BULLETIN of National Defence University of Ukraine

✦ Vol. 21 ✦ No. 2 ✦ 2026 ✦ 27-38
✦ ISSN 2617-6858
✦ E-ISSN 2617-6866
✦ Journal homepage: https://nuou-visnyk.com.ua/en
✦ UDC 159.923:159.942
✦ DOI: 10.33099/2617-6858-26-21-2-27-38

Psychological consequences of combat stress in military personnel: The relationship with self-efficacy

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✦ **Abstract.** The relevance of this study stems from the need to analyse post-traumatic disorders and their relationship with self-efficacy, given the conflicting approaches in scientific research and the limited amount of data available on military personnel carrying out combat missions. The aim of the study was to determine the level of psychological consequences of war-related stress in military personnel, to establish relationships between various symptoms and the consequences of stress, and to analyse their link with self-efficacy indicators. Psychodiagnostic methods were used to conduct the study, which enabled the assessment of the intensity of symptoms of acute stress disorder: the National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS); post-traumatic stress disorder: the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), The Short Screening Scale for DSM-IV PTSD; fatigue: Fatigue Assessment Scale – FAS; and psychosomatic disorders: Patient Health Questionnaire-15 – PHQ-15, Giessen Complaint List – GBB-24, specifically cardiac and gastric complaints, pain in various parts of the body, and psychosomatic exhaustion. Self-efficacy was assessed using the following scales: General Self-Efficacy Scale – GSEF and Allgemeine Selbstwirksamkeit Kurzskala – ASKU. The study results indicated the simultaneous presence of moderate acute stress, a significant proportion of positive screening for

Suggested Citation:
Kokun, O., Lozinska, N., Pishko, I., Oliinyk, V., & Koval, M. (2026). Psychological consequences of combat stress in military personnel: The relationship with self-efficacy. *Bulletin of National Defence University of Ukraine*, 21(2), 27-38. doi: 10.33099/2617-6858-26-21-2-27-38.

Article's History: Received: 11.11.2025; Revised: 25.02.2026; Accepted: 30.03.2026; Published: 16.04.2026

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post-traumatic stress disorder, increased fatigue, and a noticeable somatic burden (particularly regarding the "pain" and "exhaustion" components). The level of self-efficacy for the vast majority of participants remained at moderate to high levels. Regression analysis demonstrated that somatic manifestations are determined by a combination of age and stress-traumatic load, whilst fatigue is predominantly caused by stress-traumatic factors and is partially mitigated by behavioural self-efficacy. The practical value of the results lies in the possibility of their implementation for timely monitoring to identify military personnel with critical indicators of psychological trauma and to provide them with the necessary timely assistance; the development of psychological recovery and rehabilitation programmes for military personnel, where the priority is to address the consequences of traumatic stress as a key factor in somatisation, whilst the development of behavioural self-efficacy serves as an additional resource for strengthening their psychophysiological resilience

✦ **Keywords:** exhaustion; fatigue; post-traumatic manifestations; self-efficacy; somatic symptoms

✦ Introduction

Since 24 February 2022, servicemen of the Defence Forces of Ukraine have been actively repelling and containing the Russian Federation's full-scale armed aggression amid intense combat operations. The inability to rest and recover properly, problems with the unit rotation system, and constant exposure to combat stressors increasingly threaten to exhaust personnel and reduce the effectiveness of service personnel, as well as their ability to perform professional tasks on the front line accurately and without error. During their participation in combat operations, the vast majority of service personnel gain unique combat experience, which undoubtedly contributes to their professional growth and the acquisition of a high level of combat proficiency, allowing to assess in practice their ability to cope with stress and remain effective in challenging operational conditions. At the same time, prolonged exposure to the stressors of a combat environment and limited access to timely psychological support can lead to the development of acute stress disorder (ASD) and more serious consequences, such as post-traumatic stress disorder (PTSD), somatic disorders and others. Furthermore, there is an accumulation of overload and the body "transitions" into a state of exhaustion. At the same time, there remains some uncertainty as to the role played by self-efficacy under such conditions as an important psychological resource for individuals; whether it acts as a "buffer" between traumatic events and the mental health of military personnel; or whether its level is linked to the development of destructive psychological changes and psychosomatic disorders. This issue remains a matter of debate, particularly regarding military personnel who continue to carry out combat missions in conditions of high-intensity combat operations. An analysis of recent publications on this topic has revealed the ambiguity of scientific approaches to interpreting the relationship between self-efficacy indicators and post-traumatic symptoms. Y. Jian *et al.* (2022) confirmed the existence of a negative correlation between self-efficacy and the intensity of post-traumatic symptoms. The researchers confirmed that individuals with higher levels of self-efficacy were characterised by a lower susceptibility to depressive states, anxiety and PTSD symptoms. G. Zerach (2024), investigating the relationship between post-traumatic stress symptoms, self-efficacy and positive post-traumatic changes among Israeli female combat veterans, demonstrated the significance of self-efficacy in mitigating post-traumatic symptoms. Self-efficacy, according to the author, acts as an important mediator between symptoms, resources and post-traumatic growth. It modulates the extent to which a service member perceives themselves as capable of influencing the situation, applying self-regulation skills, seeking help, and realising life projects following trauma, as noted by G. Zerach (2024) and V.V. Turban *et al.* (2025).

