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K. Onyshchuk

PHENOMENOLOGY OF PROFESSIONAL DEFORMATION AMONG MILITARY PSYCHOLOGISTS OF THE NATIONAL GUARD OF UKRAINE UNDER MARTIAL LAW

The article empirically examines the phenomenological space of professional deformation among military psychologists of the National Guard of Ukraine under wartime conditions. Four components of deformation are identified: maladaptive rigidity and interpersonal tension; affective reduction; external regulation and role inflation; and hyper-responsibility. Key barriers in psychologists' work and leading support resources are determined.

Keywords: *professional deformation, professional burnout, military psychologist, components of professional deformation, work-related barriers, support resources.*

Statement of the problem. The ongoing war in Ukraine places exceptionally high demands on the psychological resilience and professional effectiveness of military psychologists, whose work constitutes an essential component of maintaining unit combat capability. As scholars V. Aleshchenko and O. Kokun emphasize, the effectiveness of an army depends not only on technical provision but also on the moral and psychological state of its personnel. In the third year of the full-scale war, researchers report staffing-related challenges – a shortage of trained specialists in combat units and staff overload – which complicate systematic monitoring of service members' psycho-emotional state and restrict access to high-quality psychological rehabilitation after combat operations. The situation is further exacerbated by the lack of unified standards for providing assistance, fragmentation of interagency efforts, and a low level of psychological culture in society [1].

Military psychologists continuously confront the consequences of combat stress among service members; however, they themselves often remain without adequate psychological support. This increases the risk of emotional burnout syndrome, loss of empathic sensitivity, excessive professional involvement, and secondary traumatization.

The specific features of military psychologists' professional activity under martial law create socio-psychological prerequisites for the stable consolidation of negative personality changes. A complex of changes in the professional and personal domains, shaped by the specificity of activity and resulting from prolonged exposure to extreme stressors, environmental influences, psycho-emotional strain, and physiological load, constitutes the phenomenon of professional deformation [11].

The wartime context underscores the need to clarify the phenomenological space of professional deformation specifically among military psychologists of the National Guard of Ukraine (NGU), because generalizations based on civilian samples do not capture the specificity of a multilayered hierarchy of subordination, regulated service, and dual role expectations. At the same time, Ukrainian scholarship lacks a sufficient number of empirically validated descriptions of deformational manifestations, work-related barriers, and self-support practices that are actually used by military psychologists. This creates a rationale for research that can delineate the most salient risks and resources in military psychologists' everyday work and provide evidence for targeted preventive programs, supervision practices, and workload management.

The problem of professional deformation among military psychologists performing duties under combat conditions remains insufficiently studied. At the same time, according to observations by Ukrainian scholars, ignoring professional deformation or relying on formalistic prevention during wartime may lead to personal consequences for specialists (psychosomatic disorders, burnout, professional devaluation) and social risks, including reduced quality of psychological assistance for service members [4, 5, 11]. The relevance of this

topic is determined by the limited empirical knowledge regarding professional deformation within this specific professional group.

Analysis of recent research and publications. In English-language scientific literature, the concept of "professional deformation" is rarely used. Instead, manifestations of negative personality changes under the influence of professional activity are considered in the context of professional risks, burnout, compassion fatigue, and secondary traumatization [14, 15, 16].

Within the present article, professional deformation is conceptualized as a relatively stable complex of changes in the motivational, emotional, cognitive, and communicative domains of professional functioning that develops under a prolonged "stress – resources" imbalance and becomes consolidated in interaction styles and behavioral regulation. In this framework, professional (emotional) burnout is not treated as a synonym of deformation but as a distinct stress-induced syndrome of exhaustion and reduced engagement that may constitute one of the mechanisms sustaining deformational shifts (in particular, through affective reduction). Compassion fatigue and secondary traumatization are interpreted as consequences of systematic exposure to others' trauma, manifested in empathic overload and symptoms of secondary stress; in this study, they are assessed as an important barrier to professional activity. Thus, burnout and compassion fatigue are regarded as phenomenologically related but conceptually distinct phenomena that may enter a causal – maintaining loop of professional deformation without replacing the construct itself.

In the Ukrainian research context, recent years have produced numerous studies examining factors, manifestations, and consequences of professional deformation across different fields. For example, the work by I. F. Arshava, K. P. Kutovyi, and I. O. Arshava shows that civil servants with high neuroticism, depressiveness, and asociality more frequently demonstrate signs of professional burnout, whereas agreeableness correlates with lower burnout levels [2]. The study by V. Lytvyn and L. Voiat analyzes factors of professional deformation among police officers as consequences of chronic stress, insufficient psychological support, and organizational culture in security structures. The authors also highlight the problem of underestimating deformational risks for the quality of law enforcement professional functioning [8]. As D. V. Shvets found, extreme service conditions in policing and persistent stress determine the accelerated development of professional deformation among personnel. Typical deformational signs among police officers were identified, including professional exhaustion, stereotyped reactions, manifestations of aggressiveness, and avoidance of responsibility for mistakes [13].

