A psycholinguistic analysis of the narratives of young adults with moral injury and post-traumatic stress disorder

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Abstract. Traumatic social upheavals such as war actualise the need to investigate the interrelation between moral injury (MI) and post-traumatic stress disorder (PTSD), particularly in young adults, a developmental period marked by heightened moral sensitivity and vulnerability. Although MI and PTSD are conceptually distinct, moral injury may contribute to the emergence or intensification of PTSD symptoms. This study examines the manifestation of MI and PTSD symptoms in young adults and analyses their narratives of war experience. The sample comprised 300 Ukrainian young adults aged 18–26, screened using the PTSD Checklist for DSM-5 (PCL-5) and the Moral Injury Symptom Scale (MISS-M-SF). Based on screening results, three groups were identified: individuals with PTSD, individuals with pronounced MI without PTSD, and a non-diagnosed comparison group. Participants produced written narratives on the topic "My experience of living through war," which were analysed using a narrative-psycholinguistic approach focusing on orientation, emotional valence, and narrative organization. The results demonstrate statistically significant differences in MI symptom profiles between respondents with and without PTSD, as well as meaningful correlations between PTSD symptom clusters and specific MI components, including moral conflict, shame, self-condemnation, and loss of meaning. Narrative analysis revealed predominantly negative orientations toward traumatic experience across groups, alongside differences in behavioural strategies, emotional focus, and the balance between individual and collective experience. Narratives of participants with PTSD showed extensive detailing of traumatic events and active coping strategies, whereas narratives of participants with MI without PTSD were characterised by ambivalence and social withdrawal. The findings underscore the close relationship between MI and PTSD in young adults experiencing war and highlight the diagnostic and therapeutic value of narrative analysis in understanding trauma-related experiences.

Keywords: moral injury, post-traumatic stress disorder, narrative analysis, war experience, young adults.

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Федотова Тетяна, Кихтюк Оксана, Майструк Вікторія, Власенко Олена. Психолінгвістичний аналіз наративів юнаків з моральною травмою та посттравматичним стресовим розладом.

Анотація. Травматичні соціальні потрясіння, такі як війна, актуалізують необхідність дослідження взаємозв'язку між моральною травмою (МТ) та посттравматичним стресовим розладом (ПТСР), особливо в юнацькому віці, періоді розвитку, що характеризується підвищеною моральною чутливістю та вразливістю. Хоча МТ і ПТСР концептуально відрізняються, моральна травма може сприяти появі або посиленню симптомів ПТСР. Це дослідження вивчає прояви симптомів МТ і ПТСР у молодих дорослих та аналізує їхні розповіді про досвід війни. Вибірка складалася з 300 українських юнаків віком 18–26 років, яких було обстежено за допомогою *PTSD Checklist for DSM*-5 (PCL-5) та *The Moral Injury Symptom Scale* (MISS-M-SF). На основі результатів скринінгу було виділено три групи: особи з ПТСР, особи з вираженою МТ без ПТСР та недіагностована контрольна група. Учасники написали розповіді на тему «Мій досвід переживання війни», які було проаналізовано за допомогою наративно-психолінгвістичного підходу з акцентом на орієнтації, емоційній валентності та організації наративу. Результати засвідчили статистично значущі відмінності в профілях симптомів МТ між респондентами з ПТСР і без нього, а також значущі кореляції між кластерами симптомів ПТСР і конкретними компонентами МТ, включаючи моральний конфлікт, сором, самоосуд та втрату сенсу. Наративний аналіз виявив здебільшого негативну орієнтацію на травматичний досвід у всіх групах, а також відмінності в поведінкових стратегіях, емоційній спрямованості та балансі між індивідуальним і колективним досвідом. Наративи учасників з ПТСР містили детальний опис травматичних подій та активних стратегій подолання, тоді як наративи учасників з МІ без ПТСР вирізняли амбівалентність та соціальна ізоляція. Результати підкреслюють тісний зв'язок між МІ та ПТСР у молоді та висвітлюють діагностичну та терапевтичну цінність наративного аналізу для розуміння травматичних переживань.