The results of the logistic regression analysis by B. Ghafoori *et al.* (2024), conducted on a sample of healthcare workers, revealed a significant inverse relationship between self-efficacy levels and the risk of developing PTSD. The models constructed demonstrated that high levels of self-efficacy may prevent the development of post-traumatic disorders in this category of staff. Drawing on a neurophysiological approach based on self-regulation of the autonomic nervous system, K. Blase *et al.* (2021) demonstrated that self-regulation skills enable the restoration of cognitive functions and emotional stability, thereby reducing post-traumatic symptoms. Given that cognitive resources and emotional resilience are integral components of self-efficacy, it is reasonable to assume that it may act as a mediator in overcoming the consequences of experienced stress. In contrast, when assessing self-efficacy as a mechanism for overcoming PTSD during the implementation of an intensive treatment programme in a group of military personnel and veterans, J.W. Murphy *et al.* (2025) confirmed that changes in the participants' self-efficacy did not precede changes in PTSD symptoms during treatment. It was found that the levels of these two indicators changed simultaneously, refuting the notion that self-efficacy is a mechanism for changes in the disorder's symptoms. In wartime, the development of self-efficacy takes on particular significance. On the one hand, self-efficacy levels in certain population groups decline somewhat; on the other hand, self-efficacy plays a key role in responses to stress, the ability to cope with threatening situations, and traumatic events.

Furthermore, self-efficacy is a significant factor in post-war personal recovery and can be developed through psychological interventions (Kredentser, 2023). The results of a study by O.R. Bereziuk (2024) showed that reduced self-efficacy has a statistically significant direct proportional effect on the emergence of depressive symptoms, and

also significantly triggers the development of anxiety in male combatants who have suffered combat-related psychological trauma. S.O. Hanaba & V.A. Pavlenko (2024) noted that high self-efficacy among military personnel with combat experience enables them to transform adversity into potential for positive change. However, the relationship between general self-efficacy and post-traumatic disorders, particularly somatic manifestations, remains insufficiently studied among military personnel who remain active combatants and continue to carry out combat missions on the front line for extended periods. The issue of the relationship between operational self-efficacy and manifestations of post-traumatic stress in this category of individuals also remains under-researched. The aim of the study was to determine the level of psychological consequences of war-related stress among military personnel, to establish relationships between various symptoms and consequences of stress, and to analyse their connection with indicators of self-efficacy.

✦ Materials and Methods

The psychological study was conducted during October-November 2025 among military personnel from combat units and combat support units performing operational tasks in the Donetsk direction. A total of 90 servicemen and servicewomen participated in the study; the vast majority were active combatants in the ongoing war (87% of participants), while a smaller proportion (13%) were members of a reserve unit without prior combat experience. The sample consisted of 89 men and 1 woman, aged between 22 and 58 years. The mean age of the group was M = 40.92, SD = 9.15, Me = 42.5. The study was conducted using eight research instruments (Ukrainian adaptations in their published formats): National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS) (Gilbar, 2025); Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) (Prins *et al.*, 2016); The Short Screening Scale for DSM-IV PTSD (Breslau *et al.*, 1999); Fatigue Assessment Scale (FAS) (Michielsen *et al.,* 2003); Patient Health Questionnaire-15 (PHQ-15) (Kroenke *et al.*, 2002); Giessen Complaint List (GBB-24) (Kokun *et al.*, 2025), which includes scales of psychosomatic exhaustion, gastric complaints, pain in various parts of the body, cardiac complaints, and overall somatic burden; Allgemeine Selbstwirksamkeit Kurzskala (ASKU) (Beierlein *et al.*, 2013); and the Generalised Self-Efficacy Scale (GSEF) (Schwarzer & Jerusalem, 1995).

The assessment was carried out under conditions of confidentiality regarding locations (taking into account security requirements and restricted access to information about unit deployment). At the time of the study, personnel were located either at temporary base sites (following return from combat missions) or directly at operational locations, provided that the security situation allowed the survey to be conducted without risk to participants. The study was conducted offline using paper-based versions of the instruments, in groups of two to five individuals. The approximate time required to complete the questionnaires was 35-45 minutes. The order of completion corresponded to the sequence of the instruments listed above. All diagnostic procedures complied with the principles of the Declaration of Helsinki of the World Medical Association (2024). Participation was voluntary, without pressure from command. Each participant received full information about the study and provided informed consent. Anonymity and confidentiality were ensured through the complete absence of identifying information and restricted access to the dataset.