The issue of professional deformation among internal affairs personnel is among the most elaborated topics in Ukrainian scholarship. An example is the 2021 publication of methodological guidelines "Prevention of Professional Deformation of a Police Officer in Stressful Situations During the Exercise of Official Powers" (O. I. Kudermina, L. M. Zakharenko, D. V. Matsibora), prepared for police officers of the National Police of Ukraine and specialists in psychological support within the system of the Ministry of Internal Affairs of Ukraine [6].

In the social sphere, researcher O. Hlavatska noted that the dynamic and stressful work of social workers often leads to negative shifts in personality, including loss of emotional balance, a sense of helplessness, and professional burnout. The author defines professional deformation as the outcome of a complex of negative factors related to professional activity and the work environment that distort the workervs personal qualities and reduce work effectiveness. Among the key causes of deformational changes, she identifies objective working condition's, subjective personality characteristics, and situational factors of work organization [3].

In psychologists' professional activity, the issue of deformation is no less acute. O. Lapa examined the problem of loss of motivation, emotional exhaustion, and insufficient resources for personal recovery among practicing psychologists [7].

Professor U. B. Mykhailyshyn, reviewing the results of empirical studies by V. N. Petrova, I. M. Khorzhevska, N. V. Tsyba, and other scholars, identifies the following phenomena as manifestations of professional deformation: a tendency to withdraw from any activity in situations of failure; a tendency to expand the scope of emotional economizing and to rely on a passive problem-solving strategy; decreased empathy; hypercontrol over one's behavior; loss of spontaneity; a drive to classify people; suspiciousness; hyper-responsibility for others; professional cynicism; stereotyping; and reduced sensitivity to lived experience [9].

In the work by N. M. Panasenko and M. V. Voitovych, the key manifestations of professional deformation characteristic of

socionomic professions are summarized, including emotional exhaustion; a tendency toward formal performance of professional functions; cynicism and emotional distancing from clients; disillusionment with the profession; violations of professional boundaries; rigidity in decision-making and interpersonal interaction; decreased self-esteem and professional confidence; deterioration of communication; and increased conflict-proneness. The authors draw special attention to the consolidation of defensive behavior patterns – formalism, avoidance of responsibility, and excessive control – that gradually transform a specialist's professional style and reduce the quality of interaction with clients [12]. Researcher I. B. Kovalova, examining professional deformation among psychologists working with critical incidents, showed that prolonged work with individuals exposed to military actions and severe life events leads to the accumulation of physical and emotional exhaustion, the development of personal helplessness, and emotional burnout syndrome, accompanied by indifference toward people and an unwillingness to experience emotions [5].

Thus, the analysis of scientific works and publications indicates that the phenomenon of professional deformation among NGU military psychologists under martial law remains insufficiently studied.

The purpose of the article is to examine the phenomenological space of professional deformation among military psychologists of the National Guard of Ukraine under wartime conditions.

The objectives are as follows: 1) to empirically examine the phenomenological set of manifestations of professional deformation among NGU military psychologists; 2) to identify organizational and socio-psychological barriers to professional activity within the NGU psychological support system; and 3) to delineate support resources and recovery sources for military psychologists.

Summary of the main material. The study involved 41 NGU military psychologists (65.9% women, 34.1% men). Three questionnaires were excluded from analysis due to incomplete and/or formal responses; the final analytical sample comprised N = 38 respondents of both genders with varying lengths of military service and professional experience as psychologists.

The mean length of military service was M = 6.78 (SD = 6.49), and the mean duration of professional psychological practice, including work in civilian positions, was M = 5.39 (SD = 4.58).

Because tenure is a quantitative variable, tenure-related differences were evaluated using rank correlations, which is an appropriate approach for comparing indicators in a sample with heterogeneous durations of professional experience.

The manifestations of professional deformation block comprised an author-developed list of 20 manifestations, used as a pilot screening instrument. It was constructed on the basis of the theoretical model and a review of Ukrainian and international sources (e.g., cynicism and emotional coldness toward clients; decreased empathy; professional stereotyping; conflict-proneness in interaction; professional indifference; inertia; problems of professional identity; inadequate self-esteem, etc.). The response format assessed the frequency of observation within the professional environment (five-point Likert scale: never – rarely – sometimes – often – very often).

The work-related barriers block included closed-ended items with the possibility of open-ended clarifications (organizational, resource-related, socio-psychological, ethical, and role-related).

The support resources block contained a list of individual, group, and organizational resources (self-regulation, supervision/intervision, rotations, recovery protocols following extreme missions, leadership support, and family resources), with an assessment of perceived effectiveness.

The survey was administered remotely; instructions emphasized anonymity, voluntariness, and the absence of "correct" answers. Completion time was approximately 12–15 minutes. The study complied with principles of anonymity, voluntariness, and informed consent; respondents could discontinue participation at any time without explanation. No personal data were collected; results were reported in aggregated form.

Data processing was performed in IBM SPSS Statistics 23.0. Factor analysis was used to identify generalized components of professional deformation and to examine how indicators cluster into meaningful blocks. These components served as the basis for interpretation and a concise description of the deformation profile in the sample.

Based on descriptive statistics for the frequency of observing manifestations of professional deformation within the professional community of NGU military psychologists, a ranked indicator profile was identified and is presented in Table 1.

