Nakulong po ako ng 7 years kaya yun din po siguro, nung wala po ako, hindi ko alam kung ano na ang ginagawa ng anak ko." (P7) ("I do not know what's happening to them because I just sell Sampaguita flowers." (P6) ; "I was imprisoned for 7 years and so perhaps, that's when I don't know what my child is doing.") (P7)

(2) Inability to sense that their children's lives were in danger : "Hindi ko alam, birthday n'ya nung kinuha s'ya, pinahirapan at pinatay." (P2) ("I was caught unaware, it was his birthday when he was abducted, tortured and killed.") (P2) Lack of readiness and difficulty in making sense of death are factors affecting complicated grief. (Nakahima, S. et al., 2012).

(3) Inability to assist their loved ones as observed within the participants'

responses : "Ako dapat ang nagtustos sa kanila. (she receives money from his son who sells drugs) (P2); "Kung siguro nuon kung may college na tsatsagain namin e... talaga namang hindi naming." (P8). ("I should've been the one to earn for them." (P2) ; "Maybe if there was college then, we would have worked hard for it... but there was no college.") (P8).

(4) Inability to act as role models : "Ang tatay rin nya nagbi bisyo...Nalaman ko lang na malala na sya nung patay na sya." (2) ; "Iniisip ko siguro kaya nagka ganyan mga anak ko dahil sa amin ding mga magulang... nag rebelde. Marami kasing nangyayari ngayon dahil sa magulang din. Ako rin po kasi... sila rin po alam rin nila ano ginagawa ng papa nila... pag nakakainom po nananakit din." (P7) ("His father also had the vice...I learned too late that the vice was already worse when he's dead." (P2) ; "I imagine : perhaps my children became like this because of parents like us...they rebelled. Many things happened because of the parents' upbringing. Me, too, they know about me...how their father hurts me whenever he gets intoxicated/drunk.") (P7).

(5) Inability to discipline their children : “Pag dating sa tropa wala po akong magawa. Hindi ko sya napipigilan magbarkada.” (P8) (“Concerning gangs, I just can't do anything about it. I can't stop him from being with them”) (P8).

In the study of Tignor and Colvin (2019), guilt is taken into account both as maladaptive and adaptive. Both shame and guilt were found to be significantly associated with PTSD (Cunningham et al. 2017).

c. Emotional Pain

The emotional pain was evident in the participants' responses :

“Hindi ko sya kayang tignan mabirap isipin... Ayaw ko, sa punirarya nga hindi ko kayang tignan e... nakabubad sya, marami syang tama. Nung nakita ko yung anak kong nakabulagta.” (P2) ; “Okay naman sa akin na makulong sya pero yung ganunin sya, pabirapan sya, yun ang masakit sa akin... pinabirapan pa nila bago nila pinatay.” (P4) ; “Naawa po ako sa anak ko. .Nabawalay sya sa amin, hindi namin sya nakaka-sama.” (P7) ; “Hanggang ngayon hindi ko pa sya dinadalarw dahil masama ang loob ko.” (P8)

“I can't look at him...it's too hard ...I can't look at him in the funeral home where I got his body, I just can't look at my child knowing he took a lot of gun hits/gunshots.”(P2) ; “It's alright to see him imprisoned justly, but to see him tortured, it's too painful for me... they tortured him before they killed my child.” (P4) ; “I feel pity for my child...He got separated/estranged from us, he wasn't able to bond with us.” (P7) ; “Up to now, I have not visited him because I feel so sad and disappointed.”) (P8).

