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Historical Trauma and Post-Traumatic Stress Disorder in Ukrainians

Introduction

Ukraine is a country whose national identity, social structures and political development have been profoundly shaped by a history of domination, repression and exploitation. Throughout the twentieth century and into the present, Ukrainians have been exposed to repeated episodes of mass violence, authoritarian rule, and external control, culminating in the ongoing Russian war against Ukraine. Following the collapse of the Russian Empire in 1917, Ukraine briefly gained independence from Russia (Yekelchik, 2007). However, this period was short-lived, as the country was forcibly incorporated into the Soviet Union by the early 1920s (Ford, 2007). As part of communist Soviet union and under the reign and suppression of Stalin, Ukrainians underwent the great famine in the 1930s which is known under the term *Holodomor*, in which approximately 3.5 to 5 million Ukrainians died (Rudnytskyi et al., 2015; Wolowyna, 2021). After regaining independence in 1991, Ukraine has again become the target of Russian military aggression, beginning in 2014 and escalating into a full-scale invasion in February 2022, resulting in extensive civilian casualties and widespread destruction (Yekelchik, 2023).

The repeated exposure to oppression and threat did not only shape Ukraine's political and social structures, but also left profound psychological consequences on both the societal and the individual level. From a psychological perspective, the experience of stressors like war and existential threat are known to increase vulnerability to trauma-related outcomes, including *post-traumatic stress disorder* (PTSD) and *complex post-traumatic stress disorder* (CPTSD; Burri & Maercker, 2014; Hoppen et al., 2021; Morina et al., 2018; Mutuyimana & Maercker, 2023). PTSD is the most common psychological disorder to arise following traumatic events (Bryant, 2019). Traumatic events can be the experience or the witnessing of any form of violence or disasters, war, illness, sudden loss or death or other disturbing and potentially overwhelming events (Kleber, 2019). Symptoms of PTSD are generally characterized by the re-experiencing of the traumatic event in form of flashbacks or nightmares, the avoidance of anything associated with the traumatic event and a persistent perception of increased threat or danger (World Health Organization, 2019). CPTSD can occur after the exposure to not only one, but to multiple, repetitive or prolonged traumatic events, from which escape is either difficult or impossible, commonly being ongoing abuse or the experience of living in a war-afflicted region (Karatzias et al., 2023). CPTSD is further characterized by severe disturbances in affect, relationships, and self-evaluation in addition to all the PTSD criteria being met (World Health Organization, 2019).

At the societal level, collectively experienced traumas can shape norms, values and behaviors, which are likely to be passed on across generations and thus have a lasting impact on the culture of a group, which in return impacts how members of these cultures perceive and process the world (El-Khalil et al., 2025; Cacace & Summers, 2025). This aligns with theories of *historical trauma*, which propose that the cumulative exposure to collective suffering and trauma can transmit psychological vulnerabilities across generations and can increase descendants' vulnerability to several negative health outcomes such as mental health problems, one of them being a heightened vulnerability to the development of trauma-related disorders like PTSD and CPTSD (Gone et al., 2019; Nagata et al., 2024).

Therefore, understanding Ukraine's history of state violence is essential for the interpretation of contemporary psychological responses to societal insecurities such as the experience of war and large-scale political violence at both an individual and a societal level. At the same time, a large body of research shows that a supportive social environment, and higher perceived social support (PSS) in particular, is associated with a lower risk of developing trauma-related disorders as well as lower severity of PTSD following trauma exposure (Sippel et al., 2024; Wang et al., 2021; Zalta et al., 2021). Additionally, social support and strong community ties can play a protective role, helping mitigate adverse outcomes such as PTSD or social fragmentation. On the other hand, social support is particularly critical in the context of historical trauma, as research on post-Soviet societies suggests that prolonged exposure to state violence and repression in authoritarian rule is associated with lower general trust, incivility and subsequently, potentially with lower PSS (Klicperova et al., 1997; Janmaat, 2006; Javakhishvili, 2018). This may increase vulnerability to trauma-related disorders in the face of recurring collective stressors such as war, as in the case of Ukraine.

Taken together, this study seeks to examine how Ukraine's historical traumas influence individuals' responses to the ongoing war and how PSS may serve as a protective factor against the development and severity of trauma-related disorders.

Theoretical Background

The Stalinist period and the Holodomor

The full-scale Russian Invasion of Ukraine in February 2022 and the accompanying war in Ukraine has been going on for over three years now, and must also be seen against the backdrop of the Russian society's and elite's centuries-old widespread views of superiority towards Ukraine, which developed during Imperial Russian and later Soviet rule and domination. These long-standing narratives of Russian superiority, as well as of

Ukrainian inferiority and weakness were actively reproduced and reinforced through Russian state ideology, media and propaganda. These portrayed Ukraine and its population as divided, politically fragmented and incapable of resistance and at the same time as a country without its own distinct identity, in need to be redeemed and guided by Russia - an image that has been, to some extent, also been reproduced in Western media representations (Oksamytna, 2023).

The origins of the contemporary image of Ukraine as well as the Russia-Ukraine conflict are deeply embedded in the Soviet system of rule, particularly in the repressive state-building policies of the Stalinist period. As Simon (2004) demonstrates, the famine of 1932 to 1933, also known as the Holodomor, was not an unintended outcome of economic mismanagement but a calculated instrument of political domination. The Stalinist regime deployed hunger, coercion, and administrative terror to eliminate both social autonomy and national distinctiveness in Soviet Ukraine. This campaign followed the reversal of *korenizatsiia*, literally *indigenization*, a policy of the 1920s designed to promote non-Russian languages, elites, and cultural institutions within the Soviet framework. In Ukraine, this policy was referred to as Ukrainization, and led to a remarkable revival of Ukrainian language, education, and public life. What began as a mechanism to secure loyalty to the Soviet state and consolidate Soviet power, increasingly came to be perceived in Moscow as a centrifugal threat, particularly in the context of peasant resistance to collectivization and the persistence of a distinct Ukrainian political identity. From 1932 onward, coercive policies such as grain confiscations, “blacklisting” of villages, travel bans, and mass deportations, were implemented with extraordinary severity in Ukraine and the ethnically Ukrainian Kuban region. This violent repression marked a decisive shift toward homogenizing totalitarian control. In Ukraine, these policies were implemented with exceptional severity, transforming famine into a weapon of state power aimed at destroying both economic resistance and national self-assertion. The destruction of Ukraine’s rural social foundations and the purge of its cultural and political elites institutionalized long-term patterns of dependence and subordination to Moscow. While the exact number of victims of the Holodomor stays debated, research suggests approximately 3.9 million excess deaths and 0.6 million in birth deficits, which sums up to around 4.5 million total losses (Rudnytskyi et al. 2015; Wolowyna, 2021), with some estimates going higher.

The Holodomor therefore represents not only a humanitarian catastrophe but a formative moment in the long-term structure in the relationship between Ukraine and Russia. By destroying Ukraine’s rural foundations, the Stalinist state eradicated much of

the social basis for autonomous development while embedding patterns of domination, denial, and historical trauma (Simon, 2004). These experiences continue to shape the post-Soviet geopolitical landscape, providing a crucial background for understanding both post-communist societal dynamics as well as the contemporary Russian-Ukrainian conflict.

Post-Communist Syndrome

There have been some prominent cultural and normative changes which many Eastern European countries that have been part of the Soviet union share. These changes have been conceptualized under the terms *post-communist syndrome* (Klicperova et al., 1997) or *totalitarian trauma* (Javakhishvili, 2018). Rather than clinical syndromes, these concepts describe recurring patterns of attitudes and behaviors, including generalized lack of trust, learned helplessness, incivility, reduced prevalence of civic and social virtues, as well as a weakened willingness to engage in community building. These patterns, which are attributed to the experience of authoritarian, and in the case of Ukraine, Soviet rule, may stem from the constant fear of being surveilled, reported, persecuted or deported for either real, perceived or even fabricated wrongdoings. Combined with a lack of resources and material as well as social insecurity, a general decline in civility and morality could be fostered (Klicperova et al., 1997).

A related but more structurally oriented interpretation is provided by Sztopka's (1993) concept of *civilizational incompetence*, which describes the perceived absence of competencies necessary for democratic and capitalist societies in post-communist Central and Eastern Europe. These include civic responsibility, tolerance in public discourse, entrepreneurial initiative, and everyday norms of trust and order. Sztopka attributes these deficits to the legacy of "real socialism" and the experience of an imposed or "fake" modernity, in which modern institutions were introduced from above while informal practices such as paternalism and nepotism persisted, eroding the cultural foundations of autonomous civic modernity. Importantly, he conceptualizes these patterns as culturally embedded and socially reinforced rather than purely psychological.

At the same time, empirical research suggests that post-communist civic deficits should not be understood as a single, coherent, or irreversible cultural syndrome. Comparative analyses of civic culture indicate that although trust and formal civic participation tend to be weaker in post-communist societies, these patterns vary considerably within and across countries and are sensitive to contemporary socio-political and economic conditions (Janmaat, 2006).

From this perspective, post-communist syndrome can be understood less as evidence of enduring civilizational incapacity and more as a historically conditioned,

context-dependent constellation of civic vulnerabilities. This interpretation emphasizes the transitional and potentially malleable nature of post-communist civic patterns, a view that is particularly relevant when examining societies shaped by profound historical violence and collective trauma.

Historical Trauma

The concept of historical trauma (HT) has gained increased attention in the field of psychological research, highlighting how collective traumatic experiences can transcend generations and manifest in contemporary populations. It has especially been studied in the context of the indigenous population of America (e.g., Guenzel & Struwe, 2020) and Canada (e.g., Barker et al., 2019; Gone et al., 2019) or the descendants of Holocaust survivors (e.g., Danieli et al., 2017; Sorscher & Cohen, 1997). Building on the observations about post-communist syndrome, attention has also been drawn to country's of the former Soviet Union which were marked by oppression that left historical wounds and changed these countries cultures permanently, one of them being Ukraine (Maercker, 2023).

While previous attempts to define HT often included the premise of colonization (Hartmann & Gone, 2014), Mutuyimana & Maercker (2023) developed a definition that can be applied to a wider range of contexts. They define HT as psychological and emotional injuries that are shared collectively across generations and result from past collective trauma. These injuries manifest as perceived discrimination and oppression, learned mistrust, culture-related syndromes, and historical thoughts of loss. They also manifest as diverse clinical psychological disorders and risk behaviors within groups that share a similar social, historical, and political background.

Moreover, it is crucial to differentiate HT from similar constructs, such as *collective trauma* or *intergenerational trauma*. By definition, HT encompasses both of these concepts, as the trauma was both experienced collectively and passed down through generations. HT, however, focuses on the past of a collective, relating to the shared clinical and non-clinical aspects and consequences of trauma within a cultural community. Intergenerational trauma, on the other hand, merely refers to the clinical aspects of trauma that can be passed down through familial generations (Mohatt et al., 2014), while collective trauma can refer to either a past or a present event (Hirschberger, 2018).

Post-Traumatic Stress Disorder

It is merely impossible to talk about trauma and related disorders like PTSD or CPTSD without talking about the topic of war, as contemporary psychological research about trauma-related disorders is mostly based on the witnessing of adverse psychological consequences inflicted by the experience of war.

The concept of trauma and a kind of „retroactivity“ of traumatic events has already been discussed in the nineteenth century by early pioneers in psychiatric research like Sigmund Freud (Horváth, 2024), influenced by the neurologist Jean-Martin Charcot, who proposed that so-called hysterical symptoms often had their origin in earlier experiences (Van Der Kolk, 2000). It became highly relevant in the aftermath of World War I, when soldiers presented symptoms like fatigue, tremors, paralysis, and emotional disturbances, which were first labeled as „shell shock“ (Crocq & Crocq, 2000). In World War II, terms like „combat exhaustion“ or „battle fatigue“ were used (Jones, 2006). After the war, studies on former war prisoners and survivors of concentration camps demonstrated how the experience of war produced chronic anxiety, depression, somatic complaints as well as personality changes even many years later (Eitinger, 1961), which supported the notion of long-lasting trauma-related outcomes.

The topic was somewhat resumed in the 1970s as Vietnam-Veterans displayed characteristic patterns of intrusive memories and avoidance, emotional numbing and hyperarousal in clinical observations, which then had been summarized as *Post-Vietnam Syndrome* (Friedman, 1981). In 1980, PTSD was finally incorporated into the 3rd edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association (APA; 1980) as an operational diagnosis. In 1992, PTSD first appeared in the International Classification of Diseases (ICD-10) by the World Health Organization (WHO).

Nowadays, PTSD is a well-established and highly relevant diagnosis in both DSM and ICD. In the latest versions of both systems, DSM-5-TR (APA, 2022) and ICD-11 (WHO, 2019), the two agree on a core of persistent symptoms of intrusive re-experiencing of the traumatic event, avoidance of reminders and a continuing sense of perceived threat, that cause significant distress or functional impairment, but differ in broadness and complexity of the diagnosis.

This study will utilize the PTSD criteria offered by ICD-11. According to ICD-11, PTSD is a psychological disorder which can develop after exposure to one or a series of traumatic events and persists for at least several weeks. The traumatic event or the multiple traumatic events can either have been directly experienced, witnessed or been learned about by the person affected. The disorder is characterized by (1) symptoms of intrusion, for instance in the form of nightmares or flashbacks, (2) symptoms of avoidance of thoughts, emotions, activities or situations related to the event, and (3) a constant perception of increased threat, for example in form of hyper-vigilance and an enhanced startle reaction. The symptoms cause significant impairment in multiple areas of functioning (WHO, 2019).

Complex Post-Traumatic Stress Disorder

Subsequent clinical work showed that chronic and early interpersonal trauma produces broader disturbances in affect regulation, self-concept and relationships, leading to proposals of a distinct post-traumatic syndrome marked by affect dysregulation, negative self-view, and relational disturbances, later operationalized as *Disorders of Extreme Stress Not Otherwise Specified* (DESNOS) in DSM-IV field trials (Herman, 1992). These trials showed that people with chronic trauma histories frequently endorsed disturbances in affect, relationships, and self-concept, and that almost all individuals meeting DESNOS criteria also met PTSD criteria, foreshadowing the later developed of the CPTSD diagnosis (Giourou et al., 2018).

In the development of ICD-11, the reorganization of stress-related disorders was proposed, leading to a model with two sibling diagnosis, PTSD and CPTSD, with CPTSD reserved for trauma-related conditions characterized by both PTSD symptoms as well as formerly mentioned disturbances in affect, relationships and self-concept, now known as *disturbances in self-organization* (DSO) symptoms (Karatzias et al., 2017).

Cloitre et al. (2013) provided empirical evidence for two related but distinct symptom profiles, differentiating PTSD and CPTSD statistically and clinically, supporting the ICD-11 proposal for two separate but related diagnoses.

Complex Post-traumatic Stress Disorder (CPTSD) as finally described in the ICD-11, is classified as a psychological disorder that can arise following trauma exposure, most likely of repetitive or prolonged nature, such as childhood abuse, torture, slavery, genocide or domestic violence. CPTSD is characterized by all PTSD criteria in addition to severe and enduring difficulties in regulating emotions, negative self-perceptions accompanied by feelings of shame, guilt and failure, and difficulties in maintaining relationships, which are also referred to as symptoms of disturbances in self-organization (DSO). As in PTSD, the symptoms cause significant impairment in several areas of functioning (WHO, 2019).

PTSD and CPTSD prevalence

Recent evidence suggests both PTSD and CPTSD are common worldwide, with especially high rates in conflict-afflicted regions. According to the WHO, 3.9% of the world population has had PTSD in their lives (Charlson et al., 2019), with the number being substantially higher in trauma-exposed, and especially in war-afflicted samples: between 1989 and 2019 the prevalence for PTSD was estimated to be 26.51% in countries affected by war (Hoppen et al., 2021).