Table 1 – Frequency of Observing Manifestations of Professional Deformation in the Professional Community of NGU Military Psychologists (N = 38)

Rank	No.	Manifestation	M	SD
1	5	External motivation for professional activity (primary orientation toward control, reporting, and evaluation)	1.76	1.40
2	3	Formal, functional approach to people	1.53	1.20
3	6	Decreased level of empathy	1.42	1.13
4	8	Loss of meaning (motivation) in professional activity	1.39	1.26
5	9	Lagging behind or absence of professional development	1.39	1.39
6	2	Cynicism and emotional coldness toward clients	1.29	1.01
7	20	Inclination toward schematic thinking and categorization of people instead of individualized analysis (reliance on simplified or dogmatic schemas)	1.21	1.14
8	1	Double ethical standards (discrepancies between declared principles and actual practices)	1.18	1.09
9	11	Pessimistic attitude toward professional difficulties	1.16	1.03
10	17	Hyper-responsibility for others' well-being (a persistent urge to console, calm, or "fix" others' lives)	1.16	1.03
11	10	Tendency to withdraw from activity in situations of failure	1.11	1.23
12	15	Reduced tolerance toward people, stigmatization, and labeling	1.11	1.23
13	14	Overestimation of one's professional role, belief in personal infallibility, exclusivity, and indispensability	1.08	1.15
14	12	Non-constructive coping strategies	1.00	1.09
15	19	Enactment of the professional role, in whole or in part, outside official duties when there is no objective necessity	1.00	1.04
16	13	Conflict-proneness in communication with colleagues or clients	0.92	1.10
17	7	Low professional and personal self-esteem	0.89	0.89
18	16	Intrusive diagnosticizing in everyday communication	0.87	0.91
19	18	Tendency to transfer professional stereotypes to other life domains and relationships	0.84	1.05
20	4	Authoritarianism and a stance of superiority over the client	0.71	0.93

As shown in Table 1, a moderate level of expression predominated for most indicators: 15 of the 20 manifestations of professional deformation were rated as occurring sometimes/often. Five manifestations demonstrated the highest mean frequency values and constituted the "core" occupational risks: external motivation, a formal approach to people, decreased empathy, loss of meaning in professional activity, and lagging behind in professional development. No statistically significant gender differences were found in the frequency of observation for any of the 20 manifestations.

A statistically significant difference between the gender groups was found for professional experience as a psychologist: women reported longer tenure ($t = 2.61$; $p < 0.05$). This should be considered as a potential socio-structural factor in the staffing composition of NGU psychologists.

No associations were identified between overall length of military service and manifestations of deformation. Thus, the duration of military service per se is not associated with the frequency of observing deformational manifestations.

In contrast, stable and systematic associations were found between tenure specifically as a psychologist and a number of deformational manifestations (Spearman's rank correlation coefficients, two-tailed tests). With increasing professional experience as a psychologist, the following manifestations became more frequent:

1) lagging behind/absence of professional development ($r_s = 0.41$; $p < 0.01$);

2) low professional and personal self-esteem ($r_s = 0.39$; $p < 0.05$);

3) tendency to withdraw from any activity in situations of failure ($r_s = 0.39$; $p < 0.05$);

4) conflict-proneness in communication with colleagues or clients ($r_s = 0.30$; $p < 0.05$);

5) cynicism and emotional coldness toward clients ($r_s = 0.26$; $p < 0.05$);

6) inclination toward schematic thinking and categorization of people instead of individualized analysis (reliance on simplified/dogmatic schemas) ($r_s = 0.25$; $p < 0.05$).

Table 2 presents the associations between length of military service, tenure in the professional psychologist position, and manifestations of professional deformation among respondents.

Table 2 – Characteristics of Associations Between Manifestations of Professional Deformation and Tenure Indicators Among Military Psychologists

Manifestations of Professional Deformation	Length of military service	Professional experience as a psychologist
1. Double ethical standards (discrepancies between declared principles and actual practices)	0.031	0.016
2. Cynicism and emotional coldness toward clients	0.259	0.258*
3. Formal, functional approach to people	0.235	-0.044
4. Authoritarianism and a stance of superiority over the client	-0.144	0.043
5. External motivation for professional activity (primary orientation toward control, reporting, and evaluation)	0.063	-0.080
6. Decreased level of empathy	0.217	0.031
7. Low professional and personal self-esteem	-0.044	0.393*
8. Loss of meaning (motivation) in professional activity	0.165	0.173
9. Lagging behind or absence of professional development	0.142	0.409**
10. Tendency to withdraw from activity in situations of failure	0.231	0.388*
11. Pessimistic attitude toward professional difficulties	0.225	0.132
12. Non-constructive coping strategies	0.123	0.124
13. Conflict-proneness in communication with colleagues or clients	0.088	0.301*
14. Overestimation of one's professional role, belief in personal infallibility, exclusivity, and indispensability	-0.028	-0.063
15. Reduced tolerance toward people, stigmatization, and labeling	0.240	0.173
16. Intrusive diagnosticizing in everyday communication	0.201	0.215
17. Hyper-responsibility for others' well-being (a persistent urge to console, calm, or "fix" others' lives)	0.024	0.008
18. Tendency to transfer professional stereotypes to other life domains and relationships	0.202	0.175
19. Enactment of the professional role, in whole or in part, outside official duties when there is no objective necessity	-0.019	0.161
20. Inclination toward schematic thinking and categorization of people instead of individualized analysis (reliance on simplified or dogmatic schemas)	0.198	0.246*

Note. Spearman's rank correlation coefficients (r_s): * $p < 0.05$; ** $p < 0.01$ (two-tailed test).