Ключові слова: моральна травма, пост-травматичний стресовий розлад, наративний аналіз, досвід війни, юнаки.

Introduction

In recent years, we have seen a growing scientific interest among researchers in studying the issues of moral injury and post-traumatic stress disorder (PTSD), their causes, and the development and implementation of preventive measures to improve the mental health of professionals and various segments of the population (Ames et al., 2021; Atuel et al., 2021; Epstein et al., 2009; Jameton, 2013; Molendijk, 2022; Sandeberg et al., 2020; Steenkamp et al., 2015).

In Ukraine, this issue has become particularly relevant due to the large-scale invasion and war on our territory, which has increased the incidence of MI and PTSD among both military personnel and civilians (Zasiekina & Kozihora, 2022; Zasiekina et al., 2022).

The concept of moral injury (MI) has a long history of study and was originally examined in the context of military resocialisation programmes (Shay, 2014; Steenkamp & Litz, 2015; Fleming, 2021; Molendijk, 2022).

Litz et al. (2009) in their continued study of moral injury, not only identify the main causes of its occurrence but also emphasize the processes of internalization and externalization of its symptoms, which are determined by the status of the person experiencing them. They further distinguish moral injury from PTSD by highlighting conscience and awareness of moral harm as key markers (Steenkamp & Litz, 2015).

A significant number of scientific works on the concept of MI focus on moral distress, which is considered a predictor of MI (Corley et al., 2001; Epstein et al., 2009; Jameton, 2013). And while the initial study of moral distress and MD mainly concerned medical workers (Figley, 2002; Sandeberg, Bartholdson, & Pergert, 2020), researchers later turned their attention to representatives of the social sphere (O'Donnell et al., 2008), police officers (Papazoglou & Chopko, 2017) and other professions (Corley et al., 2001; Nathaniel, 2006; Epstein et al., 2009; Jameton, 2013; Sandeberg et al., 2020).

Zasiekina and Zasiekin (2020) study MI from the perspective of its manifestation in the genocide survivors, stating that it is consistent with all components of morality and emphasising the fundamental distinction between MI and PTSD.

Drescher et al. (2011), defining the symptoms of MI, emphasise its fundamental distinction from the concept of mental disorder; however, as a possible factor in mental health disorders (GAD, depression, and PTSD).

Thus, MI is the result of experiencing internal conflict due to the influence of morally traumatic situations that may contradict an individual's moral beliefs. Therefore, life in wartime is a potentially traumatic situation, as it almost constantly appeals not only to situations of moral choice and the inconsistency of moral principles with an individual's behaviour, but also demonstrates their vulnerability to the actions of their social environment (Litz, Stein, et al., 2009).

In this context, it will be interesting to analyse the narratives of individuals with different levels of MT and PTSD, since narrative is a textual form that allows individuals to organise life events according to a certain plot, feel their own active position, and take responsibility for their lives. Based on the hermeneutic approach of Chepeleva, who defines narrative as a closed narrative structure that gives life events sequence and completeness, organises them in chronological or other order that obeys some single logic, we believe that by creating a narrative, the subjects will not only present their main leitmotif, themes and construction of cultural/personal experience, but also demonstrate ways of resolving contradictions, overcoming difficulties and the prospect of organising their own experience (Chepeleva, 2013, 2019).

In this regard, the aim of our study is to analyse the narratives of young adults with MI and PTSD, as representatives of this age group are extremely vulnerable to potentially morally traumatic situations in wartime.

In accordance with the aim of the study, the following research questions were formulated:

1. Are there differences in the manifestation of symptoms of MI in individuals with PTSD and respondents who have not been diagnosed with PTSD?

2. Is there a connection between MI and PTSD in young adults?

3. How do narratives in individuals with MI and PTSD differ in terms of orientation (ambivalent, emotionally neutral, negatively oriented, positively oriented) and organisation (collective/individual experience)?