Regarding CPTSD, the global pooled prevalence is estimated to be around 6.2% in the general population and 12.4% in trauma-exposed samples, with the highest prevalence in military, sexual or domestic abuse and clinical samples (Huynh et al., 2025). Other studies that investigated across different population samples (USA, Israel, Lithuania, Ireland) found prevalences of 1.8% to 7.7% for CPTSD and 3.4% to 6.7% for PTSD, illustrating a notable CPTSD burden in Western countries (Cloitre et al., 2018; Hyland et al., 2020; Hyland et al., 2021; Kvedaraite et al., 2022). A systematic review and meta-analysis by Fung et al. (2025) reported pooled prevalence rates of 2% for PTSD and 4% for CPTSD in non-war-exposed and economically developed regions and pooled prevalence rates of 16 % for PTSD and 15% for CPTSD in war-exposed or less economically developed regions. Although pooled prevalence rates should be interpreted carefully, the high prevalences for PTSD and CPTSD especially in war-afflicted regions and countries underline the need for deeper context-dependent knowledge of the development as well as effective and culturally sensitive interventions for PTSD and CPTSD. Moreover, Burri and Maercker (2014) examined the contribution of war victimization and other civil trauma on contemporary PTSD prevalence performing secondary data analysis for data of 12 European countries, and found that the aftermath of war plays a substantial role in current PTSD prevalence, as they found a strong association between PTSD prevalence and war victimization. Another systematic review and meta-analysis of epidemiological studies reported a pooled prevalence of 26% for PTSD in adult civilian war survivors who stayed in war-afflicted regions (Morina et al., 2018).

Specifically in the context of Ukraine, after the first year of the Russian invasion, an estimated prevalence of 32.9% to 39.4% was found in Ukrainian residents, while the probable prevalence was even higher in Ukrainian refugees with 47.2% (Lushchak et al., 2024). Another study found a probable prevalence of 47.5% in Ukrainian refugees, underscoring the high burden of trauma-related disorders in displaced people and refugees (Bilewicz et al., 2024). A report of PTSD prevalence in previously Russian-occupied Ukrainian villages in Eastern and Southern Ukraine conveyed positive screenings for PTSD in 47.8% to 51.33% of the sample investigated (Ressler et al., 2024). In another study investigating PTSD and CPTSD among parents who live in active Ukrainian war zones, who live in active war zones, found that all participants were exposed to multiple war-related stressors, and while 25.9% met diagnostic criteria for PTSD, 14.6% met diagnostic criteria for CPTSD, demonstrating that war-related trauma exposure is strongly linked with CPTSD prevalence in a war-affected population (Karatzias

et al., 2023). Overall, these findings indicate a markedly elevated burden of both PTSD and CPTSD among war-affected Ukrainians, particularly among refugees and populations exposed to prolonged occupation and active combat conditions.

The Current Conflict and War in Ukraine

According to figures from the Office of the United Nations High Commissioner for Human Rights (OHCHR), the war has already claimed the lives of at least 13,883 Ukrainian civilians, including at least 726 children, to this date. Additionally, the OHCHR has recorded at least 35,548 injured civilians, including 2,234 injured children, as a result of the war in Ukraine, which sums up to 43,610 killed or injured civilian victims, though this figure is believed to be significantly higher (Statista Research Department, 2025a). On top of that, as of July 2023, the number of internally displaced persons in Ukraine amounted to around 5.7 million. The majority of the internally displaced, around four million people, come from eastern Ukraine (Statista Research Department, 2023). In addition to the internally displaced people, since the start of the war in Ukraine until July 2025, around 47.3 million refugees have crossed the border into one of its neighboring countries. A total of around 6.36 million refugees have registered as displaced persons in Europe, with Poland and Germany being the countries that seem to have taken in the most refugees among the EU states (Statista Research Department, 2025b).

Given the high burden of PTSD and CPTSD both in displaced and not displaced survivors of war, it is urgent to work on finding effective treatment solutions by gathering more research about the interactions between trauma, displacement and its potential psychological outcomes, especially in a country like Ukraine that has a deep history of collective traumas both through war and political oppression.

Perceived Social Support

Social support is one of the key resources that significantly influences well-being, mental health, and coping with stress (Cobb, 1976). It can be defined as the degree to which people are attended to and cared for by others, leading them to believe they are esteemed and part of a social network with mutual responsibility (Zell & Stockus, 2025).

In well-established research, social support is understood as a multi-layered construct that encompasses emotional, instrumental, informational, and evaluative support that can have a buffering effect for a variety of pathological states for individuals in crisis (Cobb, 1976; Cohen & Wills, 1985). Cohen and Wills (1985) especially propose that the perceived availability of social support can serve as a protective resource, potentially shielding individuals from the potential negative impact of stressful events. In this stress-buffering framework, it is not merely the existence of social ties but the belief in

reliable support that mitigates negative outcomes under stress.

Moreover, numerous studies indicate that the presence of reliable social relationships not only acts as a buffer against stress, but also has long-term positive effects on physical and mental health indicators. For example, a systemic review and meta-analysis by Yeo et al. (2025) found that perceived social support (PSS) had positive associations with multiple domains of human thriving, showing the largest average associations with better mental health and work performance and additional links with physical health, lower risk-taking behaviors and better educational functioning. In another quantitative synthesis of 60 meta-analysis that investigated the association between social support and psychological adjustment, Zell and Stockus (2025) reported a robust overall association between the two constructs as well as effects of social support on several other outcomes like mental health and psychological traits, educational and workplace outcomes, depression, PTSD, stress and burnout. Importantly, the study highlighted that the effects were more prominent for PSS rather than for received social support and were detectable across different cultures and age groups (Zell & Stockus, 2025). In a meta-analysis of longitudinal studies on social support and PTSD, Wang et al. (2021) were able to show that PTSD symptoms and social support were reciprocally related over time, with social support prospectively predicting lower subsequent PTSD, as well as PTSD predicting reductions in later social support. Similarly, in another meta-analysis Zalta et al. (2021) found that social support was moderately associated with lower self-reported PTSD symptoms. Furthermore, several moderators in this relationship could be identified, one of them being source of support. At the within-person level, Sippel et al. (2024) demonstrated bidirectional associations in a recently trauma-exposed community sample, showing that positive deviations from the individuals' typical level of PSS, especially the support from friends, acted as an accelerator for PTSD symptom reduction over one year, whereas higher PTSD symptoms subsequently eroded PSS.

As CPTSD is a relatively new construct, much less research has been established about the relationship between CPTSD and PSS. Nevertheless, one cross-sectional study investigated associations between PSS, PTSD and CPTSD, provided evidence for a unique association between lower PSS and higher CPTSD DSO-symptoms as well as with increased odds of a CPTSD diagnosis, compared to PTSD. At the same time, individuals with CPTSD showed lower levels of PSS, suggesting a bidirectional association between the two constructs (Simon et al., 2019). In another study which examined the role of gender in the relationship between social support and C(PTSD) found that while PTSD and CPST severity was mostly higher in females than in males, there was no gender

difference in PSS as well as in the association between PSS and PTSD and CPTSD severity, as low PSS was associated with more severe symptoms in both genders (Fares-Otero et al., 2024).

Taken together, these findings emphasize PSS as a central protective resource against the development of both PTSD and CPTSD as well as symptom severity. PSS not only correlates with better overall adjustment but can also shape trauma recovery processes over time, as individuals who feel more socially supported seem to be less prone for the development of severe trauma-related disorders. While the relationship between PTSD and PSS has been investigated and supported through several studies, there are still gaps in psychological research concerning the specific association between PSS and CPTSD, as CPTSD as a diagnosis has only been introduced in the past years. This study therefore aims to contribute to a deeper understanding of the relationship between these constructs, especially in a population that has been victim of both historical and contemporary traumas.

Finally, HT is a relatively new construct in psychological research and has not been specifically studied in connection with PSS. Nevertheless, as existing research on HT in the context of post-Soviet societies is, among other issues, based on theories of post-communist syndrome (Klicperova et al., 1997), the assumption that HT may be related to low PSS seems plausible. Furthermore, as HT has been associated with other trauma-related outcomes like PTSD (Mutuyimana & Maercker, 2023), which in turn has been well studied regarding relations with social support (Wang et al., 2021; Zalta et al., 2021; Zell & Stockus, 2025; Yeo et al., 2025), it is of substantial importance to gather knowledge about how HT, PSS and other trauma-related outcomes such as PTSD and CPTSD could relate to each other, especially in the context of Ukraine, which has been marked by severe HT.

Present Study: Objectives and Research Questions

Prior research suggests that repeated trauma exposure as well as being part of a collective that is affected by HT may heighten vulnerability to PTSD and CPTSD development, whereas PSS constitutes a key protective resource that may be able to buffer adverse psychological effects of trauma exposure. Yet, less is known about how these processes unfold in the specific context of the Ukrainian culture, and whether they differ between those who remain in the country during the ongoing war and those who have fled Ukraine and became refugees in another country. As the history and culture of Ukraine is shaped by state violence and HT, and the country recently once again fell victim to the current full-scale war by Russia, Ukraine provides a unique context for examining how HT can affect the processing of current potentially traumatic events.

To address these gaps, the present study aims to investigate (1) differences in trauma experiences and processing between Ukrainian refugees and Ukrainian residents, (2) the role of HT in influencing the development and severity of both PTSD and CPTSD, and (3) the extent to which PSS could be able to mitigate these associations. The present study therefore translates the outlined theoretical considerations into the following research questions and hypotheses:

Q1: How does the experiencing and processing of Trauma differ between Ukrainian refugees and Ukrainian residents?

H1: There is a difference in the prevalence of meeting the clinical threshold of PTSD in Ukrainian refugees and Ukrainian residents.

H2: There is a difference in PTSD symptom severity in Ukrainian refugees and Ukrainian residents.

H3: There is a difference in HT between Ukrainian refugees and Ukrainian residents.

Q2: Is there a relationship between HT and PTSD/CPTSD?

H1: HT is a predictor of PTSD symptom severity.

H2: HT is a predictor of CPTSD symptom severity.

H3: HT is a predictor for meeting the clinical threshold for PTSD.

H4: HT is a predictor for meeting the clinical threshold for CPTSD.

H5: There is a difference in the association between HT and PTSD symptom severity in Ukrainian refugees and Ukrainian residents.

H6: There is a difference in the association between HT and CPTSD symptom severity in Ukrainian refugees and Ukrainian residents.

Q3: What influence does PSS have on the experience of Trauma?

H1: Greater PSS is associated with lower PTSD symptom severity.

H2: Greater PSS is associated with lower CPTSD symptom severity.

H3: Greater PSS is associated with lower HT symptom severity.

H4: Greater PSS is associated with a weaker association between HT and PTSD symptom severity.

H5: Greater PSS is associated with a weaker association between HT and CPTSD symptom severity.

Expected Results

Based on the literature, the present study is expected to reveal systematic differences in the experience and processing of trauma between Ukrainian refugees and Ukrainian residents. Drawing on evidence that war-affected populations show substantial but context-dependent PTSD burdens (Burri & Maercker, 2014; Hoppen et al., 2021; Morina et al., 2018), it is anticipated that prevalence rates and symptom severity of PTSD will differ between the two groups. Specifically, Ukrainian refugees are expected to show a higher prevalence of PTSD and CPTSD of both meeting the clinical threshold as well as symptom severity relative to residents, reflecting differential exposure to war-related stressors, displacement and resettlement challenges (Bilewicz et al., 2024; Lushchak et al., 2024). Moreover, given that historical and contemporary traumas are embedded in distinct sociopolitical and migratory contexts (Kirsch & Haran, 2025), HT is likewise expected to differ between refugees and residents.

Regarding the second research question, the study is expected to demonstrate a significant association between HT and PTSD as well as CPTSD symptom severity. Prior work suggests that cumulative and intergenerational trauma can increase vulnerability to a range of mental health difficulties, including PTSD and related conditions (Cacace & Summers, 2025; El-Khalil et al., 2025; Mutuyimana & Maercker, 2023). In line with this literature, HT is expected to significantly predict both PTSD and CPTSD symptom severity, as well as the likelihood of meeting clinical thresholds for these disorders, as research indicated that historically rooted, collective forms of trauma contribute to clinically relevant distress (Mutuyimana & Maercker, 2023) and can shape contemporary reactions to trauma exposure across generations (Cacace & Summers, 2025; El-Khalil et al., 2025). Furthermore, the strength of the association between HT and PTSD or CPTSD is expected to vary between Ukrainian refugees and residents, with refugees potentially exhibiting a stronger relationship between historical and current trauma responses due to compounded displacement stressors and potentially more salient engagement with collective narratives in exile (Kirsch & Haran, 2025).

In relation to the third research question, PSS is expected to function as a protective factor in the context of both historical and current war-related trauma. Meta-analytic and systematic evidence indicates that higher social support is reliably associated with better psychological adjustment and lower levels of PTSD and related symptoms across diverse populations (Wang et al., 2021; Zalta et al., 2021; Zell & Stockus, 2025; Yeo et al., 2025). Moreover, research suggests that higher levels of PSS is also related to lower risk of CPTSD development and lower symptom severity (Fares-Otero et al., 2024; Simon et al., 2019). Consistent with this, greater PSS in the given sample is expected to

be associated with lower PTSD and CPTSD symptom severity, as well as lower levels of HT-related distress. Moreover, building on longitudinal evidence for bidirectional links between social support and trauma recovery (Sippel et al., 2024) and quantitative syntheses demonstrating the broad buffering role of social support on mental health outcomes (Zell & Stockus, 2025; Yeo et al., 2025), PSS is expected to attenuate the association between HT and both PTSD and CPTSD symptom severity.

Overall, the anticipated pattern of results would underscore the central role of HT in shaping current trauma responses while highlighting PSS as a critical protective factor in the Ukrainian context.

Methods

Design

This study utilized a quantitative cross-sectional design using an online survey with a single data collection point, comparing Ukrainian refugees and residents through standardized psychological measures. The online survey was conducted with SoSci Survey (Leiner, 2025). The data was collected between 24.06.2025 and 22.10.2025 at the website <https://www.soscisurvey.de/HTukraine/>. The survey was available in Ukrainian and in English language. All adults aged 18 and over who either currently live in Ukraine, have fled Ukraine due to the current war or used to live in Ukraine and left before the war could participate, though only the data of those who either currently live in Ukraine or have fled Ukraine due to the current war was taken into the statistical data analysis, as this study's research questions were mainly targeted to these two groups. The data of the third group, people who used to live in Ukraine but left before the war, was only reported descriptively and used for validation of a measure used in this study.

As this study investigated topics sensitive in nature in a war-afflicted sample, this study was reviewed and approved regarding reasonableness and feasibility by the ethics committee of the University of Vienna under the reference number 012777. In addition to that, several precautions were taken to minimize participants' distress: the survey introduction clearly outlined the study's purpose, procedures, and voluntary nature. Participants were be informed that they can withdraw at any point without further consequences. Further, contact information for mental health support services were provided at the beginning and end of the survey, ensuring that respondents have access to professional assistance if needed.

Procedure

The survey first begun with an information and clarification page about the study on which respondents had to give their consent by clicking on a checkbox. Respondents who

fulfilled the inclusion criteria of being at least 18 years old and agreed with the terms of the study, were forwarded to the next page. Next, a survey about socio-demographic information such as gender, age, nationality, place of residence and highest level of education was presented. At this point, respondents who had not yet reached the minimum age of 18 years or were neither from Ukraine nor residents in Ukraine were excluded.