The resulting profile of changes is consistent with the assumption of a cumulative effect of psychologists' professional tasks and demonstrates a four-component structure.

The motivational component is characterized by an increase in signs of professional stagnation and motivational erosion: tendencies toward cessation of professional development, decreased self-esteem, and avoidance of active behavior after failures are observed.

The emotional (affective) component is defined by an intensification of affective reduction in interaction: manifestations of emotional coldness and cynical attitudes toward clients become more pronounced.

The cognitive component reflects rigidification of professional thinking: reliance on simplified, stereotyped, or dogmatic schemas for evaluating situations and people is observed more frequently.

The interpersonal component manifests as increased tension in interaction, particularly through higher levels of conflict-proneness.

Thus, a longer duration of professional work specifically as a psychologist is associated with greater expression of these components of professional deformation, whereas overall military service length does not demonstrate comparable associations.

Taken together, these findings can be interpreted as empirical support for the Ukrainian conceptualization of professional deformation as a phenomenon with a cumulative character: the longer a specialist remains under stressors and organizational constraints specific to psychological work, the more likely negative shifts become in the motivational, emotional, cognitive, and communicative domains of professional functioning.

In a previous study [10], the author proposed a theoretical model of professional deformation in a military psychologist, in which the initial conditions comprise three interrelated blocks: psychological characteristics (early maladaptive schemas, values, self-concept, and motivation); conditions of professional activity (everyday and extreme); and socio-psychological factors (communicative-role factors and social

environment). The interaction of these blocks affects the "stress – resources" balance: accumulation of stressors specific to a military psychologist under conditions of deficits in personal, social, and organizational resources increases the likelihood of deformational shifts.

Within this model, the professional development of a military psychologist unfolds along two alternative trajectories. Positive professional genesis is grounded in professional motivation, social tolerance (empathy and unconditional acceptance), adaptive flexibility (the ability to combine regulatory requirements with non-standard thinking), and professional self-regulation (internal locus of control, activity, adequate self-esteem, and stable professional identity). Potential professional deformation develops when a chronic "stress – resources" imbalance consolidates problematic motivation (distorted meanings and professional indifference), social intolerance (emotional callousness and cynicism), maladaptive rigidity (stereotyping and reliance on simplified schemas), and professional deregulation (external locus of control, inertia, role expansionism, and violations of professional boundaries), ultimately reducing the quality of psychological assistance.

Using factor analysis of respondents' answers to questionnaire items on manifestations of professional deformation, the set of individual indicators was generalized to demonstrate how manifestations of professional deformation "cluster" into broader meaningful blocks. To summarize the 20 frequency indicators, principal component analysis with orthogonal Varimax rotation (Kaiser normalization) was applied; factor loadings ≥ 0.50 were retained for interpretation. As a result, four components were identified, which together explained 73.23% of the variance in the indicators (Table 3).

Table 3 – Results of the Factor Analysis of Manifestations of Professional Deformation

No.	Manifestation	Component			
		1	2	3	4
Variables Included in Factor 1					
1	Lagging behind (or absence of) professional development	0.852			
2	Tendency to withdraw from any activity in situations of failure	0.806			
3	Conflict-proneness in communication with colleagues or clients	0.776			
4	Non-constructive coping strategies	0.727		0.391	
5	Reduced tolerance toward people, stigmatization, and "labeling"	0.719	0.352	0.360	0.312
6	Low professional and personal self-esteem	0.700	0.337		
7	Inclination toward schematic thinking and categorization of people instead of individualized analysis (reliance on simplified/dogmatic schemas)	0.696			0.393
8	Pessimistic attitude toward professional difficulties	0.652	0.314	0.432	
9	Intrusive diagnosticizing in everyday communication	0.641			0.416
10	Tendency to transfer professional stereotypes to other life domains and relationships	0.567			0.548
Variables Included in Factor 2					
1	Cynicism and emotional coldness toward clients	0.407	0.797		
2	Decreased level of empathy	0.391	0.724	0.338	
3	Double ethical standards (discrepancies between declared principles and actual practices)		0.675		
4	Loss of meaning (motivation) in professional activity	0.483	0.630		0.397
Variables Included in Factor 3					
1	Formal, functional approach to people		0.457	0.457	
2	External motivation for professional activity (primary orientation toward control, reporting, and evaluation)			0.832	
3	Authoritarianism and a stance of superiority over the client	0.391		0.674	
4	Overestimation of one's professional role, belief in personal infallibility, exclusivity, and indispensability	0.556		0.593	
Variables Included in Factor 4					
1	Hyper-responsibility for others' well-being (a drive to console, calm, or "fix" others' lives)				0.839
Out-of-Component Indicator					
1	Enactment of the professional role, in whole or in part, outside official duties when there is no objective necessity	0.466	0.410		0.470