Methods

The empirical programme involved the following stages of research:

- selection of valid and reliable psychodiagnostic methods for identifying the level of moral MI and PTSD, formulation of the essay topic and justification of the sample;
- submission of a package of ethical documents for consideration by the Research Ethics Board of Lesya Ukrainka Volyn National University and obtaining permission from the relevant Board to conduct the empirical research (No. 03-24/04/118);
- recruiting research subjects and forming a sample;
- determining PTSD screening;
- clarifying the specifics of identifying MT symptoms in young adulthood; processing narratives of 'My experience of war';
- analysing and interpreting empirical research results and formulating conclusions.

The following methods were used in the empirical study:

1) theoretical – review of medical and psychological literature, analysis and synthesis of psychological studies on MI and PTSD, generalisation of theoretical developments and definition of the problem area of the study;

2) empirical, represented by:

- the PTSD Symptom Self-Assessment Scale (PCL-5);
- the Moral Injury Symptom Scale (MISS-M-SF) (Zasiekina & Kozihora, 2022);

The narrative method, which allows for the study of personality traits through the transfer and transformation of internal content into text; respondents were asked to write an essay on the topic 'My experience of war' of at least 200 words in any form, which were then analysed based on the

typology of auto-narratives (ambivalent, emotionally neutral, negatively oriented, positively oriented) (Chepeleva, 2013; 2019);

3) mathematical and statistical methods: percentage and correlation analysis, determination of the measure of central tendency and Fisher's ϕ-angle transformation.

The empirical study was conducted during 2023–2024.

Results

Initially, 420 people were surveyed using the PCL-5 and MISS-M-SF, but based on the essay results, the number of diagnoses was reduced to 300.

Based on the results of the PCL-5 method, the following groups were identified:

- Group 1 – respondents who scored 34 or more points on the PCL-5 (M=46.4, SD=9.8) (55 people, of whom only 9 (16.4 %) were found to have no MT, while 46 respondents (83.6 %) were found to have MT);
- Group 2 – respondents who demonstrated high and above-average results on the MISS-M-SF scale (99 people) – none of them had a high score on the PCL-5 (M=16.9, SD=8.5);
- Group 3 – diagnosed individuals in whom no symptoms of MI and PTSD (146 respondents) (M=42.2, SD=6.2) and PTSD (M=10.7, SD=8.4) were identified.

Statistically significant differences were observed in the overall PCL-5 scores across the three groups ($p < .001$).

The demographic representation of the study participants and their answers to the questions are presented in Table 1.

Table 1

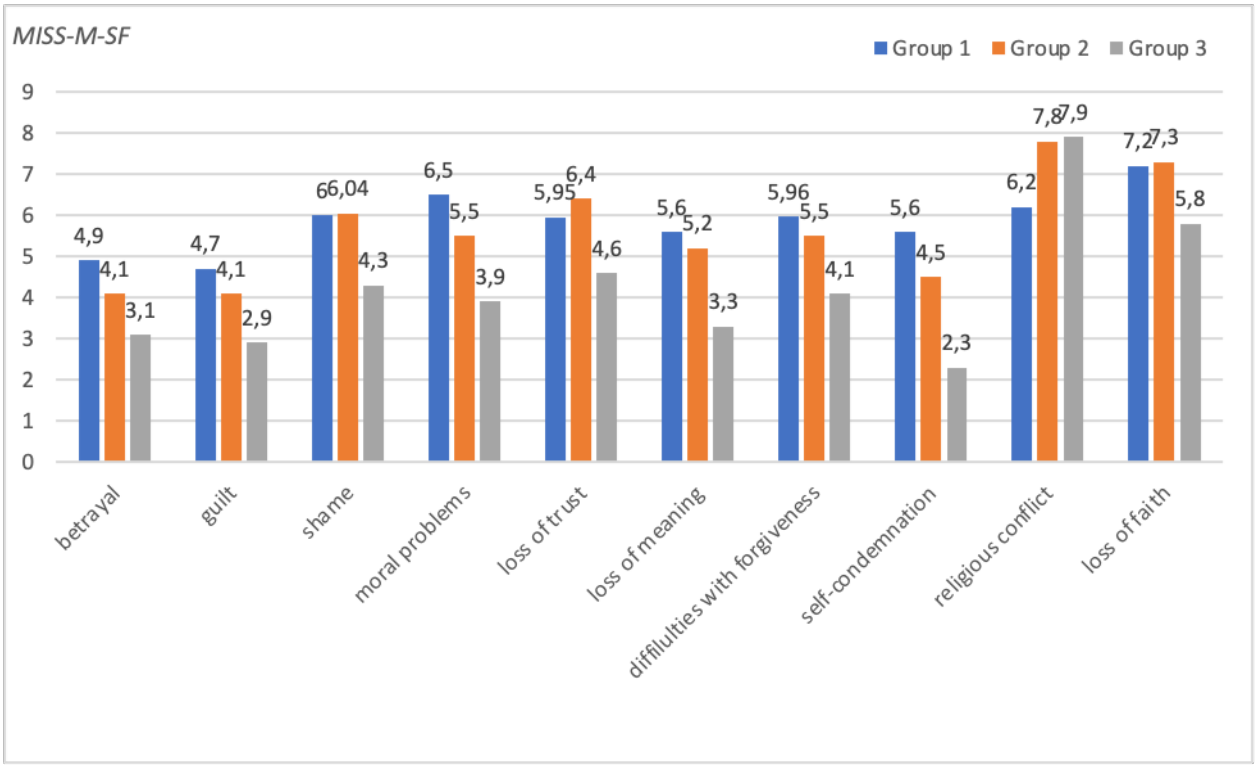
Demographic Data of Diagnosed Individuals According to Group Distribution (n=300)