After that, the International Trauma Questionnaire (ITQ; Cloitre et al., 2018) was presented to record PTBS and CPTBS symptoms. Next, the revised version of the Clinical Aspects of Historical Trauma Questionnaire 5.0 (CAHTQ 5.0; Harder & Shchotka, 2025), based on the Clinical Aspects of Historical Trauma Questionnaire (CAHTQ) by Mutuyimana and Maercker (2022), was used to assess clinically relevant aspects of HT. Finally, the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) was used to measure PSS.

In the writing process of this study, DeepL (Kutylowski, 2017) was used for overall language embellishment.

Measures

Clinical Aspects of Historical Trauma Questionnaire (CAHTQ)

The Clinical Aspects of Historical Trauma Questionnaire (CAHTQ) by Mutuyimana and Maercker (2022) is a self-report questionnaire to assess HT. The CAHTQ has been developed specifically to measure HT in a wide range of contexts and cultures. The questionnaire was validated on a sample of genocide survivors in Rwanda (Mutuyimana & Maercker, 2022) and recently adapted to the Ukrainian context and language to the CAHTQ 5.0 with minimal changes to the main version (Harder & Shchotka, 2025). In doing so, terms like „genocide“ and „aggressor“ have been changed to „collective crimes/war“ and „perpetrator“ or „those responsible“. The questionnaire is supposed to be aimed to all those who feel part of Ukraine’s historical destiny. The CAHTQ 5.0 comprises five subscales with four items each and 20-items in total, which are to be answered on a 5-Point-Likert-Scale from 0 („Never“) to 4 („Constantly“). Total scores range from 0 to 80 with a score of 0 representing no clinical aspects of HT and higher scores indicating more severe clinical aspects of HT. An exact cutoff has not yet been determined.

The first subscale, *Reproaches and historical memory*, represents feelings of disapproval towards the perpetrators expressed by Ukrainians. The items of the subscale *Mistrust and social distance* assess the severity of distrust of Ukrainians towards the perpetrators. The items of the third subscale, *Exhaustion and a sense of loss*, represent states of extreme physical or psychological fatigue as long-term consequences of trauma.

The subscale *Cultural Loss and identity* measures the subjectively perceived loss of culture-related aspects and the last subscale, *Attributable harm and its consequences*, represents beliefs about the psychological damage of Ukrainians being primarily caused by exposure to the war.

Exemplary items of each subscale are „I feel anger towards people who deny or downplay the collective crimes/wars that have had a tragic impact on Ukrainian history and society, in the past or in the present.“ (Reproaches and historical memory), „I deliberately limit my contact with people who are involved in those collective crimes/wars that have had a tragic impact on Ukrainian history and society - in the past or in the present.“ (Mistrust and social distance), „I feel that I have no control over what happens to me because of the collective crimes/wars that have had a tragic impact on Ukrainian history and society, - in the past or in the present.“ (Exhaustion and a sense of loss), „I miss the cultural life — the traditions, celebrations, and community events — that we had before these collective crimes or the war.“ (Cultural Loss and identity), „I feel that everything has lost its meaning because of these collective crimes/war.“ (Attributable harm and its consequences).

The original version of the CAHTQ total scale exhibits very good internal consistency with a Cronbach's alpha of $\alpha = .91$. Each subscale has convergent and discriminant construct validity with an average variance extracted (AVE) for all subscales greater than .50 for convergent validity and less than .85 for discriminant validity (Mutuyimana & Maercker, 2022). As no data on the reliability and validity of the CAHTQ 5.0 is available yet, this study aims to assess its reliability, validity and factorial structure within the given sample.

International Trauma Questionnaire (ITQ)

The International Trauma Questionnaire (ITQ; Cloitre et al., 2018), a 18-item self-report questionnaire, measures PTSD and CPTSD symptoms based on the ICD-11 criteria (WHO, 2022). In the original version, beyond the 18 items, a stressful and potentially traumatic event is prerequisite to meet the trauma criterion. Since it can be assumed that all participants meet this criterion, this initial item was omitted in the survey of this study.

The items are to be answered on a 5-Point-Likert-Scale from 0 („Not at all“) to 4 („Extremely“). The first six items measure the core symptoms of PTSD, followed by three items to assess functional impairment in the past month in social life, work or other areas coming with these symptoms. There are two items for each cluster of PTSD: *Re-experiencing in the here and now* (Re), *avoidance* (Av) and *sense of current threat* (Th). Examples of the items measuring PTSD core symptoms are „Having upsetting dreams that replay part of the experience or are clearly related to the experience“ (Re), „Avoiding

internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?“ (Av) and „Feeling jumpy or easily startled?“ (Th). The next six items relate to CPTSD, respectively Disturbances in Self-Organization (DSO) symptoms. The DSO symptoms are organized in three clusters as well: *Affective dysregulation* (AD), *negative self-concept* (NSC) and *disturbances in relationships* (DR). Examples are „I feel numb or emotionally shut down.“ (AD), „I feel worthless.“ (NSC) and „I find it hard to stay emotionally close to people.“ (DR). The last three items are again assessing functional impairment regarding these symptoms.

The Cutoffs for clinical relevance follow the ICD-11 PTSD and CPTSD criteria: to meet the criteria for a PTSD diagnosis, the endorsement of one symptom from each cluster as well as one indicator of functional impairment is required. To meet the clinical threshold for a CPTSD diagnosis, all the prerequisites for a PTSD diagnosis as well as the fulfillment of one of two symptoms from each of the three DSO clusters and one indicator of functional impairment (Cloitre et al., 2018).

The ITQ exhibits good internal consistency with a Cronbach's alpha of $\alpha = .87$ for the PTSD scale and $\alpha = .90$ for the CPTSD scale (Camden et al., 2023). The structural validity has been evaluated with confirmatory factor analyses (Cloitre et al., 2018; Redican et al., 2021). Good convergent and discriminant validity have been demonstrated in several studies (Cyr et al., 2022; Hyland et al., 2017).

The Ukrainian version of the ITQ used in this study was translated and validated by Ho et al. (2023). Good internal reliability for each of the subscales has been demonstrated with Cronbach's alpha values ranging between $\alpha = .73$ and $.88$ (Ho et al., 2023).

Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) is another self-report measure that evaluates the level of PSS from family, friends, and significant others, offering a measure of potentially protective factors against trauma or the development of PTSD and CPTSD.

It consists of three subscales and 12 items in total, which are to be answered on a 6-Point-Likert-Scale from 1 („Very Strongly Disagree“) to 7 („Very Strongly Agree“). Higher values correspond to a stronger perception of social support. The three subscales each represent another source of PSS. The first scale measures PSS from family, with items like „I can talk about my problems with my family“ or „My family really tries to help me“. The second scale assesses PSS from friends and contains items like „I have friends with whom I can share my joys and sorrows“ or „I can count on my friends when things go wrong“. The third subscale measures PSS from a significant other and has items like „I

have a special person who is a real source of comfort to me.“ and „There is a special person in my life who cares about my feelings“.

The MSPSS offers good internal consistency with a Cronbach's alpha of $\alpha = .88$ for the whole scale as well as moderate construct validity (Zimet et al., 1988). Additionally, strong factorial validity for the three subscales could be demonstrated (Zimet et al., 1990). The Ukrainian version used in this Study was translated by Melnyk and Stadnik (2023).

Sample

According to the power analysis, the sample should comprise around 242 respondents, with the groups in and outside Ukraine ideally being roughly the same size. The a priori power analysis was calculated using G*Power 3.1.9.6 for Mac (Faul et al., 2020) to estimate the sample size. Using an alpha error of $\alpha = .05$, a power of .80 and an odds ratio of 1.5, the minimum required sample size is $N = 242$ for logistic regression models. For multiple linear regression models and t-test, smaller minimum required samples are given, which is why the number for logistic regression models was used as orientation. The sample was recruited through several contact persons in Austria, Ukraine and Germany, as well as through multiple organizations in Austria, Germany, Ukraine and Poland, through whom the questionnaire was distributed to respondents in and outside Ukraine. Additionally, social networks and personal contacts were used to forward the study via acquaintances in and outside Ukraine. A table of all organizations and persons contacted can be found in the supplementary material of this study.

In total, there were 334 sets of recorded test data, with 222 participants who finished the whole survey. Participants took an average of 10.66 minutes to complete the survey. Three data sets had to be excluded, one of a 17-year-old female participant, as she was underage, two because of partially missing data in the ITQ-section of the survey. The final sample comprises of 219 complete and usable data sets. 214 participants conducted the survey in Ukrainian language; five participants attended the English version in the given sample.

Data Analysis

The statistical data analysis was carried out using JASP 0.95.4 (JASP Team, 2025). Initially, descriptive statistics were employed to summarize the demographic characteristics of the participants and to provide an overview of the data. All assumptions for the analyses were tested in advance. Participants with missing data were excluded from the data analysis. For the statistical analysis of the research questions, only data of Ukrainian refugees and Ukrainian residents were used.

To evaluate the hypothesis of the first research question, a chi-square-test (X^2) and t-Tests were conducted. X^2 -Test was used to investigate whether there is a difference between Ukrainian refugees and Ukrainian residents in the prevalence of meeting the clinical threshold of PTSD in the ITQ as a binary outcome. To compare PTSD and HT symptom severity between the two groups (Ukrainian refugees vs. Ukrainian residents), t-Tests for two independent groups were conducted. Furthermore, exploratively, these analyses were also done for CPTSD clinical threshold and symptom severity.

To address the hypotheses of the second research question, logistic regression, linear regression as well as multiple linear regression models were used. Linear regression was implemented to investigate the predictive value of HT on PTSD and CPTSD symptom severity, while logistic regression was used to assess the predictive value of HT on the likelihood of meeting the clinical threshold for PTSD or CPTSD based on the ITQ as binary outcomes („diagnosis“ yes / no). The regression models of the multiple linear regressions incorporated a group variable (Ukrainian refugees vs. Ukrainian residents) and an interaction term (HTxGroup) to evaluate whether the relationship between the predictor and PTSD or CPTSD outcomes vary between Ukrainian refugees and Ukrainian residents. Using logistic and linear regression offers complementary insights: while logistic regression reveals the probability of meeting the clinical threshold for PTSD or CPTSD, linear regression sheds light on the severity of symptoms depending on HT severity.

To test the hypothesis related to the third research question, simple linear regression and multiple linear regression were employed again. Linear regression was applied to evaluate the association of PSS with PTSD, CPTSD and HT symptom severity. This analysis allowed for an assessment of how varying levels of PSS affect varying levels of PTSD, CPTSD and HT symptom severity. Multiple linear regression was utilized to investigate the relationship between PSS and the association between HT and PTSD or CPTSD symptoms with HT, PSS and an interaction term (PSSxHT). This approach provides insights into whether greater PSS is associated with a weakened association between HT and PTSD or CPTSD symptom severity, essentially buffering the association between the two variables. Because moderator analyses with binary outcomes are harder to interpret due to different scales, (C)PTSD symptom severity scores were used for better interpretability of the results. For interpretation of all the results, the thresholds for effect sizes offered by Cohen (1988) were used.

Finally, to reflect upon the validity of the CAHTQ in the context of Ukrainians, confirmatory factor analysis (CFA) was conducted to evaluate the factor structure. For the CFA, the whole data set, including all three groups (Ukrainian refugees, Ukrainian

residents and Ukrainians who have left Ukraine before the current war), was used, as the CFA was not specified in the research questions. Additionally, the reliability within the sample obtained was reviewed.

Results

Assumption Checks

All inferential statistical analyses were preceded by a review of the respective model assumptions. Diagnoses were made in JASP using the statistical tests and graphical residual analyses available.

For X^2 -analyses, it was checked whether at least 80% of the expected cell frequencies were ≥ 5 , which was met. For t-tests, the normal distribution of the dependent variables was tested using the Shapiro–Wilk test and histograms. For PTSD severity, the Shapiro–Wilk test showed a significant value ($W = .98, p = .026$), which formally indicates a violation of the normal distribution assumption. However, visual inspection of the dependent variable suggested a largely normal distribution. Given the known sensitivity of the test for moderate sample sizes (Ghasemi & Zahediasl, 2012), the assumption of normal distribution was considered sufficiently satisfied for the t-test. For HT, the assumption of data normality was met ($W = .99, p = .070$). The homogeneity of variance was checked using the Levene test and was met for both PTSD severity ($F = .05, p = .826$) and HT ($F = .73, p = .394$). For linear and multiple regressions, the assumptions of normality of the residuals of all variables was evaluated using the Residuals Histogram and Q-Q Plots of standardized residuals, indicating approximate normality for all predictors. Homoscedasticity was examined with the Residuals vs. Predicted plot, showing constant variance for all predictors. Linearity between predictors and the dependent variable was assessed using Residuals vs. Covariates plots, which revealed linear relationships between all predictors and dependent variables. The Durbin-Watson test was performed on all regression models to test for Independence of error terms. The values ranged between $DW = 1.79$ and 1.9 and showed no autocorrelation of the residuals. Since all models are based on the same cross-sectional data, this was to be expected. To counteract multicollinearity, the predictors were centered. Subsequently, Multicollinearity was not critical (all $VIF < 4$). For the logistic regression models, the assumptions of linearity in the logit, residual independence, and multicollinearity were tested. The assumption of logit linearity was tested using Box-Tidwell transformation. The interaction term ($HT_SUM * \log(HT_SUM)$) was not significant, so it can be assumed that the logit linearity assumption is fulfilled. Standardized residuals, leverage values, and Cook's distance were examined as part of the residual analysis to check for possible outliers. No

conspicuous or influential observations were found. Multicollinearity was not checked since there is only one predictor in the model. Lastly, it was examined whether there were sufficient events per predictor ($EPV \geq 10$), which was fulfilled.

Sample

87.8% ($n = 194$) of the participants were female and 12.2% ($n = 27$) were male. The participants' ages ranged from 18 to 69, with a mean age of 40.84 years ($SD = 10.92$). Data normality of age was tested and given ($p = 0.138$). There were three groups in the sample: Ukrainian residents, Ukrainian refugees and Ukrainians, that left Ukraine before the war. 45.2% ($n = 99$) indicated that they currently live in Ukraine, 11% ($n = 24$) said to have left Ukraine before the current war and 43.8% ($n = 96$) said that they had left Ukraine because of the war. As the research questions of the present study are aimed at Ukrainian residents and Ukrainian refugees, 89% ($n = 195$) of the sample can be included in the statistical analysis of this study, the third group will just be reported descriptively. As of the statistically usable sample, 50.8% ($n = 99$) are in the group of Ukrainian residents and 49.2% ($n = 96$) are Ukrainian refugees.

In the group of Ukrainian residents ($n = 99$), 90.9% ($n = 90$) were female and 9.1% ($n = 9$) were male. The mean age was 39.77 years ($SD = 10.51$). As of the educational level of the participants, 74.7% ($n = 74$) had a university degree, 6.1% ($n = 6$) had completed A-levels, an International Baccalaureate or another subject-related higher education entrance qualification, 5.1% ($n = 5$) had reached a Vocational secondary certification by completing a specialized secondary school or college, 3% ($n = 3$) had a General Certificate of Secondary Education and 1% ($n = 1$) said to be still in school. 10.1% ($n = 10$) had a different degree. 68.7% ($n = 68$) of the Ukrainian residents said to be employed, 13.1% ($n = 13$) self-employed, 2% ($n = 2$) unemployed, 3% ($n = 3$) were already retired, 2% ($n = 2$) were homemakers and 5.1% ($n = 5$) stated to be none of the above. For some participants in the resident group ($n = 2$), the information provided in the "Country" item differed from their given information, whether they currently live in Ukraine or not. Since such differences do not necessarily represent a contradiction (e.g., second residence), but no further information was available, their information about whether they live in Ukraine or not, was used for group assignment. In this regard, while 86.9% ($n = 86$) stated that they live in Ukraine, 1 person reported to be living in Germany as well, and 1 person in Lithuania. Furthermore, 11.1% ($n = 11$) did not specify their country of residence. As all of the formerly mentioned participants reported to be currently living in Ukraine in a previous item which was decisive for group assignment, these participants continued to be classified as residents.

