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The phenomenon of war trauma: Ethnocultural factors and experimental evidence

Tetiana Perepeliuk*
PhD in Psychological Sciences, Professor
Mariupol State University
03037, 6/4 Preobrazhenska Str., Kyiv, Ukraine
http://orcid.org/0000-0001-6313-2279

Serhii Olkhovetskyi
PhD in Psychological Sciences, Associate Professor
Pavlo Tychyna Uman State Pedagogical University
20300, 2 Sadova Str., Uman, Ukraine
https://orcid.org/0000-0001-9135-4872

✦ **Abstract.** The relevance of the study was determined by the need to adapt existing methods for diagnosing post-traumatic stress disorder (PTSD) and its treatment to Ukrainian realities and the context of the Russian-Ukrainian war, which causes multiple traumas in both military personnel and civilians. The aim was to identify ethnocultural factors and experimental evidence in the context of war trauma. The methods of analysis were the PCL-C questionnaire and the Plutchik-Kellerman defence mechanisms questionnaire. The role of ethnopsychological factors, in particular national identity, collective memory, and cultural mechanisms for coping with stress, in the formation and experience of traumatic experiences was determined. The severity of post-traumatic stress disorder and defence mechanisms that help adapt to war conditions were analysed in a sample of Ukrainian students. PTSD is considered a delayed or prolonged psychological reaction to traumatic/stressful events that go beyond normal human experience. Such events may include disasters, combat operations, road accidents, sexual, physical or psychological abuse. Adverse factors, such as fatigue, exhaustion, and neurological diseases, may increase the risk of developing the disorder, but are not the main ones. Therefore, PTSD can manifest itself through repeated reliving of the trauma through memories, nightmares, flashbacks, destruction of reminders of the event, increased anxiety, irritability, disruption of routine, and emotional detachment. The study found that higher education students of different genders showed differences in the use of psychological defence mechanisms. Women were more likely to experience regression – a return to infantile behaviour patterns to reduce anxiety – as well as projection – transferring their own negative traits onto others. Men predominantly repressed traumatic experiences and rationalised – attempting to logically justify their own failures. The study of cultural factors in the experience of trauma has become key to understanding the variability of its manifestations and developing culturally sensitive approaches to diagnosis and therapy. In the Ukrainian context, resilience was based on collectivism, family support, and traditional values, which determined the effectiveness of overcoming the psychological consequences of trauma. The practical significance of the study lies in the use of these resources to create psychological assistance programmes that combine modern psychotherapeutic methods with national and cultural characteristics

✦ **Keywords:** psychological assistance; extreme situations; post-traumatic stress disorder; psychological defence; psychophysiological symptoms; coping; ethnopsychology