Factor 1 (32.24% of variance). Given the content of the loaded indicators, this component was interpreted as ***"maladaptive rigidity and interpersonal tension"***. The component's logic likely unfolds along the following interaction trajectory: first, excessive professionalization of everyday life accumulates (transfer of professional practices and "diagnosing" outside work); subsequently, effort-saving emerges through template-based decisions and "on-the-fly" coping, accompanied by pessimism and decreased self-esteem; at the interpersonal level, this is expressed through conflict-proneness and intolerance; ultimately, it results in developmental stagnation and avoidance of activity following mistakes.

Within the theoretical model, this component corresponds primarily to the domains of *maladaptive rigidity* (stereotyping, low flexibility) and *professional deregulation* (decreased self-esteem, inertia, role expansionism), and it also touches on motivational issues (cessation of development). Thus, the empirical structure supports the presence of a rigidity "loop" under the pressure of chronic stressors.

Factor 2 (16.30% of variance) was summarized as ***"affective reduction"***. It assumes that the impact of emotional exhaustion often induces a defensive "switching off" of feelings (reduction of empathy), which becomes consolidated through cynical attitudes and rationalizations (double standards) and ultimately undermines the profession's meaning axis – one's sense of mission and the value of providing help.

Within the theoretical model, this component directly corresponds to the block of *social intolerance* (emotional callousness, cynicism) and partly to motivational problems (loss of meaning). Accordingly, the empirical data confirm that affective "cooling" is not merely a symptom but a central node of deformational changes.

Factor 3 (13.82% of variance) was interpreted as ***"external regulation and role inflation"***. Under conditions of high procedural workload in the professional activity of military psychologists, intrinsic motivation recedes, while behavior becomes determined by external regulators. Interaction with people becomes procedural and hierarchical, and a defensive attitude of "exceptionality/irreplaceability" forms to maintain a sense of competence.

Within the coordinates of the theoretical model, this primarily reflects *professional deregulation* (external locus of control, a shift in professional identity, inadequate self-esteem) in conjunction with *problems of professional motivation* (distorted meanings of the profession). Secondarily, the component relates to *social intolerance* through the prioritization of procedure over the person (a formal approach and a stance of superiority). The distinction from affective "cooling" in Component 2 is that empathy may not be "switched off" but it is overridden by the requirement to maintain formal procedures and performance indicators.

Factor 4 (10.87% of variance) was summarized as ***"hyper-responsibility (role overload)"***. This component comprises a single salient indicator – hyper-responsibility for the state of other people (a drive to console, soothe, and "fix" another person's life). The logic of the phenomenon is as follows: excessive appropriation of responsibility for others' emotional states and decisions triggers chronic overstrain, increases the risk of self-neglect, and leads to exceeding one's competence boundaries. Over time, this results in "burning out on helping": assistance becomes impulsive rather than a balanced professional act, fatigue increases, reflection decreases, and errors in situation appraisal become more frequent.

Factor 4 directly corresponds to the block of *professional deregulation* through role expansionism (disruption of the "helping – self-preservation" balance, a shift of role boundaries within the service field) and is indirectly related to *maladaptive rigidity* (resource depletion reduces response flexibility).

An indicator outside the components was "Performing the professional role as a whole, or specific elements of it, outside service when there is no objective necessity". In other words, in this sample it behaves as a distinct item: it likely reflects isolated, situational cases rather than a stable constellation of related deformational manifestations. Practically, it should be monitored separately as a risk marker of professional boundary "blurring". Future studies should test this on a larger sample, refine the wording (to distinguish professional readiness from systematic "bringing the role home"), and, if needed, treat the item as a separate screening indicator.

Within the pilot study, a preliminary examination of the structural organization of the indicators was conducted using factor analysis, which made it possible to identify four components and describe the phenomenological space of deformation. The next stages include: 1) expert assessment of the content validity of item wording; 2) testing internal consistency of the components; 3) re-testing the factor structure on an expanded sample; and 4) convergent and discriminant validation through comparison with established

measures of professional burnout and secondary traumatic stress.

The first block of the anonymous questionnaire concluded with an opportunity for respondents to independently describe another manifestation relevant to understanding professional deformation.

Respondents' open-ended descriptions consistently delineated several interrelated lines of deformation: affective reduction ("hardening", apathy, loss of interest in activity); motivational erosion ("hard to find self-motivation", "Groundhog Day", monotony); chronic exhaustion with somatic manifestations (a sense of constant fatigue, "heaviness/stiffness" in the body); role fusion with work (constant availability, "24/365", identification of life with the profession); and social distancing (a desire to distance oneself from people, distrust). Respondents explicitly noted that such states reduce the quality of psychological support and generate internal resistance to decisions; this aligns with the quantitatively identified components: affective reduction, interpersonal tension, role overload, and motivational problems.