In the group of Ukrainian refugees, 84.4% ($n = 81$) were female and 15.6% ($n = 15$) were male. The mean age was 41.94 years ($SD = 11.07$). Questioned about the country of residence, 46.9% ($n = 45$) of the refugees lived in Germany, 24% ($n = 23$) in Austria and 17.7% ($n = 17$) in Poland. There was 1% ($n = 1$) each that stated to live in Bulgaria, Czech Republic, Lithuania, Switzerland, Egypt, United Kingdom and the USA. 4.2% ($n = 4$) did not specify. As of the educational level of the participants, 70.8% ($n = 68$) had a university degree, 9.4% ($n = 9$) had completed A-levels, an International Baccalaureate or another subject-related higher education entrance qualification. 11.5% ($n = 11$) had reached a Vocational secondary certification by completing a specialized secondary school or college and 1% ($n = 1$) said to be still in school. 7.3% ($n = 7$) had a different degree. 38.5% ($n = 37$) of the Ukrainian refugees were employed, 4.2% ($n = 4$) self-employed, 37.5% ($n = 36$) unemployed, 4.2% ($n = 4$) were already retired, 9.4% ($n = 9$) were homemakers and 6.3% ($n = 6$) stated to be none of the above.

In the third group of the sample, the Ukrainians who already left their country before the war, 87.5% ($n = 21$) of the participants were female and 12.5% ($n = 3$) were male, with a mean age of 43.25 years ($SD = 12.54$). 70.8% ($n = 17$) of this group had a university degree, 8.3% ($n = 2$) had completed A-levels, an International Baccalaureate or another subject-related higher education entrance qualification. 4.2% ($n = 1$) had reached a Vocational secondary certification by completing a specialized secondary school or college and 16.7% ($n = 4$) stated to have a different degree. 66.7% ($n = 16$) of the participants of the third group said to be employed, 8.3% ($n = 2$) self-employed, 12.5% ($n = 3$) unemployed, 4.2% ($n = 1$) were already retired, 4.2% ($n = 1$) were homemakers and 4.2% ($n = 1$) stated to be none of the above. As of the country of residency, 41.7% ($n = 10$) lived in Austria, 37.5% ($n = 9$) lived in Germany, 16.7% ($n = 4$) in Poland and 4.2% ($n = 1$) did not specify.

Descriptives

The descriptive statistics for the three measurement instruments used are displayed in Table 1, separated by group. The ITQ scores were calculated according to the original scale (0 – 4) by subtracting the minimum value of the scale from the total scores of the items ((C)PTSD items –6, DSO items –6, functional impairment items –3). The descriptive values are therefore on the same scale as in normative ITQ studies.

Research Question (1)

There was no significant difference in the prevalence of meeting the clinical threshold of PTSD between Ukrainian residents and Ukrainian refugees ($\chi^2(1, N = 195) = 3.16, p = .075, V = 0.13$). The mean values of PTSD severity did not differ significantly

between Ukrainian residents ($M = 15.74$, $SD = 7.77$) and Ukrainian refugees ($M = 17.63$, $SD = 7.28$; $t(193) = -1.73$, $p = .086$, $d = 0.14$, 95% CI [-0.53, 0.04]). There was a significant difference between the mean values of HT of Ukrainian residents ($M = 44.92$, $SD = 14.44$) and Ukrainian refugees ($M = 49.45$, $SD = 14.03$; $t(193) = -2.22$, $p = .028$, $d = -0.32$, 95% CI [-0.6, -0.04]).

Research Question (2)

The regression model for H2.1 was significant ($F(1, 193) = 127.7$, $p < .001$), and explained approximately 40% of the variance ($R^2 = .40$). HT was a significant predictor for PTSD severity ($\beta = .63$, $t = 11.3$, $p < .001$), suggesting that higher levels of HT are associated with greater PTSD severity. The regression model for H2.2 was significant as well ($F(1, 193) = 131.2$, $p < .001$), and HT was a significant predictor for CPTSD severity ($\beta = .63$, $t = 11.45$, $p < .001$), explaining 40.5% of the variance ($R^2 = .40$). The logistic regression model for H2.3 was significant ($\Delta\chi^2(193) = 38.48$, $p < .001$), and explained 24% of the variance ($R^2 = .24$). HT significantly predicted the probability of meeting the criteria of a PTSD diagnosis ($OR = 1.08$, 95% CI [1.04, 1.10], $p < .001$). The logistic regression for H2.4 was significant as well ($\Delta\chi^2(193) = 27.1$, $p < .001$). HT significantly predicted the probability of meeting the criteria of a CPTSD diagnosis ($OR = 1.07$, 95% CI [1.04, 1.11], $p < .001$) and the model explained 20% of the variance ($R^2 = .20$). The multiple linear regression model for H2.5, in which the grouping variable was added as a predictor to the regression model from H2.1, is significant as well ($F(3, 194) = 42.35$, $p < .001$), and explained 40% of the variance ($R^2 = .40$). Group membership did not significantly predict PTSD severity ($b = 0.13$, $SE = 0.3$, $\beta = .03$, $t(194) = 0.43$, $p = .665$). The interaction term between group membership and HT was not significant ($b = -0.01$, $SE = 0.02$, $\beta = -.05$, $t(193) = -0.48$, $p = .631$). The multiple linear regression for H2.6 also displayed significant results ($F(3, 194) = 45.46$, $p < .001$), and explained 42% of the variance ($R^2 = .42$). Group membership did not significantly predict CPTSD severity ($b = 0.9$, $SE = 0.46$, $\beta = .11$, $t(194) = 1.96$, $p = .051$), although a trend was observable. The interaction term between group membership and HT was not significant ($b = -0.01$, $SE = 0.03$, $\beta = -.05$, $t(193) = -0.23$, $p = .820$).

Research Question (3)

In the analysis for H3.1, the linear regression was significant ($F(1, 194) = 11.45$, $p < .001$), and PSS predicted PTSD symptom severity negatively ($\beta = -0.23$, $t = -3.38$, $p < .001$), explaining 5.6% of the variance ($R^2 = .05$). The model for H3.2 was significant as well ($F(1, 194) = 38.14$, $p < .001$). PSS predicted CPTSD symptom severity negatively ($\beta = -0.4$, $t = -6.17$, $p < .001$). The model explained 16.5% of the variance ($R^2 = .16$). The

regression model for H3.3 was significant ($F(1, 194) = 6.82, p = .010$) greater PSS was associated with lower HT severity ($\beta = -0.18, t = -2.61, p = .010$) and explained 3.4% of the variance ($R^2 = .03$). The multiple linear regression for H3.4 was significant overall ($F(3, 194) = 45.64, p < .001$) and explained 42% of the variance ($R^2 = .42$). HT was a significant positive predictor of PTSD severity ($\beta = .62, t = 10.8, p < .001$). PSS significantly predicted PTSD symptom severity negatively ($\beta = -0.13, t = -2.34, p = .020$). The interaction term between HT and PSS was not significant ($b = 0.0, SE = 0.0, \beta = .07, t(193) = 1.28, p = .229$). Finally, the model for H3.5 was significant as well ($F(3, 194) = 62.88, p < .001$), and explained 50% of the variance ($R^2 = .5$). HT predicted CPTSD severity positively and significantly ($\beta = .59, t = 11.21, p < .001$) and PSS was a negative predictor for CPTSD severity ($\beta = -0.3, t = -5.89, p < .001$). The interaction term between HT and PSS was not significant ($b = 0.0, SE = 0.0, \beta = -0.8, t(193) = 1.5, p = .136$).

Table 1

Descriptive Statistics of Clinical Data: Mean (SD); n (%)

Variable	Residents ($n = 99$)	Refugees ($n = 96$)	t	p
CAHTQ 5.0	44.92 (14.44)	49.45 (14.03)	-2.22	.028*
PTSD Severity	15.74 (7.77)	17.63 (7.48)	-1.73	.086
CPTSD Severity	23.48 (12.07)	28.56 (12.01)	-2.94	.004**
PTSD Diagnosis	36 (36.4%)	47 (49%)	3.16†	.075
CPTSD Diagnosis	17 (17.2%)	26 (27.1%)	2.79†	.095
MSPSS	66.82 (10.53)	59.64 (14.98)	3.88	<.001***

Note: (C)PTSD Diagnosis = clinically relevant threshold in ITQ met.

*** $p < .001$

** $p < 0.01$

* $p < 0.05$

† Refers to the chi-square statistic

Confirmatory factor analysis of the CAHTQ 5.0

Confirmatory factor analysis (CFA) was conducted to evaluate the structure of the revised Ukrainian version of the CAHTQ (CAHTQ 5.0; Harder & Shchotka, 2025). The five participants who completed the survey in English language were excluded from this analysis, so a sample of $n = 214$ was left for the CFA. Descriptive Statistics of the CAHTQ 5.0 subscales in the given sample for the total sample as well as for the subgroups are displayed in Table 2.

Model fit was evaluated and compared using a standard range of model fit indices. χ^2 -test was used to assess absolute fit, the root mean square error of approximation (RMSEA) and the standardized root mean square residual (SRMR) were utilized to assess model fit more accurately. Incremental fit indices, such as the comparative fit index (CFI) and the Tucker-Lewis index (TLI) were used to compare the model fit to more restricted baseline models. Model fit statistics are displayed in Table 3. Standardized factor loadings are displayed in Table 4. All factor loadings were significant and exceeded .60 except for item 14 („conflicts in my family and with close friends have increased because of the collective crimes/wars that have had a tragic impact on Ukrainian history and society, - in the past or in the present.“) with a standardized loading of .40 on the subscale Cultural loss and identity and item 19 („Because of these collective crimes/war, I drink more alcohol/smoke more or use other substances to cope with my condition or situation.“) with a standardized loading of .52 on the subscale Attributable harm and its consequences.

Average variance extracted (AVE) was .83 for Reproaches and historical memory, .57 for Mistrust and social distance, .61 for Exhaustion and a sense of loss, .47 for Cultural loss and identity and .56 for Attributable harm and its consequences. Internal reliability was good for all of the subscales with Cronbachs alpha's values of $\alpha = .93$ for Reproaches and historical memory, .78 for Mistrust and social distance, .81 for Exhaustion and a sense of loss, .64 for Cultural loss and identity and .75 for Attributable harm and its consequences. Overall internal reliability was $\alpha = .91$.

Table 2

Descriptive Statistics of CAHTQ 5.0 Subscales in total sample and subgroups: Mean (SD)

Subscale	Total sample ($N = 219$)	Residents ($n = 99$)	Refugees ($n = 96$)	Left before war ($n = 24$)
CAHTQ 5.0	47.13 (14.13)	44.92 (14.44)	49.45 (14.03)	46.96 (12.18)

Reproaches	15.62 (3.64)	15.19 (3.92)	16.04 (3.51)	15.67 (2.81)
Mistrust	14.02 (3.45)	13.86 (3.66)	14.21 (3.39)	13.96 (2.81)
Exhaustion	13.53 (3.97)	13.21 (4.16)	13.85 (3.94)	13.54 (3.23)
Cultural loss	13.58 (3.47)	12.88 (3.52)	14.28 (3.28)	13.71 (3.58)
Attributable harm	10.37 (3.8)	9.78 (3.54)	11.06 (3.97)	10.08 (3.89)

Note: First row (CAHTQ 5.0) refers to the total mean (M) and standard deviations (SD) across all five subscales of the Clinical Aspects of Historical Trauma Questionnaire 5.0 for the total sample (column 1) and the three subgroups (column 2 – 4).

Table 3

Model fit statistics for the Confirmatory factor analysis of the dimensional structure of the CAHTQ 5.0 (N = 214)

Model	χ^2	df	p	CFI	TLI	RMSEA	90% CI	SRMR
CAHTQ 5.0	395.98	160	<.001	.96	.95	.08	[.07,.09]	.07

Note: CFI = comparative fit index, TLI = Tucker-Lewis Index, RMSEA = root mean square error of approximation, SRMR = standardized root mean square residual. CFI and TLI display comparison of the model fit to more restricted baseline models. RMSEA and SRMR display accurate model fit.

Table 4

Standardized Factor loadings of the subscales of the CAHTQ 5.0 (N = 214)

Item	Reproaches	Mistrust	Exhaustion	Cultural loss	Attributable harm
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1	.91			
2	.86			
3	.96			
4	.92			
5		.61		
6		.73		
7		.74		
8		.92		
9			.75	
10			.77	
11			.72	
12			.86	
13				.74
14				.40
15				.79
16				.74
17				.89

18	.79
19	.52
20	.75

Note: Table displays standardized factor loadings based on CFA. All factor loadings were significant, $p < .001$.

Explorative Analyses

Exploratively, a χ^2 -test as well as a t-test for independent samples were conducted for CPTSD „diagnosis“ and CPTSD severity, and a t-test for independent samples was conducted for PSS. There was no significant difference in the prevalence of meeting the clinical threshold of CPTSD between Ukrainian residents and Ukrainian refugees, ($\chi^2(1, N = 195) = 2.79, p = .095, V = 0.12$). However, the t-test showed significant result ($t(193) = -2.94, p = .004, d = -0.42, 95\% \text{ CI } [-0.7, -0.14]$) and there was a significant difference between the mean values of CPTSD severity of Ukrainian residents ($M = 23.48, SD = 12.07$) and Ukrainian refugees ($M = 28.56, SD = 12.01$). Moreover, the t-test for PSS showed significant results as well ($t(193) = 3.88, p < .001, d = 0.15, 95\% \text{ CI } [.27, .84]$), indicating a significant difference between the mean values of PSS of both groups.

Discussion

This study investigated the extent to which HT can potentially affect the development or absence of trauma-related disorders such as PTSD and CPTSD. In addition, it examined whether and how the social environment of those affected, specifically the social support individuals perceive from friends, family or significant others, can be protective in this regard.

Particularly special about this study was the usage of the CAHTQ 5.0, a new version of the CAHTQ, which was specifically tailored to the context of war-afflicted Ukraine. This study aimed to help validate this measurement tool using a Ukrainian sample, which in turn could contribute to a better understanding of the phenomenology of HT in the context of Ukraine, and potentially other post-soviet countries.

Summary of results

The present study aimed to examine (Q1) how the experiencing and processing of trauma differs between Ukrainian refugees and Ukrainian residents, (Q2) how HT is

associated with PTSD and CPTSD severity, and (Q3) what influence PSS could have on the experience of trauma and trauma-related outcomes.

Overall, the findings provided partial support for the hypotheses of this study: Residency status was not associated with differences in PTSD prevalence or symptom severity. The explorative analyses displayed no difference between the group in CPTSD prevalence, but showed significant difference in CPTSD severity, as well as in PSS, between Ukrainian refugees and Ukrainian residents. Moreover, Ukrainian refugees exhibited higher levels of HT than Ukrainian residents. HT was a strong predictor for PTSD and CPTSD severity. Additionally, HT also significantly increased the likelihood of fulfilling the diagnostic criteria for both PTSD and CPTSD. Group membership did not meaningfully alter these relationships and did not moderate the relationship between HT and PTSD severity or between HT and CPTSD severity. HT remained a strong predictor for PTSD and CPTSD severity when PSS was included. Nevertheless, PSS consistently emerged as a negative predictor for symptom severity, particularly for CPTSD. Again, group membership did not alter these relationships, as the predictive role of HT and the protective role of PSS operated similarly across Ukrainian refugees and Ukrainian residents. Finally, PSS did not moderate the association between HT and either PTSD or CPTSD severity.

