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A SOLUTION-FOCUSED BRIEF THERAPY (SFBT) INTERVENTION MODEL TO FACILITATE HOPE AND SUBJECTIVE WELL-BEING AMONG TRAUMA SURVIVORS AT COMMUNITY CLINICS IN GAUTENG: A MIXED METHODS STUDY

Jolize Joubert

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Ethics statement

The author, whose name appears on the title page of this thesis, has obtained, for the research described in this work, the applicable research ethics approval. The author declares that she has observed the ethical standards required in terms of the University of Pretoria's Code of ethics for researchers and the Policy guidelines for responsible research.

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Phone: +27 (0)72 265 3584

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Jolize Joubert, PhD Candidate, University of Pretoria
And, to whom else it may concern

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Yours sincerely,

Lyn Brown (MSc. Env. Sci., UCT)

Environmental editor/scientist, based in Joburg

Associate Member of the Professional Editors Guild: BRO012

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Dedication

This study is dedicated to the participants of this study, especially for the wisdom you have shared:

“Nothing does not get better…or things do not, not get easier.”

Participant 2

“Even though things might fall apart, I have the solution in me.”

Participant 4

“There is brightness in my future, I can see the light and I can see where I’m going.”

Participant 5

“I tell myself: you’re beautiful, you’re valuable, you have a lot to contribute…keep going.”

Participant 7

Abstract

This study examined hope and subjective well-being among trauma survivors at community-based clinics in Gauteng, in order to develop a Solution-Focused Brief Therapy (SFBT) intervention model which may facilitate hope and subjective well-being. To meet this aim, a multiphase mixed methods research design was implemented. During Phase I, a cross-sectional survey design was employed to determine the incidence of hope and subjective well-being among trauma survivors (n = 120). A biographical questionnaire and questionnaires measuring hope, positive and negative affect, life satisfaction, depression, and post-traumatic stress disorder (PTSD) were administered. During Phases II and III, a multiple case study design was implemented to describe SFBT and explore the experience of hope and subjective well-being, during and after exposure to SFBT, among a small group of trauma survivors (n = 7). Qualitative data, collected from therapeutic sessions and semi-structured individual interviews, were thematically analysed. During Phase IV, findings were integrated with existing literature to develop an SFBT intervention model that could facilitate hope and subjective well-being among trauma survivors. Results from Phase I suggested that the participants experienced low levels of hope, positive affect, and life satisfaction. High levels of negative affect, as well as symptoms of depression and PTSD were evident. In Phases II and III, qualitative data indicated that SFBT contributed towards participants' experience of hope and subjective well-being. In particular, the therapeutic conversation; empathy and acceptance in therapy; visualising a better future; and focusing on strengths instead of the trauma, facilitated these experiences. Accordingly, an SFBT model, "Journey of Possibilities", was proposed to facilitate hope and subjective well-being among trauma survivors.

Keywords: community mental health, hope, solution-focused brief therapy, South Africa, subjective well-being, trauma interventions, trauma model, trauma survivors

List of Abbreviations

AHS	Adult State Hope Scale
AIP	Adaptive information processing
ASD	Acute stress disorder
BEPP	Brief eclectic psychotherapy for PTSD
BFTC	Brief Family Therapy Centre
BPP	Brief Psychodynamic Psychotherapy
BSFC	Brief Solution-Focused Counselling
CBGT	Cognitive behavioural group therapy
CBT	Cognitive behavioural therapy
CCP	Critical Community Psychology
COR	Conservation of Resources
CPT	Cognitive processing therapy
CSA	Childhood sexual abuse
CT	Cognitive therapy
CTS	Continuous traumatic stress
DSM	Diagnostic and Statistical Manual of Mental Disorders
EHDRC	Ekurhuleni Health District Research Committee
EMDR	Eye movement desensitisation and reprocessing
GFGP	Goal-focused group psychotherapy
GPS	Global positioning system
HPCSA	Health Professions Council of South Africa
MRI	Mental Research Institute
NAR	Nature adventure rehabilitation
NGO	Non-government organisations
NHI	National Health Insurance
PE	Prolonged exposure
PTSD	Post-Traumatic Stress Disorder
PWB	Psychological well-being
RCT	Randomised controlled trials

S2T	Survivor to thriver
SAM	Situationally accessible memory
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPS	South African Police Service
SASH	South African Stress and Health
SD	Standard deviation
SES	Socioeconomic status
SFBGT	Solution-Focused Brief Group Therapy
SFBT	Solution-Focused Brief Therapy
SFBTA	Solution-Focused Brief Therapy Association
SFGT	Solution-Focused Group Therapy
SPANE	Scale of Positive and Negative Experience
SWB	Subjective well-being
SWLS	Satisfaction with Life Scale
TA	Thematic analysis
UK	United Kingdom
VAM	Verbally accessible memory
Wits	University of the Witwatersrand

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Chapter 1: Rationale, Background and Research Objectives

1.1 Background and Rationale for the Study

More than 70% of the South African population is exposed to at least one traumatic event during their lifetime, with more than half of the population experiencing two or more traumatic events (Atwoli, 2015; Kaminer & Eagle, 2010; Williams et al., 2007). These findings are supported by the country's devastating annual crime report, with Gauteng being the province with the highest crime rate in the 2019/2020 financial year (South African Police Service [SAPS], 2020). The most common traumatic events South African citizens are exposed to include physical violence, accidents, witnessing of trauma, and the unexpected death of a loved one. Emotional, physical, and sexual abuse in the context of intimate relationships, and community violence, are also relatively common among South Africans (Atwoli, 2015; Eagle, 2015; Jewkes & Abrahams, 2002; Williams et al., 2007).

The violence observed in contemporary South Africa appears to be rooted in a history of racial segregation, exploitation, and oppression (Atwoli, 2015; Eagle, 2015). Furthermore, despite the establishment of a non-racial democracy in 1994, South Africa is still characterised by a culture of violence where aggression is accepted as a means of resolving problems and achieving goals. This may be ascribed to the inequality and associated psychosocial problems that still prevail in South Africa. Historical, political, economic, and social factors therefore predispose South African citizens to multiple and continuous trauma (Atwoli, 2015; J. K. Burns, 2011; Eagle, 2015; Kaminer & Eagle, 2010; Williams et al., 2007). This tends to have a cumulative negative effect on citizens' psychological health, as exposure to traumatic events is associated with a wide spectrum of adverse responses (Atwoli et al., 2013; Kaminer & Eagle, 2010; Young, 2011; Williams et al., 2007).

Trauma survivors may not only develop psychiatric disorders, such as PTSD, depression, anxiety, and substance abuse but also experience various other psychological challenges (American Psychiatric Association [APA], 2013; Brady, Killeen, Brewerton, & Lucerini, 2000; Kaminer & Eagle, 2010; Lowe, Blachman-Forshay, & Koenen, 2015). For example, exposure to trauma is often associated with increased suicidal risk, emotional and interpersonal problems, and poor self-image (APA, 2013; Atwoli, 2015; Brady et al., 2000; Scheiderer, Wood, & Trull, 2015). The

literature furthermore indicates that trauma may have an impact on people's experience of hope and subjective well-being (SWB) (Bucciol & Zarri, 2017; Calvo, Arcaya, Baum, Lowe, & Waters, 2015; Chang et al., 2015; Davies & Hinks, 2010; Irving, Telfer, & Blake, 1997; Levi, Liechtentritt, & Savaya, 2012b; Oskin, 1996).

Snyder's (2000) hope theory conceptualises hope as a cognitive-motivational construct, stemming from an additive and iterative relationship between agency thinking (goal-directed energy) and pathways thinking (planning to meet one's goals). Trauma is thus considered as a goal blockage which may erode trauma survivors' sense of hope (Snyder, 2002; Snyder, Rand, & Sigmon, 2002; Snyder, Rand, & Sigmon, 2018). For example, the literature suggests that hope is negatively related to various traumatic events, including community violence, war, and sexual assault (Chang et al., 2015; Irving et al., 1997; Levi et al., 2012b; Oskin, 1996). Despite these findings, no studies concerning the prevalence of hope among trauma survivors in South Africa could be found during the literature search for the current study. However, this topic may be particularly relevant in an Afrocentric context where hope is described as a multidimensional experience, influenced by an interplay of individual, relational, communal, and spiritual factors (Cherrington, 2018; Isaacs & Savahl, 2014; Wright, Dunbar-Krige, & Van der Westhuizen, 2015).

Although studies have indicated that traumatic events may temporarily reduce hope, it appears to be a protective factor in the aftermath of trauma. Hope not only facilitates effective coping and growth but may also buffer against the development of trauma-related psychopathology (Irving et al., 1997; Irving, Snyder, & Crowson, 1998; Levi et al., 2012a, 2012b; Oskin, 1996; Moon & Snyder, 2000). It is therefore relevant to consider the role that hope may play in the context of trauma interventions. Even though hope is considered as a common factor in psychotherapy, few studies have specifically explored how trauma interventions can instil hope (Blow & Sprenkle, 2001; Cheavens & Guter, 2018; Gilman, Schumm, & Chard, 2012; Lopez, Floyd, Ulven, & Snyder, 2000). This also applies to the South African context, where the few hope-enhancing intervention studies that have been conducted, have focused on children or healthy adults (Cherrington & De Lange, 2016; Pretorius, Venter, Temane, & Wissing, 2008; Teodorczuk, Guse, & Du Plessis, 2019).

Diener's (1984) tripartite model describes SWB as a multidimensional concept, comprised of a cognitive component (life satisfaction) and an affective component (high levels of positive affect and low levels of negative affect). According to the literature, traumatic life events have a significant, but relatively short-term, negative effect on SWB as people tend to adapt to the consequences of these events (Brickman, Coates, & Janoff-Bulman, 1978; Frederick & Loewenstein, 1999; Lucas, 2007b; Silver, 1982; Suh, Diener, & Fujita, 1996). However, the negative impact of some traumatic events, such as childhood abuse, divorce, the loss of a spouse, or severe disability, can be long-lasting (Bucciol & Zarri, 2017; Calvo et al., 2015; Lucas, 2005, 2007b; Lucas & Clark, 2006). Despite these findings, no studies concerning the prevalence of SWB among trauma survivors in South Africa were found during the literature search for the present study. Cross-national studies have highlighted the influence of cultural, economic, and political factors concerning SWB; thus, up-to-date research on SWB in a socio-culturally diverse country such as South Africa is therefore warranted (Botha & Booysen, 2014; Loubser & Steenekamp, 2017; Möller, 2001; Posel & Casale, 2011; Tov & Diener, 2013).

Nonetheless, recent literature suggests that people may also experience increased SWB and growth in the face of adversity (Karlsen, Dybdahl, & Vitterso, 2006; Seery, 2011; Veronese, Pepe, Massaiu, De Mol, & Robbins, 2017; Wade et al., 2016; Whitelock, Lamb, & Rentfrow, 2013). As positive emotions have the potential to broaden thought–action repertoires, build durable resources, and counter the downward spirals of negative emotions; SWB may also potentially play a protective role in the aftermath of trauma (Frederickson, 2000; Karlsen et al., 2006; Veronese et al., 2017). It is therefore valuable to investigate the role that SWB may play in trauma interventions. Although studies suggest that positive psychology interventions may be effective in increasing SWB, to date few studies have explored these interventions in the context of trauma (Bolier et al., 2013; Sin & Lyubomirsky, 2009). In South Africa, no research concerning this topic is available, with some studies focusing on therapeutic interventions to facilitate SWB in other contexts (Boshoff, Grobler, & Nienaber, 2015; Van Zyl, 2012).

The researcher thus proposes that Solution-Focused Brief Therapy (SFBT) may be an appropriate intervention to facilitate hope and SWB among trauma

survivors. SFBT is a brief, goal-orientated, future-focused and strength-based therapeutic approach, embedded in the paradigm of positive psychology (De Shazer, 1985; Ratner, George, & Iveson, 2012; Visser, 2013). Evidence-based research supports the effectiveness of SFBT for a variety of mental health problems; including depression, anxiety, perfectionism, substance abuse, and marital and family problems (Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Kim, 2008; Schmit, Schmit, & Lenz, 2016; Stams, Dekovic, Buist, & De Vries, 2006; Zhang, Franklin, Currin-McCulloch, Park, & Kim, 2018). Despite these findings, only a small number of empirical studies have specifically focused on the use of SFBT with trauma survivors (Froerer, Von Cziffra-Bergs, Kim, & Connie, 2018; Kim, Brook, & Akin, 2018). However, various authors support the relevance of SFBT in this context (Bannink, 2008; Froerer, Smock, & Seedall, 2009; Froerer et al., 2018; Hopson & Kim, 2004; Ogunsakin, 2015).

SFBT may be an appropriate trauma intervention, as it views a crisis as an opportunity to develop new skills, strengths, and resources (Bannink, 2008; Hopson & Kim, 2004). The future-focused orientation of SFBT also communicates that, despite the client's traumatic past, their future can still be filled with success and satisfaction. Therapists practising SFBT furthermore assume that clients are capable and resourceful, which not only creates an empowering therapeutic alliance where healing and growth can occur but also engenders feelings of hope in the aftermath of trauma (Bannink, 2008; Froerer et al., 2009, 2018; Griffin, 2015; Hopson & Kim, 2004). Additionally, SFBT techniques; such as miracle, scaling, and coping questions, and finding exceptions, are considered to be particularly valuable to clients faced with trauma (Froerer et al., 2009, 2018; Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015).

Although no SFBT studies–either internationally or locally–have specifically focused on hope or SWB in the context of trauma, research suggests that SFBT may enhance these experiences in other contexts (Bozeman, 1999; Grant, 2012; Green, Oades, & Grant, 2006; Michael, Taylor, & Cheavens, 2000; Quick & Gizzo, 2007). As per Frederickson's (2000) *broaden-and-build theory*, SFBT helps clients find alternative routes to their desired outcomes and increases positive emotions which subsequently lead to hope and SWB. The tenets of SFBT, namely the collaborative

therapeutic relationship and solution-focused conversations, appear to be particularly valuable in this regard (Blundo, Bolton, & Hall, 2014; Froerer et al., 2018; Kim & Franklin, 2015; Michael et al., 2000; Reiter, 2010). Specific SFBT techniques such as future-orientated questions, identifying clients' strengths, past successes and exceptions, as well as providing compliments may furthermore contribute towards hope and SWB (Blundo et al., 2014; Froerer et al., 2018; Michael et al., 2000; Reiter, 2010). Trauma survivors' experience of hope and SWB in the context of SFBT therefore ought to be explored further, specifically focusing on the aspects of SFBT that contribute towards these experiences.

Research supports the use of SFBT with ethnic minority groups in Asia, Mexico, America, and South Africa (Diale, 2014; Gong & Hsu, 2017; Kim et al., 2015; Seidel & Hedley, 2008; Stander, 2003; Suitt, Franklin, & Kim, 2016; Von Cziffra-Bergs, 2018). However, the only local study focusing on trauma and SFBT to date was conducted by Diale (2014). While Diale found that Solution-Focused Group Therapy (SFGT) was appropriate for black adolescents exposed to domestic violence, she suggested that specific SFBT techniques should be adapted for the South African context. Despite the lack of empirical evidence, SFBT is used by various local therapists working in trauma-saturated environments, such as private practice, universities, and correctional centres (Von Cziffra-Bergs, 2018). The researcher therefore proposes that SFBT may also be relevant for trauma survivors at community-based clinics in South Africa, especially taking into consideration the challenges related to community mental health services (De Kock & Pillay, 2017; Kaminer & Eagle, 2010; Moosa & Jeenah, 2008; Von Cziffra-Bergs, 2018).

Since the publication of The White Paper in 1997 (revised in 2009) by the Ministry of Health, as well as the introduction of the *Mental Health Care Act 17 of 2002*, excessive demands have been placed on community mental health services in South Africa. This legislation not only proposed comprehensive and integrated community-based mental health services, but also attempted to address the previous inequality and racial segregation affecting mental health service delivery in South Africa (De Kock & Pillay, 2017; Schneider et al., 2016). However, in Gauteng province, an insufficient number of community psychiatric clinics, poor accessibility of clinics, and limited mental health practitioners to service the growing number of patients have hindered the transformation process (Moosa & Jeenah, 2008). This is especially

problematic in a country where the majority of the population are dependent on the public health system (Council for Medical Schemes, 2014).

Limited awareness of, and negative attitudes towards, mental health (specifically government-based mental health services), also appear to be a concern in the country (Bezuidenhout, 2016; Kaminer & Eagle, 2010; Schneider et al., 2016). This might stem from previous inequality, current disillusionment towards government institutions, and misconduct towards mental health patients in the Gauteng Department of Health (Bezuidenhout, 2016; Kaminer & Eagle, 2010; Naidoo, Van Wyk, & Carolissen, 2004). Traditional cultural and spiritual beliefs held by a large portion of the South African population may furthermore contribute to the societal stigma associated with the use of modern mental health services (J. K. Burns, 2011; Eagle, 2015). Additionally, various South African communities are faced with the ongoing threat of community violence. As a result, psychologists cannot always guarantee that clients will return for follow-up sessions (Kaminer & Eagle, 2010; Van der Merwe & Kassan-Newton, 2007). Owing to these challenges, the use of brief therapeutic approaches such as SFBT is therefore warranted (Kaminer & Eagle, 2010; Von Cziffra-Bergs, 2018).

Due to South Africa's problem-saturated past and high incidence of trauma, it is recommended that trauma interventions should focus on clients' strengths, instead of recounting traumatic memories (Diale, 2014; Kaminer & Eagle, 2010; Van der Merwe & Kassan-Newton, 2007; Von Cziffra-Bergs, 2018). This may be valuable considering the criticism against traditional trauma-focused interventions for being confrontational, rigid, and inflexible. These approaches also often disregard the client's natural resiliency as it focuses on pathology. Exposure-orientated approaches, in particular, have exceptionally high dropout rates and can possibly retraumatise clients or lead to vicarious traumatisation among therapists (D. J. A. Edwards, 2005, 2009; Griffin, 2015; Kaminer & Eagle, 2017; Paintain & Cassidy, 2018; Schottenbauer, Glass, Arnkoff, & Gray, 2008; Van der Merwe & Kassan-Newton, 2007; Weiten, 2010). Strength-based interventions, such as SFBT, could thus be considered as an intervention model to facilitate hope and SWB among trauma survivors at community-based clinics in South Africa.

1.2 Research Question

Taking into consideration the above-mentioned background and rationale, this study intends to investigate hope and SWB among trauma survivors at community-based clinics in Gauteng in order to develop an SFBT intervention model which may facilitate these experiences. Prompted by the problem statement, the following research questions thus emerged:

- What is the prevalence of hope and SWB among trauma survivors at community-based clinics in Gauteng?
- How can the implementation of SFBT, as a therapeutic intervention, facilitate hope and SWB among trauma survivors at community-based clinics in Gauteng?
- How do trauma survivors at community-based clinics in Gauteng experience hope and SWB in the context of SFBT? and
- Which aspects of SFBT should be included in an SFBT intervention model aimed at facilitating hope and SWB among trauma survivors at community-based clinics?

1.3 Research Objectives

Based on the above-mentioned research questions, the following research objectives were formulated:

- To investigate the incidence of hope, SWB, and psychopathology (as the absence of well-being) among trauma survivors at community-based clinics in Gauteng–a quantitative study;
- To implement and describe SFBT with trauma survivors at community-based clinics in Gauteng;
- To explore the experience of hope and SWB among trauma survivors at community-based clinics in Gauteng, during and after exposure to SFBT; with particular focus on the aspects of SFBT contributing to their experiences–a qualitative study; and
- To develop an SFBT intervention model facilitating hope and SWB among trauma survivors at community-based clinics.