Depressive disorders, as well as sadness, happened from a major loss : death in the family, financial bankruptcy, personal illness (Truschel, 2019). The whole criteria for diagnosing depressive disorders is seen in DSM-IV-TR (American Psychiatric Association, 2000) or ICD-10 (World Health Organization, 2007), where the criteria are simplified to help one identify core components/parts of the depressive disorder. One should realize that a person could have depressive disorder even if not all of the symptoms are present :

1. *Loss of interest and pleasure in life's activities including loss or severe diminution of sexual interest (libido). The technical term for these presentations is anhedonia. (This was not present among the participants)*
2. *Feeling helpless and more 'down' than would appear to be merited by the sufferer's circumstances.*
3. *Loss of appetite, and in some cases recourse to overeating.*
4. *Feeling oneself to be a failure, despite there being no rational cause.*
5. *Sleep disturbances – for example, difficulty in falling or staying asleep, or sleeping too much.*
6. *Difficulty in concentrating.*
7. *Morbid thoughts (such as feeling one would be better off dead).*
8. *Severe tiredness and lack of energy.*

As cited within the study of Hogkinson and Prins (2011) perhaps the better term for depression is “melancholia” or deep gloom/sadness. It is useful to appreciate that emotional disturbance is different from daily feelings of mild depression or mood. Major depression is seen in people of any age and background, it is extremely weakening, and one can suffer from it for a very long time (Zarate, 2010).

The Somatic Preoccupations (SOM) scale has items that show bodily concerns. Bodily pain and general health problems were associated with PTSD (Bassett et al., 2014). The participants in the current study expressed the following responses :

“Shock talaga ako, ikot ako ng ikot...nasusuka po ako nung time na yon.” (P1) (P2) ; “Hindi ako nakapagsalita (crying)”(P2) ; lumalapit nga ako parang lantang gulay ako e” (P3); Hindi na ako makatulong... pumayat ako”(P3) (P6); “Masakit ito (pointing her heart) at dibdib” (P1)(P4); “high blood po ako.. parang nanigas ang katawan ko.Nanikip ang dibdib ko” (P7).

“I was shocked, I got up and felt nausea at that time, I kept moving around...”

(P1) (P2); “I couldn't speak (crying)...” (P2);“I approached, feeling like a weak vegetable...” (P3); “I couldn't sleep, I lost weight.” (P3) (P6); “This is painful (pointing heart heart) and my chest.” (P1) (P4); “I had high blood, my body felt like stiff, and my chest too.”) (P7).

The **Intrusive Experience (IE)** scale has items that show post-trauma reactions and symptoms : nightmares, flashbacks (sudden, intrusive sensory memories of a past painful incident), bad memories, current events triggers, repetitious memories/thoughts that disturb, are perceived by people to be random things from nowhere. IE scores show how the participants reported some combinations of flashbacks, nightmares, intrusive or triggered memories, cognitive or behavioral avoidance of previous traumatic events, sympathetic hyperarousal (e.g., sleep disturbance, jumpiness, irritability, hyperalertness), and various dissociative symptoms). It is a collection of recent experiences/sad events and so, the higher IE scores may connect to a previous psychological trauma that can hamper current experience/awareness and stress the person/s (Biere, 2011). This is evident in the responses of the participants. This is evident in the observed responses of the participants :

"Hindi mawala-wala sa isip ko ang ginawa nila sa anak ko. Pag naiisip ko ang pangyayari, banggang ngayon po, hindi pa rin mawala sa isip ko. Laging nasa isip ko bakit nila ginanon... sana hinuli na lang nila kung may kasalanan yung bata, hindi na nila pinabirapan" (P1) ; "Kaya ang buhay ko kapag naririnig ko buhay ng isang magulang, ang hirap. Hindi dumadaan sa loob ng isang buwan na hindi mo maalala... Hanggang ngayon naaalala ko pa. Hindi ako makalimot sa pangyayari... Hindi maalis sa isip ko." (P3) ; Pag naaalala ko, nalulungkot ako." (P4)

("I can't forget what they did to my child. I can imagine it and up to now, while it's on my mind, I think they should have just captured and imprisoned him, not tortured him" (P1) ; "My life is hard, just like how I hear parents talk about their lives. Each month I remember...up to now. I can't forget..." (P3) ; "When I remember, I feel sad." (P4)

The **Anger (ANG)** Scale. Table 11 also shows that the participants obtained a mean score of 13.89 with a standard deviation of 6.17. A high score on this scale describes pervasive feelings of annoyance, bad temper, or a sense of mistreatment that provokes angry reactions or behaviors. The subsequent responses were observed :