	Groups		
	Group 1 (n=55), %	Group 2 (n=99), %	Group 2 (n=146), %
Age			
average	18.4	18.6	19
SD	.9	1.3	1.77
Min-Mmax	18 - 22	18-25	18 - 26
Sex			
Man	12.	11.1	15.1
Woman	87.3	88.9	84.9
Gender			
Male	29.1	22.22	27.4
Female	65.5	73.74	70.5
Other	1.8	1.01	.7

Refused to answer	3.6	3.03	1.4
Moved			
Yes	21.8	11.1	11.6
No	78.2	88.9	88.4
Family history of trauma	20.0	8.1	8.2
Famine	-	-	.7
Holocaust	27.3	27.3	26.7
Other	52.7	64.7	64.4
None			
Diagnosed mental or neurological disorder	21.8	3.03	2.1
	78.2	96.97	97.9
Yes			
No			

The mean group results for the MISS-M-SF in the three groups are shown in Figure 1.

Figure 1
Mean Value of MISS-M-SF Items in Respondents of Three Groups (n=300)



Statistically significant differences were found between the first and second groups on the scales of betrayal, moral problems, self-condemnation, and religious conflict ($p < .001$).

- the first and third groups on the scales: betrayal, guilt, shame, moral problems, loss of trust, loss of meaning, difficulties with forgiveness, self-condemnation, religious conflict, and loss of faith ($p < .001$);
- the second and third groups on the scales: betrayal, guilt, shame, moral problems, loss of trust, loss of meaning, difficulties with forgiveness, self-judgment, and loss of faith ($p < .001$);
- total MISS-M-SF score: significant differences were observed between the second and third groups, as well as between the first and third groups ($p < .001$).

In the course of further analysis of the study, we considered it necessary to focus only on processing the results and analysing the narratives of respondents in the first and second groups, as they meet the criteria for positive screening for PTSD and MI.

The results of the study indicate a significant correlation between MISS-M-SF symptoms and PLC-5 clusters in the first and second groups. Among the respondents in the first group, significant correlations were found between cluster B and loss of faith; cluster D and guilt, moral conflict, loss of meaning, and self-condemnation; MI indicator; cluster E and self-condemnation; and PCL-5 level and moral conflict (see Table 2).