1.4 Theoretical Perspective

This study is grounded within the theoretical framework of positive psychology. For several decades after World War II, psychology primarily focused on assessing and curing pathology and understanding human functioning within a disease-focused medical model. As a result, salutary human experiences were often neglected. However, since the start of the 21st century, positive psychology has shifted the focus from only repairing the worst things in life to also building the best things life has to offer (Gable & Haidt, 2005; Seligman & Csikszentmihalyi, 2000). Positive psychology is thus an umbrella term for the scientific study of optimal human functioning; including positive emotions, positive character traits, and enabling institutions (Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005). Positive psychology aims to better understand and apply those factors that help individuals and communities thrive and flourish. However, it does not intend to replace what is known about human suffering, weakness, and disorder; but rather attempts to supplement this with knowledge about human resilience, strength, and growth to have a more balanced scientific understanding of the human experience (Gable & Haidt, 2005; Magyar-Moe, Owens, & Conoley, 2015; Seligman et al., 2005).

Well-being and hope are considered as two core positive psychology constructs that have been the focus of extensive research in this field. Not only is well-being viewed as the target of positive psychology, but hope is also considered to be a character strength related to various benefits (Magyar-Moe et al., 2015; Seligman et al., 2005). Contemporary positive psychology research furthermore acknowledges the possibility of growth in the context of trauma (Bannink, 2008; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). For example, Tedeschi and Calhoun (2004) coined the term *post-traumatic growth* to refer to the enhanced level of functioning or thriving in the aftermath of trauma. Positive psychology interventions thus aim to cultivate these enabling conditions of life by utilising specific treatment methods or intentional activities (Sin & Lyubomirsky, 2009).

In this regard, positive psychology views mental illness as being amendable to change. It also regards human beings as decision-makers with the capability of achieving mastery and resilience in the face of adversity (Seligman & Csikszentmihalyi, 2000). Positive psychology furthermore assumes that when clients

are labelled as competent, they become more aware of and motivated to utilise their strengths in the pursuit of complete mental health (Magyar-Moe et al., 2015). This reflects the principles and assumptions of SFBT which is described as a competency-based, future-orientated intervention (Bavelas et al., 2013). These assumptions also resonate with the personal worldview of the researcher, who views individuals as capable of overcoming adversity and recognises their strength and resilience. The researcher's worldview, and the constructs explored in this study thus aligned with the theoretical framework.

1.5 Possible Contribution of the Study

This study can make a positive theoretical contribution towards the limited evidence-based research that currently exists on SFBT in South Africa. As it is one of few studies regarding the application of SFBT with trauma survivors, both nationally and internationally, it may also contribute to new knowledge in this field. The existing knowledge base of positive psychology interventions, and particularly the experience of hope and SWB among trauma survivors at community-based clinics, may furthermore be expanded. The mixed methods research approach utilised in this study may specifically be valuable as it can provide in-depth, context-specific information. This study is also aimed at the development of an SFBT intervention model that may facilitate hope and SWB among trauma survivors at community-based clinics in South Africa. Such a model will be unique and the first of its kind, both locally as well as internationally.

The results of this study could thus inform psychological practice at community-based clinics in South Africa by providing a brief and effective intervention model. As this model may contribute to more effective service delivery, it has the potential to relieve the current burden on community mental health services and psychologists in the public sector. The application of this model may also be expanded to the practice fields of clinical and counselling psychology in various other contexts. Knowledge generated regarding the use of SFBT with trauma survivors may furthermore contribute to the training of future psychologists, social workers, and trauma counsellors at training institutions, both nationally and internationally.

1.6 Overview of the Study

Chapter 1 of this thesis provides a general overview of the study, explicating the background and rationale, and the research objectives. Chapter 2 focuses on the definition, conceptualisation, impact, and treatment of trauma, specifically in the South African context. This chapter also considers SFBT as a possible trauma intervention, highlighting the philosophical foundation and existing evidence for the effectiveness of this approach. In Chapter 3, hope and SWB are discussed, specifically considering the socio-cultural context of South Africa. Attention is also given to theoretical perspectives concerning hope and SWB, the impact trauma may have on these constructs, and the role they may play concerning psychotherapy and trauma interventions in particular. Chapter 4 describes the research methodology of the study, while the research results and interpretation are discussed in Chapter 5. In Chapter 6, the researcher proposes and describes an SFBT intervention model that may facilitate hope and SWB among trauma survivors at community-based clinics. The theoretical foundation and practical guidelines concerning this model are outlined. Chapter 7 concludes this thesis with a summary of the research findings, a discussion of the research limitations, and recommendations arising from the study.

Chapter 2: Trauma and Solution-Focused Brief Therapy as a Therapeutic Approach

2.1 Introduction

Trauma is considered to be a public health concern, both internationally and in South Africa. Due to the distinct psychological consequences associated with trauma, enormous effort has gone into the development of effective trauma interventions. However, there is limited international and local literature on the application of strength-based trauma interventions (Bryant, 2015; Fouché & Walker-Williams, 2016; Kaminer & Eagle, 2010; Nijdam & Wittmann, 2015). Owing to South Africa's diverse socio-cultural context and mental health-related challenges, the researcher proposes that SFBT be considered as trauma intervention at community-based clinics in the country.

The first part of this chapter thus gives an overview of trauma. A definition, description of the theoretical perspectives on trauma, and the consequences associated with trauma are provided. The most prominent trauma interventions are discussed, with specific attention given to strength-based approaches. Trauma in the South African context is also highlighted, considering the country's particular dynamics, incidence, and symptomology. Interventions utilised by clinicians working with trauma survivors in South Africa are then discussed.

The second part of the chapter focuses on SFBT. The history and origin of SFBT are discussed as well as its underlying assumptions, principles, and techniques. Taking into account criticisms of SFBT, the effectiveness of SFBT is highlighted by considering both outcome-based and process-orientated research. The application of SFBT beyond the traditional westernised context, including community-based mental health care, is furthermore addressed. The chapter concludes with a description of the clinical application of, and empirical evidence for SFBT as trauma intervention, both internationally and in South Africa.

2.2 Trauma

2.2.1 Defining trauma

The word trauma originates from the Greek word which means *to wound* or to tear and is commonly used to describe physical or psychological injury (Kaminer & Eagle, 2010; Reber, 1985). The Substance Abuse and Mental Health Services

Administration (SAMHSA) (2014) defines individual trauma as “an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, and spiritual being” (p. 7). Traumatic events commonly perceived as harmful or life-threatening include, but are not limited to: natural or man-made disasters, transportation accidents, physical or sexual assault, interpersonal violence, the unexpected death of a loved one, and serious physical injuries or illnesses (Atwoli et al., 2013; Kilpatrick et al., 2013). In this thesis, the term trauma is used interchangeably to refer to both the traumatic event and the adverse effects associated with the event.

The body of literature shows that more than two-thirds of the global population will experience a traumatic event at some point in their lives (Froerer et al., 2018). These events are usually unexpected, disrupt psychological equilibrium, and place excessive demands on a person’s existing coping strategies. Since the late nineteenth century, trauma has thus received significant attention from various disciplines. Not only have researchers attempted to better understand the impact of trauma, but this knowledge has also been used to inform trauma-based care. Trauma-related research, commonly referred to as traumatology, is therefore a relevant and growing field in psychology (Froerer et al., 2018; Kaminer & Eagle, 2010, 2017).

2.2.2 Theoretical perspectives on trauma

The majority of psychological theories attempt to explain why certain trauma survivors develop post-traumatic stress symptoms and others do not. These theories investigate the role that thoughts, memory, emotions, behaviours, and underlying processes play in relation to trauma and consequently inform the mechanisms behind trauma interventions (Nijdam & Wittmann, 2015). Psychological trauma can thus be conceptualised from various theoretical paradigms, each influenced by distinct discourses. Early trauma theorists primarily viewed trauma from a psychodynamic, behavioural, or cognitive perspective. Numerous authors have elaborated on these early theories, giving rise to more contemporary perspectives (Bisson, 2009; Brewin & Holmes, 2003). The most prominent trauma theories are discussed in more detail below.

2.2.2.1 Early theories on trauma

2.2.2.1.1 *Psychodynamic theories*

Psychoanalytic and psychodynamic trauma theories have a long history, originating from the previous century. Early theorists, including Freud, argued that trauma memories cannot be psychically processed, as they overwhelm the psychic system (Eagle & Watts, 2002; Freud, 1920; Horowitz, 1986; Nijdam & Wittmann, 2015; J. P. Wilson, Friedman, & Lindy, 2004). However, exposure to external stimuli related to the trauma activates various unconscious and ego-defensive mechanisms, such as denial, numbing, and avoidance, to protect the psychic system (Bisson, 2009; Nijdam & Wittmann, 2015). Trauma memories therefore remain unconscious, either due to the repression of the traumatic event, or because the event occurred during a dissociative state (Eagle & Watts, 2002; Freud, 1920; Horowitz, 1986; J. P. Wilson et al., 2004).

According to Horowitz (1986), trauma survivors experience the need to integrate new information regarding the traumatic experience, while at the same time avoid this threatening information in an attempt to protect themselves. Oscillation between the re-experiencing of traumatic events (e.g. flashbacks and nightmares) and the avoidance of trauma-related memories thus allows the traumatic information to be processed and integrated, while stagnation leads to persistence of trauma-related symptoms (Brewin & Holmes, 2003; Nijdam & Wittmann, 2015). Psychodynamic theorists have furthermore argued that previous negative interpersonal experiences related to rejection, punishment, or abandonment influence trauma responses (Nijdam & Wittmann, 2015). Bowlby (1982), the originator of attachment theory, specifically emphasised the importance of the first interpersonal relationship between the child and the caregiver in establishing relational models. These theorists thus suggest that secure relational models create a sense of safety and stability which protects an individual against future stress or trauma (Brewin & Holmes, 2003; Nijdam & Wittmann, 2015).

As a result, therapeutic approaches stemming from psychodynamic theories analyse previous experiences and utilise relevant interpersonal patterns, including the therapeutic relationship, to establish more flexible relational models (Nijdam & Wittmann, 2015). Psychodynamic theories are considered influential as they not only guided the development of psychodynamic interventions but also emphasised the wider impact of trauma. However, these theories have failed to clearly explain the

difference between flashbacks and ordinary memories, individual variations in trauma responses, and the role environmental factors may play concerning trauma (Brewin & Holmes, 2003). In an attempt to address these limitations, behavioural theorists thus provided an alternative view on trauma.

2.2.2.1.2 *Conditioning theories*

Behavioural learning theories primarily relied on the concept of fear conditioning to explain trauma (Bisson, 2009; Brewin & Holmes, 2003; Nijdam & Wittmann, 2015). For example, they assumed that a previously neutral stimulus (conditioned stimuli) acquires fear-eliciting properties when associated with a traumatic event (unconditioned stimulus) through the process of classical conditioning. A wide variety of associated stimuli can acquire these properties as a result of generalisation and higher-order conditioning. Re-exposure to reminders of the trauma (conditioned stimuli) were thus thought to elicit a fear response (Keane, Zimering, & Caddell, 1985, Mowrer, 1960; Nijdam & Wittmann, 2015). Operant conditioning furthermore maintained this fear response, as avoidance of reminders reinforced a short-term decrease of fear and tension (Bisson, 2009; Mowrer, 1960; Nijdam & Wittmann, 2015). Orr et al. (2000) highlighted that conditioned responses were more likely to develop when people are exposed to aversive events and that these responses were harder to extinguish.

Although the conditioning theories did not clearly distinguish the aetiology of trauma-related disorders from those of other anxiety disorders, they did shed light on the powerful role that reminders, arousal, and avoidance play concerning trauma symptomology. However, conditioning theories lacked clarification regarding the nature of re-experiencing symptoms, the effects of trauma on memory and the influence of emotions other than fear (Bisson, 2009; Brewin & Holmes, 2003; Nijdam & Wittmann, 2015). Conditioning theories were therefore supplemented by cognitive theories which provided a more comprehensive perspective.

2.2.2.1.3 *Cognitive theories*

The cognitive school of psychology proposed various theories regarding trauma, with the theory of shattered assumptions and information processing theories, probably being the most influential (Bisson, 2009; Brewin & Holmes, 2003). According to the *theory of shattered assumptions*, traumatic events could shatter deeply held

assumptions about the world being benevolent, meaningful, and predictable and the self as being worthy and competent (Bolton & Hill, 1996; Janoff-Bulman, 1992). This theory argued that shattered assumptions could, as proposed by Horowitz (1986), spontaneously be restructured through the re-experience and avoidance cycle, or, according to Brewin and Holmes (2003), deliberately be adjusted by reflecting on the trauma. This theory thus identified common themes in schema changes and described long term adjustment to trauma. It was also one of the few theories that recognised the possibility of positive growth in this context. However, it lacked clarity concerning the short-term impact of trauma, how trauma is represented in memory, and the influence of prior beliefs on the processing of trauma (Bisson, 2009; Brewin & Holmes, 2003).

In contrast to the theory of shattered assumptions, *information processing theories* focused on the traumatic event itself, rather than on the wider personal and social context (Brewin & Holmes, 2003). These theories proposed that traumatic events were represented in memory as interconnections between sensory, affective, and cognitive nodes, referred to as a *fear network* (Bisson, 2009; Foa & Riggs, 1993; Foa & Rothbaum, 1998; Lang, 1979). These fear networks could be activated by various environmental cues which result in hypervigilance, the intrusion of trauma memories, and avoidance behaviour (Brewin & Holmes, 2003; Foa, Steketee, & Rothbaum, 1989; Nijdam & Wittmann, 2015). According to Foa et al. (1989), the fear network could be integrated with the rest of the person's memories if the strong associations between the different nodes could be broken. Although information processing theories guided the development of prominent treatment interventions and explained how traumatic events are processed, they paid limited attention to the wide range of emotions and beliefs commonly observed among trauma survivors (Brewin & Holmes, 2003). In response to these limitations, recent theories have emerged which aim to provide more elaborative explanations.

2.2.2.2 More recent theories on trauma

2.2.2.2.1 *Emotional processing theory*

Originating from early information processing theories, emotional processing theory noted that traumatic events are uniquely represented within a fear network (Brewin & Holmes, 2003; Nijdam & Wittmann, 2015). Activation of one node in the fear network thus automatically and selectively activates other nodes which gives rise to

specific cognitive, behavioural, and physiological reactions (Foa & Rothbaum, 1998; Foa et al., 1989). Although these structures are important in triggering an appropriate fear response, they become pathological when benign stimuli are associated with fear and danger. According to the emotional processing theory, beliefs present prior, during, and after, the traumatic event may play a role in the appraisal of traumatic events (Bisson, 2009; Brewin & Holmes, 2003; Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum 1998). For example, rigid positive views about the self and the world are contradicted by a traumatic event, while rigid negative beliefs about the self and the world are confirmed. Both these processes can exacerbate feelings of incompetence or danger, which in turn create a vulnerability for developing trauma-related problems (Brewin & Holmes, 2003; Foa et al., 2007; Foa & Rothbaum 1998).

According to Foa and Rothbaum (1998), trauma memories could be integrated with other memories through a process of repeated exposure. During this process, traumatic memories would be activated and simultaneously integrated with new information incompatible with the traumatic memory. Repeated exposure would appear to be valuable as it challenged negative beliefs concerning the self and the world, preventing avoidance behaviour, and weakening physiological responses (Bisson, 2009; Brewin & Holmes, 2003; Foa et al., 2007). The emotional processing theory thus explained the mechanism behind prolonged exposure therapy. It furthermore provided some clarity regarding various trauma-related symptoms such as hypervigilance, physiological reactivity, re-experience, and avoidance of traumatic reminders. However, it has been criticised for being inflexible and too simplistic to be able to capture complex clinical phenomena (Brewin & Holmes, 2003; Foa & Rothbaum, 1998; Foa et al., 2007; Nijdam & Wittmann, 2015).

2.2.2.2.2 *Dual representation theory*

In contrast to the emotional processing theory, the dual representation theory proposed that trauma memories are processed by two different cognitive systems. These systems give rise to two distinct types of memory, referred to as verbally accessible memories (VAMs) and situationally accessible memories (SAMs) (Bisson, 2009; Brewin, 2008; Brewin, Dalgleish, & Joseph, 1996; Nijdam & Wittmann, 2015). On the one hand, VAMs are processed consciously in the ventral visual stream and the medial temporal lobe. These memories are integrated with other autobiographical memories related to the past, present, and future. They are thus transferred to a long-

term memory store and can later be recalled verbally. On the other hand, SAMs consist of autonomic and sensorimotor information directly connected to the traumatic event. These memories are not yet processed by higher cognitive functions and remain unconscious until triggered. As the SAM system does not use a verbal code, these memories are difficult to communicate to others (Bisson, 2009; Brewin, 2008; Brewin et al., 1996, Brewin & Holmes, 2003; Nijdam & Wittmann, 2015).

During traumatic events, when attention is focused on danger and survival, SAMs cannot be re-encoded as VAMs, owing to the prefrontal cortex temporarily going off-line (Nijdam & Wittmann, 2015). The content of the VAMs is therefore limited which results in irrational negative beliefs and high levels of arousal in the aftermath of trauma. Furthermore, when the unconscious SAMs are activated by trauma reminders, they give rise to re-experiencing symptoms such as dreams and flashbacks. Successful emotional processing thus depends on both these memory systems (Bisson, 2009; Brewin, 2008; Brewin et al., 1996, Brewin & Holmes, 2003; Nijdam & Wittmann, 2015).

According to the dual representation theory, cognitive readjustment occurs when new SAMs, consisting of the original trauma images, are paired with states of reduced arousal and less negative affect. This is brought about by habituation and cognitive restructuring (Bisson, 2009; Brewin, 2008; Brewin & Holmes, 2003; Brewin et al., 1996; Nijdam & Wittmann, 2015). Although the dual representation theory, does not provide a detailed outline of therapeutic procedures, it makes positive contributions towards the field of cognitive psychology and cognitive neuroscience. It also integrates observations made by social-cognitive and information processing theorists and explicitly differentiated cognitive processes happening during and after the traumatic event. However, this theory does not pay adequate attention to emotional numbing and dissociative responses frequently observed among trauma survivors (Bisson, 2009; Brewin & Holmes, 2003; Nijdam & Wittmann, 2015).

2.2.2.2.3 *Ehlers and Clark's (2000) cognitive model*

Ehlers and Clark (2000) elaborated on the classical cognitive theories and highlighted the role that cognitive appraisals play in the aftermath of trauma. According to them, pathological responses to traumatic events occur when trauma is appraised in an excessively negative manner. For example, appraisals can be directed towards

external threat (viewing the world as a dangerous place) or towards internal threat (viewing the self as incapable). Due to these appraisals, trauma survivors thus fear that the trauma may re-occur or belief they are not in control of their emotions (Bisson, 2009; Brewin & Holmes, 2003; Ehlers & Clark, 2000; Nijdam & Wittmann, 2015). The sense of threat can also be explained by the fact that trauma memories are inadequately integrated within a person's broader autobiographical memories and beliefs. Trauma recall thus becomes negatively biased and may lead to re-experiencing of the traumatic event (Ehlers & Clark, 2000; Nijdam & Wittmann, 2015).

Ehlers and Clark's (2000) model furthermore identifies various behavioural (e.g. avoidance and safety behaviour) and cognitive (e.g. rumination and dissociation) coping strategies which maintain trauma-related distress. According to this model, trauma resolution is dependent on the establishment of more adaptive appraisals and cognitions, as well as the successful integration of trauma memories. This is commonly achieved through imaginal exposure and cognitive restructuring (Bisson, 2009; Ehlers & Clark, 2000; Nijdam & Wittmann, 2015). Ehlers and Clark's (2000) cognitive model currently provides the most detailed account of the maintenance and treatment of trauma-related symptoms. It furthermore expands the understanding of how cognitive appraisals and cognitive coping strategies influence one's response to trauma (Brewin & Holmes, 2003).