The selection of diagnostic instruments was justified by their international standardisation, high relevance, and empirical validation. A key criterion for assembling the battery of methods was their suitability for rapid assessment. This is critically important when studying military personnel in combat conditions, as it allows for the collection of a maximum amount of relevant information on post-stress symptomatology within a limited time, without overburdening participants with prolonged testing. Mathematical and statistical processing of quantitative results was carried out using descriptive statistics (M, SD, Me, Min-Max, %), Pearson's correlation coefficient (r), and hierarchical regression analysis. Verification of the data using the Shapiro-Wilk test indicated normal distribution across the studied variables ($p > 0.05$), which justified the use of parametric statistical methods. Hierarchical multiple linear regression analysis was performed in IBM SPSS Statistics 22.0.0.0, with predictors entered in blocks defined a priori according to the theoretical model (control variables → stress/PTSD symptomatology → resource indicators), with evaluation of R^2, ΔR^2, and standardised β coefficients. Prior to interpretation, regression assumptions were checked, including linearity (scatterplots and residuals versus predicted values), absence of multicollinearity (Tolerance, VIF), and normality of residual distribution (Q-Q plot and assessment of standardised residuals).

✦ Results and Discussion

Among the traumatic events they had experienced, the respondents cited the following: loss of loved ones/comrades – 26 (28.9%); trauma/injury – 18 (20.0%); combat exposure/shelling – 10 (11.1%); other – 7 (7.8%) (divorce, loss of one's own health, illness among relatives); did not specify – 29 (32.2%). Descriptive statistics for the main diagnostic indicators obtained from the military personnel studied are presented in Table 1.

Table 1. *Descriptive statistics for the main indicators of the test methods*

Indicators/Range of mean values	M	SD	Me	Min	Max
Acute stress disorder (ASD) (NSESSS)/(0-4)	1.34	0.73	1.29	0.00	3.57
PTSD (PC-PTSD-5)/(0-5)	2.34	1.50	2.00	0.00	5.00

Table 1. *Continued*

Indicators/Range of mean values	M	SD	Me	Min	Max
PTSD (The Short Screening Scale for DSM-IV PTSD, Breslau)/(0-7)	2.74	1.84	2.00	0.00	7.00
Self-efficacy (ASKU)/(1-5)	3.72	0.95	3.67	0.00	5.00
Self-efficacy (GSEF)/(10-40)	29.73	5.38	30.00	14.00	40.00
Fatigue (FAS)/(10-50)	23.91	6.09	23.00	14.00	39.00
Somatic symptoms (PHQ-15)/(0-30)	10.23	4.78	9.00	0.00	26.00
Somatic symptoms (GBB-24), exhaustion/(0-24)	8.65	5.83	7.00	0.00	24.00
Somatic symptoms (GBB-24), gastric complaints/(0-24)	4.81	4.37	3.00	0.00	17.00
Somatic symptoms (GBB-24), pain/(0-24)	11.22	6.07	10.00	0.00	24.00
Somatic symptoms (GBB-24), cardiac complaints/(0-24)	5.03	4.72	4.00	0.00	19.00
Somatic symptoms (GBB-24), intensity of somatic complaints/(0-96)	29.70	18.75	25.50	1.00	77.00

Source*: compiled by the authors*

Analysis of the data presented in Table 1 allows to conclude that, at the level of mean values in this sample of military personnel, there is a combination of: moderate severity of acute stress, a substantial proportion of positive PTSD screening, elevated fatigue, and a noticeable somatic burden (particularly in the components of "pain" and "exhaustion"). For the practical interpretation of the intensity of ASD manifestations, the following gradation of symptom severity was applied: <1.00 – minimal/absent; 1.00-1.99 – mild; 2.00-2.99 – moderate; 3.00-4.00 – severe (Jensen & Simpson, 2014). Table 2 presents the distribution of the examined military personnel according to the level of ASD severity, in line with the above gradation of symptom intensity.

Table 2. *Levels of ASD (mean score 0-4)*

Level of ASD	n	%
<1.00 – minimal/absent	31	34.4
1.00-1.99 – mild	42	46.7
2.00-2.99 – moderate	15	16.7
≥3.00 – severe	2	2.2

Source*: compiled by the authors*

Minimal or absent severity of acute stress disorder (ASD < 1.00; 34.4%) characterises military personnel who exhibit only isolated stress reactions that are not persistent in nature and generally do not disrupt everyday functioning. The ability for self-control, adequate planning, and task performance is usually preserved; sleep disturbances are either absent or episodic. In practical terms, this corresponds to a state of relative adaptation under conditions of stable workload and sufficient recovery. The main risk lies in potential deterioration under repeated traumatisation, cumulative sleep deficit, or increasing physical exhaustion. Mild intensity of acute stress disorder (ASD 1.00-1.99; 46.7%) is typical of a group of military personnel who display more regular manifestations of stress reactions, including heightened vigilance, irritability, episodic difficulties in falling asleep, reduced tolerance to overload, and a tendency to avoid reminders of traumatic events. Overall functioning is preserved; however, vulnerability to conflicts, errors under fatigue, and reduced concentration towards the end of the work cycle increases. Moderate intensity (ASD 2.00-2.99; 16.7%) reflects persistent manifestations of acute stress: markedly pronounced hyperactivation (internal tension, startle reactions), frequent intrusive memories/images, emotional instability, increased avoidance of triggers, and more systematic sleep disturbances. Typically, attention and concentration deteriorate, cognitive fatigue increases, and decision-making efficiency in complex situations declines. In a military context, such a state is associated with an increased risk of dangerous errors, conflict, growth of somatic symptoms, and further progression into chronic stress-related disorders. Severe intensity (ASD ≥ 3.00; 2.2%) corresponds to a high likelihood of acute maladaptation: possible panic or dissociative episodes, sharp deterioration in sleep, abrupt mood fluctuations, significant reduction in work capacity, and dangerous behavioural reactions (impulsivity, lapses in attention, risky decision-making). For the primary interpretation of post-traumatic stress disorder (PTSD) indicators using PC-PTSD-5, a practical threshold was applied: 0-2 – negative screening; ≥3 – positive screening (increased likelihood of a PTSD profile). Table 3 presents the distribution of military personnel according to this interpretation based on PC-PTSD-5 scores.