"Naiisip ko hirap na hirap ang anak ko... parang pinabirapan talaga... Grabe po ang pagka-ano sa kanya (couldn't mention the word patay or killed) ... grabe po ang pagpapahirap sa kanya talagang tinorture sya ng husto. Sa porma pa lang sa kabaong talagang pinabirapan sya talaga... Bata pa yung anak ko... kung may kasalanan man ang anak ko ikulong nila. Napaka ano nila... napaka walang kwenta... Ang Diyos lang ang may karapatang kumuba ng buhay ng isang tao... wala silang karapatang kumitil ng buhay!... May karma, may mangyayari rin sa kanila... sana mangyari rin sa kanila, makulong o patayin din sila... " (P1) ; "Tao rin naman sila... Sanay silang pumatay ng tao!... "Maraming nakakita, ayaw lang magsalita...walang tumulong..." (P2) ; "Unang sinabi ko makabawi sana ako! Magbigantil!" (P3) ; "Naniniwala ako na planado yun... natutulog ang kapatid ko at asawa nya nung pinag babaril sila ng mga naka civilian" (P9).

("I imagine how hard it must be for my child... like he was really tortured. ...He was really, extremely (couldn't mention the word murdered/ killed) ... and the torture was just too much. The way he looked, inside the coffin, I knew he was tortured...He's too young for that... if they think he sinned/committed a crime, then just imprison him. They are so... they are worthless (authorities). God is the only One who's authorized to take a life...they don't have the right to do it !... There's karma, and justice will soon happen to them" (P1) ; "They (referring to the uniformed men) also are mere humans...but they will so easily take a life! it's not good!... I don't want to travel to groups and do stuff like that... "Many witnessed but none spoke aloud...none helped!" (P2) ; "My first thought was : revenge or to do something!" (P3); "I believed it had been planned... my brother and my sister- in-law were both asleep once they were attacked by men in civilian clothes.") (P9).

Stress, family problems, and financial issues trigger anger (Longhurst, 2019). Anger is a feeling resulting from any violent behaviors (Bilge, 2017). It is a usual reaction of those who are frustrated and maltreated. (Shahsavarani, et al. 2015). It is connected to attitudes towards justice and security laws/ systems. Violent people in criminal groups can directly do something to ordinary civilians and cause cycles of vigilante retributions (civilians are often willing to pay the next price to force the criminals to pay the consequence of their acts). Some crimes like random kidnapping, killing can lead people to create more public protections/outcries than when narcotic people are killed. Society may then feel it can have more room to deal extremely with criminals and therefore the guilty (Ponce, et al., 2018). Temper or anger negatively affects the frequency and quality of the social interaction of someone (Mcintosh et al., 2015). The anger with public services and bitterness about their family member's death/s is the standard reaction to bereavement (Stroebe et al., 2007). Parents/ families' anger through great bitterness towards public services of the government was reported within the study of Templeton, et al. (2017). In the field of offender research, dehumanization is linked to social exclusivity and mistreatment through the perceptions of threat/s (Viki, et al., 2012 as cited in Labor, et al., 2017). Anger manifests when emotions associated with behavior are frightening. Here, processing the emotion is necessary (Short, 2016). Findings in the current study reveal the participants expressed feelings of distrust and inadequacy as to how the drug operations were handled by both the police and also the civilians. Moreover, it shows that the manner in which the victims were randomly arrested/detained, kidnapped, tortured, and killed caused anger.

The major concerns explored and identified through FGDs, clinical psychological assessment, and one-on-one interviews were categorized and analyzed into six themes namely: (1) Disbelief; (2) Depression: helplessness, guilt, and emotional pain; (3) Anxiety-Arousal (Fear); (4) Anger; (5) Intrusive Experience; and (6) Defensive Avoidance. These concerns were addressed effectively in the different modules of the formulated and determined Family CoRe- based Intervention program. Further, to ensure the intervention's feasibility, the preliminary draft was given to six clinical psychologists for expert evaluation. Researcher-made evaluation tools : Program Evaluation Based on Experts, Summary of the evaluation were given to the experts to evaluate the developed Family CoRe-based Intervention Program. Moreover, Guidelines on the Efficacy Evaluation and Certification of the Family CoRe-based Intervention for Experts were utilized. Considering the experts' suggestions and recommendations, the intervention was finalized and administered to the participants.