The second block of the questionnaire examined barriers to professional activity. The first question addressed socio-psychological factors (exhaustion, empathic overload, client-related difficulties, lack of supervision, etc.). The second concerned organizational obstacles (schedule, workload, role pressure and accountability, bureaucracy, resources, security risks). An additional open-ended question asked respondents to name three most significant barriers (their own or from the proposed list).

In responses to the first question (socio-psychological barriers), respondents most frequently indicated:

– psychological resource exhaustion (39%);
– insufficient rest/sleep (39%);
– low client readiness for work (31.7%);
– absence of regular supervision/intervision (26.8%);
– compassion fatigue/secondary traumatization (24.4%);
– personal perfectionism and a tendency to assume excessive responsibility (22%);
– devaluation of personal achievements (19.5%).

Less frequently mentioned were feelings of helplessness and ethical dilemmas without procedural support (12.2% each), as well as high intensity of traumatic events (9.8%). Overall, the profile indicates a cumulative overload (exhaustion combined with insufficient recovery) together with inadequate support (supervision) and client-related barriers.

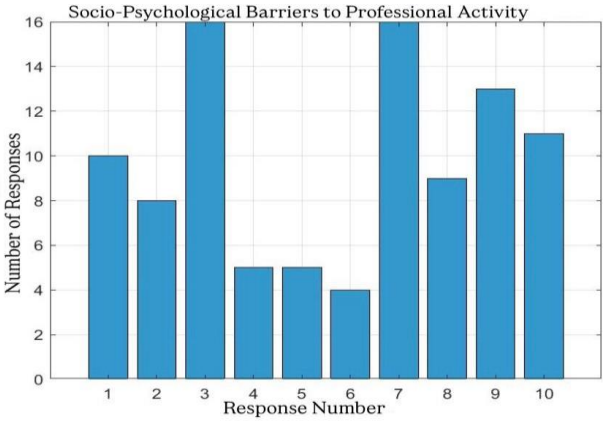

Figure 1 – Socio-Psychological Barriers to Professional Activity

In Figure 1 the numbers on the X-axis correspond to the following categories: 1 – Compassion fatigue and secondary traumatization; 2 – Devaluation of personal achievements; 3 – Psychological resource exhaustion; 4 – Feelings of helplessness and inability to provide psychological assistance; 5 – Ethical dilemmas without procedural decision-support; 6 – High intensity of traumatic content; 7 – Insufficient rest and sleep; 8 – Personal perfectionism and a tendency to assume excessive responsibility; 9 – Low client readiness for psychological work; 10 – Absence of regular supervision/intervision.

According to the results of the second question (organizational barriers), respondents reported:

– bureaucratic requirements that compete with client care (34.1%);
– lack of resources (confidential premises, equipment, materials) (34.1%);
– high accountability and the risk of sanctions for mistakes constrain professional initiatives (29.3%);
– excessive service workload and time constraints (26.8%);
– unpredictable schedules and rotations (22.0%);
– safety risks in the work environment (e.g., air-raid alerts) (22.0%);
– unclear roles and position-related expectations (17.1%);
– non-recognition of the psychological service or interference with professional autonomy (14.6%);
– conflicts within the unit and low team support (4.9%).

Thus, the key organizational barriers are procedural pressure, resource deficits, and high-responsibility demands accompanied by elevated sanction-related risks.

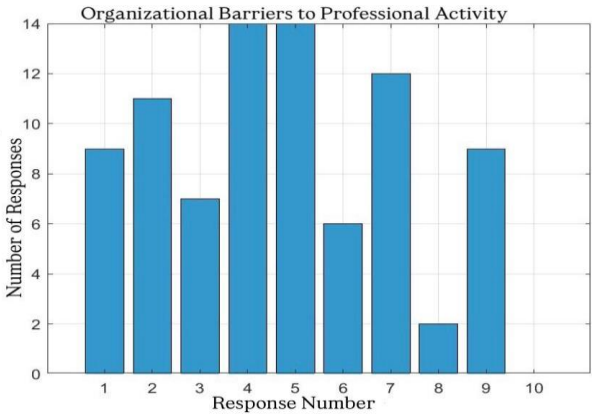

Figure 2 – Organizational Barriers to Professional Activity

In Figure 2 the numbers on the X-axis correspond to the following categories: 1 – Unpredictable schedules and rotations; 2 – Excessive service workload and time constraints; 3 – Unclear roles and position-related expectations; 4 – Bureaucratic requirements that compete with client care; 5 – Lack of resources (confidential premises, technical equipment, materials); 6 – Non-recognition of the psychological service or interference with professional autonomy; 7 – High accountability and the risk of sanctions for mistakes constrain professional initiatives; 8 – Conflicts within the unit and low team support; 9 – Safety risks in the work environment (e.g., air-raid alerts).

Open-ended responses (three main barriers) partially replicate the proposed items while also introducing additional variants. Qualitative comments reinforce the quantitative conclusions: respondents frequently mentioned bureaucracy/daily reporting, shortages of material resources and transportation, overload and lack of time/rest, safety risks (shelling, FPV drones, service in a frontline city), dual subordination and unclear roles, devaluation and interference with professional autonomy, incompetence of senior command and unethical communication, and the inability to provide systematic follow-up for clients. Respondents also reported individual factors, including perfectionism, hyper-responsibility, fatigue, decreased motivation, and feeling "out of place". Isolated responses indicated an absence of barriers. Taken together, these findings delineate a dual "scissors model": at the top – procedural and resource pressure combined with danger; at the bottom – fatigue and emotional overload; and in the middle – a gap between the demand for services and the capacity to provide systematic assistance, which directly sustains the identified components of professional deformation.

