p-ISSN: 2184-2205 e-ISSN: 2184-3414 ISBN: 978-989-35728-4-9 © 2025
https://doi.org/10.36315/2025inpact131

ETHNOPSYCHOLOGICAL FEATURES OF RETRAUMATIZATION

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Abstract

The study of the psychological states that develop from chronic psychological–traumatic situations around the world is one of the main challenges in psychological science. In light of the Nagorno-Karabakh wars, the forced displacement of ethnic Armenians, and severe, recurring traumatic events, we view re-traumatization among ethnic populations to be a highly important subject of study. The focus of this study is individual re-traumatization. The aim is to examine the ethnopsychological characteristics of the relationship between PTSD—which develops as a result of re-traumatization—and coping strategies. To achieve this aim, we used observation and clinical interview methods, along with the Mississippi Scale for Combat-Related PTSD (M-PTSD) and the Ways of Coping Questionnaire (WCQ) by Folkman and Lazarus (1988). The study involved 30 Armenian combatants aged between 55 and 75 (n = 30), who participated in the Nagorno-Karabakh wars (1991–1994, 2016, 2020). This group includes individuals who experienced an earthquake, underwent forced displacement, and are generations of those affected by genocide; they continue to serve in combat duty under conditions of ongoing re-traumatization. The study revealed relationships among the factors obtained from the methodologies. According to the analysis of the M-PTSD data, among the participants (n = 30), 13 are well-adjusted (n = 13, Max = 86, Min = 65), approximately 15 have adaptation disturbances (PSYCH) (n = 15, Max = 108, Min = 91), and 2 of the combatants have PTSD (n = 2, Max = 134, Min = 133). According to the data obtained from the WCQ methodology, the following average scores were observed: Confrontive coping (avg = 10.7), Distancing (avg = 11.3), Self-controlling (avg = 13), Seeking social support (avg = 11.6), Accepting responsibility (avg = 7.03), Escape-Avoidance (avg = 10.7), Planful problem-solving (avg = 12.2), Positive reappraisal (avg = 13.06). There are positive and significant correlations between PTSD and Confrontive coping ($r = 0.38$, $p < 0.01$), PTSD and Distancing ($r = 0.37$, $p < 0.01$), PTSD and Self-controlling ($r = 0.6$, $p > 0.001$), PTSD and Accepting responsibility ($r = 0.33$, $p < 0.05$), PTSD and Escape-Avoidance ($r = 0.31$, $p < 0.05$), PTSD and Planful problem-solving ($r = 0.45$, $p < 0.01$), as well as PTSD and Positive reappraisal ($r = 0.41$, $p < 0.01$). Negative correlational relationships were found between being well-adjusted and Self-controlling ($r = –0.32$, $p < 0.05$), well-adjusted and Planful problem-solving ($r = –0.39$, $p < 0.01$), and well-adjusted and Positive reappraisal ($r = –0.405$, $p < 0.01$). During clinical interviews, it became clear that many participants had frequently experienced anxiety about the recurrence of traumatic events such as war, deportation, genocide, and earthquakes. They also reported sleep disorder, flashbacks, grief over the loss of comrades and family, feelings of guilt, and difficulties with attention, memory, and eating. In addition, many participants experienced physical symptoms such as asthma, allergies, heart arrhythmias, skin issues, gastrointestinal and reproductive problems, cardiovascular weakness, nervous system issues, and severe headaches. Traumatization is based on ethno-cultural and national socio-psychological factors, while re-traumatization has its roots in transgenerational and collective unconscious influences. As a result of re-traumatization, only a few individuals develop PTSD; instead, most people use coping strategies and generally adapt well despite repeated traumas.

Keywords: *War, forced displacement, PTSD, ethnos, trauma.*

1. Introduction

The study of psychological states resulting chronic psychological and traumatic situations occurring worldwide is one of the pressing issues in contemporary psychological science. Military conflicts are fraught with complex socio-economic, political, and socio-psychological consequences. In this context, given the conditions of the Artsakh wars, the displacement of ethnic Armenians, and acute and recurring psychotraumatic events, we consider it essential to study the retraumatization of the

population as a consequence of war and forced displacement. In psychology retraumatization is understood either as revictimization (a series of successive traumas) or as the "reactivation" of emotions and symptoms associated with past trauma. The relevance of this topic is determined by ongoing military conflicts, forced displacements, and their psychological consequences, which affect people both at individual and collective levels.