Table 2
Correlation (Pearson's 2-tailed, r) Between MI Symptoms (MISS-M-SF) and PLC-5 Clusters in Group 1

Variables	**Cluster B**	**Cluster C**	**Cluster D**	**Cluster E**	**PCL score -5**
Betrayal	.103	.15	-.026	-.131	.015
Guilt	-.154	-.099	.371*	.136	.123
Shame	-.07	-.041	.265	.111	.087
Moral problems	.055	.054	.51**	.197	.317*
Loss of trust	-.153	-.058	-.036	-.182	-.195
Loss of sense	-.039	-.016	.304*	.232	.174
Difficulty with forgiveness	.13	.109	.185	-.030	.096
Self-condemnation	-.031	-.007	.332*	.287*	.196
Religious conflict	-.238	-.193	-.059	-.006	-.121
Loss of faith	-.279*	-.057	.0109	-.016	-.125
Total MI score	-.161	-.049	.381**	.123	.101

Note: * $p < .05$; $p < .01$ **

A significant correlation was found among respondents in the second group: cluster B with religious conflict and self-condemnation; cluster E with forgiveness and religious conflict; cluster D with shame, moral conflict, self-condemnation, and MI level; PCL-5 level with MI level (see Table 3).

Table 3
Correlation (Pearson's two-tailed, r) Between MI Symptoms (MISS-M-SF) and PLC-5 Clusters in Group 2

Variables	Cluster B	Cluster C	Cluster D	Cluster E	PCL score -5
Betrayal	-.03	.03	.014	.16	.047
Guilt	.088	.166	.078	-.088	.061
Shame	.082	.12	.273 *	.152	.213
Moral problems	.171	.215	.326 **	.207	.331
Loss of trust	-.121	-.078	-.03	.08	-.015
Loss of sense	.142	.045	.185	.066	.151
Difficulty with forgiveness	.141	.005	.023	-.211 *	-.025
Self-condemnation	.342 **	.154	.276 *	.081	.305
Religious conflict	-.329 **	-.027	-.338	-.233 *	.367
Loss of faith	-.029	-.154	-.106	.079	-.064
Total MI score	.218 *	.209	.314 **	.132	.296 **

Note: * p < .05 ; p < .01 **

Example of Narrative Analysis of a Respondent from Group 1

M. – female, 18 years old; no family history of trauma; did not travel during the war; no diagnosed mental/neurological disorder (see their narrative 1 in Appendix).

Diagnostic results: PCL-5 : cluster B – 10; cluster C – 4; cluster D – 19; cluster E – 16, total score – 49; MISS-M-SF : betrayal – 3, guilt – 9, shame – 9, moral problems – 8, loss of trust – 2, loss of meaning – 7, difficulty with forgiveness – 7, self-condemnation – 6, religious conflict – 7, loss of religious/spiritual faith – 7, MI – 65.

Narrator M. demonstrates the symptoms of PTSD:

1) in describing the first days of the war, we see an excessive focus on details of the situation itself ('...people were buying up everything in the shops, there was great panic'; '...you would have thought the village had died out in

just two days'), as well as the prevailing emotions and feelings ('..constant fear, uncertainty ..'; '... watching it increased the fear, misunderstanding, tension and anxiety'; "helplessness", '... constant uncertainty of the unknown');

2) avoidance of certain actions and behaviours ('... it's scary even to turn on the lights');

3) the presence of negative thoughts and emotions ('... the experience has been one of uncertainty, fear and despair...', '... despair, why is this happening to us...');

4) symptoms of excessive activity ('... so that we continue to fight, that's why we continue to fight...').

In her narrative, we observe symptoms of MI: shame '... uncertainty, fear and despair', '... a feeling of betrayal and despair, why is this happening to us'), loss of meaning and faith, which she constantly postulates ("... part of something bigger, a struggle for freedom and democracy...', '...we must, because we have no other choice', '...Ukraine is worth fighting for and deserves victory'); betrayal is least represented, as she believes in the support of the international community ('...and the support of the international community").

Despite the narrator's negative attitude towards her previous experience, which reveals a traumatic event and a range of negative emotions, the narrative demonstrates her clear basic life position ('fight and win'). The example of the narrative demonstrates an event (war) that radically influenced the awareness of one's own 'I', emphasised the self-worth of the person and the importance of existing experience ('Life during a full-scale invasion is a struggle, a daily struggle that reminds us of our unbreakable strength and resilience'). It is worth noting separately that the narrator emphasises the collective experience of traumatic situations – unity and joint struggle.