Interpretation and discussion of results

PTSD and HT in Ukrainian refugees vs. Ukrainian residents

Regarding the first research question, the hypotheses assumed group differences in the prevalence of meeting the clinical threshold of PTSD (H1.1) as well as in PTSD symptom severity (H1.2) and in the pronouncement of HT (H1.3).

In the given data, there were no statistically significant differences in the prevalence of PTSD between Ukrainian refugees and Ukrainian residents. Although a numerically higher proportion of refugees met PTSD criteria (49%) compared to residents (36.4%), the association was weak ($V = 0.13$) and not distinguishable from chance given the sample size of this study. Although, contrary to expectations, the PTSD prevalence among Ukrainian refugees was not significantly higher than among Ukrainian residents, the prevalences in this sample were similar to those found in other studies, e.g. 32.9 to 39.4% in Ukrainian residents and 47.5% in Ukrainian refugees (Lushchak et al., 2024).

Explorative analysis also showed no significant difference in CPTSD prevalence across groups: a numerically higher proportion of refugees fulfilled CPTSD criteria (27.1%) compared to residents (17.2%) and the association was comparably weak to the one for PTSD ($V = 0.12$).

Consistent with the prevalence findings of this study, there was also no statistically significant difference in PTSD severity between Ukrainian refugees and Ukrainian residents. The small effect size ($d = 0.14$), as well as the confidence interval including zero (95% CI [-0.53, 0.04]) reinforce the conclusion of no reliable difference, as the true difference between the two groups could also be zero. Substantively, this suggests that, PTSD symptom severity is broadly comparable across Ukrainian refugees and Ukrainian residents in the given sample. A potential explanation for the presented results could be that the Russia-Ukraine war is ongoing and Ukrainian residents are still continuously exposed to potentially traumatic experiences, especially if they are living in an active war zone. This interpretation aligns with evidence that PTSD severity increases with the number, chronicity, and accumulation of traumatic experiences (Ogle et al., 2014), as well as research demonstrating a dose–response relationship between war-related stressor exposure and (C)PTSD diagnosis (Karatzias et al., 2023). Thus, the absence of significant group differences may reflect similar trauma burdens across both populations rather than an absence of war-related psychological impact, a conclusion further supported by the given prevalence rates that are consistent with prior studies of Ukrainian refugees and residents (Lushchak et al., 2024). In future research, it would be interesting to examine whether the results would persist if the war was in the past rather than ongoing, or if patterns would change in the post-war period. Interestingly, explorative analyses displayed a significant difference in CPTSD severity between Ukrainian refugees and Ukrainian residents, implying a more severe DSO symptomatology, compared to the core PTSD symptomatology, in refugees. Given the exploratory nature of this analysis, this finding can only be interpreted cautiously. Rather than indicating a robust group difference in CPTSD, the result may suggest that other contextual factors associated with group status, such as post-migrational stressors like loss of community, may have influenced the intensity of DSO symptoms among affected individuals.

Furthermore, a statistically significant difference in HT could be detected between the two groups. In line with the expectations, HT scores were significantly higher in Ukrainian refugees than in Ukrainian residents. The effect was small to medium ($d = -0.32$), indicating a modest but meaningful group difference. This is consistent with prior research suggesting that displacement stressors can potentially heighten the engagement with collective narratives such as collective traumas in exile (Kirsch & Haran, 2025).

Overall, the pattern of the given results suggests that the most pronounced group difference lies in the HT load and implies, that displacement status alone is insufficient in explaining differences in PTSD outcomes shown in other studies (Lushchak et al., 2024).

Importantly, the findings can be framed as evidence of similar PTSD burden in terms of prevalence and symptom severity across both groups, alongside a specific, small to moderate difference in HT pronounciation, rather than as evidence of no psychological impact of displacement. The evident group difference could reflect the additional burden of displacement-related and post-migration stressors on top of the experienced war exposure. Although it was originally hypothesized that this additional stressor would affect differences in PTSD prevalence and severity, it could also be reflected in the intensity of HT, as Ukrainian refugees in their new environment potentially identify even more with the history, culture, and associated historical traumas of their country of origin, as they have to face the loss of parts of their identities such as their homes, property, employment, familiar surroundings and routines, in addition to the traumatic experiences of war. On top of that, language barriers, cultural misunderstandings and marginalization in the host country could strengthen the feeling of foreignness as well as the urge of engaging with one's culture of origin, potentially enhancing identification with their HT. All in all, the loss of a coherent life narrative could increase feelings of identity disruption and existential insecurity, which are all captured within the construct of HT (Maercker, 2023; Mutuyimana & Maercker, 2023). This interpretation could also be relevant in explaining the more severe DSO symptomatology in Ukrainian refugees, as a loss in familiarity and identity-forming surroundings may potentially enhance disturbances in self-organization.

Taken together, this pattern suggests that displacement primarily adds to cumulative trauma burden, which manifests in a more pronounced experience of HT, rather than producing large incremental differences in PTSD symptomatology.

The relationship between HT and (C)PTSD prevalence and severity

For the second research question, H2.1 to H2.2 posited that HT would predict PTSD and CPTSD symptom severity as well as with the likelihood of meeting clinical thresholds for these disorders (H2.3 & H2.4), as previous research has highlighted that collective forms of trauma can have lasting effects across generations and that HT can increase vulnerability to a wide range of mental health difficulties, including PTSD (Cacace & Summers, 2025; El-Khalil et al., 2025; Mutuyimana & Maercker, 2023). Accordingly, HT was expected to serve as a robust predictor of trauma-related symptomatology, reflecting its role in shaping contemporary responses to war-related stressors.

The given results strongly supported these claims: Higher HT was associated with higher PTSD symptom severity. HT accounted for 40% of the variability in PTSD severity, indicating a large effect and a robust relationship. The standardized coefficient ($\beta = .63$) indicates a strong positive association: as HT increased, PTSD severity increased. This

establishes HT as a robust risk factor for PTSD severity. Higher HT also predicted higher CPTSD symptom severity with 40.5% of the variance in CPTSD severity explained by HT, which is nearly identical to what was observed for PTSD, also indicating a large effect and a robust relationship by conventional standards in psychological research. The standardized coefficient ($\beta = .63$) again reflects a large effect, suggesting that higher levels of HT are robustly associated with greater CPTSD symptom severity. This demonstrates that HT is not only relevant to PTSD but extends comparably to the more complex symptom profile of CPTSD. Moreover, the similar results for both PTSD and CPTSD support the idea of HT as a central, transdiagnostic risk factor for trauma-related psychopathology rather than something specific to one diagnostic category. This further supports the interpretation of the explorative analysis regarding group differences in CPTSD severity, as the strong association observed between HT and CPTSD severity may point to HT as a potential mechanism underlying differences in symptom expression.

H2.3 and H2.4 postulated that HT would also predict the likelihood of meeting clinical thresholds for both disorders. HT significantly predicted the probability of meeting the criteria for a PTSD diagnosis. HT increased the odds of a PTSD diagnosis by 8% per unit increase in HT ($OR = 1.08$, 95% CI [1.04, 1.10]). The effect was medium to large, as the model explained 24% of the variance ($R^2 = .24$). Nagelkerke R^2 , however, is as global measure of model fit and does not reflect the strength of any single predictor and the odds ratio indicated a rather small effect according to conventional OR thresholds. Nevertheless, these effects are cumulative, and as HT is measured on a large metric scale (0 - 80), even a small OR per unit can accumulate to a meaningful effect on diagnostic outcomes across the range of the variable. This means, that differences of several points on the HT scale translate into substantially higher probabilities of meeting the criteria of a PTSD diagnosis. In conclusion, the model predicted PTSD fairly well, while the effects per unit increase were rather small.

The same applied to the model for H2.4: HT was a significant predictor for meeting the clinically relevant threshold for CPTSD. The model explained 20% of the variance, which can be interpreted as a medium to large effect for overall model fit. HT increased the odds of meeting the criteria of a CPTSD diagnosis by 7% per unit increase in HT ($OR = 1.07$, 95% CI [1.04, 1.11]), which can be interpreted as a small effect. HT seems to be having a similar effect on both PTSD and CPTSD: While each unit of HT slightly increased the odds of either diagnosis, R^2 differed (0.24 vs. 0.20), showing the models explained slightly more variance for PTSD than CPTSD.

Conceptually, these findings align with prior research linking HT to elevated risk of PTSD and related disorders (Gone et al., 2019; Maercker, 2023; Nagata et al., 2024), and empirically support the idea of HT as a transdiagnostic factor that shapes trauma-related psychopathology rather than being specific to a single disorder. Taken together, the results reinforce both the theoretical and clinical significance of HT, showing that historically rooted trauma not only contributes to greater symptom severity but also has practical implications for identifying individuals at elevated risk for PTSD and CPTSD. This highlights the importance of considering HT in assessments, interventions, and preventive strategies for populations affected by war and displacement.

Based on prior literature, it was anticipated that the association between HT and PTSD (H2.5) or CPTSD (H2.6) might differ between Ukrainian refugees and residents, with refugees potentially exhibiting stronger relationships due to compounded displacement stressors and greater engagement with collective trauma narratives in exile (Kirsch & Haran, 2025). The given results, however, provided rather little support for these hypotheses: The model for H2.5 was significant and explained 40% of the variance. However, the variance explained was not heightened by adding the grouping variable and R^2 stayed substantially the same as in the linear regression model for H2.1. Additionally, the model had a lower F -value (42.35 compared to 127.7 in model H2.1), which means that the overall predictor efficacy of variance explanation decreased and that the grouping variable did not add any further predictive power to the H2.5 model. Moreover, group membership did not emerge as significant, nor did the interaction between group membership and HT reach significance, indicating that group status neither independently predicted PTSD severity nor moderated the association between HT and PTSD. This indicates that the strength of the association between HT and PTSD is comparable for refugees and residents, and that the relationship between HT and PTSD severity appears robust across groups, with group status contributing no additional predictive power, which, taken together, provides little support for H2.5. In practical terms, this means that increases in HT were associated with higher PTSD severity to a similar extent for both groups. Thus, being a refugee did not strengthen or weaken the relationship between HT and PTSD severity; instead, HT appears to be associated to PTSD symptoms in a comparable way across both groups.

Similarly, model H2.6 investigated potential group differences in the association between HT and CPTSD. The regression model showed significance as well. This time, R^2 was slightly heightened by approximately 1.5% compared to the model without the grouping variable (H2.2), which means that the model got slightly better at explaining

variance, with the new predictor being relatively weak compared to the overall model. The model displayed a lower F -value compared to the H2.2 model (45.46 vs. 131.2), reflecting a small marginal contribution of the new predictor relative to the overall variance explained. Critically, the explained variance in this model is still comparable to the one observed in the model without the grouping predictor. Group status was examined as a potential moderator of the relationship between HT and CPTSD, but did not meaningfully alter this association: group membership itself did not emerge as a significant predictor of CPTSD severity, and the interaction between group membership and HT was not significant as well. This suggests that higher levels of HT are related to higher CPTSD severity to a similar extent among both groups, and group membership did not strengthen or weaken the impact of HT on CPTSD symptom severity, complementing the results of H2.5.

The continued significance of the overall models suggests that HT remains the primary driver of symptom severity for both PTSD and CPTSD, while group status contributes little additional explanatory power. In other words, although refugees reported higher HT on average, HT itself, rather than displacement status, is what was associated with symptom severity. This helps explain why group differences in PTSD outcomes were not observed despite differences in HT, as the relevant explanatory factor operated at the individual level - in terms of historical and contemporary trauma load - rather than the group level in the given sample. Moreover, these findings are consistent with the results of the first research question, reinforcing the notion that displacement status per se does not account for variance in trauma-related outcomes, once HT is included. Importantly, the lack of significant interaction effects showed that group membership did not change how strongly HT was related to symptom severity, meaning that higher HT was linked to higher PTSD and CPTSD symptoms in a similar way for both refugees and residents, even though refugees exhibited higher HT on average.

The influence of PSS on trauma-related outcomes

Addressing the third research question, the hypotheses proposed that greater PSS would be associated with lower PTSD (H3.1) and CPTSD symptom severity (H3.2) as well as with lower HT pronouncement (H3.3).

In line with that, higher PSS was linked to lower PTSD symptom severity. The effect was small ($R^2 = .05$). As expected, higher PSS was also associated with lower CPTSD symptom severity, with the effect being of medium magnitude ($R^2 = .16$). The findings suggest that social support may be particularly relevant in relation to the more complex symptom profile of CPTSD. This is consistent with prior evidence indicating associations

between lower PSS and higher CPTSD risk and symptom severity (Fares-Otero et al., 2024; Simon et al., 2019) and implies PSS as a meaningful resource in trauma recovery (Sippel et al., 2024). As previously discussed, lower social support as well as loss of familiar surroundings and community might be a reason for the increase in DSO symptoms in refugees. The explorative t-test also confirmed differences in PSS between the two groups, which could further support these assumptions, as PSS was higher in the group of Ukrainian residents.

Moreover, higher PSS was also linked to lower HT severity. The effect was small ($R^2 = .03$). To this date, there are no studies investigating the specific relationship between PSS and HT, but the given result was expectable, as HT was associated with learned mistrust and a general lack of incivility in prior research (Mutuyimana & Maercker, 2023), which in turn could potentially contribute to a lower level of PSS. This association additionally complements the results of explorative analyses, which revealed a group difference in PSS in the given sample. Both point to the same underlying mechanism: the finding that refugees report lower PSS than residents indicates a contextual disadvantage at the group level (e.g., disrupted social networks, marginalization), while the association further shows why that difference matters. If lower PSS is linked to higher HT severity, then the lower average PSS observed in refugees becomes theoretically meaningful rather than merely descriptive, and strengthens the conclusion, that social support might be highly relevant in HT.

Further analyses examined whether PSS could weaken the associations between HT and contemporary trauma-related outcomes: H3.4 and H3.5 predicted that higher PSS would weaken the association between HT and PTSD or CPTSD symptom severity as investigated in H2.1 and H2.2. The multivariate model used for H3.4 was significant and explained slightly more variance overall ($R^2 = .42$) than the H2.1 model, indicating that adding PSS improved explanatory power, albeit modestly. PSS emerged as a significant negative predictor of PTSD severity ($\beta = -.13$). Importantly, HT remained a strong and statistically significant positive predictor for PTSD severity ($\beta = .62$), with only a negligible reduction in effect size compared to the single-predictor model. This suggests that the association between HT and PTSD severity is stable and largely independent of PSS, implying that PSS can only mitigate the psychological burden of HT to a small extent. However, This indicates that higher levels of PSS are associated with lower PTSD symptom severity, controlling for HT. Although the effect size for PSS is smaller than the effect of HT, it is statistically meaningful and consistent with a protective or buffering role of social support suggested by established research (Cobb, 1976; Cohen & Wills, 1985).

Furthermore, this pattern is consistent with stress-vulnerability frameworks in trauma research, where strong risk factors coexist with weaker, yet meaningful, protective factors, as provided by Weisæth (1998).