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*Corresponding author

✦ Introduction

The war and large-scale humanitarian crises in Ukraine have a direct and indirect impact on people's mental health. Psychological trauma is defined in different ways, but common definitions indicate that a critical traumatic incident is often sudden and unexpected or accumulates over time, causing a person to question whether they can control its outcome and their ability to cope with the consequences, and leaving people struggling with emotional, psychological, behavioural, physical and spiritual symptoms. Trauma can be physically or psychologically threatening and affect a person's sense of safety, security, survival, or sense of self. Psychological trauma involves intense feelings that affect a person's cognitive structures and perceptions of their worldview, meaning, and life purpose. The analysis of psychological trauma in the context of war is particularly relevant, as war events cause profound emotional experiences. Despite the significant amount of research devoted to psychological trauma, its interconnection with experiences of grief, loss, spirituality, and post-traumatic growth, which are integral components of the lifelong recovery process, should be taken into account. In scientific literature, spirituality is increasingly seen as an important factor with potential for reflection, therapeutic intervention, and assessment in the context of working with psychological trauma. After traumatic events, people show increased vulnerability to spiritual crises, existential distress, and rethinking their value system (Romash *et al.*, 2022). Internal displacement, moving to another country, various types of violence, shelling, and the death of relatives during armed conflicts can significantly increase the risk of mental health problems. The impact of armed conflict increases the risk of post-traumatic stress disorder, but it does not always occur in the context of trauma, depression, and anxiety disorders. Since 2014, the experience of living under occupation along the contact line, the so-called "grey zone", the impact of all types of violence and various losses, damaged infrastructure, in particular railway and energy infrastructure, poor economic conditions and displacement have led to higher rates of mental disorders in eastern Ukraine, as well as among internally displaced persons (IDPs). In 2016, 32% of IDPs in Ukraine reported symptoms of PTSD, and 22% experienced depression, as confirmed by diagnostic questionnaires. In contrast, among the general population at the start of the war, the prevalence of PTSD was 8% and that of depression was 6.3%. Indirect consequences of armed conflict include limited access to healthcare, economic hardship, reduced living standards, negative social changes, and deterioration in physical health, including complications from chronic diseases (Holton & Snodgrass, 2023). However, there are several risk factors for developing mental health problems after experiencing trauma. For example, a study by J. Kurath *et al.* (2025) showed that refugees who reported higher levels of social isolation were more likely to experience symptoms of depression and anxiety. In conflict-affected areas, social isolation can be exacerbated by the destruction of infrastructure, displacement, and the breakdown of social networks and support systems. This can make it difficult for people to access mental health services and support and increase their risk of developing mental health problems. PTSD occurs as a prolonged or delayed reaction to stressful and traumatic situations, both short-term and long-term, especially those of a destructive nature, which can cause severe stress in a person. Adverse factors such as exhaustion, fatigue, and neurological diseases can reduce the severity of the syndrome or, conversely, exacerbate its course, but this is not proof that they are factors in the onset of PTSD.

According to M. Kanal & S.B. Rottmann (2021), typical symptoms of PTSD include flashbacks, nightmares, freezes, numbness/stupor, emotional exhaustion/depression, withdrawal from people and avoidance of situations, and behaviour reminiscent of a traumatic reaction. Typical behaviours include hyperarousal, hypervigilance, increased reaction to insomnia, fear, anxiety, etc. Depression and anxiety are often associated with the above symptoms, and suicidal thoughts may also be common. Research by L. Taylor & K.K. Turner (2025) showed that symptoms indicating the onset of PTSD are preceded by a latent period of two weeks to 2-4 months after the trauma. The disorder varies, but with systematic and comprehensive treatment, recovery occurs in most cases. However, there are also cases where the disease changes the behaviour and emotional-volitional sphere of the personality and becomes persistent in its manifestation (F62.0 according to ICD-11) and chronic. Traumatic events usually cause initial psychological distress, which in most cases subsides within a few weeks after the trauma. However, for some people affected by such events, the consequences of trauma develop into PTSD, with a conditional average risk of development of about 4%. The main symptoms include intrusive memories, avoidance of unpleasant triggers, changes in mood and cognitive functions, as well as changes in arousal and reactivity levels. This condition is associated with serious health consequences, functional impairments, an increased risk of comorbidities and mortality, and a decline in quality of life as a result of the illness (Habib *et al.*, 2022). An analysis by N.F. Al-Kubaisy & U.K.A.J. Al Qaisy (2020) of the individual impact of trauma on the civilian population revealed PTSD symptom trajectories, with peak scores typically occurring within one year of the trauma and, in some cases, up to six years. Many of these issues have been overlooked or dismissed by traditional psychiatry and other mental health disciplines. This was because, within existing medical models, trauma was seen as a universal human experience, both in terms of the widespread occurrence of stressful events and the generally accepted neurological response of the body to such situations. In particular, the emphasis was on the involvement of the emotional centres of the brain, such as the hypothalamic-pituitary-adrenal axis, the amygdala, and various endocrine functions. However, T. Filges *et al.* (2024) found significantly greater complexity in the functioning of the central nervous system in responses

to trauma and stress. They also showed the devastating effects of acute and chronic trauma, including a lowered anxiety threshold and atrophy of the hippocampus and cingulate cortex. Retrospective epidemiological data from World Health Organisation mental health studies indicate that the average duration of PTSD symptoms is about six years (Kessler *et al.*, 2017). However, their duration varies significantly depending on the type of trauma: symptoms are more prolonged in cases of war-related experiences and less prolonged in cases of accidents. The consequences of PTSD not only have a significant individual impact on a person's psychological well-being, but also create a significant economic burden and social costs due to the loss of a person's ability to work. Despite this, only a limited number of prospective longitudinal studies have been devoted to studying the long-term consequences of PTSD more than ten years after traumatic events. Thus, the aim of this article was to study not only the theoretical aspects of PTSD symptoms, but also the mechanisms of psychological defence in individuals who have experienced trauma, taking into account cultural competence and the use of non-traditional or alternative methods of treatment and support.