Example of Narrative Analysis of a Respondent from Group 2

T. – female, 18 years old; there is trauma in her family history (but not related to the Holodomor or the Holocaust); did not leave during the war; no mental/neurological illness (see their narrative 2 in Appendix).

Diagnostic results: PCL-5: cluster B – 2; cluster C – 3; cluster D – 8; cluster E – 2, total score – 15; MISS-M-SF: betrayal – 5, guilt – 6, shame – 9, moral problems – 10, loss of trust – 7, loss of meaning – 5, difficulty forgiving – 9, self-condemnation – 5, religious conflict – 8, loss of religious/spiritual faith – 8, total MI score – 72.

Thus, the narrative reveals the peculiarities of her own experience of war:

1) maximum involvement in the situation or isolation ('... I was focused, calm and followed the news,' 'I went to weave nets and ... plan my day,' '... I came back, sat in my room ...');

2) contrasting her own thoughts and feelings with those of other people ('relationship with my parents grew worse ... views on the situation ...');

3) decreased social activity ('I spent my days weaving nets,' 'I did not want to talk to most people ...').

The following symptoms of MI were presented: betrayal ('... the idea that I had been deceived about the reliability of peace,' '... observing the degradation of national self-awareness'); feelings of guilt ('...extreme feelings of guilt, frequent helplessness...', '... reduced feelings of guilt'); shame ('... the best thing for me is to focus on obligations and opportunities...'); moral problems ('... radicalism...', '... feelings of hatred...'); loss of trust ('... my parents had their own business', '... my brother and sister stayed with relatives'); difficulty with forgiveness ('...I expressed my feelings in poems...'); self-condemnation ('...I hardly listened to music...', '...before the start of the academic semester, I had never been to a party with my peers', '...I started paying less attention to events in the country...'); loss of meaning and loss of faith ('...the thought that there is no future for me in Ukraine,' '...no idea of a future in other countries'); religious conflict, despite the high significance of the indicator, is not represented in the narrative.

The narrative presented has a negative focus on previous experiences, but in overcoming the traumatic situation, the narrator alternately uses voluntary isolation and excessive involvement in socially useful activities ('I spent my days weaving nets,' '... I got up, had breakfast, ... went to weave nets ...'). In describing the negative experience of war, we are shown a situation with parents and close friends that reinforces a positive outlook on the future and a clear plan for further action.

Discussion

With regard to the first research question, it should be noted that there are significant differences in the manifestation of MI symptoms in individuals with PTSD and respondents who have not been diagnosed with PTSD. The corresponding results are consistent with the assertion that MI, significantly worsening an individual's mental health, can be a predictor of PTSD. This mainly applies to potentially traumatic situations that threaten the individual's physical existence, in which they face a moral choice and are vulnerable to others' actions. If the situation does not involve a moral choice but threatens the individual's physical functioning, the person may develop only some of the symptoms of MI alongside PTSD (Litz et al., 2009; Drescher et al., 2011; Papazoglou & Chopko, 2017; Zasiekina & Zasiekin, 2020; Zasiekina et al, 2022).

If young men are diagnosed with a high level of PTSD according to the PCL-5 and have MI, the latter is represented by the following symptoms: shame, moral conflict, loss of trust, loss of meaning, difficulty forgiving, religious conflict, and loss of faith.

In respondents who score high on the PCL-5 but low on the MISS-M-SF, the above-mentioned symptoms of MI are more intensely observed in the form of loss of trust, religious conflict, and loss of faith. That is, it can be assumed that extremely important symptoms in the experience of MI in young adults with probable PTSD are loss of trust in most people, incomprehension of why God sends them such trials and, accordingly, a decrease in their level of religiosity or faith.

In situations of deep MI experience, they often blame themselves for excessive activity or inactivity, exaggerated concern about their own beliefs and values, and problems with self-forgiveness.

It was interesting to note that respondents without PTSD and MI, as well as those with other diagnoses, scored high on the religious conflict scale, which may indicate a heightened sense of justice typical of this age group.