2.2.2.3 Critique of current theoretical perspectives

The above-mentioned theories not only explain the role of memory processes, appraisals and coping strategies concerning trauma but also provide a theoretical underpinning for the development of some of the most prominent trauma interventions (Bisson, 2009; Brewin, 2008; Brewin & Holmes, 2003; Ehlers & Clark, 2000; Foa, 1998; Froerer et al., 2018; Horowitz, 1986; Mowrer, 1960; Nijdam & Wittmann, 2015). However, although these theories are considered insightful and influential; they pay limited attention to psychological growth, positive emotions, adaptive behaviour, coping, and resilience in the aftermath of trauma. The majority of these theories also focus on traumatic memories embedded in the past and neglect the possibilities and hope associated with the future (Froerer et al., 2018).

Although the literature suggests that political, social, cultural, and personal factors should be taken into account when conceptualising trauma, few of the existing

trauma theories have considered the broader socio-cultural context (Kagee & Naidoo, 2004; Kaminer & Eagle, 2010; Maercker & Horn, 2013). This necessitates a more holistic, ecological, and integrated view of trauma to better understand the unique impact it has on an individual. This is especially relevant in a diverse, multi-cultural country such as South Africa (Kagee & Naidoo, 2004). However, irrespective of how trauma is defined or conceptualised, clinicians and researchers agree that trauma has a distinct impact on individuals' psychological functioning. The negative and positive psychological consequences of trauma are elaborated upon below.

2.2.3 Psychological consequences of trauma

2.2.3.1 Negative psychological consequences

Exposure to trauma can produce a wide spectrum of adverse responses, ranging from mild and temporary disequilibrium, which abates spontaneously, to severe and chronic distress. Several different factors such as the severity and duration of the traumatic event, the victim's age, gender, prior mental status, and relationship to the perpetrator, as well as socio-cultural factors, may influence how a person reacts to trauma (APA, 2013; Froerer et al., 2018; Kaminer & Eagle, 2010, 2017; Lowe et al., 2015). Although only a small minority of people exposed to trauma develop long-term psychopathological symptoms, this can have a debilitating impact on a person's functioning and should thus be considered (Kaminer & Eagle, 2010; Lowe et al., 2015).

2.2.3.1.1 *Post-Traumatic Stress Disorder*

As the most widely researched trauma-related psychiatric disorder, PTSD was first introduced in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (APA, 2013). According to the fifth edition of the DSM (DSM-V), PTSD can be diagnosed after direct or indirect exposure to actual or threatened death, serious injury, or sexual violence. To meet the diagnostic criteria for PTSD, intrusive and avoidance symptoms, as well as alterations in cognition, mood, arousal, and reactivity should also be present for at least one month. This symptom pattern should furthermore cause significant distress and impairment in important areas of a person's functioning (APA, 2013).

The most common intrusive symptoms include distressing memories, dreams, flashbacks, and psychological distress, or physiological reactivity when exposed to trauma-related cues. Avoidance symptoms usually refer to the avoidance of

memories, thoughts and feelings, and external reminders (e.g. people, places, activities) associated with the traumatic event (APA, 2013). Furthermore, alterations in cognition and mood may involve persistent negative beliefs about oneself, others, or the world; persistent negative feelings (e.g. guilt, blame, anger); and an inability to experience positive emotions. Additionally, changes in arousal and reactivity tend to manifest as increased irritability, hypervigilance, sleep disturbances, and reckless behaviour (APA, 2013).

2.2.3.1.2 *Other DSM-V trauma-related disorders*

Acute stress disorder (ASD) is also considered to be a trauma-related disorder in the DSM-V (APA, 2013). Similar to PTSD, ASD is typically characterised by re-experiencing of the traumatic event, strong emotional or physiological reactivity in response to trauma reminders, or avoidance of triggers related to the trauma. However, dissociative symptoms such as dissociative amnesia, derealisation or depersonalisation are a unique feature of ASD. The symptoms usually also begin immediately after exposure to the traumatic event and can be present for three days to a month following the traumatic event (APA, 2013). In addition to PTSD and ASD, the DSM-V also classifies *reactive attachment disorder*, *disinhibited social engagement disorder* and *adjustment disorder* as trauma- and stressor-related disorders (APA, 2013). However, for the purposes of this study, these conditions will not be discussed in detail.

2.2.3.1.3 *Trauma-related disorders not included in the DSM-V*

People exposed to repeated trauma over a long period, such as childhood abuse, interpersonal violence, or war torture, tend to display a unique clinical presentation (Herman, 1992; Mahoney & Markel, 2016). This manifestation, commonly referred to as *complex PTSD* (C-PTSD), is characterised by identity disturbances, uncontrollable emotions, interpersonal difficulties, feelings of worthlessness, dissociative tendencies, impulsivity, and self-destructive behaviour. Somatic conditions, eating disorders, and substance abuse are also more commonly observed among this group (Crawford-Browne & Benjamin, 2012; Herman, 1992; Jewkes & Abrahams, 2002; Kaminer & Eagle, 2010; Mahoney & Markel, 2016). Although the DSM-V criteria for PTSD were revised to include some of these aspects, C-PTSD is currently not included as a separate diagnosis in the DSM-V (APA, 2013). However, various authors argue that C-PTSD should be considered as an

independent diagnosis, as it encompasses the multiple comorbid conditions frequently associated with long-term trauma exposure (Eagle, 2015; Mahoney & Markel, 2016).

In addition to C-PTSD, other patterns of symptomology, which do not fit with the classic presentation of PTSD, are observed. For example, *continuous traumatic stress* (CTS) describes exposure to chronic traumatic stressors, such as living in prolonged conflict zones or pervasively violent communities. In contrast to C-PTSD, CTS has no post-trauma period as the trauma continues relentlessly (Crawford-Browne & Benjamin, 2012; Eagle, 2015; Kaminer & Eagle, 2010). People living in these contexts present with more prominent hyperarousal and hypervigilance than re-experiencing symptoms. Somatic symptoms, concentration problems, irritability, feelings of guilt and despair, as well as self-destructive behaviour are also commonly observed among this population (Crawford-Browne & Benjamin, 2012; Eagle, 2015). Victims exposed to continuous trauma frequently respond either with social withdrawal and passivity, or violence and aggression, to maintain a sense of agency and survive under such conditions. This perpetuates the vicious cycle of violence and trauma that can lead to further distress and psychological problems (Eagle, 2015; Kaminer & Eagle, 2010; Williams et al., 2007).

2.2.3.1.4 *Additional psychological challenges*

Individuals with PTSD are 80% more likely than those without PTSD to have comorbid mental disorders (APA, 2013). The most common comorbid conditions include: depressive disorders (e.g. major depressive disorder, dysthymia), bipolar disorder, anxiety disorders (e.g. panic disorder and phobias), and substance use disorders (APA, 2013; Brady et al., 2000; Kaminer & Eagle, 2010; Lowe et al., 2015). Considerable debate still exists as to whether these disorders are present before trauma exposure and they thus create a vulnerability to develop PTSD; or whether the distressing experience of PTSD results in comorbid disorders. However, the literature agrees that comorbid conditions not only increase PTSD symptom severity and duration, but also decrease therapeutic prognosis for trauma survivors (Brady et al., 2000; Kaminer & Eagle, 2010; Scheiderer et al., 2015).

Besides PTSD, trauma survivors also struggle with various other psychological problems. For example, exposure to traumatic events is associated with increased suicidal ideation, and suicide attempts (APA, 2013; Atwoli, 2015; Brady et al., 2000).

People exposed to trauma, especially childhood sexual abuse, are also more likely to struggle with emotional, interpersonal, and sexual problems during adulthood (Maniglio, 2009). Furthermore, borderline personality disorder; characterised by unstable interpersonal relationships, self-image and emotions, as well as impulsivity; is commonly observed among adult survivors of childhood sexual abuse (APA, 2013; Brady et al., 2000; Scheiderer et al., 2015).

Further, possible psychosomatic symptoms such as chronic pain, fatigue, and gastrointestinal ailments, are frequently reported by people exposed to trauma (Froerer et al., 2018; Lowe et al., 2015; Tedeschi & Calhoun, 2004). Finally, the literature indicates that trauma may be associated with hopelessness and decreased life satisfaction (Bucciol & Zarri, 2017; Calvo et al., 2015; Chang et al., 2015; Davies & Hinks, 2010; Irving et al., 1997; Levi et al., 2012b; Oskin, 1996). It is therefore evident that exposure to traumatic events can lead to a wide spectrum of psychological challenges.

2.2.3.2 Positive psychological consequences

Although trauma-related research has predominantly focused on distress and psychopathology, attention to increased personal strength and psychological growth following trauma has increased in recent years (Bannink, 2008; Tedeschi & Calhoun, 2004). The literature indicates that, as many as 30%–70% of trauma survivors report positive changes in at least one domain of life. While trauma-related distress and growth frequently co-exist, a confined focus on distress and the negative consequences of trauma can, unfortunately, lead to a biased understanding of post-traumatic reactions (Bannink, 2008; Jayawickreme & Blackie, 2014; Joseph & Butler, 2010; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). It is therefore important to also consider possible positive psychological consequences associated with trauma.

2.2.3.2.1 *Post-traumatic growth*

Tedeschi and Calhoun (2004) coined the term *post-traumatic growth*, referring to positive psychological changes observed among people who encounter traumatic life events. They conceptualise the term as a multidimensional construct characterised by a greater appreciation for life, more intimate social relationships, heightened feelings of personal strength, greater engagement in spiritual questions, and the recognition of new possibilities following trauma. Post-traumatic growth is therefore

more than merely recovering or surviving from trauma, but also refers to an enhanced level of functioning or thriving in the aftermath of trauma (Bannink, 2008; Jayawickreme & Blackie, 2014; Tedeschi & Calhoun, 2004).

Empirical studies reported post-traumatic growth in the context of rape and sexual assault, man-made and natural disasters, chronic physical illnesses, and bereavement (Albuquerque, Narciso, & Pereira, 2018; Joseph & Butler, 2010; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). However, the exact mechanism or process behind post-traumatic growth is still vague. According to Tedeschi and Calhoun (2004), a prerequisite for the development of post-traumatic growth is that the event must be sufficiently traumatic, cause distress, and challenge a person's cognitive schemas. Research furthermore suggests that post-traumatic growth occurs through the process of rebuilding and expanding existing cognitive schemes to formulate new constructive beliefs, goals, and identities which incorporate the traumatic experience. Deliberative rumination and meaning-making appear to play a significant role in facilitating this process (Jayawickreme & Blackie, 2014; Linley & Joseph, 2004; Park, 2010; Tedeschi & Calhoun, 2004).

Specific personality traits (e.g. extraversion, optimism, openness to experience), resilience, high levels of dispositional hope and positive affect, as well as social support and spirituality, are also associated with greater adversarial growth. Studies furthermore show that growth increases with time, following the traumatic event (Albuquerque et al., 2018; Bannink, 2008; Jayawickreme & Blackie, 2014; Joseph & Butler, 2010; Linley & Joseph, 2004; Reinecke, 2017; Tedeschi & Calhoun, 2004). Post-traumatic growth is associated with various psychological advantages such as post-event adjustment, lowered levels of distress, and greater satisfaction with life (Jayawickreme & Blackie, 2014; Linley & Joseph, 2004). Clinicians should thus be aware of the potential for positive change following trauma, and consider trauma interventions which may promote growth (Albuquerque et al., 2018; Joseph & Butler, 2010). Strength-based trauma interventions may specifically be relevant, both internationally and in South Africa (Kaminer & Eagle, 2010; Walker-Williams, 2012). Before exploring such trauma interventions, it is important to first understand the complexity of trauma in the South African context.

2.2.4 Contextualising trauma in South Africa

2.2.4.1 The South African context

South Africa is characterised by a history of violence brought about by past constitutional racial segregation, exploitation, and oppression during the apartheid era (Atwoli, 2015; Eagle, 2015). Despite the establishment of a non-racial democracy in 1994, South Africa still experiences a culture of violence where aggression is accepted as a means of resolving problems and achieving goals (Kaminer & Eagle, 2010; Williams et al., 2007). This is evident in pervasive service delivery protests, violent student demonstrations, brutal xenophobic attacks, political unrest, and police brutality and torture (Eagle, 2015). The violence observed in contemporary South Africa is thus rooted in a history of social inequality and deprivation (Bloom & Reichert, 1998; Gathiram, 2005).

Unfortunately, disadvantaged communities characterised by various psychosocial stressors and limited resources continue to be a concern in South Africa (J. K. Burns, 2011; Eagle, 2015; Kaminer & Eagle, 2010). Communities faced with poverty, high illiteracy rates, unemployment, family disruption, gangsterism, and substance abuse are more likely to experience criminal activities, gender-based violence, and high-risk behaviour (Atwoli et al., 2013; Jewkes & Abrahams, 2002; Schneider et al., 2016; Sibanda-Mojo, Khonje, & Brobbey, 2017; Van der Merwe & Kassan-Newton, 2007; Williams et al., 2007). South Africa is furthermore burdened by an alarmingly high incidence of HIV/AIDS which is commonly associated with declining health, grief, stigma, discrimination, and significant psychological distress (J. K. Burns, 2011; Schneider et al., 2016; Young, 2011). It is therefore clear that an interplay of historical, political, economic, and social factors predisposes South Africans to experiencing traumatic events.

2.2.4.2 Incidence and nature of trauma in South Africa

2.2.4.2.1 *Incidence and most common traumatic events*

The majority of South Africans are exposed to at least one traumatic event during their lifetime, with more than half of the population experiencing multiple traumatic events (Atwoli, 2015; Kaminer & Eagle, 2010; Williams et al., 2007). According to Atwoli (2015), the most common traumatic events South African citizens experience are physical violence, accidents, witnessing of trauma, and the unexpected

death of a loved one. Emotional, physical, and sexual abuse in the context of intimate relationships, as well as community violence are relatively common among South Africans (Eagle, 2015; Jewkes & Abrahams, 2002; Williams et al., 2007).

According to the South African Stress and Health (SASH) study, the most comprehensive psychiatric epidemiological study conducted to date in South Africa, 21% of the population is exposed to physical violence during their lifetime (Williams et al., 2007). These statistics are supported by the country's devastating annual crime report, identifying Gauteng as the province with the highest number of violent crimes in the 2019/2020 financial year (SAPS, 2020). According to this report, approximately 25 murders or attempted murders occurred daily in Gauteng during this period. The number of common assaults and robberies with aggravating circumstances were indicated to be ten times this amount (SAPS, 2020). Although young men are the most frequent victims of violent crimes due to their engagement in gang activities, alcohol abuse, and high-risk behaviour; women are frequently exposed to domestic abuse and interpersonal violence (Norman, Matzopolous, Groenwald, & Bradshaw, 2007; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009).

For example, the literature suggests that South African women are six times more likely to be killed by their partner through intimate partner violence compared to international statistics (Abrahams et al., 2009). The incidence of sexual offences is also higher among females in South Africa. According to the annual crime report, approximately six sexual offence cases are reported every hour in South Africa. These include rape, sexual assault, attempted sexual offences, and contact sexual offences (Kaminer & Eagle, 2010; SAPS, 2020). It is thus clear that, despite the legislative and institutional attempts to protect and promote the rights of women in South Africa, violence against women continues unabated (Appelt, 2006; Diale, 2014; Jewkes & Abrahams, 2002; Sibanda-Mojo et al., 2017).

In addition to physical and sexual violence, South Africans also experience indirect traumatisation (witnessing or hearing about a trauma that occurred to someone close to them), and the unexpected death of a loved one. It seems that men are more likely to witness a traumatic event, while women are more likely to experience sudden bereavement. As many as 50% of the PTSD cases in South Africa are associated with indirect traumatisation (Atwoli, 2015; Williams et al., 2007). This might

reflect the African worldview of ubuntu which values group solidarity, compassion, respect, and collective unity (Diale, 2014; Mokgoro, 1998). As South African citizens' individual well-being may be related to the well-being of their family and community, it leaves them particularly vulnerable to the trauma inflicted on others (Atwoli et al., 2013; Williams et al., 2007). However, the high incidence of indirect traumatisation may also be related to multiple and continuous trauma observed in South African communities (Eagle, 2015).

2.2.4.2.2 *Multiple and continuous trauma*

According to the SASH study, 56% of the South African population is exposed to more than one traumatic event and 16% experience as many as four or five traumatic incidents during their lifetime. Men appear to be at higher risk for exposure to multiple traumatic events (Williams et al., 2007). Economically disadvantaged communities in South Africa are also exposed to continuous trauma. This can be ascribed to the high incidence of community violence, witnessing and hearing about violence in the neighbourhood, and citizens being worried about their own safety and that of their loved ones (Kaminer & Eagle, 2010). It is therefore clear that very few South Africans are unaffected by trauma and, for many, exposure to potentially traumatic experiences is an inescapable part of daily life. This burden tends to have a cumulative negative effect on one's psychological health. It is for this reason, that South Africans often display distinct trauma-related symptoms (Atwoli et al., 2013; Kaminer & Eagle, 2010; Williams et al., 2007; Young, 2011).

2.2.4.3 Trauma symptomology in South Africa

2.2.4.3.1 *Negative trauma-related consequences*

Despite the high incidence of traumatic events, compared to international samples, South Africans experience lower than anticipated levels of PTSD (Atwoli et al., 2013; Eagle, 2015; Williams et al, 2007). For example, the SASH study found a lifetime PTSD prevalence of 2.3% among South African trauma survivors, while European and North American studies reported an incidence of 7.4% and 6.8% respectively (De Vries & Olff, 2009; Kessler et al., 2005; Williams et al, 2007). However, this does not mean that South Africans are unaffected by trauma, as several methodological and diagnostic factors could influence these results. For example, it appears that South African citizens tend to express trauma-related stress somewhat differently from commonly observed patterns (Atwoli, 2015; Kaminer & Eagle, 2010).

The literature indicates South Africans present with fewer avoidance symptoms, although they have more emotional and somatic problems, and are also more likely to experience psychotic episodes and alcohol abuse problems (J. K. Burns, Jhazbhay, Esterhuizen, & Emsley, 2011; Watt et al., 2012; Williams et al., 2007). Other psychiatric disorders, especially major depressive disorder, are also more commonly diagnosed among South African trauma survivors, than PTSD (Subramaney, 2006). This particular pattern of psychological symptoms is often referred to as sub-clinical PTSD, as it does not meet the full criteria for PTSD (Atwoli, 2015; Kaminer & Eagle, 2010). Various authors suggest that the impact of trauma in South Africa might be better explained by atypical forms of PTSD, such as complex PTSD and CTS, discussed in section 2.2.3.1.3. It is therefore clear that the trauma symptomology reported by South Africans differs markedly from the PTSD observed in first world countries (Crawford-Browne & Benjamin, 2012; Kaminer & Eagle, 2010).

2.2.4.3.2 *Positive trauma-related consequences*

Consistent with international studies, resilience and psychological growth are observed among South African trauma survivors (Appelt, 2006; Bannink, 2008; Froerer et al., 2018; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004; Walker-Williams, 2012). Although there is only limited literature concerning the incidence of post-traumatic growth in South Africa, several studies have identified some form of post-trauma benefit. For example, growth was observed among parents who had lost a child, violent crime survivors, rape survivors, adult survivors of childhood sexual abuse, and paramedics in South Africa. Participants in these studies highlighted positive personal, psychological, and emotional growth; a greater appreciation for life; and greater compassion for others following exposure to trauma (Kaminer, Booley, Lipshitz, & Thacker, 2009; Kaminer & Eagle, 2010; Reinecke, 2017; Walker-Williams, 2012).

This indicates that trauma-related growth not only offers individual benefits but also has the potential to transform social narratives in trauma-ridden societies (Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). Researchers have therefore suggested that aspects of growth be incorporated in trauma interventions (Albuquerque et al., 2018; Joseph & Butler, 2010). However, thus far, the majority of prominent trauma interventions have paid limited attention to the potential of adversarial growth and positive psychological changes following trauma.