Table 3. *Results for PTSD (PC-PTSD-5) (mean score 0-5)*

Category	n	%
0-2 (negative screening)	43	50.6
≥3 (positive screening)	42	49.4

Source*: compiled by the authors*

In practical terms, a positive screening result on the PC-PTSD-5 indicates the presence of persistent symptoms of traumatic stress, which are typically manifested in sleep disturbances, emotional tension, avoidance of reminders of the event, heightened vigilance, and related features. In the sample of military personnel, a positive PC-PTSD-5 result is associated with higher levels of acute stress, somatic complaints, and fatigue, as will be discussed below based on the results of the correlation analysis (Table 10). This highlights the complexity of the issue and the need for a multidisciplinary approach to its resolution. For the primary interpretation of DSM-IV PTSD indicators, the following threshold was applied: 0-3 – negative; ≥4 – positive (high likelihood of a PTSD profile). Table 4 presents the distribution of military personnel according to this interpretation based on DSM-IV PTSD scores.

Table 4. *Results for PTSD (DSM-IV PTSD) (mean score 0-7)*

Category	n	%
0-3 (negative screening)	57	64.0
≥4 (positive screening)	32	36.0

Source: *compiled by the authors*

A key finding is that a positive screening result for DSM-IV PTSD in this sample of military personnel is associated with a more pronounced "functional impact" (with greater increases in fatigue and somatic symptoms (Table 10). In practical terms, this means that DSM-IV PTSD can be used as a more "stringent" criterion for prioritising support when service resources are limited and it is necessary to identify the highest-risk groups. To interpret the indicators characterising the degree of fatigue according to the FAS, the thresholds specified in Table 5 were used (the study participants were categorised according to these thresholds).

Table 5. *Fatigue levels according to the FAS (average score 10-50)*

Level	n	%
<22 (normal)	36	40.4
22-34 (fatigue)	47	52.8
≥35 (severe fatigue)	6	6.7

Source: *compiled by the authors*

Based on the obtained results, each level of fatigue among military personnel can be characterised as follows. Normal (FAS < 22; 40.4%). This condition is characterised by a relatively adequate level of energy resources and recovery. Presence of fatigue (FAS 22-34; 52.8%). This level indicates a significant reduction in endurance and recovery capacity. Typical manifestations include increased cognitive fatigue, reduced concentration, irritability, an increase in somatic symptoms, sleep disturbances, and heightened sensitivity to stressors. In a military context, this may present as a gradual decline in effectiveness during the second half of the workload cycle, an increase in minor errors, and a rise in interpersonal conflicts. Severe fatigue (FAS ≥ 35; 6.7%). High risk to safety and operational effectiveness: slowed reactions, reduced decision-making quality, emotional breakdowns, exacerbation of pain/somatic complaints, and pronounced sleep disturbances. For somatic symptoms according to the PHQ-15, four threshold values were used (Table 6).

Table 6. *Levels of somatic symptoms according to the PHQ-15 (average score 0-30)*

Level	n	%
0-4 – minimal	9	10.0
5-9 – low	38	42.2
10-14 – moderate	25	27.8
≥15 – high	18	20.0

Source: *compiled by the authors*

A substantive interpretation of the severity levels of somatic symptoms in military personnel according to the PHQ-15 can be presented as follows:

- PHQ-15 0-4 (10.0%) – minimal symptoms: somatic manifestations are either absent or situational;
- PHQ-15 5-9 (42.2%) – mild symptoms: somatic manifestations are present but do not usually significantly impair functioning;
- PHQ-15 10-14 (27.8%) – moderate symptoms: somatic symptoms become regular, affecting sleep/work performance;
- PHQ-15 ≥15 (20.0%) – severe symptoms: high somatic burden, often with a complex stress profile.

Analysis of the severity of somatic complaints in military personnel using the GBB-24 showed that the most pronounced subscales are "pain" (M = 11.22) and "exhaustion" (M = 8.65), followed by cardiac and gastric complaints. For the operational practical interpretation of the overall GBB-24 level (intensity of complaints), empirically derived quartiles (based on the distribution of this sample) were used: low

intensity: ≤16 (25%); moderate: 17-41 (50%); high: ≥42 (25%). The empirical GBB-24 total scores (intensity of complaints) for the military personnel studied are presented in Table 7.