Working on the answer to the second question, we can state that in the research group with high PCL-5 and MISS-M-SF scores, the excessive frequency of intrusive memories is associated with a decrease in the level of religious faith, and a large number of negative thoughts and emotions about the situation, characterised by a high level of MI symptoms related to: feelings of shame, moral conflict, loss of meaning in life, and a tendency to consider oneself worthless (self-condemnation), which is, accordingly, associated with excessive personality reactivity.

In this group, the PTSD indicator is associated with moral conflict of the personality, which indicates a person's awareness of the violation of their own beliefs and values as a result of certain actions and deeds. In the research group with high levels of MI without PTSD, we note the following: the absence of intrusive memories in experiences is more likely to be associated with the actualisation of a lack of understanding of God's adequate attitude towards oneself and self-judgement; a large number of negative experiences and emotions are associated with feelings of shame, moral conflict, self-condemnation, and the presence of reactive arousal is explained by difficulties with forgiveness. It is worth noting the presence in this group of a high level of MI and the actualisation of negative memories, experiences of negative feelings, emotions and general reactive arousal, which clearly indicates a close connection between PTSD and MI.

In response to the third question of the study, we note that in the narratives of the respondents in the first group, we observe excessive detail of the traumatic event and a description of a certain type of behaviour that is

socially acceptable and performed without question (often without critical evaluation); a fixation on negative emotional states and experiences, as well as, in 75 % of individuals, the presentation of active strategies for overcoming the traumatic situation (through escape-avoidance or active resistance). The analysed narratives in this group reveal an extremely wide range of symptoms of MI, represented by feelings of guilt, shame, loss of meaning, moral conflict, self-condemnation, religious conflict, and loss of faith.

In general, narratives from the first research group (regardless of MI level) are negative (in 99 % of individuals), reflecting a negative attitude towards the traumatic situation. However, they demonstrate the respondents' clear basic life position and the formation of their future desires and intentions. the traumatic event is a starting point for them in developing a life plan, focusing on their own transformation, realising their uniqueness and value, the importance of living 'here and now' (individual experience of narrative organisation), as well as emphasising the importance of involvement in the social community to achieve a common goal, experience the traumatic situation, and overcome its consequences (collective experience of narrative organisation).

The narratives of the respondents in the second group demonstrate ambivalence in behaviour during traumatic situations (from excessive activity to seclusion and isolation), contrasting their position, opinions and feelings with those of others. They represent the entire spectrum of MI symptoms in the essay, the most striking of which are: shame, moral conflict, problems with trust and forgiveness, self-condemnation, loss of meaning and faith. The narratives studied belong to the negative type, but we would like to note that they very sharply represent the conflict situations experienced by the subjects and their cause-and-effect relationships. In the corresponding narratives, one can trace a life position that emphasises the integration of acquired experience into personal (individual experience of narrative organisation) and social service through involvement in volunteer activities (collective experience).

Conclusions

A comparison of demographic data reveals no significant differences in the percentage representation of respondents across research groups by sex and gender. However, the percentage of individuals with an established mental/neurological diagnosis among those who screened positive using the PCL-5 and MISS-M–SF methods is higher than in other diagnosed groups. The same applies to the results obtained for questions regarding relocation during the war and the presence of trauma in family history. It should be noted that

the demographic data presented has only been partially processed, which may be an area for further detailed analysis.

The identification of research groups (according to PTSD and MI screening) contributed to a more thorough study of the relationship between their PTSD and MI symptoms. Thus, among individuals with positive PTSD screening, respondents were identified who did not have MI. Although their share was insignificant, this allowed us to identify common symptoms of MI in individuals with PTSD (regardless of the level of MI): shame, moral conflict, loss of meaning, difficulty forgiving, and to identify the presence of specific symptoms: loss of trust, religious conflict, and loss of faith. The relevant findings outline the possibility of a positive prognosis for developing a system of measures to prevent MI in young people and generally improve the mental health of individuals in the relevant age group.

The identification of specific links between PTSD and MI symptoms in the research groups (regardless of the level of PTSD and MI) made it possible to determine a common correlation trend, which demonstrates: the link between intrusive memories and the level of religious conflict experienced; the presence of negative thoughts and emotions associated with experiencing moral conflict and self-condemnation.