✦ Materials and Methods

In a survey conducted between October 2024 and May 2025 at regional higher education institutions (HEIs) in the Cherkasy region, 118 applicants aged 18 to 21 responded. In terms of gender, the ratio was 79 females to 39 males. The study was conducted online and anonymously. In accordance with the provisions of the World Medical Association's Declaration of Helsinki, the empirical study adhered to the principles of professional ethics and ensured the personal responsibility of researchers for their activities, as well as using proven methods approved by the central bodies of the Ukrainian Psychological Association (WMA, 2024). The manifestation of PTSD symptoms was diagnosed using the PCL-C questionnaire. The methodology was designed to study the symptoms of post-traumatic stress disorder in the context of medical and psychological rehabilitation, and can also be used for preliminary diagnosis of PTSD. The questionnaire contained 17 items, which respondents rated on a 5-point scale: 0 – never, 4 – very often. According to the PCL-C, the severity of symptoms over the past month was assessed. Both the overall PTSD score and the severity of symptoms for each cluster (according to DSM-5) were determined. Since as of 2025 there are no normative indicators for the PCL-C methodology for Ukrainian civilians, this study was based on the results of samples of students from higher education institutions in France and the United Kingdom from the study by A.R. Ashbaugh *et al.* (2016) who had experienced traumatic events (Table 1).

Table 1. *Indicators of PTSD symptoms in higher education students who have experienced psychological trauma*

PCL-C Scale	Sample of students (United Kingdom) (n = 388)				Sample of students (France) (n = 262)			
	m	sd	min	max	m	sd	min	max
Intrusion	5.6	4.9	0	20	5.8	4.5	0	18
Avoidance	2.7	2.4	0	8	2.7	2.5	0	8
Cognitive alterations	7.1	6.9	0	28	6.7	6.5	0	26
Arousal	5.5	5.3	0	24	5.2	5.3	0	24
Overall	20.9	19.5	0	80	20.4	18.8	0	76

Note: *n – number of respondents in the sample; m – mean value; sd – standard deviation; min – minimum value; max – maximum value*
Source: *developed by the authors based on research by A.R. Ashbaugh et al. (2016)*

These indicators were used as a comparative basis for interpreting the results of the Ukrainian sample. This methodology took the form of a self-report, with respondents filling in the items themselves and the researcher explaining certain items that were unclear if necessary. To study the characteristics of students' defence mechanisms in the context of traumatic experiences, Plutchik's "Lifestyle Index" methodology, adapted by Grebennikov, was used. Psychological defence mechanisms were considered as derivatives of emotions, each of which is formed to regulate one of the basic emotions. To study defence mechanisms, the activity of which can serve as an indirect indicator of the level of intrapersonal conflict, the Plutchik-Kellermann questionnaire was used, which made it possible to assess the level of tension, hierarchy and overall severity of psychological defence mechanisms. The data obtained were subjected to statistical analysis using Pearson's correlation r-criterion, Student's t-criterion and Mann-Whitney U-criterion, which made it possible to identify both linear relationships between variables and differences between groups in terms of parametric and non-parametric indicators. Further interpretation of the results was carried out in qualitative measurement with subsequent content generalisation. Statistical data processing and graphical visualisation of the results were performed using the SPSS 21.0 program.

✦ Results and Discussion

At the initial stage of the study, the severity of PTSD symptoms was assessed using the PCL-C questionnaire. Both the overall index of PTSD severity and indicators for three main criteria were determined: B – intrusion, C – avoidance, D – arousal. The results for the total indicator of respondents are presented in Table 2.