Table 7. *Empirical levels of GBB-24 total (intensity of complaints; mean score 0-96)*

Level (by quartiles)	Range	Sample proportion (%)
Low	≤16	25
Moderate	17-41	50
High	≥42	25

Source*: compiled by the authors*

Thus, the results obtained using the GBB-24 indicate a predominance of "pain" and "exhaustion", which is characteristic of a combination of stress and a lack of recovery. In practical terms, a GBB-24 total ≥42 (upper quartile) is recommended as a criterion for "high somatic burden", particularly if there is concurrent PTSD-positive screening or a FAS ≥ 22. Clinical "red flags" requiring medical clarification regardless of psychological interpretation include: progressive pain of unknown origin, pronounced cardiac symptoms, sudden weight loss, loss of consciousness, neurological deficits, bleeding, prolonged fever, other signs requiring immediate medical assessment. Before analysing the results of the self-efficacy assessment of military personnel using the GSEF and ASKU methods, it should be noted that, due to the specific wording of its statements, the GSEF is designed to identify a person's basic belief in their ability to cope with life's difficulties, which allows for the assessment of general self-efficacy as a stable personality trait (Schwarzer & Jerusalem, 1995). ASKU, despite retaining the term "general" in its title, essentially operates as operational self-efficacy. It allows for the determination of the specific confidence of participants in their ability to successfully perform a complex task under adverse circumstances. That is, a person is confident that they know how to act at a specific moment. In the scientific psychological literature, when studying self-efficacy using the ASKU methodology, researchers employ such concepts as "operational", "situational", "specific", "functional" and "behavioural" self-efficacy. Within the scope of this study, the term "operational/behavioural" self-efficacy is used, as it is defined as most accurately reflecting the readiness of military personnel to function effectively in high-stress situations. The results for the military personnel studied using two self-efficacy assessment methods (GSEF and ASKU) are presented in Tables 8 and 9.

Table 8. *Levels of self-efficacy according to GSEF*

Level	n	%
≤26 – low	23	25.5
27-31– medium	45	50
32-40 – high	22	24.5

Source*: compiled by the authors*

Table 9. *Levels of self-efficacy according to GSEF*

Level	n	%
<3 – low	8	9.1
3-3.99 – medium	43	48.9
≥4 – high	37	42.0

Source*: compiled by the authors*

The obtained data indicate that, overall, self-efficacy within the sample is relatively preserved; however, 25.5% of military personnel demonstrate a low level (resource vulnerability). Given the degree of danger, the real threat to life, and the unpredictability of the combat environment, this result can be explained by the objective complexity of combat tasks. When assessing the situation, military personnel understand that it may at times be "stronger" than they are, and that their personal control over events is often limited. Importantly, in the regression models, general self-efficacy (GSEF) does not offset the impact of stress on somatic symptoms and fatigue. At the same time, behavioural self-efficacy (ASKU) demonstrated a buffering effect on fatigue: higher ASKU is associated with lower FAS scores when controlling for ASD and DSM-IV PTSD. This suggests that, in practice, it is advisable to strengthen behavioural mechanisms of "operational" self-efficacy, including skills of state regulation, recovery planning, implementation of small achievable steps, and restoration of a sense of control. To determine the relationships between symptoms and the consequences of stress exposure, as well as their potential association with self-efficacy indicators, a correlation analysis was conducted. The most informative correlations between the applied diagnostic measures are presented in Table 10.

Table 10. *Key correlations (most informative relationships)*

Pair of indicators	R	p
PHQ-15 – GBB-24 total	0.83	<0.001
FAS – PHQ-15	0.64	<0.001
FAS – GBB-24 total	0.67	<0.001
ASD – DSM-IV PTSD	0.62	<0.001
ASD – PC-PTSD-5	0.58	<0.001
ASD – FAS	0.53	<0.001
ASD – PHQ-15	0.48	<0.001
DSM-IV PTSD – PHQ-15	0.54	<0.001
DSM-IV PTSD – FAS	0.51	<0.001
ASKU – GSEF	0.46	<0.001
Age – PHQ-15	0.29	0.006
Age – GBB-24 total	0.30	0.005

Source*: compiled by the authors*

The content and practical significance of the key correlations shown in Table 10 between the diagnostic indicators used in the study involving military personnel are interpreted as follows:

1. PHQ-15 – GBB-24 total (r = 0.83) – "a unified core of somatic burden". The very strong association between PHQ-15 and the total GBB-24 score indicates that both instruments essentially reflect a common latent construct – the overall severity of somatic burden/somatisation (albeit with different emphases). In practical terms, this is important for two reasons: first, the results are robust and not dependent on the specificity of a single scale; second, for screening purposes, a shorter or more convenient instrument may be selected without losing the overall picture of somatic complaints (with due consideration of goals and regulations). At the same time, it should be emphasised that high somatic scores do not imply a "purely psychological" origin of complaints; they require parallel medical evaluation where indicated (i.e. in the presence of "red flags").