The model for H3.5 substantially increased explanatory power, accounting for 50% of the variance in CPTSD severity, which represents an improvement over the single-predictor model. HT remained a strong, positive, and significant predictor ($\beta = .59$), with only a modest reduction in effect size compared to the simple regression in the H2.2 model, indicating HT as an independent and stable influence on CPTSD severity. Nevertheless, PSS emerged as a significant negative predictor of moderate multitude ($\beta = -.30$), suggesting that higher PSS is associated with lower CPTSD symptom severity, even when controlling for HT. The magnitude of this effect was notably larger than what was observed for PTSD in the earlier model (H3.4), indicating a particularly meaningful protective role of PSS in relation to CPTSD. This is consistent with the findings in the analysis for H3.1 and H3.2 and supports findings of prior research, which demonstrated the broad buffering role of social support on several mental outcomes (Zell & Stockus, 2025; Yeo et al., 2025). Across both models, HT and PSS independently predicted trauma-related symptom severity. However, contrary to expectations, PSS did not moderate the association between HT and either PTSD or CPTSD severity. One possible explanation could be that HT represents a trauma-related burden whose impact on symptom severity may be less affected by buffering effects of social support. While PSS was associated with lower symptom severity overall, its influence may operate independently rather than by reducing the effect of HT. This interpretation is consistent with models suggesting that social support primarily affects post-trauma adjustment and symptom maintenance, rather than altering the impact of trauma exposure itself (Wang et al., 2021).

Taken together, these findings suggest that PSS functions as a general protective factor, but does not substantially change the strength of the relationship between HT and trauma-related symptom severity. When taking into account the results from the explorative analyses, it seems reasonable to assume that group membership could influence CPSTD severity partly through differences in PSS. Refugees' higher trauma exposure and displacement-related stressors may erode social networks, reduce access to stable support systems, or alter perceptions of support available, which in turn could contribute to greater CPTSD symptom severity. The fact that PSS shows a robust main effect on CPTSD, while not moderating the association between HT and CPTSD, is consistent with a mediation pathway rather than with a moderating effect of PSS.

Empirically, the prerequisites for mediation appear partially met: (a) there were significant group differences in PSS, (b) PSS significantly predicted CPTSD severity when controlling for HT, and (c) HT and group membership were associated with CPTSD severity. However, it would be needed to demonstrate whether HT or group membership would significantly predict PSS, and whether the direct effect of HT (or group membership) on CPTSD severity would be meaningfully reduced when PSS would be included in the model. Even if the reduction was modest, a significant indirect effect would support a partial mediation of PSS. Future research could clarify whether lower PSS could be a mediator through which HT or group membership relate to more severe CPTSD symptomatology.

Overall, across all findings, a clear and consistent pattern emerged: HT was as a robust risk factor for trauma-related symptomatology as well as for meeting diagnostic thresholds for both PTSD and CPTSD, whereas PSS showed a protective association with symptom severity, especially for CPTSD. At the same time, differences between Ukrainian refugees and Ukrainian residents were less pronounced than expected: Group membership did not directly predict PTSD or CPTSD outcomes, despite being associated with higher HT, and the moderation analysis suggested that neither group membership nor PSS did change the strength of the association between HT and (C)PTSD symptom severity. This indicates that trauma-related outcomes were primarily influenced by vulnerabilities and resources on an individual level, rather than by displacement status alone. The exploratory analyses yielded particularly intriguing findings, suggesting that the severity of DSO symptoms may be linked to the experience of forced displacement primarily through indirect pathways rather than through direct alterations of core trauma symptomatology. Specifically, displacement may contribute to increased DSO severity via losses in PSS, pointing toward a potential mediating role of PSS in the association between displacement status, HT, and CPTSD outcomes. At the same time, alternative explanations cannot be ruled out, including the possibility that individuals with lower PSS or more severe HT are more likely to flee in the first place. Finally, it remains unclear whether DSO symptoms predominantly emerge as a consequence of the trauma inflicted by war, the experience of displacement itself, or post-migration stressors related to adaptation in the host country. These questions highlight important directions for future longitudinal and process-oriented research.

Confirmatory Factor Analysis of the CAHTAQ 5.0

The confirmatory factor analysis provided substantial support for the proposed five-factor structure of the Ukrainian CAHTQ 5.0. Overall model fit indices indicated an

acceptable to good fit between the model and the observed data. Although the χ^2 -test was statistically significant ($\chi^2(160) = 395.98, p < .001$), this result was expected given the sensitivity of the χ^2 -statistic to sample size (Alavi et al., 2020). Therefore, greater emphasis was placed on approximate and incremental fit indices.

The incremental fit indices demonstrated good model fit, with a CFI of .96 and a TLI of .95, exceeding commonly accepted thresholds of .95 for well-fitting models. The RMSEA value of .08 (95% CI [.07, .09]) indicated an acceptable, though not excellent, level of approximate fit, while the SRMR value of .07 further supported the adequacy of the model. Taken together, these indices suggest that the five-factor model adequately represents the latent structure of the CAHTQ 5.0 in the Ukrainian sample.

All standardized factor loadings were statistically significant, and closer examination showed that most items loaded strongly on their intended factors, with loadings exceeding .60, indicating that the items were good indicators of their respective latent constructs. Two exceptions were observed: Item 14, assessing interpersonal conflicts attributed to collective crimes or war, demonstrated a relatively low loading (.39) on the Cultural loss and identity subscale. Similarly, Item 19, assessing substance use as a coping response, showed a moderate loading (.52) on the Attributable harm and its consequences subscale. While the loading for Item 19 remained within an acceptable range for applied research, the loading for Item 14 falls below commonly recommended thresholds (Evudottir & Heimisson, 2024), suggesting that this Item may be a weaker indicator of its latent construct and may warrant further examination or refinement in future research.

Convergent validity, as assessed via average variance extracted (AVE), was strong for Reproaches and historical memory (.83), Mistrust and social distance (.57), Exhaustion and a sense of loss (.61), and Attributable harm and its consequences (.56), all meeting or exceeding the recommended threshold of .50. In contrast, the AVE for Cultural loss and identity (.47) fell slightly below the recommended threshold, which is consistent with the comparatively weaker factor loading observed for Item 14 and suggests limited convergent validity for this subscale.

Internal consistency estimates further supported the reliability of the CAHTQ 5.0. Cronbach's alpha values indicated excellent reliability for Reproaches and historical memory ($\alpha = .93$), good reliability for Mistrust and social distance ($\alpha = .78$), Exhaustion and a sense of loss ($\alpha = .81$), and Attributable harm and its consequences ($\alpha = .75$), and acceptable reliability for Cultural loss and identity ($\alpha = .64$). The total scale demonstrated excellent internal consistency ($\alpha = .91$), supporting its use as a comprehensive measure of HT-related experiences.

In summary, the CFA results support the factorial validity and internal reliability of the Ukrainian version of the CAHTQ 5.0. The findings indicate that the instrument reliably captures five distinct, but related dimensions of HT. Minor weaknesses observed for the Cultural loss and identity subscale suggest that further refinement or item-level revision may enhance its psychometric performance for future studies.

Limitations

The present study holds several methodological, contextual and analytical limitations, which will be addressed in this chapter.

First, the design of this study was cross-sectional, meaning data were only captured at one point in time, which limits the ability to establish causal relationships between the variables examined. Although the construct of HT is associated with events in the past, it is nevertheless a present phenomenon, and it is important to note that no causal conclusions can be drawn with regard to the results of HT in association with other constructs. In addition to that, the data collection took place during an ongoing war, meaning that participants' responses may have been influenced by acute stressors, media exposure, or rapidly changing personal circumstances. As a result, the measured constructs may reflect transient states rather than stable psychological characteristics, which limits the interpretability of the findings and their applicability.

Moreover, participants were recruited via online channels, which may have introduced self-selection bias. Individuals who chose to participate might differ systematically from those who did not, for example in terms of psychological distress, interest in mental health topics, or personal relevance of the topic. This limits the generalizability of the findings and may have led to an overrepresentation of participants with heightened awareness of or sensitivity to the topic of psychotraumatology. Further, this study relied exclusively on self-report data, which can hold biases like social desirability, that may or may not affect the reliability of the given data. As the data did not conclude clinician-rated assessments or behavioral indicators, conclusions about clinical relevance are also limited in this study. Additionally, the sensitive nature of the trauma-related questions might have caused distress to some participants, despite the precautions taken.

Concerning the sample of the study, it is important to note that is not representative for the Ukrainian population, as 87.8% was female and the sample was highly educated, as in all three groups at least 70% of the participants had an university degree. This was to be expected, as participation in psychological surveys is often disproportionately female and highly educated, and many potential male participants in Ukraine are currently more

difficult to reach, as many of them are stationed as soldiers. The lack of male participation might be of further importance in this study, as it can be assumed that the results would potentially have been more severe in some cases, as men who served or are serving as soldiers are highly likely to have been exposed to extremely traumatic events, probable of prolonged nature, which puts them in a heightened risk for the development of trauma-related disorders.

It is also important to note that some data that could have been meaningful for both interpretation and transferability of the results of this study have not been recorded: several potentially relevant confounding variables were not controlled for, such as socioeconomic status, length of exposure to war-related stressors, access to social and psychological support services, region of residency or mental health history. The absence of these controls limits the ability to disentangle the unique contribution of HT from other contextual stressors. Especially for the group of Ukrainian residents, it would have been interesting to survey in which parts of Ukraine participants live, in order to examine and understand more precisely how regional factors such as direct involvement in active warfare influence the results. There could also be regional effects on the pronunciation of HT, which should be investigated in future research.

While all of the questionnaires that were used have been adapted to the Ukrainian language, and in the case of the CAHTQ 5.0, to the Ukrainian history, the translation might not fully capture some cultural nuances, since it was only adapted recently and a peer-reviewed validation is not available yet, potentially affecting the validity of the tool. To support the validation process of the CAHTQ 5.0, a CFA was conducted in the present study, and good overall validity could be determined. Additionally, the original CAHTQ by Mutuyimana and Marcker (2022) was validated on a sample of genocide survivors in Rwanda, where good internal consistency and validity was demonstrated, which allows for the assumption of at least acceptable validity in the Ukrainian adaption. Overall, this study was the first one to use and validate the CAHTQ 5.0 in a Ukrainian sample. Moreover, there was also no validation data available for the Ukrainian translation of the MSPSS (Мельник & Стаднік, 2023), but as there is evidence for at least good internal consistency, moderate construct validity and strong factorial validity in the original version of the MSPSS (Zimet et al., 1988; Zimet et al., 1990), it was assumed that the Ukrainian translation also had at least acceptable validity. In future research, a validation of the Ukrainian MSPSS should be conducted.

Although the construct of HT refers to historical and collective experiences, participants' perceptions of these experiences are subject to recall bias and current

cognitive appraisal. Present emotional states may have shaped how past or collective events were remembered and evaluated, potentially inflating associations between HT and current psychological outcomes. Some items of the CAHTQ 5.0, particularly those referencing interpersonal conflicts, may be interpreted differently in an ongoing or recent conflict setting. This may have influenced response patterns and factor loadings, limiting the generalizability of the findings to post-conflict or non-conflict populations.

Finally, regarding the CFA of the CAHTQ 5.0, while approximate fit indices were emphasized, reliance on these indices may still obscure localized areas of model misfit that could be more evident in alternative samples or with larger, more heterogeneous populations. Consequently, the stability of the model fit across different Ukrainian subpopulations remains to be established. In addition to that, the CFA provides evidence for factorial validity and internal consistency but does not address other important aspects of construct validity, such as criterion-related validity, test-retest reliability, or measurement invariance across demographic groups (e.g., gender, region, displacement status). Without such analyses, it remains unclear whether the factor structure and item functioning are stable across time and subgroups.

Clinical Implications

The findings of the present study have several important implications for the clinical setting as well as for both future research.

First, the results highlight that both Ukrainian refugees and residents are experiencing substantial trauma-related burden, suggesting that interventions should not be limited to displaced populations alone. Given the comparable PTSD and CPTSD prevalences and symptom severity across both groups, mental health services should be tailored to address ongoing exposure to war-related stressors for residents, alongside the displacement-related challenges faced by refugees and the core PTSD and CPTSD symptomatology. Moreover, the results displayed HT as a robust risk factor for both PTSD and CPTSD symptom severity. This underscores the need for culturally sensitive mental health assessments and interventions that consider the historical and cultural context of trauma exposure, particularly for populations affected by prolonged conflict. As HT was significantly higher in Ukrainian refugees it is particularly important to derive HT-sensitive assessments and interventions for displaced people that are specifically tailored to the culture and history of Ukraine. Mental health professionals should be aware that individuals with elevated HT are at increased risk for severe trauma-related symptomatology, regardless of displacement status, emphasizing the importance of individualized screening and risk assessment. The supported five-factor structure and

strong overall reliability of the Ukrainian CAHTQ 5.0 suggest that the instrument can be used in clinical and community settings to assess distinct dimensions of HT-related experiences, informing targeted screening and intervention planning. However, clinicians should interpret scores on the Cultural loss and identity subscale with caution given its comparatively weaker psychometric performance.

Furthermore, PSS emerged as a meaningful protective factor, especially in relation to CPTSD. While PSS did not substantially reduce the impact of HT on PTSD, its stronger association with CPTSD suggests that interventions designed to strengthen social support networks may be particularly effective in buffering complex trauma symptomatology in historically traumatized populations. Importantly, the lack of significant interaction effects indicates that while social support is generally protective, it does not appear to change the strength of the association between HT and trauma-related symptoms. This suggests that interventions to enhance social support should complement, rather than replace, trauma-focused therapies. Programs promoting community engagement, peer support, and family cohesion could therefore play a critical role in mitigating psychological distress, complementing more traditional therapeutic interventions.

Implications for Future Research

Future research could further explore the mechanisms through which HT influences trauma responses, including potential mediators such as coping strategies and resilience factors. Longitudinal studies are needed to examine how HT interacts with contemporary trauma exposure such as ongoing war-related stressor over time, and would be meaningful to determine whether the effects of HT on PTSD and CPTSD persist, intensify, or weaken as populations navigate post-conflict recovery. Such designs would also allow for stronger inferences regarding potential causal associations. Longitudinal designs could also explore whether moderation emerges at particular stages of post-trauma adjustment or under different conditions of ongoing stress. It should be noted, that conducting such a study would be challenging, given that it is certainly not simple to conduct a longitudinal study during an ongoing war.

Moreover, while PSS demonstrated a protective resource, in particular for CPTSD, future research should investigate the mechanisms underlying this effect. For example, studies could explore which specific type of PSS (family, friends, or significant other) is more effective in buffering trauma-related symptoms, or whether PSS interacts with other resilience factors, such as coping strategies or psychological flexibility. Future research could also investigate whether different types or qualities of social support may moderate trauma-related outcomes in ways not captured by PSS.

Additionally, the lack of pronounced differences between refugees and residents suggests that trauma-related outcomes are primarily influenced by factors on the individual-level. Future research could examine additional moderating variables that may interact with HT, such as socioeconomic status, access to mental health care, cultural factors, or cumulative exposure to recent trauma. These investigations could help explain variability in trauma responses within both displaced and non-displaced populations.

Finally, research should expand on the under-explored relationship between HT and PSS. The present study found that higher HT was associated with lower PSS, although only in small magnitude, possibly reflecting mistrust or social disengagement stemming from HT. Future studies could examine this relationship in more depth, exploring the bidirectional dynamics between HT and social resources as well as their implications for designing culturally sensitive interventions. Moreover, future research may benefit from examining whether social support moderates trauma-related outcomes at specific stages of processing or recovery, rather than at the level of cumulative trauma exposure. Since neither group membership nor PSS significantly moderated the effect of HT on PTSD/CPTSD, future studies could investigate other individual, social, or contextual variables that may alter this relationship. It should be further examined if PSS is a possible mediator in the relationship between trauma exposure, group membership, and CPTSD severity. Specifically, studies could test whether lower PSS partially explains why refugees or other high-risk groups experience more severe CPTSD symptoms.