On one hand, 100% of the expert evaluators were very satisfied as to how the program would help alleviate trauma symptoms. Eighty-three percent (83%) of the expert evaluators were very satisfied as to how the program provides insights and skills for reducing trauma symptoms and maintaining a positive outlook in life. Moreover, the experts were likewise very much satisfied with the appropriateness of the sessions. Positive remarks were as follows : promising program ; the activities per module are adequate and organized to meet the objectives ; the activities are good and can target the specific objectives of the modules, and could provide stress management tips.

On the other hand suggestions and recommendations were as follows : Deliver the program that could best be understood by the participants (i.e. Filipino) and at a time when no other apparent unrest (i.e. economic, calamity, etc.) are taking place ; there is a need to elaborate more on the materials and the procedures to be done during the activities ; Inclusion of time frame/ duration for each session. Sample of the actual module containing the forms, activity sheets, lecture, and processing questions would be more helpful. The researcher acted on the suggestions and/or recommendations of the expert evaluators by translating the lectures and the activity instructions in Filipino ; the time frame and the materials needed for the activity, instructions, and procedures were included in the manual for Family CoRe-based Intervention Program.

The evaluators were asked to make their remarks on the following areas : Objective of the Family CoRe-based Intervention ; The Core Component of Family Therapy, CBT and Reality into the Family CoRe intervention ; Number of Modules and sessions ; Module Topics ; Duration of the treatment ; Regarding the variables Trauma symptoms, and Ethical consideration in respecting individuals, culture and religion. Results showed that the expert evaluators had positive remarks on the developed Family CoRe-based intervention program.

OUTLINE OF THE FAMILY CORE-BASED INTERVENTION PROGRAM

Module I : Trauma and Trauma Symptoms : Broaching

Module II : Reality : Looking Through (to address disbelief)

Module III : Hope : Clinging to Life (to address depression)

Module IV : Catharsis : Letting Go (to address anger)

Module V : Choice : Making Decisions (to address anxiety-arousal/fear)

Module VI : Acceptance : Moving Forward (to address intrusive experience)

Module VII : Forgiveness : Getting Healed (to address defensive avoidance)

It has three stages : Stage I is the **Initial Phase** (Fall, 2013), which includes the opening session, which is intended to build rapport, establish and understand the therapeutic goals, and orient the participants on the group norms set for the intervention. Moreover, it has Module 1 that explains trauma and trauma symptoms.

Stage II is the **Working Phase**, which includes Modules 2 to 5. Topics are Reality, Hope, Catharsis, and Choice). Stage III is the **Termination Phase** (Fall, 2013), which includes Modules 6 and 7 with the topics on Acceptance and Forgiveness. The last session focuses on closing the therapeutic intervention with the belief that the goals are met : to alleviate the trauma symptoms.

The first module is intended to better understand trauma and realize how the symptoms of trauma were manifested and observed. The **second module's objective** is to address disbelief by assisting the participants in identifying events that are associated with the positive and negative thoughts that could affect emotions and, to identify and label such emotions that could, later on, affect actions and influence behavior. The **third module's objective** is to address depression specifically that of helplessness, guilt, and emotional pain. The **fourth module** is intended to facilitate the participants in addressing anger and gain useful perspectives and experiences from each other. The **fifth module** is intended to address anxiety-arousal/fear ; explore the possibilities and plan for their lives, and take responsibility for the choices made. The Family CoRe- based intervention program concluded with the evaluation and post-test. The **sixth module's objective** is to address intrusive experiences and the **seventh module** is intended to address being defensively avoidant of the event by realizing the importance of forgiveness and affirmation of oneself. In a study conducted by Witvliet (2001), findings show that anger and sadness lessens when the participants imagined responding to their offenders in a forgiving way like granting forgiveness. The current study shows that with the module on forgiveness, the participants were able to address not only anger and sadness but also defensive avoidance. Individuals who have high forgiveness have a lower level of anger (Zhang, et al., 2019).