The third block of the questionnaire focused on support resources. The closed-ended question provided a list of potential recovery sources (social support, professional formats, individual self-regulation practices, organizational approaches). Respondents then provided open-ended answers to the question: "When it was most difficult recently, what specifically helped you in practice? ".

Respondents reported that the following resources were helpful:

– time spent with family and close others (70.7%);
– collegial support within the unit (56.1%);
– humor and brief team-based "recovery rituals" (53.7%);
– physical activity (48.8%);
– sleep and recovery practices (36.6%);
– clear planning and task prioritization (34.1%);
– individual psychotherapy/counseling (29.3%);
– training, continuing education, and participation in seminars (29.3%);
– leadership support (24.4%);
– supervision with a qualified supervisor (24.4%);
– intervision meetings with colleagues (24.4%);
– relaxation, breathing, and grounding techniques (7.3%);
– mindfulness practices (7.3%);
– limiting exposure to traumatic materials and reasonable rotation (4.9%);
– spiritual practices/chaplaincy support (2.4%).

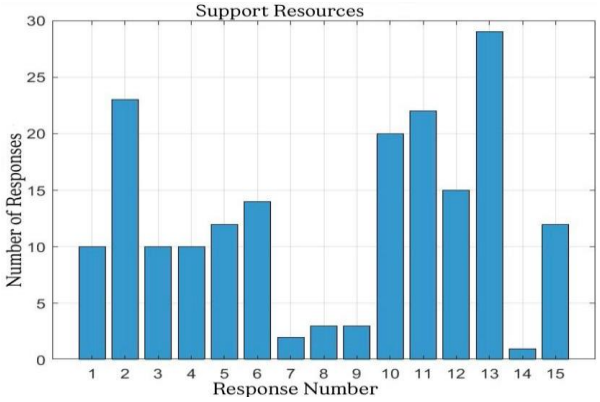

Figure 3 – Support Resources for Professional Activity

In Figure 3 the numbers on the X-axis correspond to the following categories: 1 – Leadership support; 2 – Collegial support within the unit; 3 – Supervision with a qualified

supervisor; 4 – Intervision meetings with colleagues; 5 – Individual psychotherapy/ counseling; 6 – Clear planning and task prioritization; 7 – Limiting exposure to traumatic materials and reasonable rotation; 8 – Relaxation, breathing, and grounding techniques; 9 – Mindfulness practices; 10 – Physical activity; 11 – Humor and brief team-based "recovery rituals"; 12 – Sleep and recovery practices; 13 – Time spent with family and close others; 14 – Spiritual practices/chaplaincy support; 15 – Training, continuing education, and participation in seminars.

In summary, the leading resources are social ties (family, colleagues) and basic recovery (sleep/rest, physical activity), which are strengthened by professional support formats (supervision, intervision, psychotherapy, and training).

In open-ended responses to the question "When it was most difficult recently, what specifically helped you in practice?", respondents mentioned: sleep/rest/leave; time with family and friends, as well as support from partners/parents/colleagues; switching activities, hobbies, walking, music, and creative practices; psychotherapy (including EMDR, and occasionally NLP), supervision, and training; in isolated cases, pharmacological support (antidepressants); and organizational changes (transfer to another unit or battalion). References to emotional "detachment" as a temporary protective strategy were also reported. Overall, the pattern confirms the predominance of basic recovery strategies and social support, reinforced by professional tools (therapy, supervision), and in crisis cases, by organizational decisions that reduce stress load.

It is appropriate to note the study limitations. The analytical sample (N = 38) is limited, which constrains the generalizability of the findings to the broader community of NGU military psychologists. The study design is based on respondents' self-reports; therefore, the observed associations should be interpreted as preliminary, indicative patterns. The reported empirical findings, in addition to professional deformation among military psychologists, may also relate to other phenomena (e.g., emotional burnout, compassion fatigue, individual strategies of professional adaptation), given that the sample does not include a sufficient number of psychologists with extensive professional experience. In subsequent research, the sample will be expanded by recruiting psychologists from different units and regions of service, as well as by ensuring stratification across key professional parameters (tenure, task type, and intensity of exposure to traumatic content).

Conclusions

1. In the pilot study (N = 38; NGU military psychologists), most manifestations of professional deformation within the professional community were observed at a moderate frequency level (15 of 20), whereas five manifestations demonstrated high frequency: external motivation for professional activity (primarily oriented toward control, reports, and evaluations); a formal, functional approach to people; decreased empathy; loss of meaning (motivation) in professional activity; and lagging behind (or absence of) professional development.

2. No associations were found between gender and the frequency of deformational manifestations. At the same time, women reported longer professional tenure as psychologists ($t = 2.61$; $p < 0.05$), which should be considered as a socio-structural factor in the staffing composition.