It should be noted that the post-traumatic stress disorders resulting from recurring traumatic events or the reactivation of past traumatic experiences, as causes of collective trauma formation, haven't been sufficiently studied from socio-psychological and, specifically, ethno-psychological perspectives. Collective trauma, as a psychological and emotional injury resulting from the shared experience of a traumatic event, remains in the collective unconscious and is transmitted to subsequent generations. This study examines the ethno-psychological characteristics of post-traumatic stress disorders and retraumatization that arise from ongoing, recurring socio-psychological traumas, historically recurring, and intergenerational traumatization.

As we know, traumatic events (such as war, captivity, loss, disability, sexual violence, displacement, etc.) experienced by individuals prior to participating in combat contribute to the intensification of their negative impact (retraumatization). As a result of retraumatization, over time, an individual may develop emotional numbness as a form of psychological resistance. Consequently, the repetition of traumatic experiences complicates the process of coping with the trauma, including the PTSD symptoms.

In fact, at the level of an ethnos, the nature of the formation of a traumatic psychological structure may be determined by the forms of trauma present in the collective unconscious of the population, such as genocide, forced displacement, earthquakes, recurring wars, and their characteristic features. Therefore, the specifics of retraumatization at the ethnos level are conditioned by the historically experienced traumas of that ethnos. Hence, in the context of the historical experiences of the Armenian people and the processes of traumatization and retraumatization, we emphasize the importance of studying the ethno-psychological characteristics of the population's retraumatization.

The concept of "traumatization" is often equated with "retraumatization" (Duckworth & Follette, 2012). Retraumatization stems from the psyche's traumatic experiences. Psychological trauma often goes unnoticed or insufficiently recognized in society. It encompasses a wide spectrum of events, from natural disasters and wars to interpersonal conflicts, leaving a deep mark on the human psyche and contributing to the development of borderline states. As a result, the development of trauma is influenced, on the one hand, by the intergenerational transmission of historical and cultural traumatic experiences and, on the other hand, by the presence of childhood traumas in an individual (Stolorow, 2016).

Fischer describes psychological trauma as the demobilization of an individual's defense mechanisms, a decrease in sensitivity, and the experience of an imbalance between threatening circumstances and the individual's ability to cope with them. Traumatized individuals are often characterized by feelings of loss and anxiety, a frustrated mental state, and a sense of unmet needs (Kalshed, 2011). Kuz'mina notes that personal development often occurs through the experience of trauma, supported by studies showing that individuals who have faced trauma in the past are less vulnerable in stressful situations (Kuz'mina, 2023).

The absence or loss of personal resources in a traumatic situation plays a key role in the intergenerational transmission of retraumatization. The chain of resource loss lies at the core of intergenerational retraumatization (Hobfoll, 1988). Transgenerational trauma, as a component of biogenic trauma, is characterized by the repetition of the unconscious patterns of the lineage. Transgenerational trauma is passed down through multiple generations, shaping recurring life scenarios among family members (the ancestor syndrome) (Yalom, 2014).

Retraumatization triggers memories of past threats and the repeated loss of loved ones, often accompanied by enduring feelings of fear, terror, and helplessness (Isaeva & Sutaeva, 2016).

The psychological consequences of traumatic experiences are not uniform; their subjective impact varies depending on the nature of the traumatization and the individual's unique characteristics (B'yudzhental' Dzh., 2001).

Brown and co-authors, in their article, highlight that prior trauma may predispose an individual to heightened reactivity to new traumatic events, thereby increasing the likelihood of retraumatization (Pazderka et al., 2021).

Combat trauma is one of the most common sources of retraumatization, occurring in combat zones. Factors that intensify PTSD symptoms and raise their likelihood include the duration of time spent in war zones, the frequency and type of involvement in combat operations, and the specific nature of the trauma (e.g., combat injuries, captivity, displacement). Conversely, the shorter the period spent in a war zone and the lower the intensity of exposure, the rarer PTSD occurs, and recovery is easier. Repeated participation in wars further exacerbates PTSD manifestations (Kolpakova, 2022).

2. Design and method

2.1. Study design

To achieve the objectives of our research, we employed observation, clinical interviews, the **Mississippi Scale for Combat-Related PTSD (M-PTSD)**, and the **Ways of Coping Questionnaire** by Folkman & Lazarus (1988). The study revealed connections between the factors identified through these methodologies. A total of 30 combatants (n=30), all Armenians aged 55 to 75, participated in the study. The participants were veterans of the Artsakh wars (1991–1994, April 2–5, 2016, and the 44-day war of 2020). Some of them have varying degrees of disability but continue to serve on border duty, remaining in conditions of ongoing retraumatization.