PHASE II

3.2 The Significant Difference Between the Pre and Post-test Mean Scores of the Participants on Trauma Symptoms as Measured by the Trauma Symptoms Inventory- 2.

Commonly used measures of central tendency (mean) and variability (standard deviation or variance, minimum and maximum values of the variable) were included in the description of data. The pretest for the four (4) symptoms of trauma with intervention indicated the following results: self-disturbance (pre-self) has an average score of 46.40 with a dispersion of 19.97 scores from the mean; traumatic stress (pre-trauma) has an average score of 64.80 with a dispersion of 16.35 score from the mean; mexternalization (pre-ext) has an average score of 32.20 with a dispersion of 9.68 scores from the mean; and, somatization (pre-soma) has an average score of 19 with a dispersion of 7.18 from the mean. The post-test for the four (4) trauma symptoms with intervention specified the following: self-disturbance (post-self) has an average score of 12.40 with a dispersion of 13.96 scores from the mean; traumatic stress (post-trauma) has an average score of 17.6 with a dispersion of 16.09 score from the mean; externalization (post-ext) has an average score of 16.20 with a dispersion of 12.7 scores from the mean; and, somatization (post-soma) has an average score of 5.4 with a dispersion of 5.55 from the mean, respectively.

Among the four factors measured by the instrument Trauma Symptoms Inventory-2, Post-traumatic Stress (TRAUMA) got the highest score during pretest and after the program has been implemented, there was an improved score from the posttest of the participants. Meaning, the intervention was successful in alleviating the trauma symptoms. Depression (D) has standard deviation (pre-dep = 6.11 and post-dep = 4.6) from the mean (pre-dep = 17.4 and post-dep = 4.2), respectively. From the standard deviation of 6.11, it became 4.60, meaning the intervention was successful in alleviating symptoms of depression. Intrusive experience (IE) has the mean of 18 and 5.20, respectively. Anxious Arousal-Anxiety (AA-A) has the mean of 8.6 and 2.6. Anxiety- Arousal scores show how the participants are undergoing symptoms of worry (fears, phobias, panic, hyperarousal like too much alertness/wakefulness, stress, jumpiness). Extreme worry in forms linked with trauma exposure (e.g. abuse, assault, disaster, accident-victims). Defensive avoidance (DA) has the mean scores of 17 and 6.2, respectively. Among the clinical scales on Posttraumatic Stress (TRAUMA), Intrusive Experiences (IE) got the highest score during pretest and after the program was implemented, there was an improved posttest score. Meaning, the intervention was successful in alleviating symptoms of Intrusive experiences (IE) among the participants. Anger (Ang) has the standard deviation (pre-Ang = 3.35 and post-Ang = 5.83) from the mean (pre-Ang = 16.2 and post-Ang = 6), respectively. Anger (ANG) got high pre-test scores and after the program was implemented, there was an improved posttest score. Meaning, the intervention was successful in alleviating the Anger (ANG) among the participants. The participants got high pre-test score on Somatization (SOM), Somatic Preoccupations- Pain (SOM-P), and after the program was implemented, there was an improved posttest score. Meaning, the intervention was successful in alleviating the somatic preoccupations specifically that of pain experienced by the participants. Different physical reactions (e.g. pain and a problem with the stomach, the problem with digesting foods, sleeplessness,

stressed/tensed feeling) characterized by traumatizing events were reported in the study of Vandepoll, (2011). In the current study, the researcher observed *physical* reactions (gastric upset, digestive difficulties, insomnia, tension) from the participants.

Baseline Trauma Symptom Levels (Pre-test) Quantitative assessment using the Trauma Symptoms Inventory-2 (TSI-2) at baseline indicated that participants experienced clinically elevated distress. The Post-traumatic Stress (TRAUMA) factor recorded the highest mean score, followed by Self-Disturbance (SELF), Externalization (EXT), and Somatization (SOMA). Specific clinical scales within the TRAUMA factor showed that Anxious Arousal (AA) and Defensive Avoidance (DA) were the most salient difficulties, both recording the highest pre-test mean of 19.33. Other elevated scales included Depression ($M = 17.22$), Somatic Preoccupations ($M = 16.67$), and Intrusive Experiences ($M = 16.56$).