The analysis of narratives was carried out taking into account the representation of clusters (intrusion; avoidance; negative thoughts and emotions; symptoms of excessive reactivity), PCL-5, and symptoms (betrayal, guilt, shame, moral problems, loss of trust, loss of meaning, difficulty forgiving, self-condemnation, religious conflict, loss of religious/spiritual faith), MISS-M-SF. If they were expressed in the narrative, they were recorded and compared with the results of the corresponding methods. It was found that the narratives of respondents with PTSD (regardless of the level of MI experience) have a negative orientation towards past experiences, but reveal a clear basic life position of the narrators; the traumatic event is a starting point for them in the development of their life plan (individual experience of narrative organisation), and the possibility of overcoming its consequences involves social involvement (collective experience of narrative organisation). The narratives of respondents with MI (without PTSD) also have a negative orientation, but are characterised by ambivalence in behaviour in traumatic situations. They present a basic life position that is distinguished by the maximum integration of traumatic experience into existing personality (individual experience of narrative organisation) and a position of social service (collective experience).

The study does not claim to be exhaustive and has certain limitations and caveats, in particular regarding scientists' approaches and views on understanding MI and PTSD, and may not provide complete information or results.

Disclosure Statement

The authors reported no potential conflicts of interest.

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Appendix

Narrative 1

M: Constant fear, uncertainty about the future, powerlessness, and danger became insurmountable for some people and led to deep psychological and physical trauma. Because I am from a small village, those were the worst first days. People were buying up everything in the shops, there was great panic, the news was on 24/7, and watching it only increased the fear, misunderstanding, tension and anxiety, especially in the evening, when it was scary to even turn on the lights. Looking out onto the street, you would have thought the village had died out in just two days'. But thanks to the determination of our army and the support of the international community, we were able to stand up and fight, even if not side by side, then morally, supporting each other and helping materially. Life during a full-scale invasion is a struggle, a daily struggle that reminds us of our unbreakable strength and resilience. My personal experience has been one of uncertainty, fear and despair. On the one hand, there is a sense that we are part of something bigger, a struggle for freedom and democracy, and the realisation that our actions and sacrifices are important not only for our lives, but also for the future of our Ukraine. On the other hand, there is a constant fear of

the unknown, the uncertainty of each day and the pain of watching the destruction of our country and the suffering of our people, a feeling of betrayal and despair, why is this happening to us? The mental strain is heavy, and the emotional rollercoaster is exhausting. And yet, despite the difficulties, we continue to fight because we have to, because we have no other choice. This is a reminder that no matter how dark the night, no matter how bleak the prospects, there will always be hope that we will continue to fight, and that is why we continue to fight, because Ukraine is worth fighting for and deserves victory.

Narrative 2

T: My memories of the first three days of the invasion are clear. Everything before and after is blurred. On the first day, I barely noticed what was happening and did not worry. The first three months after 24 February felt the same. I was focused, calm, and followed the news. My relationship with my parents grew worse because we saw the situation in the country differently. I spent my days weaving nets. I got up, had breakfast, went to weave nets, ate lunch there, came back, sat in my room with the lights off (because of blackouts), and went to bed. I never felt lonely. Two close people left for abroad, my parents had their own business, and my brother and sister stayed with relatives. I did not want to talk to most people. I became more sensitive to justice, disliked much of the world, and felt deceived about peace. I hardly listened to music… Before the start of the academic semester, I had never been to a party with my peers. I started paying less attention to events in the country and less aware of the decline in national identity. Living through a full-scale invasion brought me a strong sense of belonging, radicalism, hatred, extreme feelings of guilt, helplessness, apathy, and tears. I cannot imagine walking or being outside at night, and I do not remember life before 24 February. I expressed my feelings in my poems. Tears, discussions, sharing important information, and financial help reduced feelings of guilt. Lately, I have felt very helpless, and this feeling is growing, along with the thought that there is no future for me in Ukraine, no idea of a future in other countries'. Still, I try to focus on my duties and opportunities to help speed up victory. I am very grateful to the Armed Forces of Ukraine and volunteers. Glory to Ukraine!