2.2.5 Trauma interventions

2.2.5.1 Prominent international trauma interventions

Enormous effort, has gone into the development of intervention strategies aimed at reducing the adverse psychological effects of trauma (Bryant, 2015). Clinicians working with trauma survivors currently utilise a variety of therapeutic approaches, ranging from early crisis intervention strategies and psychotropic treatment to evidence-based trauma-focused psychotherapy (Bryant, 2015; D. J. A. Edwards, 2009; Kaminer & Eagle, 2010). However, the focus of this study is on post-trauma interventions. Although these interventions are often described as integrative or multimodal, they are usually rooted within a specific theoretical paradigm (Cusack et al., 2016; D. J. A. Edwards, 2005, 2009; Kaminer & Eagle, 2010; Mahoney & Markel, 2016).

2.2.5.1.1 *Brief psychodynamic therapy*

As one of the most well-known interventions, brief psychodynamic therapy continues to be popular among clinicians working with trauma survivors (D. J. A. Edwards, 2009; Paintain & Cassidy, 2018). This approach incorporates principles of general psychodynamic psychotherapy, and Horowitz's (1986) conceptualisation of trauma, as discussed in Section 2.2.2.1.1. Brief psychodynamic therapy therefore focuses on integrating traumatic material within the psyche, finding meaning in the event and linking it with unconscious processes, and providing a supportive and containing therapeutic relationship (Cusack et al., 2016; Kaminer & Eagle, 2010; Krupnick, 2002; Paintain & Cassidy, 2018).

Trauma-focused brief psychodynamic therapy comprises three distinct phases, each with separate tasks and goals, usually conducted over 12–15 sessions (Paintain & Cassidy, 2018). Although randomised controlled studies examining psychodynamic therapy with trauma survivors are limited, brief psychodynamic treatment appears to be effective in addressing various PTSD symptoms (Krupnick, 2002; Paintain & Cassidy, 2018; Schottenbauer et al., 2008). The literature shows that psychodynamic therapy is particularly relevant for addressing the interpersonal sequelae of trauma. However, it does not appear suited for chronic or more complex PTSD, which might require a more comprehensive approach (Krupnick, 2002; Mahoney & Markel, 2016; Schottenbauer et al., 2008).

2.2.5.1.2 *Cognitive behavioural therapy*

Cognitive behavioural therapy (CBT) is a broad therapeutic category based on principles of learning and conditioning, and cognitive theories discussed in Sections 2.2.2.1.2 and 2.2.2.1.3. The CBT approaches have the strongest evidence-base for treating PTSD and include, but are not limited to; cognitive processing therapy (CPT), cognitive therapy for PTSD (CT-PTSD) and prolonged exposure (PE) (Cusack et al., 2016; Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Paintain & Cassidy, 2018; Resick & Schnicke, 1992; Schottenbauer et al, 2008). The majority of CBT interventions are prescriptive and structured and incorporate the following three aspects, either alone or in combination: exposure to traumatic memories or reminders to reduce anxiety; cognitive restructuring to modify maladaptive beliefs; and skills training to manage trauma-related anxiety (Cusack et al., 2016; Kar, 2011; Mahoney & Markel, 2016; Paintain & Cassidy, 2018). Following is a description of the most prominent CBT approaches.

Cognitive processing therapy

Stemming from cognitive theories, CPT assumes that negative emotions can interfere with the emotional and cognitive processing of trauma memories (Galovski, Wachen, Chard, Monson, & Resick, 2015). It is comprised of distinct phases focusing on assessment, psychoeducation, writing a detailed narrative account of the traumatic event, cognitive restructuring, addressing beliefs about the event's meaning and implications, as well as relapse prevention. The therapy is commonly administered over 12 sessions, lasting 60–90 minutes each; in individual, group, or combined formats (Cusack et al., 2016; Galovski et al., 2015; Paintain & Cassidy, 2018). A large body of literature support CPT's effectiveness with PTSD among diverse populations, including women with complex trauma histories and a variety of comorbid psychological disorders (Galovski et al., 2015; Resick, Nishith, Weaver, Astin, & Feuer, 2002).

Cognitive therapy for PTSD (CT-PTSD)

Cognitive therapy for PTSD (CT-PTSD) originates from Ehlers and Clark's (2000) cognitive model of trauma, as discussed in Section 2.2.2.2.3. This is a formulation-driven treatment, tailored to the problems of each client, and aims to: a) reduce excessively negative appraisals of the trauma and its consequences; b) reduce re-experiencing by expanding trauma memories and identifying triggers; and c) reduce

cognitive and behavioural strategies which maintain the sense of current threat (Ehlers & Wild, 2015). Various techniques are used in CT-PTSD to accomplish these goals, such as Socratic questioning, reclaiming your life assignments, imaginal reliving, narrative writing, and site visits. It is usually delivered over 10–12 weekly sessions, lasting between 60 and 90 minutes (Cusack et al., 2016; Ehlers & Wild, 2015; Foa & Rothbaum, 1998; Resick & Schnicke, 1992). Several randomised control trials supported the efficacy of CT-PTSD with adults exposed to a wide range of traumatic events and with various comorbid conditions. The strength of this approach specifically lies in the fact that clients display low dropout rates and report high satisfaction scores (Ehlers & Wild, 2015).

Prolonged exposure

Based on emotional processing theory discussed in Section 2.2.2.2.1, PE makes use of imaginal (e.g. recounting aloud), or in vivo (e.g. approaching situations or objects) exposure to activate fear in a safe therapeutic setting. By repeatedly reliving the traumatic event, PE seeks to desensitise the patient in order for the traumatic event to no longer be associated with feelings of anxiety (Foa & Rothbaum, 1998; McLean, Asnaani, & Foa, 2015; Paintain & Cassidy, 2018). The therapy typically consists of 8–15, 90 minutes, individual sessions. During these sessions, psychoeducation, training in controlled breathing and PE are addressed (Cusack et al., 2016; Foa & Rothbaum, 1998; McLean et al., 2015). This approach appears to be effective across different types of trauma and for trauma survivors with a variety of comorbid psychological disorders. Although PE is associated with rapid change and maintenance of treatment gains over time, not all clients exposed to PE respond to, or complete their treatment protocol (Cusack et al., 2016; Kar, 2011; Keane, Marshall, & Taft, 2006; McLean et al., 2015).

2.2.5.2 Other trauma interventions

2.2.5.2.1 *Brief eclectic psychotherapy*

Brief eclectic psychotherapy for PTSD (BEPP), developed during the 1980s and 1990s, is a comprehensive, integrative therapeutic approach which incorporates elements of both CBT and psychodynamic approaches (Gersons, Meewisse, & Nijdam, 2015). It focuses on the acceptance of emotions, understanding the meaning of feelings, and facing the reality of the traumatic event and its consequences. There are 16 weekly sessions, each lasting 45-minutes, that incorporate the following

elements: psychoeducation; imaginal exposure; writing tasks and use of mementos; finding meaning and integrating the trauma; then ending the process with a farewell ritual (Cusack et al., 2016; Gersons et al., 2015). Although BEPP was originally developed for police officers, it appears to be effective with various other populations exposed to trauma (Cusack et al., 2016; Gersons, Carlier, Lamberts, & Van der Kolk, 2000; Lindauer et al., 2005; Schnyder, Müller, Maercker, & Wittmann, 2011).

2.2.5.2.2 *Eye movement desensitisation and reprocessing*

Guided by the adaptive information processing model (Shapiro, 1995), eye movement desensitisation and reprocessing (EMDR) is an integrative cognitive approach. This model assumes that adverse life experiences overwhelm the information processing system, and therefore trauma memories become frozen in time. The approach thus aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event (Cusack et al., 2016; Shapiro & Laliotis, 2015). The eight-phase treatment approach applied in EMDR utilises simultaneous sets of eye movements to establish links between the initially unprocessed experience and other related memory networks (Stickgold, 2002). Although the number of sessions and the length of the various phases depend upon the complexity of the case, EMDR typically consists of 8–12 weekly, 90 minutes sessions (Friedman, 2003; Shapiro & Laliotis, 2015). It appears to be effective for a wide range of trauma populations, with some studies suggesting that EMDR is superior to exposure-based CBT. This might be because, unlike trauma-focused CBT models, EMDR does not involve recounting of the traumatic event, direct challenging of beliefs, or extended exposure (Shapiro & Laliotis, 2015).

2.2.5.2.3 *Narrative exposure therapy*

Narrative exposure therapy conceptualises trauma-related symptoms as a disorder of memory and is based on some of the principles of dual representation theory, referred to in Section 2.2.2.2.2 (Brewin & Holmes, 2003; Ehlers & Clark, 2000). Narrative exposure therapy aims to reconnect SAM and VAM, focusing on the most arousing experiences (Elbert, Schauer, & Neuner, 2015). The client and therapist collaboratively construct a chronological narrative (lifeline) of the client's life story, focusing on the traumatic experiences. Using imagined exposure, trauma-related fear is thus connected with episodic facts concerning the here and now. Narrative exposure therapy is usually conducted over 4–12 sessions of 90 minutes each (Cusack et al.,

2016; Elbert et al., 2015). This approach showed to be effective for a variety of traumatic events, including complex and continuous trauma. Narrative exposure therapy is also described as being easy to disseminate and has a low dropout rate. This strength might be ascribed to narrative exposure therapy's emphatic and respectful stance, honouring the survivor's experience, and restoring their dignity (Elbert et al., 2015; Jacob, Neuner, Mädl, Schaal, & Elbert, 2014; Schauer & Schauer, 2010).

These prominent international trauma interventions appear to be effective in processing and integrating trauma memories, decreasing trauma-related distress, and addressing maladaptive cognitive and behavioural coping strategies among trauma survivors (Cusack et al., 2016; Ehlers & Wild, 2015; Elbert et al., 2015; Foa & Rothbaum, 1998; Galovski et al., 2015; Gersons et al., 2015; Krupnick, 2002; Shapiro & Laliotis, 2015). However, as this study was conducted in the South African context, it is relevant to also consider the most prominent trauma interventions utilised by local therapists.

2.2.5.3 Prominent trauma interventions in the South African context

Due to the prominence of trauma in South Africa, it is inevitable that the majority of mental health practitioners in South Africa will have contact with trauma survivors at some point (Kaminer & Eagle, 2017). Despite the distinct trauma symptomology mentioned earlier, the majority of trauma interventions in South Arica are grounded on international research. South African clinicians thus mostly utilise traditional forms of psychotherapy, such as CBT as well as psychodynamic and psychoanalytic psychotherapy, when working with trauma survivors (Eagle & Watts, 2002; D. J. A. Edwards, 2005, 2009; Jalal, Kruger, & Hinton, 2018; Kaminer & Eagle, 2017). However, due to various challenges, such as language and resource barriers, these traditional approaches often need to be adapted to accommodate the South African context (Eagle & Watts, 2002; Jalal et al., 2018; Van der Merwe & Kassan-Newton, 2007). The most prominent trauma interventions applied in South Africa, is discussed in more detail below.

2.2.5.3.1 *Psychodynamic therapy*

Although Brief Psychodynamic Psychotherapy is commonly used by international therapists working with trauma survivors, South African clinicians in

private practice tend to implement longer term psychodynamic and psychoanalytic therapeutic approaches (Kaminer & Eagle, 2010). According to Eagle and Watts (2002), longer term therapy is specifically utilised with clients exposed to multiple traumatic events, a phenomenon frequently observed in South Africa. Many South African clinicians, even those practising from an integrative or eclectic perspective, also seem to incorporate aspects of psychodynamic thinking, especially meaning-making (Kaminer & Eagle, 2010). The literature furthermore suggests that adaptations of group psychoanalysis are used with traumatised communities in South Africa. However, evidence regarding the impact of either short- or long-term psychodynamic therapy with trauma survivors in South Africa is limited (Kaminer & Eagle, 2010).

2.2.5.3.2 *Cognitive behavioural therapy*

In South Africa, CBT approaches have the strongest evidence-base for treating trauma and appears to be the most popular therapeutic model for clinicians working with trauma survivors (Kaminer & Eagle, 2017). Consistent with international practice, the most common CBT approaches utilised by local therapists include PE, CPT, and cognitive therapy (CT) (Ehlers & Clarke, 2000; Foa & Rothbaum, 1998; Resick & Schnicke, 1992). Although not as widely used as in the United Kingdom (UK) and the United States, EMDR is also employed by some practitioners in South Africa and appears promising (Kaminer & Eagle, 2010; Shapiro, 1995). However, due to various language and resource barriers, specific aspects of CBT-based approaches are often used, instead of entire protocols. Such applications tend to be more group focused and incorporate locally salient metaphors, proverbs, and analogies (Jalal et al., 2018; Kaminer & Eagle, 2010). Although Jalal et al. (2018) found that multiplex CBT, one of these adapted approaches, was appropriate for a sample of traumatised South Africans, the true validity and reliability of these approaches remains unknown.

2.2.5.3.3 *The Wits trauma model*

Following international trends, many clinicians in South Africa also apply integrative or eclectic approaches to assist trauma survivors. The most influential of these is the Wits trauma model (D. J. A. Edwards, 2009; Eagle, 1998; Kaminer & Eagle, 2010). This model was developed by psychotherapists from the University of the Witwatersrand (Wits) and stems from both psychodynamic, and CBT modalities. The Wits model is usually applied over 2–12 sessions, and can be used with both simple and more complex forms of trauma. The model consists of five components

that can be used interchangeably in different sessions, depending on the client's needs. These components include telling and retelling the story, normalising symptoms and responses, addressing self-blame or survivor guilt, enhancing mastery and social support, and facilitating meaning (Eagle, 1998). This model is currently utilised by several non-government organisations, welfare bodies, and trauma clinics in the country. Although limited control-based and comparative research is available on the effectiveness of the Wits model, anecdotal reports from both therapists and clients suggest that it is useful (Bean, 2008; Kaminer & Eagle, 2010). However, this model is predominantly problem-orientated and disregards the potential for growth following adversity.

2.2.5.4 Critical perspective on prominent trauma interventions

The majority of international and local trauma interventions stem from the traditional medical model, with a strong emphasis on pathology. Despite its effectiveness and acceptance among trauma therapists, pathology-focused therapeutic approaches are criticised for having numerous limitations (D. J. A. Edwards, 2009; Kaminer & Eagle, 2017). For example, practitioners frequently describe traditional trauma-focused models as being confrontational, rigid, and inflexible and disregarding the client's natural resiliency. Exposure-orientated approaches, in particular, have exceptionally high dropout rates and can possibly retraumatise clients (D. J. A. Edwards, 2005, 2009; Griffin, 2015; Kaminer & Eagle, 2017; Paintain & Cassidy, 2018; Schottenbauer et al., 2008; Weiten, 2010). Therapists working from pathology-orientated approaches are also more likely to report vicarious traumatisation and burnout (D. J. A. Edwards, 2005; Van der Merwe & Kassan-Newton, 2007).

In addition, the majority of prominent trauma interventions are conducted over 8–12 individual sessions. Although this might be considered as short- to medium-term therapy; various economic, resource- and time-related factors limit the practicality of attending and delivering this number of sessions. Hence, clients and clinicians are seeking approaches that are brief and cost-effective, but still useful (Kaminer & Eagle, 2010; Nijdam & Wittmann, 2015). In light of the above-mentioned criticisms, it is therefore promising that studies suggest that direct engagement with traumatic material may not be a critical component for treating PTSD (Benish, Imel, & Wampold, 2008). According to recent literature, non-specific therapeutic factors, such as a

trustworthy therapeutic relationship, possibly play a more significant role in the improvement of trauma symptomology, than any specific therapeutic technique (Wampold & Imel, 2015). Considering these findings, the researcher therefore proposes that brief strength-based therapeutic approaches, embedded in the paradigm of positive psychology, ought to be investigated as trauma intervention, both internationally and in South Africa.

2.2.5.5 Strength-based trauma interventions

2.2.5.5.1 *International strength-based trauma interventions*

Strength-based trauma interventions differ from traditional trauma-focused approaches as they deliberately focus on positive emotions, identifies client strengths and resources, and they encourage optimal human functioning (Bannink, 2008). For example, narrative therapy places a strong emphasis on resilience and survival following adversity (Draucker, 1998; Merscham, 2000; White & Epston, 1990). In contrast to narrative exposure therapy discussed in Section 2.2.5.2.3, narrative therapy does not require the traumatic event to be recounted. It rather aims to separate the client from the trauma story, deepening and enriching the story of survival. This is accomplished by strategically using language, respecting the expertise of the client, and establishing a collaborative therapeutic relationship (Draucker, 1998; Erbes, Stillman, Wieling, Bera, & Leskela, 2014; Merscham, 2000; White & Epston, 1990). Although not as widely researched as either CBT or psychodynamic approaches, narrative therapy appears to be effective in assisting traumatised clients. According to international studies, trauma survivors exposed to narrative therapy have reported reduced PTSD symptoms, felt empowered and hopeful, and experienced a sense of agency (Draucker, 1998; Erbes et al., 2014; Merscham, 2000). The application of similar strength-based trauma interventions, in the South African context, is discussed below.

2.2.5.5.2 *Strength-based trauma interventions in South Africa*

Fouché and Walker-Williams (2016) expanded the Wits trauma model, discussed in Section 2.2.5.3.3, by including a strength-based component. Their proposed intervention model, *Survivor to Thriver* (*S2T*), draws on psychodynamic, CBT, as well as strength-based narrative approaches, and was specifically developed to treat adult survivors of childhood sexual abuse. The aim of S2T is to identify personal strengths (e.g. coping skills, external support, resources) emanating from the

sexual abuse, and to create a future path of growth, despite the abuse. Facilitators therefore assist clients in re-authoring their trauma narrative and guiding them towards defining themselves as a thriver, instead of a victim or merely a survivor (Fouché & Walker-Williams, 2016). The S2T intervention seemed to be effective among South African women exposed to sexual abuse. Clients not only reported post-traumatic growth and increased emotional awareness, but also noted a sense of empowerment and self-efficacy following exposure to this intervention (Walker-Williams & Fouché, 2017).

Additional strength-based approaches applied with trauma survivors in the South African context include narrative therapy, the conservation of resources model, and SFBT (Appelt, 2006; Diale, 2014; Van der Merwe & Kassan-Newton, 2007; Von Cziffra-Bergs, 2018). Although these approaches differ in theory and practice, they share a collaborative and strength-based nature. However, further studies confirming the efficacy of these models are needed to contribute to the evidence-base of strength-orientated trauma interventions in South Africa (Fouché & Walker-Williams, 2016). This study thus endeavours to investigate SFBT, a specific strength-based therapeutic approach, in the context of trauma. As the majority of South Africans depend on the public health system, this approach may be particularly relevant to community-based mental health services (Council for Medical Schemes, 2014).

2.2.6 Evaluative summary

Trauma appears to be a relevant and growing concern in the field of psychology, both internationally and in South Africa. Significant research was conducted regarding the theoretical perspectives underlying trauma and the associated adverse consequences (Froerer et al., 2018; Kaminer & Eagle, 2010). However, recent studies have also acknowledged the possibility of adversarial growth and positive psychological changes in the aftermath of trauma (Bannink, 2008; Tedeschi & Calhoun, 2004). Although numerous evidence-based interventions are available to address PTSD and other trauma-related problems, the majority of these interventions appear to be pathology-orientated (Cusack et al., 2016; Krupnick, 2002). Research concerning strength-based trauma interventions and positive experiences following exposure to traumatic events is therefore warranted.

This is particularly relevant in the South African context where various historical, political, economic, and social factors predispose South African citizens to multiple and continuous trauma (Atwoli, 2015; Kaminer & Eagle, 2010; Williams et al., 2007). Despite trauma having distinct symptomology, only a few interventions, such as the Wits trauma model and S2T intervention, were specifically developed for the South African context. A few of these interventions can be described as being strength-based (Eagle, 1998; Fouché & Walker-Williams, 2016; Jalal et al., 2018). Owing to several challenges experienced by South Africa's community mental health services, such interventions may be especially relevant in this context (De Kock & Pillay, 2017; Kaminer & Eagle, 2010; Moosa & Jeenah, 2008; Von Cziffra-Bergs, 2018). Hence, it is proposed that the use of brief, strength-based trauma interventions be investigated at community-based clinics in South Africa. One such approach, SFBT, which the researcher identified to be particularly relevant in this context is discussed in the following section.