3.3. The efficacy of the program using TSI-2 as post-test, noting the significant change from the initial clinical assessment (pre-test) and after the implementation of the Family CoRe-based intervention program.

A paired t-test for the pre and post-trauma symptom inventory was conducted to determine if the mean differences between pretest and post-test were significant at 5% level.

The paired t-test for the pre and post-tests of self-disturbance (self), posttraumatic stress (trauma), externalization (ext), and somatization (soma). Hedge's g (d unbiased) was also computed to determine the level of effect size between the standardized difference between pre and post-tests of depression and the four subscales. Coe (2002) mentioned that the effect size measured the size of the difference between pre and post-groups and considered it as a true measure of the significance of the difference. Cohen considered $d = 0.2$ as small, $d = 0.5$ as medium, and $d = 0.8$ as large effect size indicating that difference is trivial (even if statistically significant) if two group means don't differ by 0.2 standard deviations or more (Coe 2002). Moreover, the pre- and post-test paired mean difference of the four indicators of Trauma Symptoms Inventory, namely: self-disturbance

(34.00, $\rho = 0.041$), post-traumatic stress (47.2, $\rho = 0.023$), and somatization (13.6, $\rho = 0.035$) were found to be significant at 5% level. The results suggest that post-test scores of posttraumatic stress (TRAUMA) were lower than the pre-test scores. The Hedge's g showed that the highest effect size was 1.10 ($cles = 0.76$) indicating that the score sampled at random from post- test was lesser than the score sampled from the pretest. The Hedge's g effect size of 1.10 indicates that 76%% of 5 respondents ($3.8 \approx 4$ respondents) in the post- intervention group have lower trauma post-test score in the four indicators of traumatic stress. Externalization (EXT) (16, $\rho = 0.123$) was not significant at a 5% level indicating that the pre and post intervention mean scores didn't differ from each other. Hence, the post-intervention given to the respondents has no effect on their externalization. The significance of the mean difference of the pre and post-test indicators of posttraumatic stress (TRAUMA) made the researcher rejects the null hypothesis (H_0) that "there are no significant mean differences between pre and post-test indicators of traumatic stress at 5% level." Except for the externalization. The study concluded that the post-test scores of self-determination, trauma, and somatization differed significantly from the pre-test at a 5% level. Hence, the participants' intervention scores were higher in the pre-test than in the post-test indicating that the intervention was successful in lowering traumatic symptoms.

The significance of mean difference of the pre and post-test of the three indicators (defensive avoidance, intrusive experiences, and anxious arousal) of posttraumatic stress made the researcher reject the null hypothesis (H_0) that "there are no significant mean differences between pre and post-tests indicators of traumatic stress at 5% level." Except for the two insignificant indicators, the study concluded that the post-test scores of the dissociation, defensive avoidance, and intrusive experiences differed significantly from the pre-test at 5% level. Hence, the participants' intervention scores were higher in the pre-test than in the post-test indicating that intervention was successful in lowering posttraumatic stress by means of improving defensive avoidance, and intrusive experiences of participants.

Efficacy of the Intervention (Pre-test vs. Post-test) Following the implementation of the Family CoRe-based program, post-test results showed a substantial decrease in trauma symptoms across all four primary factors. The most significant improvement was observed in the TRAUMA factor, which dropped from a clinically elevated 64.80 to 17.60. These quantitative improvements were validated by participant narratives, which indicated a shift from immobilizing fear and avoidance toward restored agency and improved daily functioning. The use of Hedge's g confirmed that these changes represented a substantial effect size, even within the study's small sample.

The analysis of this study was conducted through a **sequential exploratory mixed-methods design**, divided into two distinct phases to develop and then validate the Family CoRe-based intervention.

1. Qualitative Analysis (Phase I)

The initial phase focused on identifying core trauma themes to inform program development.