2. FAS – PHQ-15 (r = 0.64) and FAS – GBB-24 total (r = 0.67) – "fatigue as an amplifier of somatic symptoms and functional impairment". Strong positive correlations indicate that fatigue in this sample is not an isolated phenomenon but rather a systemic component of overall distress. The practical logic is as follows: when recovery is insufficient (sleep, routine, rotations, cumulative overload), the body "shifts" into a state of exhaustion, against which somatic symptoms (pain, cardiac/gastric manifestations, general weakness) increase. Accordingly, addressing only "psychological symptoms" without correcting fatigue/recovery may produce limited effects. Similar findings were reported by R. Eglinton & M.C. Chung (2011), who examined the relationship between fatigue and somatisation, demonstrating that fatigue is significantly positively correlated with somatic manifestations, which they interpret as a maladaptive protective mechanism. N. Afari *et al.* (2014), based on a meta-analysis, argue that fatigue is a key component of psychosomatisation, showing that traumatic experience increases the risk of chronic fatigue syndrome by 2.7 times; fatigue thus appears not as an isolated symptom but as part of a broader spectrum of functional somatic complaints with a shared neurobiological basis.

3. ASD – DSM-IV PTSD (r = 0.62) and ASD – PC-PTSD-5 (r = 0.58): "transition from acute reaction to a traumatic profile". Moderately strong correlations between the ASD index and PTSD screening measures indicate that acute stress manifestations and the traumatic symptom complex exist along a continuum: as acute symptom severity increases, the likelihood of a more persistent PTSD profile also rises. In practical terms, this confirms the value of ASD as a marker of urgency – when ASD ≥ 2, prompt intervention is advisable rather than waiting for spontaneous recovery, especially if a positive PTSD screening is already present. These findings are consistent with the longitudinal study by R.A. Bryant *et al.* (2012), which demonstrated a stable positive correlation between ASD and PTSD indicators, pointing to a universal pattern of psychological response to trauma.

4. ASD – FAS (r = 0.53) and ASD – PHQ-15 (r = 0.48): "stress → exhaustion → somatic symptoms". These correlations align with a functional model in which excessive strain is accompanied by hyperactivation and sleep disturbance, leading to the accumulation of fatigue; against this background, somatic symptoms increase. The practical implication is that interventions targeting sleep, reduction of hyperactivation, and tension are aimed not only at restoring a "comfortable state" but also at preventing somatic burden and reducing the risk of functional disorganisation.

5. DSM-IV PTSD – PHQ-15 (r = 0.54) and DSM-IV PTSD – FAS (r = 0.51): "traumatic stress has a pronounced functional footprint". Traumatic screening is associated not only with psychological manifestations but also with somatic symptoms and fatigue. Thus, PTSD symptomatology in this sample of military personnel serves as a marker of comprehensive functional deterioration. The presence of a statistically significant relationship between post-traumatic manifestations and somatic symptoms in individuals who have experienced trauma has also been established in other studies, including those by L. Astill Wright *et al.* (2020) and M. Stanisławska-Kubiak *et al.* (2023).

6. Age – PHQ-15 (r = 0.29) and age – GBB-24 total (r = 0.30): "age-related somatic contribution". These moderate correlations indicate that somatic burden partially increases with age. This may reflect the accumulation of

chronic conditions, consequences of prolonged load and injuries, as well as changes in bodily sensitivity. Practically, this implies the need for age-adapted recovery strategies: more careful monitoring of pain, blood pressure, cardiac symptoms, recovery windows, and sleep patterns.

7. ASKU – GSEF (r = 0.46): "a shared resource core, but different applied sensitivity". This moderate association indicates that both scales reflect a common resource domain (self-efficacy). However, as shown in subsequent regression analyses, ASKU appears to be closer to "operational/behavioural" self-efficacy, which is sensitive to fatigue, whereas GSEF is more general and does not always offset the effects of traumatic stress.

Thus, the results of the conducted study did not find significant correlations between indicators of general self-efficacy and post-stress consequences among military personnel who continue to perform their assigned duties. By contrast, among other categories studied by C.C. Benight *et al.* (2018) and A. Goreis *et al.* (2020), reliable relationships between these indicators were identified, leading to the conclusion that a higher level of self-efficacy is associated with a reduction in post-stress manifestations. Predictive analysis was conducted using hierarchical regression to identify predictors determining levels of somatisation (PHQ-15, GBB-24 total) (Tables 11-12) and fatigue (FAS) (Table 13). The overall logic involved constructing hierarchical models (steps) in which variables were entered sequentially:

1) age;
2) ASD + DSM-IV PTSD;
3) self-efficacy (GSEF).

The results presented in Tables 11-13 are shown in the following format: R^2, ΔR^2, standardised β and significance level.

Table 11. *Hierarchical regression for PHQ-15*

Step	Predictors	R^2	ΔR^2	β (std)	p
1	Age	0.082	-	0.286	0.006
2	+ ASD	0.381	0.300	0.239	0.030
	+ DSM-IV PTSD			0.369	0.001
	(Age in the mode)			0.232	0.008
3	+ GSEF	0.381	0.000	insignificant	>0.05

Source*: compiled by the authors*

The above model demonstrates that somatic symptoms (PHQ-15) among the examined military personnel are largely determined by three components:

1. Age (R^2 = 0.082 at step one; β = 0.29). This reflects a "baseline" somatic background: with increasing age, the likelihood of chronic conditions, pain, and cardio- and gastrointestinal symptoms rises, thereby amplifying overall somatic symptomatology.