Table 2. *Results according to the total score of the PCL-C method (n = 118)*

Number of points	Number of respondents and %
Up to 30	36; 30.51
30-35	38; 32.20
36-44	44; 37.29
More than 45	0

Source: *developed by the authors*

Respondents could receive a minimum score of 17 and a maximum score of 85, with 34 points being the arithmetic mean for this questionnaire. A diagnosis of PTSD can only be confirmed with scores above 45 points. The results presented in Table 2 show that most participants (74 people) scored between 30 and 35 points, which indicates the absence of critical PTSD symptoms, while 44 participants scored between 36 and 44 points, indicating the presence of certain symptoms that may lead to PTSD. Therefore, they should receive psychological support/assistance upon request to protect themselves from re-traumatisation. A larger number of respondents had IDP status and had left the combat zones. In particular, no respondents were found to require specialised assistance at relevant medical facilities. Table 3 presents the results of the study on the use of psychological defence mechanisms, taking into account the gender aspect.

Table 3. *Gender aspect of indicators of the use of psychological defence mechanisms according to Plutchik's "Lifestyle Index" methodology, adapted by Grebennikov*

Types of psychological defence	Gender	Mean	Student's t-test	p (significance level)
Repression	Female	6.571	2.633	0.001
	Male	9.176		
Regression	Female	7.546	2.273	0.003
	Male	4.834		
Displacement	Female	5.571	0.571	0.566
	Male	5.756		
Denial	Female	4.71	0.386	0.628
	Male	4.18		
Projection	Female	7.57	2.331	0.002
	Male	5.13		
Compensation	Female	3.286	2.372	0.002
	Male	6.176		
Hypercompensation	Female	5.71	0.597	0.481
	Male	5.59		
Rationalisation	Female	2.714	2.594	0.001
	Male	4.235		

Source: *developed by the authors*

The results presented in Table 3 showed that female respondents are more prone to regression and projection, while male respondents are more prone to repression, compensation and rationalisation (the differences are statistically significant at $p < 0.05$). Women tend to revert to childish behaviour in stressful situations and attribute their own negative traits to other people, while men tend to artificially forget traumatic memories by transferring them to the unconscious, create pseudo-arguments to explain failure, and achieve alternative successes in order to maintain their positive self-esteem. Over time, growing evidence of the neurological consequences of trauma has not diminished the importance of new research on ethnocultural variations in clinical parameters such as onset, manifestation, course, and outcomes of diseases. These variations required careful analysis to understand their causes. Although numerous studies in the fields of cross-cultural psychology, psychological anthropology, and transcultural psychiatry have already revealed significant ethnocultural differences in disorders such as depression, anxiety, and psychotic states, the issue of ethnocultural variations in PTSD remained unacceptable to the broader scientific community (Vredeveldt *et al.*, 2023). This is because recognition of ethnocultural characteristics threatened two key concepts. First, the universality of the biological basis of mental disorders, and second, the fundamental assumptions of a new model of understanding PTSD, which was based on the idea of the universal nature of traumatic experiences. Assuming the existence of ethnocultural influences on the development of trauma and PTSD would have forced a re-evaluation of the role of cultural factors in the formation of disorders and, in general, would have emphasised the flexibility of the human psyche and brain. Such assumptions contradicted the established model of "disease" in psychiatry. As identified by C.D. Wilson-Mendenhall & K.J. Holmes (2023),