- **Thematic Categorization:** Data from literature reviews, Focus Group Discussions (FGDs) with community leaders, and in-depth interviews were analyzed to identify six primary themes: disbelief, depression (encompassing helplessness, guilt, and emotional pain), anxiety-arousal (fear), anger, intrusive experiences, and defensive avoidance.
- **Expert Validation:** The formulated program was evaluated by six clinical psychologists using descriptive statistics to assess its relevance, feasibility, and therapeutic structure.

2. Quantitative Analysis (Phase II)

This phase employed a single-subject, one-group pretest-posttest experimental design to measure the program's efficacy. Analysis included descriptive statistics such as means and standard deviations to summarize pre- and post-test scores.

- **Descriptive Statistics:** The researcher utilized SPSS Version 23 to calculate measures of central tendency (mean) and variability (standard deviation, minimum, and maximum values) to profile the participants' trauma symptoms at baseline and after the intervention.
- **Paired t-test:** A paired t-test was conducted to determine if the mean differences between pre-test and post-test scores were statistically significant at a 5% level.
- **Hedges' g:** To account for the small sample size ($N=5$), Hedges' g was used to provide an unbiased estimate of effect size. This metric quantified the magnitude of the program's impact, with a score of 1.10 indicating that 76% of participants experienced significantly lower post-test trauma scores.

3. Clinical Profiling (TSI-2)

The Trauma Symptoms Inventory-2 (TSI-2) served as the primary analytical framework, measuring four factors: Self-Disturbance (SELF), Post-traumatic Stress (TRAUMA), Externalization (EXT), and Somatization (SOMA). Analysis involved interpreting T-scores, where scores at or above 65 were classified as clinically elevated.

4. Impact Evaluation

The final analysis stage utilized **post-narrative analysis** of participant feedback to validate quantitative findings. This involved analyzing qualitative responses regarding significant changes in participants' thoughts, emotions, and behaviors, which corroborated the statistical reductions in trauma symptoms.

This study successfully developed and evaluated the Family CoRe-based (FamCoRe) intervention program, a pioneering psychological tool specifically tailored for family members of victims of drug-related violence. The discussion aligns with the research objectives and provides a comprehensive analysis of the program's development, clinical profiles, and therapeutic efficacy.

Development and Theoretical Integration

The FamCoRe program was meticulously constructed through a sequential, exploratory mixed-methods process, ensuring that the seven modules were grounded in participants' lived experiences. By integrating Cognitive Behavior Therapy (CBT) and Reality Therapy, the intervention addressed both the cognitive distortions and the loss of agency common in trauma survivors. CBT-informed modules targeted the identification of maladaptive appraisals—such as the intense guilt parents felt for being unable to protect their children—and provided strategies for cognitive restructuring. Concurrently, Reality Therapy's WDEP technique (Wants, Doing, Evaluation, Planning) empowered participants to shift from a state of "learned helplessness" toward present-focused, controllable actions, thereby restoring a sense of personal responsibility and hope.

Baseline Clinical Profile: The Trauma Landscape

At the outset, participants exhibited a distinct profile of psychological distress, with the Post-traumatic Stress (TRAUMA) factor showing the highest clinical elevation. Notably, the TRAUMA scale in the TSI-2 does not explicitly mention a specific event, which suggests that the participants' distress was a broad, systemic response to a context of continuous threat, social stigma, and sudden violent loss.

The clinical scales of Anxious Arousal (AA) and Defensive Avoidance (DA) were the most salient baseline difficulties. The elevated AA reflects a state of chronic hypervigilance, often described in narratives as a fear of "setback revenge" or distrust of both police and civilians. High DA scores revealed a significant reliance on emotional and behavioral numbing—such as "keeping busy" or refusing to speak about the incident—which, while protective in the short term, often prevents the necessary emotional processing for long-term healing.

Efficacy by Symptom Domains

The quantitative results demonstrated that the intervention was highly effective in reducing Post-traumatic Stress (Hedge's $g = 1.10$) and Self-Disturbance (Hedge's $g = 0.67$).