2.2. Data analysis

Through observation and clinical interviews, we gathered information about the participants' family status, the presence of psychosomatic symptoms, sleep disorders, eating behavior disorders, feelings of guilt, and the presence or absence of physical trauma. The participants described war as an evil, a futile act causing the death of innocent people, an act of service to the nation and homeland, patriotism, or a catastrophe.

During the clinical interviews, it became clear that some participants had been dealing with these issues since the First Artsakh War, while others had developed them after the 1988 Spitak earthquake. They reported that following these traumatic events, they frequently experienced anxiety related to reliving the trauma, sleep disorders (difficulty falling asleep, restless sleep, hypersensitivity to minor stimuli, and the sensation of being back on the battlefield while sleeping), flashbacks, grief over the loss of comrades and family members, feelings of guilt (questioning why they survived when their comrades or family members did not), attention and memory impairments, eating behavior disorders, and psychological dependencies.

The participants often experienced symptoms such as constipation, allergies, nausea, skin issues, gastrointestinal and digestive problems, cardiovascular insufficiency, nervous system disorders, acquired diabetes, and acute kidney pain. Medications were typically ineffective in alleviating acute headaches, lowering high blood pressure, resolving constipation, or addressing other problems.

The participants emphasized the issue of national traumas, such as displacement, genocide, wars, and earthquakes. They explained these traumas through ethnocultural, national socio-psychological, and religious factors, highlighting how their continuity, recurring narratives, and historical-cultural interpretations are passed down through generations, creating transgenerational connections.

3. Results

3.1. Results obtained from the first and the second scale

Below, we present the data obtained from the Mississippi Scale for Combat-Related PTSD (M-PTSD) methodology (see Table 1).

Table 1. (n=30).

Validation groups	N	Max	Min	SD
Well-adjusted	13	86	65	39.67
Psych	15	108	91	48.97
PTSD	2	134	133	33.87

Below, we present the data obtained from Ways of Coping Questionnaire methodology by Folkman, S., & Lazarus, R. S. (1988) (see Table 2).

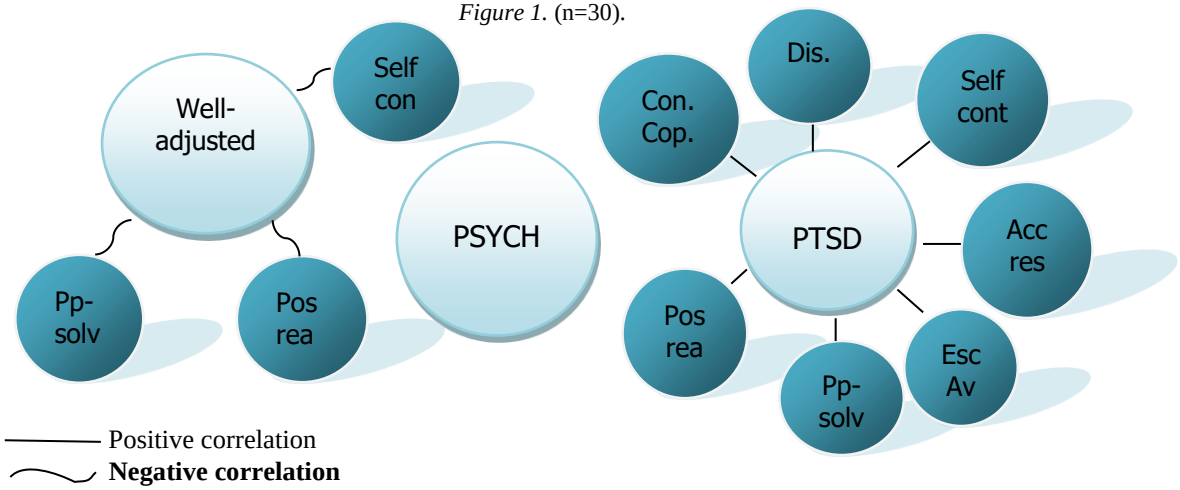
Table 2. (n=30).

Coping scales	Avg	Max	Min
Confrontive coping	10.7	15	6
Distancing	11.3	16	6
Self-controlling	13	21	9
Seeking social support	11.6	17	5
Accepting responsibility	7.03	12	1
Escape-Avoidance	10.7	18	3
Planful problem-solving	12.2	18	6
Positive reappraisal	13.06	18	5

3.2. Results obtained from the correlation analysis

Having the indicators from both methodologies, we present below the direct and inverse correlations between the data obtained from the **Mississippi Scale for Combat-Related PTSD (M-PTSD)** and the **Ways of Coping Questionnaire** by Folkman & Lazarus (1988) (see Figure 1).

Figure 1. (n=30).