2. ASD and DSM-IV PTSD (together adding 30% of explained variance). ASD reflects the current intensity of the acute stress response, which directly affects sleep, tension, and bodily sensations. DSM-IV PTSD represents a more structured traumatic profile associated with more persistent regulatory disturbances (hyperactivation, avoidance, intrusions). Together, they explain why somatic symptoms intensify not only due to "age-related factors" but also as a result of stress-traumatic load.

3. GSEF does not add explanatory power at step three. This does not mean that self-efficacy is "unimportant"; rather, it indicates that at the observed levels of stress, the primary contribution to PHQ-15 is made by symptom domains (ASD/PTSD) and the age-related somatic background. In practical terms, reducing PHQ-15 requires prioritising interventions that normalise sleep, reduce tension, manage pain, and stabilise traumatic symptoms. Strengthening self-efficacy may serve as a supportive, but not primary, mechanism. Thus, PHQ-15 is best explained by a combination of traumatic stress (DSM-IV PTSD), acute stress (ASD), and age. The inclusion of GSEF does not increase the explanatory capacity of the model. Table 12 presents the regression results showing the contribution of acute stress reaction indicators and DSM-IV PTSD in explaining the variance of the total GBB-24 score.

Table 12. *Hierarchical regression for GBB-24 total*

Step	Predictors	R^2	ΔR^2	β (std)	p
1	Age	0.088	-	0.296	0.005
2	+ ASD	0.370	0.283	0.258	0.022
	+ DSM-IV PTSD			0.336	0.003
	(Age in the mode)			0.236	0.009
3	+ GSEF	0.379	0.009	insignificant	>0.05

Source*: compiled by the authors*

The model for GBB-24 total reflects the following logic: age explains part of the variance, but the main increase in explanatory power is contributed by ASD and DSM-IV PTSD. This indicates that somatic complaints among the military personnel in the studied sample are not merely a "medical background", but to a considerable extent a

stress-induced functional consequence. Thus, the intensity of somatic complaints (GBB-24) is largely determined by stress-traumatic load and age, while the contribution of GSEF is also not statistically significant. Similar results were obtained in a large-scale epidemiological study by C.W. Hoge *et al.* (2007) among regular U.S. military personnel one year after returning from combat operations in Iraq (sample size: 2,863 infantry brigade soldiers). Using regression analysis, the researchers identified PTSD as a powerful predictor of somatisation among military personnel. However, a distinguishing feature of that study is that the analysis was conducted independently of the participants' age. The key role of post-traumatic manifestations in intensifying somatic complaints was also confirmed by B. Eslami *et al.* (2019), who studied civilian adults across various European countries (n = 4,467). Table 13 presents the results of assessing the contribution of the examined predictors in explaining the variance of the FAS indicator.

Table 13. *Hierarchical regression for FAS*

Step	Predictors	R^2	ΔR^2	β (std)	p
1	Age	0.088	-	0.296	0.005
2	+ ASD	0.370	0.283	0.258	0.022
	+ DSM-IV PTSD			0.336	0.003
	(Age in the mode)			0.236	0.009
3	+ GSEF	0.379	0.009	insignificant	>0.05

Source: *compiled by the authors*

The above model of fatigue allows for a conclusion of particular practical importance: age is not a significant predictor of fatigue ($R^2 = 0.014$; not significant). This indicates that fatigue in this sample of military personnel is largely a product of current states (stress, sleep, workload), rather than age-related factors. Since ASD and DSM-IV PTSD together explain 33-34% of the variance in FAS, fatigue emerges as a key functional consequence of acute and traumatic strain, logically linking the following symptom chain: hyperactivation → sleep disturbance → exhaustion → somatic complaints. For comparison, it should be noted that the results of a study by R. Eglinton & M.C. Chung (2011), conducted on a sample of patients with chronic fatigue syndrome using hierarchical regression analysis, showed that PTSD is not a significant predictor of fatigue but affects it indirectly. In the present model, GSEF does not provide a significant contribution, whereas ASKU does and is a significant predictor ($\beta = -0.21$; $p = 0.024$). This suggests that "operational/behavioural" self-efficacy (short-term, action-oriented, and linked to actual control) is more relevant for reducing fatigue. In practical terms, even under conditions of substantial stress load, interventions aimed at developing specific skills (such as recovery planning, state regulation, and achievable control steps) may serve as an effective lever for reducing fatigue. In the study by E. Nygaard *et al.* (2016), general self-efficacy was identified as a significant predictor of reduced post-traumatic stress symptoms. In another study, E. Nygaard *et al.* (2017) found that, over time, post-stress symptoms themselves become a factor that reduces general self-efficacy, gradually depleting the individual. Regarding coping self-efficacy, it is important to highlight the results of a four-wave study conducted by M.W.G. Bosmans & P.G. van der Velden (2015), the aim of which was to investigate the interaction between coping self-efficacy and post-traumatic symptoms. The researchers demonstrated that self-efficacy for coping is a predictor of a reduction in disorder symptoms – a higher level of self-efficacy reliably predicts a reduction in PTSD symptoms. At the same time, the results confirmed the absence of an effect of post-stress manifestations on coping self-efficacy.