- **Depression and Self-Disturbance:** The significant reduction in the SELF factor highlights the program's success in addressing melancholia and complicated grief. The narratives revealed that the depression was deeply rooted in helplessness and a perceived failure to act as "role models". The modules on Hope and Reality (Modules 2 and 3) were critical in validating these grief reactions while challenging self-blaming appraisals.
- **Intrusive Experiences and Avoidance:** The improvement in Intrusive Experiences (IE) suggests that as participants gained strategies to manage reminders and reduce avoidance, the frequency of flashbacks and nightmares decreased.
- **Anger and Somatization:** While Anger (ANG) was the least elevated scale at baseline, it remained clinically relevant due to perceptions of injustice and "worthless" authorities. The reduction in ANG and Somatization (SOMA) indicates that the program facilitated both emotional regulation and physical relief from trauma-related tension and "chest pain".

Qualitative Validation and Social Harmony

The efficacy of the program was substantially validated by the participants' reports of achieving "peace of mind" and the ability to "forgive oneself and others". The forgiveness module (Module 7) was highlighted as a transformative component, allowing participants to move beyond the "culture of death and hate" and find a renewal of commitment to their remaining family members. This transition is essential not only for individual mental health but for maintaining social harmony within the community, especially in areas where vigilante violence and extrajudicial killings have fractured the social fabric.

Limitations and Future Directions

Despite the high effect sizes, the study's findings are limited by a small sample size ($N=5$) and a one-group pretest-posttest design. The lack of a control group makes it difficult to definitively attribute all improvements solely to the intervention. Furthermore, the Externalization (EXT) factor did not show a statistically significant change ($q = 0.123$), suggesting that behavioral expressions of trauma or external coping mechanisms may require longer-term therapy or "postvention" support.

Future research should utilize true experimental designs with larger, more diverse samples—including siblings and spouses—and conduct extended post-tests to evaluate the durability of the program's effects. Additionally, the FamCoRe model could be adapted for other traumatic contexts, such as families affected by the COVID-19 pandemic or large-scale disasters.

4. CONCLUSION

The present study establishes that the Family CoRe-based (FamCoRe) intervention program is a pioneering attempt at developing a structured psychological response to the trauma symptoms experienced by family members of victims of drug-related violence. The findings underscore that the sudden and violent loss of a loved one within the context of drug enforcement campaigns significantly impairs the mental health of surviving relatives. Specifically, these individuals grapple with a complex trauma profile characterized by disbelief, depression (encompassing helplessness, guilt, and emotional pain), anger, anxiety/fear, intrusive experiences, and defensive avoidance.

The statistical and qualitative evidence confirms that the FamCoRe program is effective in addressing and alleviating these trauma symptoms. By integrating Cognitive Behavior Therapy (CBT) and Reality Therapy, the program facilitates a transition

from "learned helplessness" and deep-seated guilt toward acceptance, personal agency, and a renewal of commitment to life. Ultimately, the study concludes that providing a validated space for families to process their grief is essential for restoring social harmony and individual well-being in communities fractured by violence.

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AUTHOR CONTRIBUTIONS

Eva Evangelio- Pacayra: Conceptualization, Investigation, Methodology, Laboratory Analysis, Data Curation, Formal Analysis, Writing—Review & Editing.

Lucila Bance: Adviser

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

ETHICS STATEMENT

The study was reviewed and ethically approved by the University of Sto. Tomas- Manila, Ethics Review Committee (ERC). It was initiated only after proper approval of the Ethics Review Committee according to applicable local regulations. The instrument, Trauma Symptoms Inventory 2 (TSI-2) was purchased by the researcher. Thus, the author's permission of using it was no longer secured.

The researcher also abides by the clinicians'/ psychologists' rules of conduct etc. when conducting her study and intervention program on the said participants of the study. Each participant was ensured of the anonymity and confidentiality of their identity and contributions to the research. They were informed of the nature of the research. All data gathered were used exclusively for the purposes of the study. Referrals were made when necessary.

As regards the implementation of the FamCoRe-based intervention program, the researcher strictly followed the guidelines on the risk-based public standards for COVID-19 mitigation. Hence, consent was given to the set of participants since its implementation happened during the COVID-19 pandemic.

DATA AVAILABILITY STATEMENT

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

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