this model sought to establish psychiatry as a medical discipline with clear diagnoses, detailed symptoms, and standardised treatment protocols. The foundations of this approach were formed in the 1980s thanks to the influence of the neo-Kraepelinian school. As a result, there is still some resistance to the idea of ethnocultural determinants of traumatic disorders and PTSD. At the same time, there is a reverse trend among proponents of rethinking models of traumatic experiences and PTSD itself. They call for broadening perspectives and taking cultural factors into account when determining the causes and treatment of such conditions. Another challenge to the "universal" view of trauma and PTSD has arisen due to the growing interest in the concept of culturally determined disorders. Although this concept was quite old in anthropology and transcultural psychiatry, traditional psychiatry resisted the idea for many years and simply viewed disorders in non-Western cultures as variants of Western disorders or as "exotic" phenomena not worthy of attention. However, under increasing pressure from psychiatrists, "culturally determined disorders" gained increasing credibility in psychiatry and were finally listed in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) (1994). This quickly raised questions about whether PTSD could be a culturally specific disorder. The debate over PTSD has now joined the debate over culturally specific disorders, creating a complex discussion of both concepts (Fernandes *et al.*, 2024). According to G. Theisen-Womersley (2021), the rational position is that all mental disorders are culturally conditioned, including Western ones, since their onset, course, and response are determined by the sociocultural context. No psychological disorder is completely independent of cultural influence. There has also been a significant increase in the number of scientific publications devoted to the ethnocultural aspects of mental trauma, in particular post-traumatic stress disorder (PTSD), as researchers and clinicians continue to explore and incorporate cultural variables (e.g., concepts of personality, ethnic identity, religious status, gender status and roles, cultural history, concepts of health and disorder) into their clinical and research efforts (Patel & Hall, 2021).

Given the current scientific discussions, it is appropriate to conduct a detailed study of the concept of culture, in particular its definition and significance in shaping complex and potentially traumatic social realities. P.P. Grau *et al.* (2022) defined culture as a set of learned behavioural patterns and meanings that arise in a specific life context and are passed down from generation to generation to ensure survival, adaptation, and effective integration into the environment. These patterns are dynamic and constantly changing in response to individual, social, and environmental challenges. Culture manifests itself externally through artefacts, roles, social conditions and institutions, while internally it encompasses values, beliefs, expectations, cognitive approaches, ontological foundations, practical principles, personal characteristics and worldviews. It can be situational in nature, short-lived or much longer in its impact. A key component of the concept of culture is its ability to construct reality. Culture acts as a matrix that determines the way of personal perception (Mahon, 2022). Table 4 shows in detail the process of socialisation through culture, which influences the formation of all behavioural aspects.

Table 4. *Stages of cultural construction of reality*

First stage	There exists an innate human impulse to describe, understand, and anticipate the world through the ordering of stimuli
Second stage	An undamaged human brain not only reacts to stimuli but organises, associates, and symbolises them, and in the process generates patterns of explicit and implicit meanings that help support survival, adaptation, and adjustment
Third stage	The process and product of this activity are to a significant extent culturally contextualised. They are generated and shaped through sensory, linguistic, behavioural, and interpersonal practices that comprise the process of cultural socialisation
Fourth stage	The preservation of stimuli as accumulated life experience, both in representational and symbolic forms in the brain and in external forms (such as books), gives rise to a shared cognitive and affective process that helps create cultural continuity over time (i.e., past, present, and future) for both individuals and groups. To a significant degree, individual and collective identities are formed through this very process
Fifth stage	Through socialisation, individual and group preferences and priorities are rewarded or punished, thus supporting and/or modifying cultural constructions of reality (i.e., ontogenesis, epistemology, praxeology, cosmology, ethos, values and behavioural modelsr)
Sixth stage	"Reality" is thus culturally constructed. Different cultural contexts create different realities through processes of cultural socialisation

Source: *K. Yuval et al. (2020)*

Culture structures personal attitudes towards reality and forms perceptual and empirical patterns for describing, interpreting, predicting and managing the surrounding world. It is important to note that this applies to both "normal" and "disordered" behaviour patterns (Ogden, 2021). This ethnocultural construct can be viewed as a cognitive filter that determines an individual's interpretation of the surrounding reality and continuously influences the process of understanding the social environment. Understanding reactions to traumatic events is complicated by the influence of ethnocentrism. This phenomenon manifests itself when a particular cultural system considers its own worldview and values to be universal or uniquely correct (Habib *et al.*, 2022). This approach causes methodological and practical difficulties in research and clinical practice, particularly within Western approaches to