There are positive and significant correlations between PTSD and Confrontive coping ($r = 0.38$, $p < 0.01$), PTSD and Distancing ($r = 0.37$, $p < 0.01$), PTSD and Self-controlling ($r = 0.6$, $p > 0.001$), PTSD and Accepting responsibility ($r = 0.33$, $p < 0.05$), PTSD and Escape-Avoidance ($r = 0.31$, $p < 0.05$), PTSD and Planful problem-solving ($r = 0.45$, $p < 0.01$), as well as PTSD and Positive reappraisal ($r = 0.41$, $p < 0.01$). Negative correlational relationships were found between being well-adjusted and Self-controlling ($r = –0.32$, $p < 0.05$), well-adjusted and Planful problem-solving ($r = –0.39$, $p < 0.01$), and well-adjusted and Positive reappraisal ($r = –0.405$, $p < 0.01$).

According to the results, only 2 out of 30 combatants displayed PTSD symptoms. The higher the PTSD score, the more pronounced the coping strategies used by the combatant. Experiencing a traumatic event, they either strive to overcome difficulties or reduce and counter/avoid its negative consequences.

The following direct correlations were found between the seven coping strategies and PTSD:

- **Confrontive coping**: Combatants using this strategy exhibit impulsivity and conflict-proneness due to traumatic events. The predictability in their actions reduces and they focus on overcoming negative emotions rather than resolving the traumatic situation itself. They display inadequate goal-directed behavior and rationality in traumatic situations.
- **Distancing**: Combatants using this strategy devalue their experiences to reject traumatic memories and negative emotions. They avoid topics related to the traumatic event, often treating them with humor or distracting themselves with various activities. This increases the likelihood of devaluing their experiences and ignoring the possibilities for overcoming the trauma.
- **Self-controlling**: Combatants employing this strategy deliberately suppress emotions stemming from traumatic events, leading to PTSD symptoms. They overly control their behavior and hide their mental state. As a result, they are often perceived as emotionally distant. They tend to distrust others, conceal their feelings and anxieties out of fear of self-disclosure, and show high self-demand.
- **Accepting responsibility**: This strategy involves a heightened sense of responsibility regarding behavior and decision-making. Combatants using this strategy are characterized by high levels of self-criticism and guilt, even though they often seek responsible roles. After taking on responsibilities, they analyze every action and link even minor mistakes to their own flaws. They frequently feel guilty about the deaths of comrades in war, associating it with their perceived failures.
- **Escape-Avoidance**: This strategy involves denial or rejection of the war as a reality, often describing it as a "bad dream." Combatants avoid taking responsibility for addressing challenges and may exhibit hyperarousal, passivity, or impatience. Some use alcohol or drugs to relieve psychological tension.

- **Planful problem-solving**: This strategy aims to overcome traumatic situations through a purposeful analysis of the situation and behavior, development of problem-solving strategies, and planning based on past experiences and available resources. However, combatants with PTSD symptoms often exhibit excessive rationality, lacking emotionality, intuition, and spontaneity in their behavior.
- **Positive reappraisal**: This strategy seeks to overcome negative emotions related to the problem by reframing them positively as a stimulus for personal growth. It reflects a transcendental orientation to the problem, emphasizing self-development.

Inverse correlations were observed between **Well-adjusted** combatants and the **Self-controlling**, **Planful problem-solving**, and **Positive reappraisal** strategies. This can be explained by the fact that well-adapted combatants do not rely on these strategies. Their emotions, cognitive sphere, and behavioral manifestations are balanced. They have developed self-regulation skills, can build healthy interpersonal relationships, and effectively address their own problems.

4. Discussion and conclusion

It can be concluded that the prevalence of PTSD resulting from retraumatization is relatively low. This is largely due to the use of coping strategies and the high level of adaptation combatants develop after facing multiple traumas. Combatants with PTSD often face not only universal traumatic events but also deeply personal losses (grief over the loss of a child, divorce, etc.). Despite these challenges, they tend to use various coping strategies to handle their symptoms.

After experiencing trauma, combatants commonly report anxiety from reliving the events, sleep disturbances, flashbacks, grief over the loss of comrades or loved ones, feelings of guilt, difficulty concentrating, memory problems, disordered eating behaviors, and psychological dependencies. Common physical symptoms among participants included constipation, allergies, nausea, skin problems, gastrointestinal and digestive issues, cardiovascular insufficiency, nervous system disorders, acquired diabetes, and acute kidney pain.

Traumatization is based on ethno-cultural and national socio-psychological factors, while re-traumatization stem from transgenerational and collective unconscious influences. As a result of re-traumatization, only a few individuals develop PTSD; instead, most people use coping strategies and generally adapt well despite repeated traumas.

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