Additional research is also needed to establish other forms of validity, including criterion-related and longitudinal validity, to strengthen the evidence base for the CAHTQ 5.0 in Ukrainian populations.

Taken together, these directions could enhance a deeper understanding of both risk factors and protective resources in war-affected and historically traumatized populations to support the development of more targeted interventions that are designed for specific contexts and cultures, addressing both historical as well as contemporary trauma exposure.

Conclusion

The present study investigated the associations between historical trauma (HT), trauma-related disorders (PTSD and CPTSD), and perceived social support (PSS). The results highlighted the significant role of both HT and PSS in shaping trauma-related outcomes among Ukrainian refugees and Ukrainian residents during the ongoing war. HT emerged as a robust, transdiagnostic risk factor, strongly predicting both PTSD and CPTSD symptom severity and increasing the likelihood of meeting clinical diagnostic

thresholds, regardless of displacement status. While displacement was associated with higher HT and lower PSS, it did not directly alter (C)PTSD symptom severity, suggesting that vulnerabilities and resources on the individual level are more influential than group membership. PSS consistently demonstrated a protective effect, particularly in CPTSD, although it did not moderate the impact of HT. Explorative findings suggested that differences in PSS may partly explain elevated CPTSD severity among refugees, pointing to a potential mediating pathway. The Ukrainian version of the CAHTQ 5.0 revealed strong factorial validity and reliability, supporting its use for assessing distinct dimensions of HT, though minor refinements in future studies could enhance some of the subscales.

Beyond the statistical models, the findings of this study also reflect the profound, often invisible burdens carried by individuals living through war and displacement. For many Ukrainians, the psychological scars of both contemporary and historical traumas are not just clinical symptoms, as they are intertwined with everyday experiences of loss, identity disruption, and uncertainty. Elevated HT may shape how those affected perceive their safety in this world, their trust in others, and how they imagine the future, while lower (perceived) social support can leave individuals isolated in the midst of ongoing adversity. Even small differences in PSS could translate into meaningful differences in how those affected cope with the aftermath of trauma. Even when clinical symptoms are not severe enough to meet diagnostic thresholds, the emotional weight can still profoundly affect relationships, work, and the ability to envision a stable future. The results highlight that trauma often cannot be fully understood without considering social and cultural contexts, and that interventions must go beyond symptom management to actively restore social networks, community cohesion, and a sense of continuity in life. Ultimately, the results should also serve as a reminder that behind each participants' scores in this sample lies a human story of vulnerability, resilience, and the need for meaningful support that goes beyond what statistics can capture.

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Appendix

English Abstract

Historical trauma (HT) theories posit that past collective exposure to violence can shape contemporary psychological vulnerabilities. Ukraine's history of state repression as well as the ongoing war provide a unique context for examining these processes. This study investigated associations between HT, post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD) among a sample of Ukrainian refugees and Ukrainian residents and examined perceived social support (PSS) as a potential protective resource. Using a cross-sectional online survey, data was collected from 195 Ukrainian adults. Participants completed standardized measures to assess the variables of interest. Ukrainian refugees reported significantly higher HT than residents, whereas PTSD prevalence and severity did not differ between groups. Explorative analyses revealed significant group differences in CPTSD severity and PSS. HT emerged as a significant predictor for both PTSD and CPTSD symptom severity and significantly increased the likelihood of meeting diagnostic criteria for both disorders. Higher PSS was associated with lower HT, PTSD and CPTSD severity, but did not mitigate the relationship between HT and PTSD or CPTSD. Group status did not alter any of these relationships. To reflect upon the validity of the CAHTQ 5.0 in a Ukrainian sample, confirmatory factor analysis was conducted. The proposed five-factor structure and good overall model fit could be demonstrated. These findings support the relevance of HT in the Ukrainian context and highlight the protective value of PSS. The results emphasize the clinical importance of historically informed and culturally sensitive approaches to trauma assessment and intervention-planning in war-afflicted populations such as Ukraine.

German Abstract

Theorien über Historisches Trauma (HT) postulieren, dass kollektive Gewaltexposition in der Vergangenheit individuelle Reaktionen auf gegenwärtige Traumaexposition beeinflussen können. Die Ukraine, mit ihrer von staatlicher Gewalt geprägten Geschichte, sowie dem aktuellen Krieg, bietet einen einzigartigen Kontext für die Erforschung jener Prozesse. Die vorliegende Studie untersuchte die Beziehungen zwischen HT, post-traumatischer Belastungsstörung (PTBS) und komplexer PTBS (KPTBS) in einer Stichprobe von ukrainischen Geflüchteten und ukrainischen Einwohner*innen. Die wahrgenommene soziale Unterstützung (PSS) wurde als potenzielle Schutzressource untersucht. Anhand einer querschnittlichen Online-Umfrage und unter Verwendung standardisierter Messinstrumente wurden Daten von 195 erwachsenen Ukrainer*innen erhoben. Ukrainische Geflüchtete zeigten eine signifikant höhere HT-Ausprägung als Einwohner*innen, während sich die Prävalenz und Symptomschwere von PTBS zwischen den Gruppen nicht unterschied. Explorative Analysen zeigten signifikante Gruppenunterschiede hinsichtlich PSS und der Symptomschwere von KPTBS. HT erwies sich als signifikanter Prädiktor für die Symptomschwere von PTBS und KPTBS und erhöhte die Wahrscheinlichkeit, die diagnostischen Kriterien für beide Störungen zu erfüllen, signifikant. Ein höherer PSS-Wert war mit einem geringeren HT-Wert sowie einer geringeren PTBS und KPTBS Symptomschwere assoziiert, ohne die Beziehung zwischen HT und PTBS oder KPTBS zu verändern. Der Gruppenstatus hatte keinen signifikanten Einfluss auf diese Beziehungen. Zur Überprüfung der Validität des CAHTQ 5.0 in einer ukrainischen Stichprobe wurde eine konfirmatorische Faktorenanalyse durchgeführt. Es konnte die vorgeschlagene Fünf-Faktoren-Struktur bestätigt, sowie eine gute Gesamtpassung des Modells nachgewiesen werden. Diese Ergebnisse stützen die Relevanz von HT im ukrainischen Kontext sowie die protektive Rolle von PSS. Die Ergebnisse betonen die klinische Relevanz historisch fundierter und kultursensibler Ansätze für Interventionen in kriegsbetroffenen Populationen wie der Ukraine.

Supplementary Material

CAHTQ base version 27.05.25 5.0

Scale: 0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Constantly

Клінічні аспекти опитувальника щодо історичних травм – CAHTQ – Україна (мінімальні зміни до основної версії)

Clinical Aspects of the Questionnaire on Historical Trauma - CAHTQ - Ukraine
(minimal changes to the main version.)

Інструкція:

Будь ласка, знайдіть трохи часу, щоб задуматися про те, як поточний і минулий досвід війни, колективного насильства чи потрясінь вплинув на вас особисто або на вашу родину/спільноту. Це може включати події, які ви не пережили безпосередньо, але які продовжують формувати ваші думки, почуття або відчуття ідентичності.

Під поняттям «українській народ» у цьому опитувальнику маються на увазі всі, хто відчуває себе частиною історичної долі України.

Позначте, наскільки часто ви відчували або переживали наведене протягом останніх місяців, думаючи про колективні травматичні події, які мали вплив на українську історію чи на ваше життя.

Будь ласка, оберіть одну відповідь на кожне твердження за шкалою нижче:

Шкала: 0 = Ніколи 1 = Рідко 2 = Іноді 3 = Часто 4 = Постійно

Instructions:

Please take some time to reflect on how current and past experiences of war, collective violence or upheaval have affected you personally or your family/community. This may include events that you have not experienced directly but that continue to shape your thoughts, feelings or sense of identity.

The term 'Ukrainian people' in this questionnaire refers to all those who feel part of Ukraine's historical destiny.

Please indicate how often you have felt or experienced the following in recent months when thinking about collective traumatic events that have had an impact on Ukrainian history or your life.

Please select one answer for each statement on the scale below:

Докори та історична пам'ять/ Reproaches and historical memory
1. Я відчуваю злість до людей, які заперечують або применшують ті колективні злочини, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час.
2. Мене ранять люди, які підтримують ті колективні злочини/війну, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час.

3. Я відчуваю злість до людей, які применшують відповідальність винуватців тих колективних злочинів/війни, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 4. Мене дратують люди, які применшують відповідальність винуватців тих колективних злочинів/війни, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 1. I feel anger towards people who deny or downplay the collective crimes/wars that have had a tragic impact on Ukrainian history and society, in the past or in the present. 2. I feel hurt by people who support those collective crimes/wars that have had a tragic impact on Ukrainian history and society, in the past or in the present. 3. I feel anger towards people who diminish the responsibility of the perpetrators of those collective crimes/wars that have had a tragic impact on Ukrainian history and society - in the past or in the present. 4. I am irritated by people who downplay the responsibility of those responsible for those collective crimes/wars that have had a tragic impact on Ukrainian history and society, - in the past or in the present.
Недовіра та соціальна дистанція/ Mistrust and social distance 5. Я загалом не довіряю людям через ці колективні злочини/війну. 6. Мені боляче через те, що я живу поруч із людьми, які мають стосунок до цих колективних злочинів/війни. 7. Я свідомо обмежую контакт із людьми, які мають стосунок до тих колективних злочинів/війни, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 8. Я відчуваю занепокоєння (дискомфорт/недовіру), коли зустрічаю когось, хто пов'язаний із винуватцями тих колективних злочинів/війни, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 5. I generally do not trust people because of these collective crimes/war. 6. I feel hurt because I live next to people who are involved in these collective crimes/war. 7. I deliberately limit my contact with people who are involved in those collective crimes/wars that have had a tragic impact on Ukrainian history and society - in the past or in the present. 8. I feel anxious (uncomfortable/distrustful) when I meet someone who is associated with the perpetrators of those collective crimes/wars that have had a tragic impact on Ukrainian history and society - in the past or in the present.
Виснаження та відчуття втрати/ Exhaustion and a sense of loss 9. Я відчуваю, що моя гідність (і гідність моєї країни) була принижена через ті колективні злочини/війну, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 10. Я відчуваю, що не маю контролю над тим, що зі мною відбувається, через ті колективні злочини/війну, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час.

11. Я відчуваю себе зрадженим людьми, інституціями чи країнами, від яких очікував(ла) допомоги через ці колективні злочини/війну. 12. Я відчуваю безсилля, коли стикаюся з проблемами через ті колективні злочини/війну, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 09. I feel that my dignity (and the dignity of my country) has been degraded by those collective crimes/war that have had a tragic impact on Ukrainian history and society - in the past or in the present. 10. I feel that I have no control over what happens to me because of the collective crimes/wars that have had a tragic impact on Ukrainian history and society, - in the past or in the present. 11. I feel betrayed by people, institutions or countries from whom I expected help because of these collective crimes/war. 12. I feel powerless when faced with problems because of the collective crimes/wars that have had a tragic impact on Ukrainian history and society, - in the past or in the present.
Культурні втрати та ідентичність/ Cultural loss and identity 13. Мене засмучує, що я не живу в одному районі зі своїми родичами та колишніми сусідами через ті колективні злочини/війну, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 14. конфлікти в нашій родині та з близькими людьми посилилися через ті колективні злочини/війну, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 15. Я сумую за тим, як ми проводили час зі членами родини та родичами до тих колективних злочинів/війни, що мали трагічний вплив на українську історію та суспільство – у минулому чи в наш час. 16. Мені не вистачає культурного життя — традицій, свят і громадських подій — які ми мали до цих колективних злочинів або до війни. 13. I am saddened that I do not live in the same neighbourhood as my relatives and former neighbours because of the collective crimes/war that have had a tragic impact on Ukrainian history and society, - in the past or in the present. 14. conflicts in my family and with close friends have increased because of the collective crimes/wars that have had a tragic impact on Ukraine history and society, - in the past or in the present. 15. I miss the way we spent time with family members and relatives before the collective crimes/wars that have had a tragic impact on Ukrainian history and society, - in the past or in the present. 16. I miss the cultural life — the traditions, celebrations, and community events — that we had before these collective crimes or the war.
Приписана шкода та її наслідки Attributable harm and its consequences 17. Я маю відчуття, що через ці колективні злочини/війну все втратило сенс. 18. Через ці колективні злочини/війну я не маю мотивації працювати. 19. Через ці колективні злочини/війну я вживаю більше алкоголю/палю більше або використовую інші речовини, щоб впоратися зі своїм станом чи ситуацією.

20. Через ці колективні злочини/війну я помітив(ла), що мене легко вивести з рівноваги.

17. I feel that everything has lost its meaning because of these collective crimes/war.

18. I have no motivation to work because of these collective crimes/war.

19. Because of these collective crimes/war, I drink more alcohol/smoke more or use other substances to cope with my condition or situation.

20. Because of these collective crimes/war, I have noticed that I am easily overwhelmed.

List of recruitment (Deutsch)

Land	Sprache	Organisation	Kontaktperson	Email	Anfrage am	Antwort
Austria	ENG	Universität Wien	Dr. Oleksandra Romanuk	oleksandra.romanuk@univie.ac.at	17.03.2025	Positiv
Austria	DE	Asylkoordination Österreich	Mag.a Marion Kremla	kremla@asyl.at	23.06.2025	Ausstehend
Austria	DE	Pfarre St. Barbara	Dr. Taras Chagala	pfarre@st-barbara-austria.org	03.07.2025	Positiv
Ukraine	DE	Freundin eines Familienmitglieds	Lesia Shevtsova	lesia.shevtsova@ukr.net	07.07.2025	Positiv
Großbritannien	ENG	University of Exeter & Ukrainian Psychotrauma Center	Dr. Larysa Zasiekina	L.Zasiekina@exeter.ac.uk	15.07.2025	Ausstehend
Ukraine	ENG	Ukrainian Association of Neuropsychology	Antonia Krakovska	forever.chatskiy@gmail.com	28.07.2025	Positiv
Ukraine	ENG	izhziya regional institute of postgraduate pedagogical edu	Assoc. Prof. Dr. Tetiana Kravchenko	november74t@gmail.com	01.08.2025	Ausstehend
Deutschland	DE	Licht im Osten	Marisa Truckseß, Waldemar Benzel	io.org; MTrucksess@io.org; WBenzel@io.org	01.08.2025	Positiv
Austria	ENG	Hnizdo Innsbruck	Oleksandra Terentyeva	hnizdo.innsbruck@gmail.com	06.08.2025	Positiv
Deutschland	DE	Mission für Süd-Ost-Europa (MSOE) e.V.	Thomas Schewior	omas.schewior@msoe.org; info@msoe.org	06.08.2025	Positiv
Austria	ENG	RIDNA DOMIVKA - ukrainischer Kulturverein in Graz	Unbekannt	graz@ridnadomivka.at	02.09.2025	Ausstehend
Austria	DE	Projekt NEDA	Mag.a Deborah Klingler-Katschnig	Klingler-Katschnig@extern.gesundheitsv	02.09.2025	Positiv
Austria	DE	FIRA - Interkulturelles Psychotherapiezentrum NiederAust	Benjamin Ticevic	jeffira@diakonie.at	02.09.2025	Positiv
Austria	DE	Caritas Wien: Garderob 137	Natalia Bandura & Sophie Höfer	lia.bandura@caritas-wien.at; V.Koshil@e	09.09.2025	Positiv
Austria	DE	Caritas Österreich/Flüchtlingshilfe	Lisa Steinkogler	formation@caritas-ooe.at; fhi-wels@carit	09.09.2025	Positiv
Austria	DE	DIAKONIE - Beratungszentrum Ukraine	Unbekannt	ine@diakonie.at; diakonie@diakonie.at; a	09.09.2025	Positiv
Österreich	DE	Diakonie Unterprojekte	Unbekannt	ratung.ost@diakonie.at; mobeb@diakonie	09.09.2025	Ausstehend
Österreich	DE	HAYAT - Betreuungszentrum für Folter- und Kriegsüberleb	Dr. Cecilia Heiss	ilia.heiss@hemayat.org; office@hemayat	09.09.2025	Positiv
Österreich	DE	Samariterbund	Unbekannt	wien.at; info.wien@samariterwien.at; wsc	09.09.2025	Ausstehend
Deutschland	DE	Malva	Unbekannt	malva@interface-wien.at	09.09.2025	Ausstehend
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Österreich	DE	Tralalobe	Unbekannt	.at; florian.stummelreiter@tralalobe.at; inf	09.09.2025	Ausstehend
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Österreich	ENG	Center of Ukrainian Researchers in Austria	Unbekannt	info@f-zentrum.at	09.09.2025	Positiv
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Österreich	DE	ZEBRA	Kirsten Arbeiter	office@zebra.or.at	09.09.2025	Positiv
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Deutschland	DE	Deutsch-Ukrainische Gesellschaft	Unbekannt	stand@deutsch-ukrainische-gesellschaft	09.09.2025	Ausstehend
Deutschland	DE	Bravery	Chris Knickerbocker	info@bravery.berlin	09.09.2025	Positiv
Deutschland	DE	Deutsch-Ukrainisches Forum e.V.	Unbekannt	office@d-u-forum.de	09.09.2025	Ausstehend
Deutschland	DE	ch-Ukrainische Gesellschaft für Wirtschaft und Wissenscha	Lukas Augustin	nfo@dug-ww.com; lukas-augustin@live.d	09.09.2025	Positiv
Ukraine	ENG	ch-Ukrainische Gesellschaft für Wirtschaft und Wissenscha	Prof. Dr. Romanovskyi	info@uacu.edu.ua	09.09.2025	Ausstehend
Deutschland	DE	PlusUkrDe e.V.	Unbekannt	plus.ukr.de@gmail.com	09.09.2025	Ausstehend