2.3 Solution-Focused Brief Therapy

2.3.1 Background on solution-focused brief therapy

2.3.1.1 History and origin

The need for brief, strength-based interventions has been advocated for some time. During the second half of the twentieth century, the traditional problem-focused approach to psychotherapy was challenged by various psychotherapists. This resulted in a paradigm shift in the field of psychology with therapists looking for ways to make therapy briefer, goal-orientated and pragmatic (Visser, 2013). Milton Erikson, a pioneering therapist of that time, together with researchers and therapists from the Mental Research Institute (MRI), played a significant role in the emergence of solution-focused thinking (Ratner, George, & Iveson, 2012; Visser, 2013). The MRI therapists deemed it unnecessary to talk extensively about the client's past or underlying problem causes. They rather focused on identifying what the client does to maintain the problem and replacing it with more effective behaviour (De Shazer,1985; Ratner et al., 2012; Visser, 2013).

Inspired by the work of the MRI, Steve De Shazer and Insoo Kim Berg started the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin in 1978 (De Shazer, 1982, 1985, 1988; Visser, 2013). In association with a team of other researchers, their

goal was to build knowledge about what worked in therapy by conducting exploratory, observational studies. Little attention was paid to diagnosis, history taking, or exploration of the problem. They also made a conscious effort to focus on solutions, instead of problems (Gingerich & Eisengart, 2000; Visser, 2013). Researchers from the BFTC therefore systematically removed traditional problem-focused elements from therapy sessions and took note of spontaneous events in the therapeutic encounter which influenced clients to be more optimistic, hopeful, energetic, and full of ideas. These exploratory studies ultimately led to the foundation of SFBT as it is known today (Gingerich & Peterson, 2012; Ratner et al., 2012; Visser, 2013).

During the 1980s and 1990s, De Shazer (1982, 1985, 1988, 1991) published various writings on the processes, techniques, and interventions underlying SFBT. These publications inspired other authors and therapists in the field, that then contributed to the expansion of the solution-focused model, and the development of SFBT techniques (Gingerich & Eisengart, 2000; Iveson, 2002; Ratner et al., 2012; Visser, 2013). Subsequently, in 2008 the Research Committee of the Solution-Focused Brief Therapy Association (SFBTA) published a research treatment manual to delineate the underlying philosophies and principles of SFBT, and to guide the research and practice of SFBT (Bavelas et al., 2013).

2.3.1.2 Principles and assumptions of solution-focused brief therapy

2.3.1.2.1 *The philosophical foundation of solution-focused brief therapy*

Although SFBT is not grounded within a specific theory, it is underpinned by strong philosophical influences (Ratner et al., 2012). The approach originated from the constructivist philosophy that views reality as invented, rather than discovered (De Shazer, 1991). Over time, SFBT has also become associated with social constructionism and Wittgenstein's notion of language games. According to this notion, language takes on different meanings, depending on the context in which it is used, and the rules that are applied (De Shazer, 1991; Ratner et al., 2012). For example, a solution-focused language game tends to be positive, hopeful, and future-focused, and it constructs the possibility of a better future (De Shazer et al., 2007). It also minimises emphasis on past failings and problems but instead focuses on clients' previous and future successes, as well as their strengths (Bavelas et al., 2013; Berg, 1994).

The solution-focused approach can thus be distinguished from problem-solving, as problem-solving language focuses on the details of the problem and what is needed to solve the problem. In contrast, solution-focused language focuses on the details of a preferred future, despite the presence of a problem (Froerer & Connie, 2016; Iveson, 2002; Kim, 2008). Owing to the importance of dialogue between the client and the therapist, the therapeutic alliance is often considered to be one of the most important elements of the SFBT process (Froerer & Connie, 2016). The solution-focused therapist is seen as a collaborator and consultant who takes on a stance of *not knowing* and of leading from one step behind, while the client is seen as the expert (Bavelas et al., 2013). The therapist thus believes in the client's expertise and competence and communicates a positive, respectful, and hopeful attitude (Froerer & Connie, 2016; Ratner et al., 2012).

2.3.1.2.2 *Basic assumptions of solution-focused brief therapy*

Based on this philosophical foundation, SFBT therapists are guided by several assumptions regarding clients and therapy. The basic tenets that inform SFBT are as follows (Bavelas et al., 2013; De Jong & Berg, 2007; De Shazer, 1985; De Shazer et al., 2007; Proudlock & Wellman, 2011; Ratner et al., 2012; Von Cziffra-Bergs, 2018):

- The solution is not always related to the problem; exploring the cause of the problem is thus not necessary to resolve the problem;
- The therapeutic focus should be on the client's desired outcome, rather than on past problems or current conflicts;
- The language used to build solutions is different from that used to diagnose and treat problems;
- Solutions are co-constructed between the client and the therapist, during the therapeutic conversation;
- No problem happens all the time; there are always exceptions that can be used to build solutions;
- All clients are motivated towards change;
- A small change can lead to bigger changes;

- Clients are the experts of their own lives and have the resources, skills, and competencies to resolve their own problems; and
- The therapist's responsibility is to help clients identify what they want and move closer to that desired outcome.

2.3.1.3 Solution-focused brief therapy process

2.3.1.3.1 *Classic solution-focused brief therapy*

From the above-mentioned assumptions, it is evident that the SFBT process is distinct from other, more traditional, therapeutic approaches (Bavelas et al., 2013). Classic SFBT, also referred to as *SFBT 1.0* (McKergow, 2016), as outlined by the research treatment manual, and various other publications, place particular emphasis on the use of techniques and questions to facilitate therapeutic change. Some of these techniques and questions are outlined below (Bavelas et al, 2013; Berg, 1994; De Jong & Berg, 2007; De Shazer, 1988; Franklin, Zhang, Froerer, & Johnson, 2017; Froerer & Connie, 2016; Froerer et al., 2018; Iveson, 2002; McKergow, 2016; Proudlock & Wellman, 2011; Ratner et al., 2012):

- Eliciting pre-session change

Questions asked by therapists to identify changes made by the client, before they attended the therapy session, e.g. *"What changes have you noticed that have happened or started to happen since you called to make this appointment?"*

- Constructing solution-focused goals

Questions asked by therapists to set personal salient, clear, specific, and attainable goals. Clients are usually encouraged to frame goals as the presence of a solution, rather than the absence of a problem, e.g. *"What are your best hopes for this session?"*

- Miracle questions

Questions asked to help clients envision their preferred future and develop a detailed description of what will be different when this becomes a reality, e.g. *"Suppose that one night, while you were asleep, a miracle happened and this problem was*

solved. How would you know? What is the first sign that will tell you something is different?"

- Exception-finding questions

Questions asked to elicit times when the problem is absent or less severe to identify strengths, skills, and resources that can be used to move towards their desired outcome, e.g. *"In the past week, has there been a time when the problem was causing you less distress?"*

- Coping questions

Questions asked to elicit the client's previous successes and instances of past coping to identify strengths, skills, and resources that can be used to move towards their desired outcome, e.g. *"How have you been coping until now?"*

- Scaling questions

Questions asked to scale the client's progress, motivation, confidence, or hope on a scale from 0 (negative) to 10 (positive) to amplify progress and motivate clients towards further change, e.g. "*On a scale from 0 to 10, where 10 resembles your desired outcome, where are you today?"*

- Compliments

Validating what clients are doing well and reflecting client strengths to amplify progress and motivate clients towards further change, e.g., "*Your perseverance to find help really stands out for me".*

- Assigning homework/tasks

Suggesting a between-session task for clients to try, based on what was discussed during the session. This can be an observational, behavioural, or experimental task and usually focuses on encouraging the client to do more of what works.

However, these techniques are not used according to a formulaic or rigid structure as SFBT is a flexible approach, tailored to the goals of each specific client. Therapists generally use what works, in a manner that applies to each client (Ratner

et al., 2012). Although SFBT is referred to as a brief intervention, this does not imply it has to be time-limited or short-term. Although SFBT is generally conducted over 4–6 sessions, single-session therapy is also practised (Courtnage, 2020; Ratner et al. 2012). Further, according to De Shazer (1991), SFBT takes as long as is needed to reach the client's goal and not one session more.

2.3.1.3.2 *New directions in solution-focused brief therapy*

Although the above-mentioned techniques and questions are still relevant and employed by SFBT therapists, the purpose of these questions has evolved over the past two decades (McKergow, 2016). Recent developments in SFBT have shifted the focus from techniques to the notion that the therapeutic dialogue serves as the intervention. The therapist therefore no longer asks questions to gather information and devise interventions, but rather strategically uses the collaborative communication process to expand the descriptions of what clients want different in their lives (Bavelas, et al., 2013; Connie & Froerer, 2020; Froerer & Connie, 2016; Froerer et al., 2018; McKergow, 2016). This is commonly referred to as solution-building. Through a process of listening, selecting, and building, the therapist guides the client towards describing a detailed desired outcome. By constructing new versions of reality, change is created (Bavelas, et al., 2013; Froerer & Connie, 2016; Froerer et al., 2018; McKergow, 2016).

McKergow (2016) describes these new directions in SFBT as *SFBT 2.0*. He highlights that at the commencement of therapy, modern SFBT therapists focus on their client's best hope for therapy and the difference this best hope will make in the client's life; this is done instead of setting specific behavioural goals. Due to the role of the therapist shifting from designer of interventions to elicitor of detailed descriptions, less emphasis is placed on providing compliments, homework tasks and suggestions at the end of a session. The most apparent difference between *SFBT 1.0* and *SFBT 2.0* is probably the focus on strategic therapeutic conversations, instead of isolated SFBT questions being used haphazardly in sessions (McKergow, 2016). Two of these contemporary SFBT models are described below.

A solution-focused art gallery

Froerer et al. (2018) and Chris Iveson, as stated by McKergow (2016), use an *art gallery* metaphor to refer to the SFBT conversation. As in an art gallery, the SFBT

session has different *rooms to visit* with different components to look at and examine. Although this metaphor implies a certain direction and purpose of travel, the client and therapist may spend more time in one room, may go back and revisit certain rooms, or may explore something else in the gallery. It therefore serves as a guide to each therapeutic process (McKergow, 2016). Froerer et al. (2018) outline this art gallery metaphor when working with trauma survivors as follows:

- The *best hope/desired outcome room*

The first room of the art gallery is where the therapist establishes the client's *desired outcome* for the session, e.g. *"What is your best hope from our talking today?".* This question serves as a contract between the client and the therapist and guides the conversation for the rest of the session (Ratner et al., 2012). This room is where the client often describes the trauma or problem. Although the therapist does not ignore these details or stop the client from talking about their trauma, they rather listen and reflect details that contribute to the client's desired outcome (Froerer et al., 2018).

- The *resource talk room*

The purpose of the second room in the art gallery is language expansion. The therapist therefore asks questions that help clients step away from their trauma or problem for a moment and talk about other aspects of their lives, e.g. *important people, talents, achievements, qualities, values etc.* The therapist then uses the vocabulary and strengths discovered in this room to develop a detailed description of the client's preferred future (Froerer et al., 2018).

- The *preferred future room*

This room is considered the most important room of the gallery as it is the place where change happens in the session. The therapist elicits a detailed description of the preferred future by asking questions about the presence of the client's best hopes and the signs they will notice when these hopes are present. A personalised version of the *miracle question* (where the client's exact words are used), as well as detail-orientated follow-up questions, are used to walk the client step by step through their miracle day. This is often referred to as brain-stretching as it helps clients create a new reality through language (Froerer et al., 2018; McKergow, 2016).

- The *session closing room*

The goal of the final room in the art gallery is to preserve the work that was done in the previous rooms and leave the authority with the client. The therapist thus refrains from providing psychoeducation, homework, or compliments in this room; but rather helps clients to identify what stands out for them. This can be done by merely asking: "*What stood out for you"* or encouraging the client to notice signs of their preferred future being present and how they made it happen. On this note, the SFBT session comes to an end (Froerer et al., 2018).

The Connie-Froerer diamond model of solution-focused brief therapy

Similar to the solution-focused art gallery, Connie and Froerer (2020) recently proposed a diamond model to outline the SFBT language process. They suggest that each SFBT session is characterised by three distinct steps or tasks which guide the therapist and client through the session. These steps are:

- Step 1: Desired outcome

Similar to the first room of the art gallery, the first step of this model is to establish the client's desired outcome. This is accomplished by the therapist asking the client what their best hope is for the session. At this stage, it is important for the therapist to distinguish between the client's desired outcome and goal (means of achieving their desired outcome). The therapist might therefore use additional questions to clarify the desired outcome, e.g. "*What will be different if [the desired outcome is met]? What would you like to feel instead of [the problem]?*" (Connie & Froerer, 2020).

- Step 2: Description of the desired outcome

The second step is for the therapist to help the client elicit a detailed description of the presence of their desired outcome. This can be accomplished by using four different methods, utilising specific SFBT questions and techniques. However, the purpose is not to use all these methods in one session or in a specific order, but rather to strategically use specific questions and techniques while maintaining a solution vision. These four methods are discussed briefly below (Connie & Froerer, 2020).

Resource talk: The therapist encourages the client to describe themselves in an incongruent way by asking questions about their strengths, skills, resources, and support in other areas of their life. The therapist therefore gets to know the best version of the client to connect these resources with the client's desired outcome.

Scaling: The therapist uses the scaling question discussed above, to identify where the client is concerning their desired outcome at a specific moment. The therapist might also ask what the highest is the client has ever been on the scale or how come they are not lower on the scale. However, instead of asking what they need to do to take one step closer to their desired outcome, the purpose of this question is for the client to describe what will be different when they are one step higher on the scale.

Preferred future: The therapist makes use of specific questions in order for the client to create a clear description of the presence of their desired outcome. Although the miracle question, described above, is the most popular way to ask about the client's preferred future, other future-focused questions or presuppositional language (e.g. suppose, when, if etc.) may also be used.

History of outcome: The therapist encourages the client to describe instances of the desired outcome being present in the past. These may include past success(es) or more recent exceptions to the problem. Again, the therapist may use some of the questions (e.g. exception-finding question) described previously. However, the focus remains on the presence of the desired outcome, instead of the absence of the problem (Connie & Froerer, 2020).

- Step 3: Closing

Similar to the SFBT art gallery, the final step of the Connie-Froerer diamond model is to close the session by honouring the work that was done during the session. The therapist will thus end the session by indicating that time has come to an end and asking the client whether they want to schedule another session. However, the therapist does not provide any advice or homework, and they trust the client to take authority for their own change process (Connie & Froerer, 2020).

Although the literature suggests that these new directions in SFBT are briefer, more effective, and elegant when compared to more established versions of SFBT,

they are not considered to be superior to, or a substitute for, classic SFBT (McKergow, 2016).

2.3.1.4 Critical perspectives on solution-focused brief therapy

Taking into account the assumptions, principles, and techniques described above, SFBT may be criticised for being too simplistic and superficial (Kim, 2008). First, critics argue that SFBT does not give sufficient attention to complex dynamics which underlies problems and is therefore not adequate for treating more serious and complex problems (Kim, 2008; Schmit et al., 2016). However, proponents of SFBT advocate that the simplicity of the approach is, in fact, a strength which helps the therapist stay true to the client's goals and enables them to build unique solutions with each client (Froerer & Connie, 2016). SFBT, moreover, assumes that change occurs when people shift the way they describe their worlds and experiences, irrespective of what underlies the problem (Ratner et al., 2012).

Second, SFBT is condemned as being overly positive, optimistic, and dismissive of clients' problems (Ratner et al., 2012). Although SFBT therapists tend to focus on future possibilities and solutions, they are not problem-phobic. For example, therapists will empathically validate and acknowledge clients' problems, while shifting the focus of the conversation towards solutions (Bavelas et al., 2013; Froerer et al., 2018; Ratner et al., 2012). Third, SFBT is criticised for placing excessive emphasis on behaviour, while ignoring emotions and maladaptive thought patterns. However, SFBT advocates argue that emotions play a prominent role in building solutions and constructing more useful behaviours in SFBT. It is thus believed that solution-focused language elicits positive emotions which serve as resources during the solution-building process (Ratner et al., 2012).

Finally, strengths-based approaches such as SFBT are often described as being atheoretical and pragmatic and are considered to lack empirical evidence (Ratner et al., 2012). However, SFBT does have standards of practice and possesses an underlying philosophy and framework. These standards of practice are clearly outlined in the SFBT treatment manual which was developed to guide practice and research (Bavelas et al. 2013; De Shazer et al., 2007). More rigorous research on SFBT has also accumulated over the past decade, and researchers have been using randomised controlled trials (RCTs) and quasi-experiments to evaluate this approach.

This contributes to the growing evidence on the effectiveness of SFBT and its current recognition as an evidence-based practice (Bavelas et al., 2013; Franklin, 2015).

2.3.2 Evidence of effectiveness of solution-focused brief therapy

2.3.2.1 Clinical application of solution-focused brief therapy

Despite the criticisms expressed about SFBT, it has gained popularity among professionals due to its flexible, collaborative, strength-orientated, and short-term nature. SFBT is currently practised in a broad range of settings in North and South America, Europe, Asia, and South Africa (Froerer et al., 2018; Gingerich & Peterson, 2012; Kim, 2008; Ratner et al., 2012). According to literature, SFBT is used for the treatment of depression, anxiety, perfectionism, substance abuse, marital and family problems, and in physical rehabilitation (Carr, Smith, & Simm, 2014; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Kim et al., 2018; Ratner et al., 2012; Schmit et al., 2016; Smock et al., 2008). SFBT is also applied with children experiencing academic and behavioural problems, intellectual difficulties, as well as at-risk youth (Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Kim & Franklin, 2009; Ratner et al., 2012; Roeden, Maaskant, & Curfs, 2014; Schmit et al., 2016). As can be expected, the empirical support for the effectiveness of SFBT has grown significantly over the past two decades. The most relevant outcome-based research concerning SFBT is reviewed below.

2.3.2.2 Outcome-based research on solution-focused brief therapy

2.3.2.2.1 *Meta-analytic studies and systematic reviews*

Meta-analyses and systematic reviews of experimental and quasi-experimental studies indicated that SFBT is an effective therapeutic approach with a variety of psychological problems (Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Kim, 2008; Schmit et al., 2016; Stams et al., 2006; Zhang et al., 2018). The first meta-analytic review conducted by Stams et al. (2006) included 21 studies, comprising a total of 1,421 participants from various populations. The researchers reported that SFBT had a statistically significant effect when compared to clients who received no treatment. Although the effect of SFBT was similar to other therapeutic approaches, SFBT outcomes occurred sooner than with other approaches. These findings suggested that SFBT may be a cost-effective therapeutic approach in a wide range of contexts (Stams et al., 2006).

Kim (2008) conducted a second meta-analytic study, which included 22 SFBT studies with a total of 1,349 participants. He evaluated the effectiveness of SFBT with externalising behavioural problems, internalising behavioural problems, as well as family/relational problems. Although SFBT demonstrated positive treatment effects for all three outcome measures, only the mean effect size for internalising behavioural problems appeared to be statistically significant. These findings suggested that SFBT is particularly effective with internalising behavioural problems such as depression, anxiety, self-concept, and self-esteem (Kim, 2008).

More recently, a meta-analysis conducted by Schmit et al. (2016), supported Kim's (2008) findings. They found that, although the mean effects size for decreasing internalising symptoms in youth and adults was relatively small, participants still benefitted from SFBT when compared to other treatment approaches or no treatment at all. According to SFBT's assumptions outlined in Section 2.3.1.2.2, these small changes may lead to larger changes over time. Although more follow-up studies concerning the long-term effects of SFBT are needed, therapists may find this approach favourable due to its short-term nature (Schmit et al., 2016).