✦ Conclusions

The results of the study showed that the vast majority of military personnel have moderate to high levels of both general self-efficacy (74.5%) and operational self-efficacy (90.9%), indicating that they retain the ability to self-regulate and adapt in extremely challenging operational conditions. At the same time, 49.4% of the study group screened positive for post-traumatic stress disorder (PTSD) according to the PC-PTSD-5 scale and 36% according to the DSM-IV PTSD criteria, indicating the prevalence of traumatic consequences among the study population. The results of the FAS scale assessment indicate a significant problem of fatigue among military personnel: more than half of those surveyed (52.8%) experience a significant decline in stamina and the ability to recover. This is accompanied by cognitive manifestations (reduced concentration), irritability, somatic symptoms, sleep disorders and increased vulnerability to stressors. Particular attention should be paid to those with severe fatigue (6.7%), as this condition is associated with serious risks to safety and the quality of task performance. An analysis of somatisation indicators among the participants revealed that almost half of the participants (47.8% (PHQ-15)) have moderate to high levels of somatic symptoms, which regularly affect their sleep and work performance. This is confirmed by data from the GBB-24 questionnaire, where 75% of the subjects are characterised by a moderate or high level of somatic complaints, indicating a close interconnection between psychological and somatic aspects of health. The results showed that a coherent system of interrelated manifestations has developed in the sample of military personnel studied: traumatic/acute stress is

associated with increased fatigue and somatic burden. Somatic manifestations (PHQ-15 and GBB-24) reflect a common core of somatisation/somatic complaints, whilst fatigue acts as a systemic amplifier of functional impairment. Regression models have shown that somatic burden is determined by a combination of age and stress-traumatic load (ASD + DSM-IV PTSD), whilst fatigue is predominantly caused by stress-traumatic factors and is partially buffered by behavioural self-efficacy (ASKU). In practical terms, this justifies the need for integrated medical and psychological support, where the priority targets are sleep and recovery, reducing hyperarousal, managing pain/somatic complaints, and developing "operational" self-efficacy as a resource for maintaining work capacity. Future research may expand understanding of the effectiveness of combined interventions that integrate psychological approaches (for example, cognitive behavioural therapy aimed at enhancing self-efficacy) with medical treatments (such as the prescription of antidepressants) to reduce post-traumatic symptoms and psychosomatic disorders among military personnel.

✦ Acknowledgements

None.

✦ Funding

None.

✦ Conflict of Interest

None.

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Психологічні наслідки бойового стресу у військовослужбовців: зв'язок із самоефективністю

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✦ **Анотація.** Актуальність дослідження визначена необхідністю аналізу посттравматичних порушень та їх взаємозв'язку з самоефективністю, враховуючи суперечливі підходи у наукових дослідженнях і обмежену кількість даних серед військовослужбовців, які виконують бойові завдання. Метою дослідження було визначення рівня психологічних наслідків стресу війни у військовослужбовців, встановлення взаємозв'язків між різними симптомами та наслідками стресового впливу, а також аналіз їх зв'язку з показниками самоефективності. Для проведення дослідження було застосовано психодіагностичні методики, які дозволили оцінити інтенсивність прояву симптомів гострого стресового розладу: National Stressful Events Survey Acute Stress Disorder Short Scale – NSESSS; посттравматичного стресового розладу: Primary Care PTSD Screen for DSM-5 – PC-PTSD-5, The Short Screening Scale for DSM – IV PTSD; втоми: Fatigue Assessment Scale – FAS; психосоматичних порушень: Patient Health Questionnaire-15 – PHQ-15, Giessen Complaint List – GBB-24, зокрема серцевих та шлункових скарг, болю у різних частинах тіла та психосоматичного виснаження. Дослідження самоефективності здійснювалося за допомогою методик: General Self-Efficacy scale – GSEF і Allgemeine Selbstwirksamkeit Kurzskala – ASKU. Результати дослідження засвідчили наявність одночасно помірної вираженості гострого стресу, суттєвої частки позитивного скринінгу посттравматичного стресового розладу, підвищеної втоми і помітного соматичного тягаря (особливо за компонентами «біль» та «виснаження»). У більшої частини вибірки зафіксовано середні та високі значення за шкалою самоефективності. Регресійний аналіз довів, що соматичні прояви визначаються поєднанням віку та стрес-травмівного навантаження, тоді як втома переважно зумовлена саме стрес-травмівними чинниками та частково пом'якшується поведінковою самоефективністю. Практична цінність результатів полягає у можливості їх впровадження для своєчасного моніторингу щодо виявлення військовослужбовців з критичними показниками психотравматизації і надання їм необхідної своєчасної допомоги; розробки програм психологічного відновлення і реабілітації військовослужбовців, де пріоритетним напрямом є корекція наслідків травмівного стресу як ключового чинника соматизації, а розвиток поведінкової самоефективності виступає додатковим ресурсом зміцнення їхньої психофізіологічної стійкості

✦ **Ключові слова:** виснаження; втома; посттравматичні прояви; самоефективність; соматичні симптоми