Deutschland	DE	Dachverbandes der ukrainischen Organisationen in Deuts	Unbekannt	info@dach-ukraine.de	09.09.2025	Positiv
Deutschland	DE	Feine Ukraine e.V.	Unbekannt	lilia.kettler@feineukrai	10.09.2025	Ausstehend
Deutschland	DE	Norddeutsch-Ukrainischer Hilfsstab (NUH)	Unbekannt	info@hilfe-ua.de	10.09.2025	Ausstehend
Deutschland	DE	Ukraine Hilfe Hamburg	Unbekannt	info@ukraine-hilfe-hamburg.org	10.09.2025	Ausstehend
Deutschland	DE	Bürgerstiftung Hamburg	Veronika Detel	info@buergerstiftung-hamburg.de	10.09.2025	Positiv
Deutschland	DE	Centra Hamburg	Elena Leltschuk	info@centra-hamburg	10.09.2025	Positiv
Deutschland	DE	Ukrainisches Institut in Deutschland (Berlin)	Dr. Kateryna Rietz-Rakul	germany@ui.org.ua	10.09.2025	Ausstehend
Deutschland	DE	entralverband der Ukrainer in Deutschland e.V. (ZVUD e.V.)	Ludmila Mosch	info_zvud@gmx.de	10.09.2025	Ausstehend
Deutschland	DE	Allianz ukrainischer Organisationen	Oleksandra Bienert	info@ukr-alliance.de	10.09.2025	Ausstehend
Deutschland	DE	Kul'tura e.V.	Olga Pischel (Vorsitzende)	contact@kultura.agency	10.09.2025	Ausstehend
Deutschland	DE	ive für Wissensaustausch, Empowerment und Kultur IWEK	Danylo Poliluev-Schmidt	iwekev@gmail.com	10.09.2025	Ausstehend
Deutschland	DE	Potsdam-Ukraine Soziokultureller Hub e.V.	Alona Konrad	info@push-ua.de	10.09.2025	Positiv
Österreich	DE	Diakonie Sozialberatungsstelle	Unbekannt	beratung.wien@diakonie.at	11.09.2025	Ausstehend
Deutschland	DE	AG Ukraine-Chemnitz-Europa e.V.	Veronika Smalko	ukraine.chemnitz@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	redok Leipzig; Deutsch-ukrainischer Kultur und Bildungsv	Unbekannt	info@oseredok-leipzig.de	11.09.2025	Ausstehend
Deutschland	DE	Ukrainische Gemeinde. In der Stadt Werdau (WDA UA e.V.)	Marija Perkhalets	hallo@wda-ua.ev.de	11.09.2025	Ausstehend
Deutschland	DE	Deutsch-Ukrainische Vereinigung Sachsen-Anhalt e.V.	Mykhailo Nykolaichuk	info@ukraine-sachsen-anhalt.de	11.09.2025	Ausstehend
Deutschland	DE	Ukrainische Landsleute in Thüringen e.V.	Vasyl Vitenko	ukrainelandsleute.thueringen@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	Ukrainisch-Deutsches Kulturzentrum SIC e.V.	Liudmyla Sientsova	ukr.de.sich@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	Nord Haus UA e.V.	Tetiana Podobinska-Shtyk	nordhaus.ukraine@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	Vereinigung der Ukrainer Norddeutschlands e.V.	Rostyslav Sukennyk	usch-hamburg@web.de	11.09.2025	Ausstehend
Deutschland	DE	Deutsch-Ukrainischer Kulturverein	Martin Dietze	nfo@deutsch-ukrainischer-kulturverein.de	11.09.2025	Positiv
Deutschland	DE	Freie Ukraine Braunschweig e.V.	Igor Piroshchik	info@freieukraine-braunschweig.de	11.09.2025	Positiv
Deutschland	DE	Herz für die Ukraine e.V.	Tetyana Chernyavska	info@herz-ukraine.de	11.09.2025	Ausstehend
Deutschland	DE	Blau-Gelbes Kreuz Deutsch-Ukrainischer Verein e.V.	Linda Mai	info@bgk-verein.de	11.09.2025	Ausstehend
Deutschland	DE	Pro Ukraine e.V.	Vera Kostjuk Busch	DRUIIBusch@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	utsch-ukrainischer Verein in Aachen „Ukrainer in Aachen e	Anna Kysil	kontakt@ukrainer-in-aachen.de	11.09.2025	Ausstehend
Deutschland	DE	Integrations- und Kulturverein „Lerche e.V.“	Irina Shtern	lercheukr@web.de	11.09.2025	Positiv
Deutschland	DE	Wir sind Ukrainer e.V.	Oleh Paslavskiy	info@wsu-ev.de	11.09.2025	Negativ
Deutschland	ENG	Ukrainian Coordination Center e.V.	Viktoria von Rosen	uainfmm@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	Ukrainisches Institut für Bildungspolitik e.V.	Unbekannt	uistytut@aol.com	11.09.2025	Negativ
Deutschland	DE	Verein der Ukrainer in Franken e.V.	Unbekannt	verein@ukrainer-in-franken.de	11.09.2025	Ausstehend
Deutschland	DE	Ukrainischer Verein Augsburg e.V.	Unbekannt	info@ukrainischer-verein-augsburg.de	11.09.2025	Ausstehend
Deutschland	DE	Bamberg; UA e.V.	Unbekannt	info@bamberg-ua.de	11.09.2025	Ausstehend
Deutschland	DE	Frei geboren e.V.	Oksana Palagniuk	freigebohren.bruchsal@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	Ukrainischer Kultur- und Bildungsverein Stadt Fellbach e.V.	Unbekannt	ukr.verein.fellbach@gmail.com	11.09.2025	Ausstehend
Deutschland	DE	Deutsch-Ukrainische Gesellschaft Rhein-Neckar e.V.	Kateryna Malakhova	info@dug-rhein-neckar.de	11.09.2025	Ausstehend
Deutschland	DE	Deutsch-Ukrainische Gesellschaft e.V.	Oksana Vyhoska	info@dug-freiburg.de	11.09.2025	Ausstehend
Deutschland	DE	Ukrainisches Atelier für Kultur und Sport e.V.	Unbekannt	info@uaks.de	11.09.2025	Ausstehend
Deutschland	DE	Ukrainer in Stuttgart e.V.	Roman Kolodiy	verein@ukraine-stuttgart.de	11.09.2025	Ausstehend
Deutschland	DE	Ukrainer in Karlsruhe. Deutsch-Ukrainischer Verein e.V.	Unbekannt	ukrainerinkarlsruhe@gmail.com	11.09.2025	Ausstehend
Polen	ENG	Ukrainian House (Ukrainski Dom)	Unbekannt	konsultacje@ukrainskidom.pl	12.09.2025	Ausstehend

Polen	ENG	Association of Ukrainians in Poland	Unbekannt	stariat@ukraincy.org.pl ; biuro@ukrainski.c	12.09.2025	Ausstehend
Polen / Ukraine	ENG	Polish-Ukrainian Chamber of Commerce	Unbekannt	info@ukr.com ; kyiv@pol-ukr.com ; ukrpol-kyiv@	12.09.2025	Ausstehend
Ukraine	ENG	Kyiv Metropolitan University	Oleksandr Turutsev	sev@kubg.edu.ua ; + alle vice-rectors und	12.09.2025	Ausstehend
Ukraine	UKR	Bogomolets National Medical University	Unbekannt	kancnmu@nmu.ua ; pknm@nmu.ua	12.09.2025	Ausstehend
Ukraine	UKR	Bukovinian State Medical University	Unbekannt	office@bsmu.edu.ua	12.09.2025	Ausstehend
Ukraine	UKR	Kharkiv Regional Medical College	Unbekannt	kharvmedcollege@gmail.com	12.09.2025	Ausstehend
Ukraine	UKR	Danilo Halytsky Lviv National Medical University	Unbekannt	office@meduniv.lviv.ua	12.09.2025	Ausstehend
Ukraine	UKR	Donetsk National Medical University	Unbekannt	contact@dsnu.edu.ua	12.09.2025	Ausstehend
Ukraine	UKR	Dnipro State Medical University	Unbekannt	dnu@dnu.edu.ua	12.09.2025	Ausstehend
Ukraine	UKR	an International University of Human Development „Ukrai	Unbekannt	office@uuu.ua	12.09.2025	Ausstehend
Ukraine	UKR	International Humanitarian University	Unbekannt	info@ihu.edu.ua ; priemnayamgu@gmail.com ; mgu_re	12.09.2025	Ausstehend
Ukraine	UKR	ate Higher Educational Institution „Kyiv International Univer	Unbekannt	info@kymu.edu.ua	12.09.2025	Ausstehend
Ukraine	UKR	ogdan Khmelnytsky Melitopol State Pedagogical Universit	Unbekannt	pk-mdpu@ukr.net ; rektorat@mdpu.org.ua	12.09.2025	Ausstehend
Ukraine	UKR	Chernihiv Polytechnic National University	Unbekannt	csu@stn.cn.ua	12.09.2025	Ausstehend
Ukraine	UKR	Drohobych Ivan Franko State Pedagogical University	Unbekannt	du.ua ; psychol.service@dspu.edu.ua ; pkf	12.09.2025	Ausstehend
Schweiz	DE	Gravita (Schweizerisches Rotes Kreuz)	Jelena Cosic	ravita-srk@hin.ch ; jelena.cosic@gravita.c	12.09.2025	Positiv
Österreich	DE	Institut für Neuropsychotherapie	Mag. Thomas Weber	traumafokus@proton.me	12.09.2025	Ausstehend
sterreich / Ukraine/ Unga	ENG	Invisible University for Ukraine	Unbekannt	info@invisible-ua.org ; okrasinko@gmail.com ; ShuliakovaN	16.09.2025	Ausstehend
Österreich	ENG	Institut für Wissenschaft am Menschen	Unbekannt	thasewendkatharina@iwm.at ; gamberag	16.09.2025	Ausstehend
Österreich	DE	Universität Graz, Institut für Slawistik	Prof. Tatjana Petzer	tatjana.petzer@uni-graz.at	18.09.2025	Positiv
Österreich	DE	LBI Menschenrechte	Prof. Michael Lysander Fremuth	michael-lysander.fremuth@univie.ac.at	18.09.2025	Positiv
Österreich	DE	rechpartnerin für Ukrainehilfe (Tatjana Petzer, Universität	Iryna Orlova	info@iiryna-orlova.at	18.09.2025	Positiv
Österreich	DE	Universität Graz, Institut für Psychologie, Astra-Projekt	Dr. Svitlana Antonyuk	svitlana.antonyuk@uni-graz.at	18.09.2025	Positiv
Österreich / Ukraine	UKR	Von Irina Malikova	Margo Sarkosova	margopersimmon@gmail.com	18.09.2025	Ausstehend
Österreich / Ukraine	UKR	Von Irina Malikova	Alina Ivlezeva	alina.lovecheva@gmail.com	18.09.2025	Ausstehend
Tschechien	ENG	ry of Education, Youth and Sport on the armed conflict in U	Unbekannt	ukrajina@msmt.gov.cz ; ukrajina@dzc.cz	06.10.2025	Ausstehend
Tschechien	ENG	Society for All (SoFa)	Unbekannt	so-fa.cz ; akademie@so-fa.cz ; olga.slowik@	06.10.2025	Positiv
Tschechien	ENG	One world for school (?) JSNS.CZ	Unbekannt	stachota@jsns.cz ; marianka.mackova@js	06.10.2025	Ausstehend
Tschechien	ENG	Department of Psychology, Masaryk University	Unbekannt	s.muni.cz ; lacinova@fss.muni.cz ; jezek@fss	06.10.2025	Ausstehend
Tschechien	ENG	Caritas Czech Republic in Ukraine	Natalia Viter	talja.viter@caritas.cz ; ukraine.hr@caritas	06.10.2025	Ausstehend
Polen / Großbritannien	ENG	Wonder foundation/FATIMA project	Unbekannt	contact@wonderfoundation.org.uk	06.10.2025	Ausstehend
International	ENG	Alight	Unbekannt	info@WeAreAlight.org	06.10.2025	Positiv
Deutschland	DE	Bund ukrainischer Studenten in Deutschland e.V.	Katerina Proskura	vorstand@sus-n.org	06.10.2025	Ausstehend
Deutschland	DE	Freundschaft kennt keine Grenzen e.V.	Maria Melnik	maria.melnik@t-online.de	06.10.2025	Ausstehend
Deutschland	DE	PLAST Ukrainischer Pfadfinderbund in Deutschland e.V.	Stepan Demjaniv	info@plastde.org	06.10.2025	Ausstehend
Deutschland	DE	Ukrainischer Frauenverband in der BRD e.V.	Maria Kowlyszyn	kowalyszynm@yahoo.com	06.10.2025	Ausstehend
Deutschland	DE	Ukrainische Ärztevereinigung in Deutschland	Dr. Med. Andrzej Batruch	orguaevd@gmx.de	06.10.2025	Ausstehend
Deutschland	DE	Kulturzentrum GOROD	Unbekannt	info@gorod.de	06.10.2025	Ausstehend
Deutschland	DE	Ukrainische Griechisch-Katholische Pfarrei München	Pfr. Wolodymyr Viitovitch	ugkkm@t-online.de	06.10.2025	Ausstehend
Deutschland	DE	Ukrainische Freie Universität München	Unbekannt	sekretariat@ufu-muenchen.de	06.10.2025	Ausstehend
Minnesota	ENG	Ukrainian American Community Center	Unbekannt	info@uacmn.org	10.10.2025	Ausstehend
Minnesota	ENG	The Center for Victims of Torture	Unbekannt	CVT@CVT.org ; newtactics@cvf.org	10.10.2025	Ausstehend