Gingerich and Peterson's (2012) study revealed even more compelling evidence for the effectiveness of SFBT with a wide variety of behavioural and psychological outcomes. They reviewed 43 controlled outcome studies of which 74% of the studies reported significant positive effects from SFBT, while 23% reported positive trends. The strongest evidence of effectiveness was found for the treatment of depression in adults. SFBT also appeared to compare well with established alternative treatments and, at times, even demonstrated to be more effective. According to these results, SFBT used fewer sessions than established therapies, suggesting that SFBT is briefer and more cost-effective when compared to these alternatives. This study furthermore noted that the number and sophistication of SFBT studies steadily increased over the past several decades, supporting SFBT's effectiveness and efficiency (Gingerich & Peterson, 2012).

2.3.2.2.2 *Qualitative studies*

In-depth qualitative studies supported the results of the above-mentioned systematic reviews and meta-analyses (Carr et al., 2014; Lloyd & Dallos, 2006, 2008; Simon & Nelson, 2005). For example, interviews and case studies revealed that clients

involved in SFBT experienced increased feelings of self-efficacy, empowerment, and pride. A sense of optimism and hopefulness, as well as feeling more confident to achieve future goals, were also expressed by participants. In one study, participants specifically referred to SFBT as being the start of their journey back to where they wanted to be in life (Carr et al., 2014; Lloyd & Dallos, 2006, 2008).

Based on the above-mentioned studies, it is evident that a growing body of literature demonstrates SFBT's effectiveness as an evidence-based intervention. Despite this evidence, few studies examined the mechanisms of change behind SFBT (Franklin, 2015; Franklin et al., 2017). In an era with a growing emphasis on evidence-based practices, it is thus important that researchers also investigate the aspects of the therapeutic encounter which is effective and contribute to therapeutic change (Froerer & Connie, 2016). This highlights the importance of rigorous process-orientated research.

2.3.2.3 Process-orientated research on solution-focused brief therapy

2.3.2.3.1 *Meta-analytic studies and systematic reviews*

McKeel (2012) published one of the first process-orientated reviews focusing on the outcomes achieved using specific SFBT therapeutic techniques. He found that techniques such as solution-talk, presuppositional questions, and identifying positive exceptions contributed towards positive outcomes in therapy sessions. According to him, solution-talk fostered increased rapport between the client and therapist, while presuppositional questions directed clients to look for positive change and personal strengths and resources. McKeel (2012) also indicated that scaling and miracle questions contributed to clients' goals being reached and engendered a sense of hope during the SFBT process. First session tasks furthermore led to increased client cooperation and positively contributed to the client's view of the problem and the therapeutic process (McKeel, 2012).

Building on these findings, Franklin et al. (2017) conducted a systematic review of change process literature to investigate why and how SFBT works. According to this study, strength- and resource-orientated techniques (e.g. pre-session change, first session tasks, scaling questions, and exception questions) contributed significantly to the effectiveness of SFBT. Besides specific SFBT techniques, the results also highlighted the importance of linguistic methods (e.g. collaborative language) and

style-orientated skills (e.g. therapeutic alliance) during the SFBT process. Findings from this review specifically identified the co-construction of meaning as a linguistic method that is effective for building solutions with clients. The researchers thus concluded that SFBT techniques and linguistic methods may co-function to facilitate change in the SFBT process. However, the exact way they interact is not yet clear (Franklin et al., 2017).

Froerer and Connie (2016) confirmed the importance of linguistic/style-orientated skills in a qualitative Delphi study conducted with 42 SFBT experts from around the globe. The majority of participants in this study referred to the collaborative language process as being synonymous to the therapeutic alliance. According to them, this process is fostered by the respectful and curious stance SFBT therapists take. However, experts involved in this study did not regard specific SFBT techniques (e.g. miracle question, scaling question) as critical components in the solution-building process. Instead of using techniques from a pre-selected list of possibilities, they rather emphasised that therapists should customise each question or statement to the individual client. Following the new directions in SFBT referred to in Section 2.3.1.3.2, Froerer and Connie (2016) thus identified the collaborative language process between the client and the therapist as the central and key component of solution-building in SFBT.

2.3.2.3.2 *Micro-analytic studies*

Due to the fundamental role language plays in the SFBT therapeutic process, microanalysis was used to examine moment-by-moment communication exchanges in therapy (Froerer & Jordan, 2013; Jordan, Froerer, & Bavelas, 2013; Korman, Bavelas, & De Jong, 2013; Tomori & Bavelas, 2007). These studies aimed to better understand the details of SFBT language that contribute towards therapeutic change. Results indicated that expert SFBT therapists mostly use positive formulations (e.g. echoing, paraphrasing, or summarising) during sessions and focused more on positive topics in clients' lives (e.g. strengths and resources). Clients responded overwhelmingly positive to these formulations, illustrating the impact SFBT language has on clients (Froerer & Jordan, 2013; Jordan et al., 2013; Tomori & Bavelas, 2007).

Micro-analytic studies furthermore compared the language of SFBT to that of traditional therapeutic approaches; such as CBT, motivational interviewing and client-

centred therapy (Froerer et al. 2013; Jordan et al., 2013; Korman et al., 2013; Tomori & Bavelas, 2007). Results indicated that SFBT therapists are more likely to preserve the client's exact words and add significantly fewer of the therapist's interpretations. The SFBT therapists' questions and formulations were also primarily positive, while client-centred and CBT therapists' language were primarily negative These findings are congruent with the assumptions of SFBT and thus confirm therapists' adherence to the philosophy of SFBT (Froerer & Jordan, 2013; Froerer et al. 2013; Korman et al., 2013). Although microanalysis is still a developing research approach, findings from these studies added to the research base of SFBT and contributed to more effective practice, training, and supervision in the field of SFBT (Jordan et al., 2013).

2.3.2.3.3 *Qualitative studies*

Qualitative studies investigating clients' and practitioners' experiences of SFBT echoed findings from the above-mentioned studies (Carr et al., 2014; Lloyd & Dallos, 2006, 2008; Simon & Nelson, 2005). For example, studies suggested that collaboratively involving clients during the therapeutic process and allowing them ownership of the therapeutic change are useful aspects of SFBT. Qualitative literature furthermore emphasised the value of the therapeutic alliance, specifically the therapist's solution-focused and non-judgemental stance. Visualising the preferred future in detail, as well as the use of scaling questions also appeared to be beneficial (Carr et al., 2014; Lloyd & Dallos, 2008; Simon & Nelson, 2005). In addition, SFBT questions aimed to identify exceptions and enquire about instances of coping as well as problem-free areas of life seemed to shift problem-orientated conversations towards solution-focused talk (Lloyd & Dallos, 2006).

From the above-mentioned findings, it is evident that strength- and resource-orientated techniques, linguistic methods, as well as the therapeutic alliance contribute towards therapeutic change in SFBT. However, studies integrating process-orientated and outcome-based research are needed to understand the true impact of solution-building (Franklin et al., 2017; Froerer & Connie, 2016; McKeel, 2012). This may specifically be relevant to explore in culturally diverse contexts.

2.3.2.4 Solution-focused brief therapy beyond the traditional context

2.3.2.4.1 *Nonclinical application of solution-focused brief therapy*

Until recently, the majority of SFBT studies was conducted in a traditional therapy setting. However, evidence for the effectiveness of SFBT in various other settings is growing (Gingerich & Peterson, 2012). In addition to clinical practice, SFBT is used in schools, coaching, organisational consulting, management, and medical settings (Franklin, Trepper, Gingerich, & McCollum, 2012; Gingerich & Peterson, 2012; Kim & Franklin, 2009; Ratner et al., 2012). Zhang et al. (2018) conducted the first meta-analysis of the effectiveness of SFBT in medical settings. Their study included RCTs which focused on patients' psychosocial health (e.g. depression, psychosocial adjustment to illness), behavioural health (e.g. physical activity, nutrition score) and functional health (e.g. body mass index, individual strength) outcomes. Results indicated that SFBT is an effective intervention for psychosocial outcomes and a promising therapeutic approach for behavioural outcomes. These findings thus suggest that SFBT can benefit patients in medical settings and may improve the quality of healthcare services (Zhang et al., 2018).

Studies also considered SFBT's utility in community mental health settings (Mireau & Inch, 2009; Proudlock & Wellman, 2011). Mireau and Inch (2009) investigated the use of Brief Solution-Focused Counselling (BSFC) with clients utilising community-based mental health services in Canada. They found that BSFC contributed to shorter wait-list times, a reduction in dropout rates, and improvement in symptomology, as reflected by the Outcome Questionnaire-45. Proudlock and Wellman (2011) furthermore conducted an explanatory mixed methods study to investigate the impact of SFGT for adults with severe and enduring mental health difficulties in a community-based context in England. All participants from this study showed an improvement, as measured by the Mental Health Recovery Measure. Results from this study suggested that SFGT offer a cost-effective way of treating adults with a variety of presenting problems in a community context (Proudlock & Wellman, 2011). SFBT therefore offers promising opportunities beyond the traditional clinical context.

2.3.2.4.2 *Solution-focused brief therapy in diverse contexts*

Although the majority of outcome- and process-orientated research has been conducted in regions such as the United States and Europe, evidence for the use of

SFBT among ethnic minority groups also exists (Kim et al., 2015). Various studies conducted in China, Taiwan, Hong Kong, Japan, and Korea showed that SFBT is an appropriate intervention for Asian clients with mental health-related problems (Gong & Hsu, 2017; Kim et al., 2015). Consistent with international studies, SFBT appeared to be most effective with internalising disorders such as depression and anxiety among the Asian population. Literature specifically suggested that the action-orientated and strength-based nature of SFBT helped Asian clients to address, instead of deny their problems. The client-centred approach of SFBT also shows respect for group cohesion and family piety, thus honouring the values of the Asian culture (Gong & Hsu, 2017; Kim et al., 2015). A systematic review of SFBT outcome studies with Latinos in the United States and Latin American countries also supported SFBT's effectiveness with this vulnerable group in various settings (Suitt et al., 2016). Seidel and Hedley (2008) furthermore highlighted the benefit of SFBT with older adults in Mexico who experienced problems related to relationships or psychological well-being. They found that only three sessions of SFBT contributed significantly to participants' post-test improvement and perception of goal achievement.

On the African continent, SFBT is creatively applied in schools, universities, medical settings, communities, organisations, and private practices (Von Cziffra-Bergs, 2018). Despite the lack of research concerning the application of SFBT among the African population, South African therapists support SFBT's relevance in this culturally diverse context (Diale, 2014; Stander, 2003; Von Cziffra-Bergs, 2018). The brief and effective nature of SFBT is highlighted as an advantage for under-resourced communities. Its focus on collaboration and creating a sense of community (an inherent part of the African philosophy of Ubuntu), furthermore makes it a valuable therapeutic approach among South Africans. Owing to South Africa's problem-saturated past and high incidence of trauma, local therapists also find strength-based, future-orientated therapeutic approaches empowering (Diale, 2014; Von Cziffra-Bergs, 2018). The researcher therefore proposes that the possible value of SFBT as trauma intervention should be investigated, specifically in the South African context.

2.3.3 Solution-Focused Brief Therapy as trauma intervention

2.3.3.1 International trauma studies

2.3.3.1.1 *Empirical evidence for solution-focused brief therapy*

Despite SFBT being recognised as an evidence-based practice, only a few empirical studies have specifically focused on the use of SFBT with trauma survivors (Froerer et al., 2018; Kim et al., 2018). For example, Kim et al. (2018) focused on the effectiveness of SFBT with parents (in the child welfare system) who experienced substance misuse and trauma-related symptoms. These researchers randomly assigned participants to either an SFBT treatment group or control condition (e.g. CBT or motivational interviewing). Results from this study indicated that both groups decreased on the Addiction Severity Index-Self-Report (ASI-SR) and the Trauma Symptom Checklist-40 (TSC). SFBT specifically had a positive effect on anxiety, depression, sexual abuse trauma, and sleep disturbances. However, the between-group effect sizes were not statistically significant on either measure, indicating that SFBT had a similar effect compared to the traditional therapeutic approaches. Nonetheless, these findings supported the use of SFBT and provided a strength-based alternative for treating substance use and trauma-related symptoms (Kim et al., 2018).

Whitehead et al. (2018) furthermore described the impact of a solution-focused orientated group programme, "*Give us a break*!", developed for young people experiencing ongoing difficulties as a result of significant adverse events (e.g. bereavement or family-related adjustment). This programme incorporated the key elements of SFBT as it aimed to increase participants' resilience, develop a possibility-orientated outlook, recognise strengths, identify goals, develop effective coping strategies, and celebrate progress. Results indicated that this programme had a positive impact on young people's sense of relatedness, sense of mastery, social-emotional competence, and optimistic thinking. According to the researchers, these personal resources contributed towards resilience and acted as a defence against negative change and loss. It further served as an important protective factor for future adverse events (Whitehead et al., 2018).

2.3.3.1.2 *Application of solution-focused brief therapy*

Regardless the limited empirical evidence for SFBT as trauma intervention, various researchers support its relevance when working with trauma survivors

(Bannink, 2008; Froerer, Smock, & Seedall, 2009; Froerer et al., 2018; Hopson & Kim, 2004; Ogunsakin, 2015). The therapy is applied with clients exposed to violent crime, interpersonal violence, war conflict, childhood sexual abuse, other childhood traumas, as well as loss and grief. The SFBT therapy model is also recommended for preventing and coping with suicide (De Castro & Guterman, 2008; Fiske, 2008, Froerer et al., 2018; Henden, 2008; Sharry, Darmody, & Madden, 2002). A study conducted by Froerer et al. (2009) furthermore supports the use of Solution-Focused Brief Group Therapy (SFBGT) for patients diagnosed with HIV/AIDS. SFBGT was found to help patients deal with associated emotional challenges such as stigmatisation, feelings of guilt and shame, as well as loss, grief, and hopelessness. The value of SFBT in the context of trauma is echoed by the large number of useful books written on this topic (Bannink, 2008; Y. Dolan, 1991; Froerer et al., 2018; Furman, 1998; Henden, 2011; O'Hanlon & Bertolino, 1998).

Literature suggests that SFBT is an appropriate trauma intervention as it views a crisis as an opportunity to develop new skills, strengths, and resources, which may be used in future crisis situations. It thus goes beyond returning a client to their pre-crisis state of functioning (Bannink, 2008; Hopson & Kim, 2004). SFBT's future-focused orientation also communicates that, although the traumatic past cannot be changed, the future can still be filled with success and satisfaction. SFBT therapists therefore validate the existence of problems and challenges but assume that clients have all the resources to overcome these problems. This creates an empowering therapeutic alliance where healing and growth can occur (Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004). By amplifying moments of control, bravery, and remarkable strength, SFBT furthermore engenders feelings of hope and empowerment in the aftermath of trauma (Bannink, 2008; Froerer et al., 2009, 2018).

Specific SFBT techniques may particularly be valuable in this context. For example, the miracle question assists clients to set clear future goals and shifts their focus towards a preferred future where the trauma is resolved (Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015). Finding exceptions and asking coping questions also guide clients to reflect on their past and identify what is already working. This emphasises clients' strengths and instils a sense of hope and confidence within themselves and their future (Froerer et al., 2009, 2018; Ogunsakin, 2015). Scaling

questions furthermore create an expectancy of change which motivates and empowers clients towards further progress. Moreover, compliments provided by SFBT therapists help clients recognise their own strengths and ultimately assist them to view themselves as trauma survivors, instead of victims (Bannink, 2008; Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015). From the literature, it can be concluded that SFBT may be a relevant strength-based approach for clients managing trauma. It is thus important to also consider how SFBT is utilised as trauma intervention in South Africa.

2.3.3.2 Trauma studies in the South African context

2.3.3.2.1 *Empirical evidence for solution-focused brief therapy*

Consistent with international literature, limited research exists on implementing SFBT with trauma survivors in South Africa. Up to date, Diale (2014) conducted the only study specifically focusing on trauma and SFBT in the South African context. Diale utilised an exploratory case study design to explore black adolescents' experiences of SFGT as a therapeutic approach to address challenges associated with domestic violence. Results indicated that SFGT assisted participants to focus on solutions rather than problems, offered them the opportunity to realise their inner potential, and created a sense of community and collectivism. Problem-free talk, exception-finding, and complimenting were identified as especially useful with this population. However, Diale (2014) suggested that specific therapeutic techniques (e.g. miracle question and metaphors) should be adapted to be relevant in the African culture.

2.3.3.2.2 *Application of solution-focused brief therapy*

Although limited research is available concerning the application of SFBT with trauma survivors in South Africa, anecdotal reports suggest that this approach is used by various local therapists working in trauma-saturated contexts. For example, case studies illustrate how SFBT is used in private practice with clients exposed to violent crime, with university students exposed to physical and sexual assault, as well as with offenders burdened by complex traumatic pasts (Froerer et al., 2018; Stander, 2003; Von Cziffra-Bergs, 2018). SFBT is furthermore used by lay school counsellors in rural parts of KwaZulu-Natal, and psychologists working on the Phelophepa Train of Hope (Von Cziffra-Bergs, 2018). This train operates as a mobile healthcare hospital which provides medical, optometric, dental, educational, and psychological services to

impoverished rural areas of South Africa. These communities are particularly vulnerable to trauma, as they are under-resourced and burdened by psychosocial challenges (Transnet Foundation, 2019; Von Cziffra-Bergs, 2018). The use of SFBT with trauma survivors in various South African communities thus amplifies the international patronage for SFBT as trauma intervention (Bannink, 2008; Froerer et al., 2018; Hopson & Kim, 2004; Ogunsakin, 2015; Von Cziffra-Bergs, 2018).

This notion is supported by the researcher and various other SFBT therapists (Barnascone, 2018; Grobler, 2018; Hansen & Joubert, 2018; Ncube, 2018; Von Cziffra-Bergs, 2018). First, SFBT creates a future-orientated mindset and opens new possibilities which foster a sense of hope in the aftermath of trauma. Second, by acknowledging strengths and resources, SFBT therapists empower trauma survivors to construct solutions and take control of their present situation. Third, SFBT therapists do not dwell on the traumatic details of adverse events, as this amplifies clients' deficits and is counterproductive for growth. As a result, clients as well as therapists are protected from further traumatisation and from becoming victims of therapy. Lastly, SFBT is described as practical and goal-driven which appeal to diverse populations and assist clients in reaching their goals in a shorter period. These advantages thus highlight SFBT's applicability with trauma survivors, specifically in the South African community mental health context.

2.3.3.3 Current gaps in the literature

Regardless of the subjective support for SFBT as a trauma intervention, further outcome- and process-orientated research needs to be conducted to determine the value of SFBT with this population (Froerer et al., 2018). Despite recommendations that trauma interventions should shift their focus to strengths, possibilities, and post-traumatic success, limited international literature is available on the effectiveness of SFBT with adult trauma survivors (Bannink, 2008; Kim et al. 2018). No clear treatment guidelines are therefore available to inform therapists about what works, with whom, and under what conditions. This highlights the need for rigorous trauma-focused SFBT studies, with a strong emphasis on implementation and fidelity to guide future practice (Kim et al., 2018; Whitehead et al., 2018).

This sentiment is echoed by local researchers expressing a need for the development of trauma interventions that replenish strengths and resources in

individuals and communities exposed to continuous, repetitive trauma (Diale, 2014; Fouché & Walker-Williams, 2016; Van der Merwe & Kassan-Newton, 2007). D. J. A. Edwards (2005) furthermore argued that trauma interventions should be tailored to individual cases and be contextually sensitive in order to build an appropriate evidence-based practice for the treatment of trauma in South Africa. The cross-cultural applicability of SFBT with trauma survivors thus ought to be investigated. Cross-cultural studies should specifically explore how SFBT can, on the one hand, be better adapted to fit the cultural and ethnic values of a specific population; while on the other hand, still adhere to treatment fidelity (Diale, 2014; Gingerich & Peterson, 2012; Kim et al., 2015). This is specifically important for a therapeutic approach, such as SFBT, with its origins in the United States and with the majority of research conducted in western countries (Gong & Hsu, 2017; Schmit et al., 2016).