mental health. The dominance of Western scientific paradigms, shaped by economic, political and military factors, is not evidence of their objectivity or universality, but merely reflects historical and institutional superiority. Ethnocentric orientations in mental health have led to systemic errors, biases, and abuses in the diagnosis, assessment, and treatment of individuals from non-Western cultures and ethnic or racial minorities (Carmassi *et al.*, 2020). Q. Alemi *et al.* (2023) emphasise that ethnocentric assumptions about trauma and traumatic events continue to be an obstacle to an accurate understanding of traumatic disorders and other forms of psychopathology and maladjustment. However, in contemporary research, the inclusion of ethnocultural factors in the understanding of PTSD is common. In the context of the previously provided definition of culture and the recognised limitations imposed by ethnocentrism, many scientists and specialists now recognise that virtually every aspect of trauma-related mental disorders is shaped by cultural determinants (Yuval *et al.*, 2020). This points to the need for professionals and researchers to develop competence in taking into account the influence of ethnocultural factors on the processes of diagnosis, assessment, and psychotherapy. In the contemporary world, the concept of cultural competence is increasingly being applied, especially in the context of trauma work. It encompasses not only ethnocultural socialisation, but also proficiency in computer technology, foreign languages, writing and many other areas (Gopalkrishnan & Babacan, 2022). Ethnocultural competence refers to the ability to accurately understand the significance of cultural aspects in research, teaching and clinical service delivery. A.W. Garrity (2022) has determined that in a globalised society, healthcare professionals and service providers are increasingly faced with difficulties in communicating with, assessing, diagnosing and treating patients from different ethnocultural traditions. Encounters between them are often characterised by contrasting or even conflicting cultural interactions (e.g., a Nigerian doctor and a Korean patient), highlighting the need to develop cultural competence as a critical professional skill (Gould *et al.*, 2021). Although it is impossible to achieve perfect cultural competence, especially when interacting with different cultures, its level can be assessed based on knowledge of the key features of another culture. The presence or absence of relevant knowledge can either increase or decrease the accuracy of clinical decisions, depending on its scope and depth. The use of culturally insensitive approaches poses significant risks to the effectiveness of psychotherapeutic and diagnostic work (Molendijk *et al.*, 2024). Within each culture, there are specific models, rituals, and protocols aimed at restoring the mental health of individuals who have experienced catastrophic events, traumatic experiences, or extreme stress situations. An analysis by S. Campos *et al.* (2023) showed that, depending on the cultural context, these practices may include what the Western medical community classifies as non-traditional or alternative treatments. These include shamans, healers, herbal medicine, somatic practices, dancing, indigenous incantations, and recitations. Western psychologists mostly rely on verbal methods to access the patient's experience and healing, but for many non-Western patients, these methods prove ineffective or even unacceptable. Therefore, the healing process often requires the use of various modalities that allow working with traumatic experiences beyond verbal communication. J. Kurath *et al.* (2025) identified the variability of cultural mediation through linguistic and sensory aspects as a fundamental issue for all psychopathology. Personal experience of an event cannot be completely separated from the ways in which it is understood through the senses and language. Cultural characteristics determine the nature of these mediation mechanisms, thereby influencing the perception of reality (McDermott *et al.*, 2024). If different cultures define the concepts of Self, reality, and normativity differently, then expecting them to be similar in such complex phenomena as mental disorders or pathological forms of behaviour is inappropriate. According to A.J. Wright (2021), differences in cultural context create a completely unique view of experience as a phenomenon that varies depending on the sensory and linguistic foundations of each culture. Therefore, cultural factors are decisive in shaping the perception of reality, ways of understanding traumatic experiences and models of responding to them, since it is the system of values, traditions and social norms inherent in a particular culture that influences the interpretation of events, the level of emotional experience and the choice of behavioural strategies. This necessitates taking into account the ethnocultural context not only in research, but also in the diagnosis, psychocorrection, and treatment of mental disorders, especially those arising from traumatic events.