3. Overall length of military service was not associated with the frequency of deformational manifestations; thus, duration of service per se does not determine the intensity of professional deformation in a psychologist.

4. Systematic associations (Spearman's rank correlations) were identified between longer tenure specifically as a psychologist and lagging behind/absence of professional development, low professional and personal self-esteem, a tendency to withdraw from any activity in situations of failure, conflict-proneness in communication with colleagues or clients, cynicism and emotional coldness toward clients, and an inclination toward schematic thinking and categorization of people instead of individualized analysis (reliance on simplified/dogmatic schemas).

5. Factor analysis yielded partial convergence between the components of professional deformation and the theoretical model. Four components were identified in the structure of deformation: 1) maladaptive rigidity and interpersonal tension (developmental lag, withdrawal from activity in situations of failure, conflict-proneness in communication, non-constructive coping strategies, decreased tolerance, stigmatization, low self-esteem, schematic thinking, a pessimistic attitude toward professional difficulties, intrusive diagnosing, and a tendency to transfer professional stereotypes to other life domains and relationships); 2) affective reduction (cynicism/emotional coldness, decreased empathy, double standards, loss of meaning); 3) external

regulation and role inflation (external motivation, formalism in contacts, authoritarianism, overestimation of one's professional role); 4) hyper-responsibility (excessive appropriation of responsibility for others' well-being). The indicator "performing the professional role outside service without objective necessity" did not load on any component and requires separate monitoring as a marker of boundary "blurring".

6. Socio-psychological barriers in psychologists' work included depletion of resources and insufficient recovery (39% each), low client readiness (31.7%), and lack of regular supervision/intervision (26.8%). Organizational obstacles included bureaucratic demands and shortage of material resources (34.1% each), high accountability/risk of sanctions (29.3%), excessive workload (26.8%), and an unpredictable schedule and safety risks (22% each).

7. Respondents identified the most effective support resources as time with family and close ones (70.7%), support from colleagues (56.1%), humor and brief team "recovery rituals" (53.7%), physical activity (48.8%), sleep/recovery practices (36.6%), planning (34.1%), as well as professional formats – individual psychotherapy, training, and supervision/intervision (approximately 24–29%).

8. Overall, the findings provide empirical support for conceptualizing professional deformation as a cumulative process: prolonged exposure to stressors and organizational constraints specific to military psychologists increases the likelihood of developing maladaptive rigidity and interpersonal tension, affective reduction, external regulation and role inflation, and hyper-responsibility.

Further research is expected to involve the development of an authorial instrument for diagnosing professional deformation among military psychologists. Empirical testing of the theoretical model and substantiation of the four components in the deformation structure are planned.

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К. І. Онищук

ФЕНОМЕНОЛОГІЯ ПРОФЕСІЙНОЇ ДЕФОРМАЦІЇ ВІЙСЬКОВИХ ПСИХОЛОГІВ НАЦІОНАЛЬНОЇ ГВАРДІЇ УКРАЇНИ ПІД ЧАС ВОЄННОГО СТАНУ

Проаналізовано феноменологію професійної деформації військових психологів Національної гвардії України в умовах воєнного стану. Дослідження проведено як анонімне опитування; остаточна аналітична вибірка становила N=38. Прояви деформації оцінювалися за авторським переліком із 20 індикаторів (5-бальна шкала частоти) у поєднанні з блоками бар'єрів у професійній діяльності та ресурсів підтримки. Дослідження показало, що більшість проявів мають середній рівень частоти, а п'ять із них вирізняються високою інтенсивністю: зовнішня мотивація діяльності; формальний,

функціональний підхід до людей; зниження рівня емпатії; втрата сенсу професійної діяльності; відставання професійного розвитку.

За допомогою факторного аналізу виокремлено чотири ключові компоненти деформації:

1) дезадаптивна ригідність і міжособистісна напруженість;

2) афективна редукція;

3) зовнішня регуляція та рольова інфляція;

4) гіпервідповідальність.

Серед провідних соціально-психологічних бар'єрів у професійній діяльності найчастіше зазначали недостатній відпочинок/сон та виснаженість ресурсів, низьку готовність клієнтів та брак регулярної супервізії/інтервізії. Ключовими організаційними перешкодами названо бюрократичні вимоги та недостатність матеріальних ресурсів.

Провідні ресурси відновлення: час із родиною та близькими, підтримка колег, гумор та короткі командні «ритуали відновлення», фізична активність.

Практичне значення дослідження полягає у можливості застосування результатів для моніторингу психоемоційного стану військових психологів, своєчасного виявлення професійних ризиків, організації профілактичних заходів та розроблення програм професійної підтримки.

У подальших дослідженнях передбачається розроблення авторської методики для діагностики професійної деформації військових психологів та емпіричної перевірки теоретичної моделі.

Ключові слова: *професійна деформація, професійне вигорання, військовий психолог, компоненти професійної деформації, бар'єри в роботі, ресурси підтримки.*

Onyshchuk Kristina – Adjunct, National Academy of the National Guard of Ukraine
https://orcid.org/0009-0005-7108-4218