Furthermore, qualitative research regarding the application of SFBT will contribute to the theory and practice of this approach. It is thus suggested that future research should explore the experience of SFBT with different client groups to develop a greater understanding of the aspects of SFBT that individuals find useful (Carr et al., 2014; Simon & Nelson, 2005). This is specifically relevant for utilising SFBT with trauma survivors in South Africa. Kagee and Naidoo (2004), specifically, recommended that people's stories should be heard, explored, and reflected on, because they are appropriate to local and contextualised realities in a developing country such as South Africa. It was also stated by D. J. A. Edwards (2005) that well-conducted case studies provide context-specific details that RCTs often lack. This confirms the need for in-depth qualitative studies, exploring South Africans' experiences of trauma interventions such as SFBT.

2.3.4 Evaluative summary

The therapeutic approach of SFBT is brief, goal-orientated, future-focused and strength-based. Since its origin in the twentieth century, this approach has gained significant popularity and is currently utilised by a range of professionals in various settings. Extensive evidence-based research has also confirmed the effectiveness of SFBT for treating a variety of mental health problems. It appears particularly appropriate for the treatment of internalising behavioural problems, such as depression, anxiety, self-concept, and self-esteem (Gingerich & Eisengart, 2000;

Gingerich & Peterson, 2012; Kim, 2008; Schmit et al., 2016; Stams et al., 2006; Zhang et al., 2018). The effectiveness of SFBT was also echoed in cross-cultural studies conducted in diverse contexts, including South Africa (Diale, 2014; Kim et al., 2015; Suitt et al., 2016; Zhang et al., 2018). According to process-orientated studies, the therapeutic alliance and collaborative dialogue between therapists and clients may specifically contribute to the value of SFBT (Franklin et al., 2018; Froerer & Connie, 2016; McKeel, 2012).

Although limited, there is a body of international and local literature on the application of SFBT in the context of trauma. The SFBT approach is used by various clinicians working with trauma survivors (Bannink, 2008; Fiske, 2008; Froerer et al., 2018; Kim et al., 2018; Von Cziffra-Bergs, 2018). It seems to assist clients in: dealing with trauma-related symptoms; developing strengths, skills, and resources; and in instilling a sense of hope in the aftermath of trauma. International and local therapists have identified SFBT's future-orientated and strength-based notion as relevant when working with trauma survivors. Specific language techniques also appear useful in this context (Bannink, 2008; Diale, 2014; Froerer et al., 2018; Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015; Von Cziffra-Bergs, 2018). However, it is important that these techniques are adapted and relevant to the specific context in which it is applied (Diale, 2014; Gingerich & Peterson, 2012; Kim et al., 2015). Future research should therefore explore the cross-cultural use and adaptation of SFBT as a strength-based trauma intervention.

2.4 Conclusion

The prevalence of trauma appears to be a concern both internationally and locally. Due to South Africa's distinct political history and particular psychosocial context, exposure to multiple and continuous trauma are particularly common in the country. As a result of the distinct psychological consequences associated with trauma, various theoretical perspectives and interventions have been developed to conceptualise and manage trauma. However, the majority of these models in South Africa have been guided by international research directions and can be described as pathology-orientated.

Numerous criticisms have been raised regarding pathology-orientated trauma interventions. Trauma interventions should thus also aim to focus on building positive

emotions, client strengths and resources, and psychological growth in the aftermath of trauma. Although several clinicians, both internationally and in South Africa, utilise strength-based trauma interventions, limited research is available on the application and effectiveness of these interventions. No clear treatment guidelines thus exist to inform clinicians in this regard.

The researcher proposes that SFBT, a strength-based therapeutic approach, be investigated as a trauma intervention in South Africa. This approach appears to be effective for a wide range of problems and in various contexts. Further, it may specifically be relevant to trauma survivors owing to its future-orientated, strength-based, and collaborative nature. The brief and practical stance in SFBT may also appeal to clinicians working at community-based clinics in South Africa where numerous challenges are faced. The researcher therefore aims to investigate how SFBT may facilitate positive experiences, such as hope and subjective well-being, among trauma survivors in this context. The construct is elucidated in the following chapter.

Chapter 3: Hope and Subjective Well-Being

3.1 Introduction

Over the past few decades, positive psychology has shifted the focus of psychotherapy away from treating and preventing mental illnesses towards promoting mental health. Researchers have thus highlighted the significance of positive psychology constructs, such as hope and SWB, in relation to mental health and optimal psychological functioning (Seligman & Csikszentmihalyi, 2000). Although hope and SWB are impacted by traumatic events, these constructs also appear to play a protective role in the context of trauma (Calvo et al., 2015; Frederickson, 2000; Levi et al., 2012a, 2012b; Veronese et al., 2017). Interventions that instil hope and SWB among trauma survivors may thus be valuable and deserve further attention. Taking into consideration that SFBT increases hope and SWB in other contexts, this approach appears particularly useful to investigate (Blundo et al., 2014; Bozeman, 1999; Grant, 2012; Green et al., 2006; Quick & Gizzo, 2007). Owning to the fact that local literature concerning SFBT is limited, the current study aims to explore how SFBT may be used to facilitate hope and SWB among trauma survivors.

The first part of this chapter focuses on the construct of hope, with hope-based therapeutic interventions, and relevant research that has been conducted in South Africa being discussed. The experience of hope in relation to trauma is furthermore highlighted. The second part of this chapter describes SWB, with specific attention given to interventions that may enhance well-being, and the experience of SWB in the South African context. The influence trauma has on SWB, and the buffering role it may play concerning trauma is then highlighted. The chapter concludes by considering the relationship between the two variables being studied, namely hope and SWB.

3.2 Hope

3.2.1 Defining hope

The concept of *hope* has fascinated theologians, philosophers, scientists, and the general public throughout the ages and has been referred to in both good and evil terms. For example, the ancient Greeks held conflicting perspectives, with some viewing hope as a precious virtue that must be persevered; and others describing hope as the worst evil that must be confined (Callina, Snow, & Murray, 2018; Gallagher,

2018). From a theological perspective, Christianity considers hope to be one of the three cardinal theological virtues, founded on God's promise of an eternal future. Similarly, Buddhism bases hope on the expectation that an individual's good moral choices will direct their life in a positive direction. From a theological perspective, hope is viewed as embracing future possibilities, as well as involving endurance and motivation (Moltmann, 1993; O'Hara, 2013; Snyder, 2000).

Some philosophers provided a predominantly negative definition of this construct. For example, Nietzsche (1896) conceptualised hope as serving no constructive function, and Camus (1955) viewed hope as a delusion that distracts an individual from living and valuing the present life. In contrast, other philosophers such as Hobbes, Descartes, Spinoza, Lock, and Hume shared a more positive sentiment and referred to hope as a desire for an end that is perceived to be good and possible. The latter philosophers thus viewed hope as an emotion that occupies a conceptual space between certainty and impossibility (Callina et al., 2018). The dictionary furthermore provides multifaceted definitions of hope. As a noun, it is defined as a pre-existing objective entity, predominantly outside of one's control. However, hope as a verb is described as a subjective reality, involving a sense of motivation and energy directed towards action (O'Hara, 2013; Webster's Dictionary, 2006). Despite these various, often contradictory, definitions of hope, the majority of descriptions acknowledge elements of a positive future expectation, agency, and trust (Callina et al., 2018).

3.2.2 Psychological perspectives on hope

Stemming from these historical, theological, and philosophical definitions, a wide range of theoretical perspectives concerning hope have emerged. Although most theories of hope have considered hope to be a positive expectation towards future outcomes, major divergences regarding the basic qualities of hope still exist. For this study, only the most prominent psychological perspectives are considered.

Although hope was largely ignored as a research topic until the first half of the 20th century, writers thereafter began to highlight the significance of hope in relation to human health and well-being (Erikson, 1964; Frank, 1968; Frankl, 1959; Fromm, 1968; Gallagher, 2018; Menninger, 1959; Stotland, 1969). Researchers began recognising

the vital role that hope plays in promoting recovery during psychotherapy, making it a renowned topic in the field of positive psychology (Blundo et al., 2014; Callina et al., 2018; Gallagher, 2018; Seligman & Csikszentmihalyi, 2000). Initially, psychological theories shared the central premise that hope represents a positive expectation for goal attainment. This was commonly referred to as the *bare-bones* conception of hope (Callina et al., 2018; Gallagher, 2018; Snyder, 2000). Additionally, Stotland (1969) highlighted the importance of agency in working towards one's goals, while Erikson (1964) acknowledged the crucial role that a trusting environment plays in the development of hope. However, in the field of positive psychology, Snyder (2000) provided one of the most influential theories on hope.

3.2.2.1 Snyder's (2000) hope theory

Building on early perspectives concerning hope, Snyder defined hope as "a positive motivational state that is based on an interactively derived sense of successful agency (goal-directed energy) and pathways (planning to meet one's goals)" (Snyder, Irving, & Anderson, 1991, p. 287). He thus conceptualised hope as a cognitive-motivational construct, consisting of goals, pathways, and agency thinking. Although the different components of hope are factorially distinct from one another, they are also highly correlated and work together to affect perceptions of future success and goal-directed behaviour (Snyder, 2000; Snyder, Harris et al., 1991). Snyder (1994, 2000, 2002) also assumed that a hopeful disposition is primarily learned during childhood and through significant life experiences.

Snyder and colleagues (Snyder, Harris et al., 1991, Snyder et al., 1996) furthermore distinguished between *trait or dispositional hope* on the one hand, and *state or situational hope* on the other. Dispositional hope functions as an enduring attitude or approach to life and is less likely to fluctuate in response to environmental changes (Snyder et al., 1996). In contrast, situational hope describes the current feelings an individual has regarding a particular situation and may therefore fluctuate over time or be influenced by interventions (Farran, Herth, & Popovich, 1995; Snyder et al., 1996). This study focused on the latter, as it aimed to explore how a specific intervention may change participants' experience of hope. The three components of hope, as conceptualised by Snyder (2000) are set out below.

3.2.2.1.1 *Goals, pathways, and agency thinking*

Hopeful thinking emerges in the presence of a meaningful and valuable goal which activates an iterative and additive relationship between pathways and agency thinking (Snyder, 2000; Snyder et al., 2002, 2018). Snyder and colleagues referred to *goals* as the cognitive component that anchors hope theory. Goals thus provide the targets of mental action sequences and may either be approach orientated (e.g. moving towards an outcome that is currently not in place) or avoidance-orientated (e.g. moving away from an aversive outcome or status) (Snyder et al., 2002, 2018). Goals usually fall within six distinct domains (e.g. social relationships, romantic relationships, family life, academics, work, and leisure activities) and may be short- or long-term in nature (Snyder, Harris et al., 1991, Snyder et al., 2018). According to Snyder and colleagues, goals need to be reasonably important to occupy conscious thought. Although hope is observed in the presence of both unachievable as well as mundane goals, it appears to flourish under probabilities of intermediate goal attainment (Snyder, 2002; Snyder et al., 2002, 2018).

While goals set the target direction for an individual's thoughts and actions, pathways serve as the routes to reach these goals. *Pathways thinking* thus refers to one's perceived ability to identify strategies or useable routes to obtain desired outcomes. This is often described as *mental waypower* or the affirming internal belief that *I'll find a way to get this done* (Magaletta & Oliver, 1999; O'Hara, 2013; Snyder, 1994, 2000; Snyder et al., 2002, 2018). In any given situation, pathways thinking is associated with the capability to generate at least one useable route. However, in the face of impediments or goal blockages, the production of several pathways is important (Snyder et al., 2018). High-hope people thus find it easy to identify a clear pathway towards their goals and appear to be flexible thinkers. If their primary route is blocked, they are more likely to identify alternative pathways and effectively reach their desired goals (Snyder, 2000, 2002; Snyder, LaPointe, Crowson, & Early 1998).

Agency thinking refers to the motivational component of hope theory. It is the perceived energy to initiate and maintain movement along the identified pathway. Authors frequently refer to this as the *mental willpower* or the agentic internal belief that *I can do this* (Magaletta & Oliver, 1999; Snyder, 1994, 2002; Snyder et al., 2002, 2018). Such agentic self-talk thus re-affirms high-hope people's perceived ability and

increases their confidence in the decisions they make towards goal attainment (Snyder, 2002; Snyder et al., 1998). Although agency thinking is important in all goal-directed thought, it specifically appears valuable in the face of impediments as it channels motivation to the best alternative pathway (Snyder, 1994, 2000; Snyder et al., 2002, 2018).

3.2.2.1.2 *The role of emotions in Snyder's hope theory*

Although Snyder's (2000) hope theory prioritised the cognitive-motivational processes behind hope, he acknowledged that positive emotions could flow from perceptions of successful goal pursuit. These perceptions can either result from an unconstrained movement toward desired goals or from effectively overcoming goal blockages (Snyder, 2000; Snyder et al., 2002, 2018). For example, major impediments or life stressors challenge goal attainment, and necessitate adjustment of pathways and agentic processes. If stressors are overcome and goals are attained, the resultant positive emotions will reinforce perceived pathways and agentic capabilities regarding future goal pursuits, thus increasing hope (Snyder, 2000, 2002; Snyder et al., 2002).

In contrast, if goals are not attained, the resultant failure-derived negative emotions will cycle back to influence subsequent perceived pathways and agentic capabilities in various situations. Positive cognitive and affective feedback from the perceived benefits of the current goal pursuit and previous goal pursuits thus increases hope (Snyder, 2000, 2002; Snyder et al., 2018). According to Snyder (2002), high-hope people therefore display enduring positive emotions and resilience, and low-hope people are more likely to experience negative emotions and depressive manifestations. These dispositional tendencies appear to be relatively stable, even in the context of impediments.

3.2.2.1.3 *Critical perspective on Snyder's hope theory*

Snyder's (2000) theory is distinct from previous conceptualisations of hope as it places dual emphasis on the goal itself, and the thinking processes in pursuit of the goal. It furthermore acknowledges the role that emotions play with regards to goal attainment, especially in the face of impediments. This theory also deemphasises the connotation of positive expectation in goal attainment and recognises that goals can be re-adjusted, even when one fails to achieve the original goal (Snyder et al., 2018).

Although Snyder's hope theory is considered to be influential and valuable, it has a number of limitations.

First, Snyder's model does not take into account the initial sentiments on hope, such as the importance of a positive future orientation and trust (Callina et al., 2018). Second, Snyder's theory of hope is predominantly individualist, focusing on self-efficacious private hope. According to Webb (2013), Snyder's conceptualisation of hope is divorced from considerations of the wider social, economic, and political context. Lastly, various authors have argued that hope theory fails to explain why some people remain hopeful in situations where they feel they cannot do anything to attain their goal (Tong, Fredrickson, Chang, & Lim, 2010). According to Tong et al. (2010), hope can be felt as long as a person believes that an important goal can be attained, even if they do not believe in their own ability to obtain it. Authors have therefore proposed that agency thinking might play a more prominent role in hope than pathways thinking (Pettit, 2004; Tong et al., 2010). In order to address these limitations, various theorists have proposed alternative psychological theories, some of which are considered in the section below.

3.2.2.2 Alternative psychological perspectives on hope

3.2.2.2.1 *Extending hope theory: Internal and external locus-of-hope*

Bernardo (2010) argued that Snyder's hope theory had failed to articulate whether agency and pathways are self-determined, or influenced by external agents. Bernardo therefore proposed an extension of hope theory by adding *locus-of-hope* as a dimension of hope. According to Bernardo, locus-of-hope refers to whether the components of hope involve internal or external agents, and internally or externally generated pathways. For example, an internal locus-of-hope refers to the individual as the agent of goal attainment cognitions, while an external locus-of-hope refers to significant others and external forces as agents of goal attainment cognitions. With regards to the external locus-of-hope, he proposed three sub-dimensions, namely family, peers, and supernatural/spiritual beings or forces (Bernardo, 2010). This conceptualisation was supported by earlier studies that had suggested that goal-directed cognitions may involve the goals and actions of other people (Bandura, 2001; Markus & Kitayama, 2003; Miller, 2003).

Besides providing some evidence for the distinctiveness of the two loci of hope and the theoretical relatedness of the three external locus-of-hope dimensions, Bernardo (2010) also proposed cultural differences with regards to these dimensions. For example, he found that individualism was associated with the more disjoint conceptions of agency, and it was assumed to underlie the internal locus-of-hope dimension. However, collectivism was associated with more conjoint models of agency, assumed to underlie the various external locus-of-hope dimensions. This highlighted the need to consider relational and spiritual dimensions of hope in order to fully understand the human experience of hope (Bernardo, 2010).

3.2.2.2.2 *Hope as perceived by people*

Snyder's theory was also criticised for not reflecting how everyday people define hope; as shown in qualitative studies, hope is a complex phenomenon (Tong et al., 2010). For example, Scioli, Ricci, Nyugen, and Scioli (2011) described hope as being comprised of mastery, attachment, survival, and spiritual systems. Various other researchers also considered spirituality and religiosity to be at the root of hope (Dufault & Martocchio, 1985; Farran et al., 1995; Scioli et al., 2011). Furthermore, hope was conceptualised as belonging to the virtue of transcendence, allowing people to build connections to something bigger than themselves (Peterson & Seligman, 2004). These studies identified a need to conceptualise and measure hope on a broader level in order to include individuals' unfiltered judgement of their own level of hopefulness (Tong et al., 2010). However, one of the challenges of defining and measuring hope, is that it is often confounded with other positive psychology constructs (Snyder et al., 2018). This necessitates the need to distinguish hope from these constructs.

3.2.3 Distinguishing hope from other psychological constructs

3.2.3.1 Hope and optimism

Hope and optimism share a positive future orientation and both of them emphasise the importance of goal-outcomes (Carver & Scheier, 2002; Snyder et al., 2002, 2018). Compared to hope theory, optimism theories primarily focus on generalised expectations and pay limited attention to one's personal control in actualising those expectations. Theories regarding optimism also place a stronger emphasis on agency-like thoughts, whereas hope theory gives equal and iterative emphasis to pathways and agentic thoughts (Carver & Scheier, 2002; O'Hara, 2013;

Scheier & Carver, 1985; Snyder et al., 2018). Hope theory furthermore explicitly attends to the aetiology of positive and negative emotions, which most theories concerning optimism fail to address. Researchers therefore agree that hope and optimism are similar, yet distinct, constructs (Carver & Scheier, 2002; Magaletta & Oliver, 1999; Seligman, 1991; Scheier & Carver, 1985).

3.2.3.2 Hope and self-efficacy

Hope and self-efficacy are associated with the activation of important goal-related outcomes and self-motivational behaviour. However, hope tends to be dispositionally and situationally based, and elf-efficacy is primarily focused on situation-specific goals (Bandura, 1982; Snyder, 2000; Snyder et al., 2018). Bandura's (1982) self-efficacy theory also refers to outcome expectancies and efficacy expectancies that are considered to be similar to hope theory's pathways and agency thoughts. However, Bandura prioritised the importance of situational self-efficacy (agency thoughts), while Snyder's hope theory acknowledged the interdependent function of both agentic and pathways thinking (Bandura, 1982; Snyder et al., 2018).

Self-efficacy theory emphasises the perceived capability of performing specific goal-directed actions (*I can*), but hope theory focuses on the intentionality to take action (*I will*). Further, self-efficacy theory does not give attention to associated emotions (Bandura, 1982; O'Hara, 2013; Snyder et al., 2018). It is logical that the factor structures of hope and self-efficacy differ, suggesting that they are distinct constructs (Magaletta & Oliver, 1999). Although hope, as defined by Snyder, is theoretically distinct from certain positive psychology constructs, it also coincides with others (Bandura, 1982; Carver & Scheier, 2002; Snyder et al., 2002, 2018). These constructs should thus be considered unique members of the positive psychology family which collectively offers psychological benefits to people (Snyder et al., 2018).