✦ Conclusions

The results of the empirical study and their interpretation showed that the respondents, namely students of higher education institutions in the Cherkasy region, did not have critical signs of PTSD, but still had certain symptoms that could lead to its onset, in particular the use of psychological defence mechanisms such as regression, repression and displacement. At the same time, the data showed that there were no respondents who needed specialised help from relevant medical institutions. The results showed the need for a broader contextual analysis, in particular taking into account socio-cultural factors that can influence the experience, manifestation and overcoming of traumatic experiences. It has been proven that the integration of cultural context is a necessary condition for an adequate understanding of individual and collective responses to trauma. An analysis of existing approaches showed that difficulties arise both within traditional psychiatric models of helping people with PTSD and due to insufficient attention to the ethnocultural characteristics of experiencing and processing traumatic events. The results emphasised the advisability of using multicultural and interdisciplinary approaches that take into account the multidimensional influence of cultural determinants

on the formation and overcoming of the consequences of trauma. It was also found that when responding to national or international crisis situations, Western specialists encounter limitations in their models due to differences in cultural perceptions of the nature of trauma, its causes and consequences. It has been established that although traumatic events are a universal phenomenon, behavioural, psychological and social responses to them vary significantly across cultures. In the context of the Ukrainian experience, it is particularly important to take into account culturally determined strategies for stress resistance and collective recovery. Thus, prospects for further research lie in studying culturally determined strategies for stress resistance and collective recovery, as well as in identifying ways to integrate international experience in trauma therapy with national approaches to improve the effectiveness of psychotherapeutic and rehabilitation programmes during wartime.

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✦ Conflict of Interest

None.

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Феномен травми війни: етнокультурні фактори та експериментальні докази

Тетяна Перепелюк
Кандидат психологічних наук, професор
Маріупольський державний університет
03037, вул. Преображенська, 6/4, м. Київ, Україна
http://orcid.org/0000-0001-6313-2279
Сергій Ольховецький
Кандидат психологічних наук, доцент
Уманський державний педагогічний університет імені Павла Тичини
20300, вул. Садова, 2, м. Умань, Україна
https://orcid.org/0000-0001-9135-4872

✦ **Анотація.** Актуальність дослідження зумовлена необхідністю адаптувати існуючі методики діагностики посттравматичного стресового розладу (ПТСР) і його терапії до українських реалій та контексту російсько-української війни, яка зумовлює множинні травми як у військових, так і у цивільних. Метою було визначення етнокультурних факторів та експериментальних доказів у контексті травм війни. Методами аналізу стали опитувальник PCL-C та опитувальник захисних механізмів Плутчика-Келлермана. Було визначено роль етнопсихологічних факторів, зокрема національної ідентичності, колективної пам'яті та культурних механізмів подолання стресу, у формуванні та проживанні травматичного досвіду. На вибірці українських студентів проаналізовано вираженість посттравматичного стресового розладу та захисні механізми, які допомагають адаптуватися до умов війни. ПТСР розглянуто як відстрочена або затяжна психічна реакція на травматичні/стресові події, що виходять за межі звичайного людського досвіду. Такі події можуть включати катастрофи, бойові дії, дорожньо-транспортні пригоди, сексуальне, фізичне або психологічне насилля. Несприятливі чинники, зокрема втома, виснаження, неврологічні захворювання можуть підвищувати ризик розвитку розладу, але не є провідними. Тому ПТСР може проявлятися у вигляді повторюваного переживання травми через спогади, кошмари, знищення нагадувань про подію, підвищену тривожність, дратівливість, порушення звичного ритму життя та емоційну відстороненість. В ході дослідження було виявлено, що здобувачі вищої освіти різної статі проявляли відмінності у використанні механізмів психологічного захисту. У жінок частіше спостерігалася регресія – повернення до інфантильних моделей поведінки для зменшення тривоги, а також проекція – перенесення власних негативних рис на інших. У чоловіків переважали витіснення травматичних переживань і раціоналізація – спроби логічно виправдати власні невдачі. Вивчення культурних факторів у переживанні травми стало ключовим для розуміння варіативності її проявів і розроблення культурно чутливих підходів до діагностики та терапії. В українському контексті стійкість ґрунтується на колективізмі, родинній підтримці та традиційних цінностях, що визначають ефективність подолання психологічних наслідків травми. Практична значущість дослідження полягає у використанні цих ресурсів для створення програм психологічної допомоги, які поєднують сучасні психотерапевтичні методи з національно-культурними особливостями

✦ **Ключові слова:** психологічна допомога; екстремальні ситуації; посттравматичний стресовий розлад; психологічний захист; психофізіологічна симптоматика; копінг; етнопсихологія