3.2.4 Operational definition of hope

Snyder's theory of hope is considered the most influential and widely studied theory of hope in psychology. This is despite the emergence of several contemporary perspectives on hope in the last decade (Gallagher, 2018). The theory not only provides clinicians with a foundation for reliably understanding and measuring hope, but is also used to enhance adaptive ways of functioning in various spheres

(Gallagher, 2018; Snyder et al., 2018). In the current study, the researcher thus conceptualises and measures hope according to Snyder's (2000) theory, while both acknowledging criticisms that have been directed at this theory and considering socio-cultural context.

3.2.5 Hope in a socio-cultural context

Although the majority of research concerning Snyder's theory has been conducted in western contexts, the literature highlights that hope is influenced by socio-political contexts, cultural beliefs, and worldviews (Chang & Banks, 2007; Daphne, 2011; L. M. Edwards & McClintock, 2018; Sue & Constantine, 2003). Hope thus appears to be a universal construct that exists across time and context, but is conceptualised and experienced in different ways (Lopez, Snyder, & Pedrotti, 2003). For example, the socio-cultural context in which people exist may influence the goals they develop, the impediments they face, and the resources they rely on to maintain motivation towards goal attainment (L. M. Edwards & McClintock, 2018; Snyder, 1995). The experience of hope in diverse populations, such as South Africa, should thus be considered.

3.2.5.1 Cross-cultural differences in hope

Chang and Banks (2007) conducted one of the few cross-cultural studies concerning Snyder's hope theory and compared levels of hope (agentic and pathways thinking) among European Americans, African Americans, Latinos, and Asian Americans. Contradictory to expectations, minority groups did not have lower levels of hope, compared to the western group. For example, African Americans reported greater pathways thinking, but Latinos reported greater agentic and pathways thinking when compared to European Americans. As a result, the authors hypothesised that early experience or anticipation of goal-related obstacles may provide opportunities for goal enhancement among minority groups. Members of these groups may thus be able to advance situations for themselves in which they can manage or circumvent exposure to goal-limiting barriers in the future (Chang & Banks, 2007).

Qualitative differences regarding hope were also observed across racial and ethnic groups. Although pathways and agency thinking have been considered important components of hope across cultures, the source of people's strengths and

resources to goal attainment appears to differ for different racial groups (Chang & Banks, 2007; L. M. Edwards & McClintock, 2018). In the African context, studies suggest that pathways thinking has been strongly influenced by an individual's faith and belief in God that enables them to achieve their goals (Asamoah, Osafo, & Agyapong, 2014; R. Li et al., 2010). The quantitative and qualitative differences regarding hope may thus be explained by different cultural values and ethnic identities (L. M. Edwards & McClintock, 2018). Taking into consideration these differences, it is thus important to consider hope in the diverse South African context.

3.2.5.2 Hope in the South African context

3.2.5.2.1 *Empirical findings on hope in South Africa*

African countries (including South Africa) are commonly embedded in a rich Afrocentric worldview which acknowledges an interconnectedness among the self, the community, and the spiritual world. Hope researchers have therefore endeavoured to explore how these countries conceptualise and experience hope (Daphne, 2011). In the South African context, such studies have primarily focused on vulnerable youth (Cherrington, 2018; Isaacs & Savahl, 2014; Wright et al., 2015).

For example, a group of rural South African children described hope as a multi-layered, multidimensional experience for attaining a better life on contextual, personal, relational, and collective levels. These levels were portrayed as interrelated, interdependent, and influenced by the individual's cultural and spiritual belief system or worldview (Cherrington, 2018). Similarly, vulnerable young people, living in an HIV/AIDS prevalent South African setting, viewed hope as being comprised of various processes (Wright et al., 2015). They not only identified predatory processes that challenge hope, but also referred to protective and promoting processes that support hope. Participants furthermore acknowledged both constructive intra- and interpersonal forces which support and empower them to survive and thrive in the face of adversities. Processes that identify possibilities and illuminate pathways to a brighter future were specifically emphasised as important components of hope (Wright et al., 2015).

Isaacs and Savahl (2014) also explored the sense of hope among adolescents residing in a high-violence community in South Africa. Consistent with popular perspectives on hope, participants perceived hope as a future and goal-orientated

construct. However, they identified a strong link between religion and hope, and equated hope to prayers and faith. Participants furthermore emphasised the importance of hope in seeing them through difficult challenges, specifically with regards to goal-setting and future-planning. However, adolescents also noted that perpetration of violence was associated with a loss of hope for the future, especially hope for the community (Isaacs & Savahl, 2014). These Afrocentric conceptualisations of hope highlight its multidimensional nature and give specific attention to the interdependent relationship between individual, relational, communal, and spiritual factors. These conceptualisations thus go beyond the prevalent view of individual goal achievement and advocate an ecological perspective on hope (Cherrington, 2018; Isaacs & Savahl, 2014; Wright et al., 2015).

Despite the unique conceptualisation of hope in the African context, limited literature regarding the prevalence of hope among South Africans is available (Boyce & Harris, 2013; Guse & Vermaak, 2011). For example, Boyce and Harris (2013) explored hope levels using data from a 2009 national survey. They observed higher levels of hope among people living in urban areas, compared to rural settings. Male participants also scored slightly higher than females, while no discernible correlation between hope and age could be found. According to Boyce and Harris, the link between levels of hope and race was unequivocal, with Indians being the most hopeful, followed by white, black, and coloured individuals. With regards to social position, those participants who perceived themselves to be of lower social class were less hopeful than those from a higher position. These findings appeared to reflect the continued negative association between hope levels and membership of previously marginalised groups in South Africa. Further longitudinal studies were recommended to explore the cause and effect of hope in the country (Boyce & Harris, 2013).

Furthermore, Guse and Vermaak (2011) explored the degree of hope among a group of South African adolescents from different population groups. They also aimed to establish the possible moderating effect of socioeconomic status (SES) on the relationship between hope and psychosocial well-being. Results suggested relatively high levels of hope among adolescents and reported no statistically significant differences between different racial groups. Although a statistically significant relationship was found between hope and psychosocial well-being, SES did not play

a moderating role. These findings suggested that, despite variances in SES, South African adolescents seemed to be equally hopeful (Guse & Vermaak, 2011).

Despite the few studies exploring the experience of hope among South African youth, only a limited amount of research has focused on the experience and prevalence of hope among adults. Nevertheless, the existing studies have contributed by recognising the need for improved understanding of indigenous perspectives in the field of hope, and provided a foundation for developing and designing hope-enhancing interventions in South Africa (Cherrington, 2018; Guse & Vermaak, 2011; Isaacs & Savahl, 2014; Wright et al., 2015). Some of these interventions, and the impact they have on participants' levels of hope, are now considered.

3.2.5.2.2 *Hope-enhancing interventions in the South African context*

The majority of research on hope-enhancing interventions in South Africa focus on children (Cherrington & De Lange, 2016; Teodorczuk et al., 2019). For example, a study conducted by Cherrington and De Lange (2016) indicated that hope-orientated visual participatory processes (e.g. collage-making, drawing, and the Mmogo-method®) can strengthen South African primary school children's hope on personal, relational, and collective levels. Teodorczuk et al. (2019) furthermore evaluated the effect of positive psychology interventions on hope among adolescents living in a child and youth care centre in South Africa. These interventions consisted of six structured weekly sessions aimed at identifying and building character strengths and cultivating positive emotions and hope. Although no statistically significant differences in hope could be found between the experimental and control groups, qualitative feedback after the interventions suggested improvement. These findings indicated that certain psychotherapeutic interventions have hope-enhancing benefits for South African children, but that further mixed methods research was needed (Cherrington & De Lange, 2016; Teodorczuk et al., 2019).

Pretorius et al. (2008) conducted one of the few published studies focusing on hope enhancement interventions for adults in South Africa. This intervention was based on Snyder's hope theory and consisted of six, two-hour sessions conducted over five days. Pre- and post-test scores indicated that the hope enhancement intervention was effective at increasing levels of hope. Significant increases in pathways thinking and hopeful expectations for the future were observed, as

measured by the Hope Scale and the Hopefulness Subscale of the Hunter Opinions and Personal Expectations Scale (HOPES HS). Although these findings appeared promising to clinicians, the study sample was relatively heterogeneous and free of pathology (Pretorius et al., 2008). Means of enhancing hope and the effectiveness of hope-enhancing programmes among adults in South Africa thus deserve further attention (Guse & Vermaak, 2011; Pretorius et al., 2008; Teodorczuk et al., 2019). This may specifically be relevant in the context of trauma.

3.2.6 Hope in the context of trauma

Hope theory conceptualises trauma as an impediment or goal blockage which interferes with an individual's normal goal attainment (Snyder et al., 2002, 2018). Goal obstruction therefore triggers a sense of lost agency which may lead to feelings of dysphoria, anger, and frustration. These negative emotions often prompt trauma-related thoughts and memories which may halt goal-directed thinking and subsequently reduce hope (Long & Gallagher, 2018). Although a traumatic event may reduce hope, hope also appears to play an important role in coping with difficult life situations. Hope not only reduces stress and prevents the development of trauma-related problems, but also promotes more adaptive responses during adversity. Hope may therefore act as a protective factor in the aftermath of trauma (Levi et al., 2012b; Long & Gallagher, 2018). It is therefore important to consider the role of hope as this relates to trauma.

3.2.6.1 The negative impact of trauma on hope

3.2.6.1.1 *Trauma and decreased hope*

The literature suggests that traumatic events and the associated negative psychological consequences may erode trauma survivors' hope. Herman (1992) observed that trauma victims lose the ability to think about the future, while Janoff-Bulman (1992) pointed out that a traumatic event challenges the positive beliefs people have about themselves and the world. According to Snyder (2002), variables such as violence, victimisation, loss, and non-supportive environments contribute to diminished hope in the context of trauma. Studies have supported these observations and have suggested that hope is negatively related to various traumatic events (Chang et al., 2015; Irving, et al., 1997; Levi et al., 2012b; Oskin, 1996).

For example, Oskin (1996) identified a negative relationship between exposure to community violence and children's levels of hope. This relationship appeared to be stronger for younger girls who experienced direct victimisation (Oskin, 1996). Irving et al. (1997) also found that combat veterans of the Vietnam war experienced significantly lower levels of dispositional hope, compared to other clinical populations. They specifically reported lower agency scores, suggesting that although they believed they can find strategies for accomplishing life goals, they lacked the energy or determination to do so. These findings indicated that trauma survivors with deficient agency may benefit more from motivational, rather than skills-based interventions (Irving et al., 1997). Studies have furthermore shown that hope is negatively associated with sexual assault among college students, although Chang et al. (2015) found that in the latter sample, the presence of hope was related to lower suicidal risk, as it assisted participants to identify and sustain greater reasons for living.

3.2.6.1.2 *Trauma and hopelessness*

The negative impact traumatic events may have on hope is further highlighted by the sense of hopelessness reported by trauma survivors (Long & Gallagher, 2018; Machado, de Azevedo, Facuri, Vieira, & Fernandes, 2010; Panagioti, Gooding, & Tarrier, 2012; Scher & Resick, 2005; Spokas, Wenzel, Stirman, Brown, & Beck, 2009). Although hopelessness implies a lack of hope, it should be noted that hope and hopelessness are considered fundamentally distinct constructs, each situated on their own bipolar spectrum. Hopelessness commonly involves negative thoughts about the future, while low-hope refers to a lack of positive thoughts regarding the future. An individual can therefore have high leves of hope (agency and problem-solving abilities) on one spectrum, while at the same time experience hopelessness (negative future-orientated thoughts) on the other (Grewal & Porter, 2007; Huen, Ip, Ho, & Yip, 2015).

Despite the distinct differences between hopelessness and hope, it is important to reflect on hopelessness to fully comprehend the impact trauma has on hope (Long & Gallagher, 2018). As Folkman (2010) stated, “the significance of hope is perhaps best understood by the consequences of its absence” (p. 901). For example, Machado et al. (2010) reported that 22% of women exposed to sexual violence experienced moderate to severe hopelessness in the first month following the traumatic event. This decreased to 10% six months after the event (Machado et al., 2010). Similarly, Spokas

et al. (2009) found that men with a history of childhood sexual abuse (CSA) reported significantly higher levels of hopelessness, compared to those without a CSA history. The authors proposed that people exposed to CSA are more likely to attribute the negative life event to internal causes, which may increase their likelihood of experiencing hopelessness (Spokas et al., 2009).

Furthermore, Scher and Resick (2005) reported that hopelessness was associated with self-reported symptoms of PTSD among women exposed to sexual or physical interpersonal violence. These findings suggested that hopelessness is a variable risk factor for the development of PTSD symptoms in the aftermath of trauma (Scher & Resick, 2005). In agreement with these findings, Panagioti et al. (2012) reported that individuals with PTSD scored significantly higher than trauma victims without PTSD on measures of hopelessness, defeat, entrapment, suicidal behaviour, and depression. Results from the latter study furthermore proposed that hopelessness is significantly associated with suicidal behaviour among participants diagnosed with PTSD (Panagioti et al., 2012). Although these studies have highlighted the negative impact trauma has on hope, it would be beneficial if the findings were replicated in other populations (and with different traumatic events) to establish generalisability. The beneficial role hope may play in the context of trauma should also be considered.

3.2.6.2 The benefits of hope in the context of trauma

3.2.6.2.1 *Hope and positive coping*

At times, it might appear as if people with high levels of hope do not suffer disappointments as frequently as people with low levels of hope. However, it rather seems as if they differ in the way they view and approach difficult experiences (Snyder, 2000). According to the literature, people with high levels of hope tend to view impediments as useful resources towards attaining their goals, focus on successes, despite failures, and demonstrate desirable coping strategies in the face of adversity (Reff, Kwon, & Campbell, 2005, Snyder, 1994; Snyder, Lehman, Kluck, & Monsson, 2006). For example, studies have suggested that pathways thinking drives the use of a broader range of coping strategies, but agency thinking drives greater persistence with a specific coping strategy (Long & Gallagher, 2018; Snyder, 2000; Snyder et al., 2006).

With regards to trauma, research indicated that hope is associated with problem-focused and emotional-approach coping strategies. Emotional-approach coping, in particular, was associated with resilience, and decreased risk for the development of PTSD and depressive symptomatology (Affleck & Tennen, 1996; Hassija, Luterek, Naragon-Gainey, Moore, & Simpson, 2012; Snyder, Harris et al., 1991). These coping strategies contrasted starkly with the avoidance-coping strategies employed by people with low levels of hope. Avoidance-coping not only exacerbated distress, but also inhibited emotional processing among trauma survivors (Chang, 1998; Glass, Flory, Hankin, Kloos, & Turecki, 2009; Hassija et al., 2012; Snyder, Cheavens, & Michael, 1999). Hope is thus associated with positive coping strategies which may assist people to cope effectively in the aftermath of trauma.

3.2.6.2.2 *Hope and post-traumatic growth*

As discussed in Chapter 2 (Section 2.2.3.2.1), people who encounter traumatic life events may experience positive psychological changes, commonly referred to as post-traumatic growth (Bannink, 2009; Tedeschi & Calhoun, 2004). As shown in the literature, hope plays an important role in facilitating psychological growth across a wide range of traumatic events. Besides promoting positive coping strategies, several mechanisms whereby hope influences post-traumatic growth has been proposed (Cabral, 2010; Kaye-Tzadok & Davidson-Arad, 2016; Kroo & Nagy, 2011; Long & Gallagher, 2018). For instance, researchers have suggested that hope is positively related to cognitive flexibility and the capacity to establish new goals. It also allows reliance on other life roles such as relationships, career, and recreation when original goals are blocked. Hope is furthermore associated with reduced negative rumination and benefit-finding in the aftermath of trauma, variables that contribute towards post-traumatic growth. Hope therefore tends to shift an individual's attention from fixating on the traumatic event to problem-solving and adaptation (Affleck & Tennen, 1996; Ai et al., 2011; Ciarrochi, Parker, Kashdan, Heaven, & Barkus, 2015; Kaye-Tzadok & Davidson-Arad, 2016; Snyder et al., 2002).

The literature has furthermore suggested that high-hope people have a sense of self-efficacy and confidence in their capacity to adapt to difficulties and losses. As a result, they tend to view obstacles as challenges and focus on successes, rather than failures. This possibly provides them with the agency and motivation to grow and not merely recover from a traumatic event (Ai, Tice, Whitsett, Ishisaka, & Chim, 2007;

Snyder, 1994, 2000, 2002). In addition, people with high levels of hope are less likely to experience negative emotional reactions and distress, and are thus quicker to regain their sense of agency and motivation when faced with impediments (Long & Gallagher, 2018; Snyder, 2000). Finally, hopeful people are more likely to reach out and utilise their social support networks to help them cope with challenging life circumstances. As a result, such people can experience growth in their interpersonal relationships which may contribute towards post-traumatic growth (Long & Gallagher, 2018).

However, the type and amount of adversity an individual is exposed to may mediate the relationship between hope and post-traumatic growth. For example, Stermac, Cabral, Clarke, and Toner (2014) found that lower levels of distress among survivors of sexual assault were associated with greater post-traumatic growth. This relationship appeared to be mediated by hope and specifically agency thinking (Stermac et al., 2014). Furthermore, Keinan, Shrira, and Shmotkin (2012) reported that high exposure to other-orientated traumatic events (e.g. witnessing or hearing about the traumatic events experienced by a loved one) are associated with more depressive symptoms, but a higher quality of life and hope among ageing Israelis. These results suggest that certain types of trauma, like other-orientated adversity, may have less of an impact on the mediating role of hope. It was furthermore proposed that exposure to a greater amount of adversity may be associated with higher levels of hope, and therefore greater post-traumatic growth (Keinan et al., 2012).

However, more research regarding the role of trauma dynamics in the relationship between hope and post-traumatic growth is needed. Similarly, the unique mechanisms by which hope influences post-traumatic growth should be explored further (Cabral, 2010; Kaye-Tzadok & Davidson-Arad, 2016; Keinan et al., 2012; Kroo & Nagy, 2011; Long & Gallagher, 2018; Stermac et al., 2014). Besides facilitating post-traumatic growth, hope is also inversely related to markers of psychopathology, such as depression and anxiety (Caretta, Ridner, & Dietrich, 2014; Hirsch, Visser, Chang, & Jeglic, 2012; Long & Gallagher, 2018). It is therefore important to consider the possible beneficial role hope plays in relation to trauma-related psychopathology and the implications this has with regards to psychotherapeutic interventions.

3.2.6.2.3 *Hope and trauma-related psychopathology*

As highlighted in Chapter 2 (Section 2.2.3.1), psychopathological symptoms such as depression and anxiety are often associated with increased suffering and poorer therapeutic prognosis among trauma survivors. However, studies have demonstrated an inverse relationship between hope and depression in a wide range of populations (Alacron, Bowling, & Khazon, 2013; Ritschel & Sheppard, 2018; Thimm, Holte, Brennen, & Wang, 2013). For example, depressed individuals are inclined to be more pessimistic regarding the possibility of achieving their goals, feel as if they have less control over the outcome of their goal pursuits, generate less specific goals, and have lower intrinsic motivation towards approach-orientated goals (Dickson, Moberly, & Kinderman, 2011; Dickson & Moberly, 2013; Winch, Moberly, & Dickson, 2015). Hope may also act as a moderator variable between risk factors for depression, such as rumination and perfectionism (Geiger & Kwon, 2010; Mathew, Dunning, Coats, & Whelan, 2014). Depressed individuals may thus have lower levels of hope, but hope can also act as a protective factor against the development of depression

With regards to anxiety, empirical studies suggest that higher levels of hope are associated with lower levels of anxiety (Gana, Diagre, & Ledrich, 2013; Graham, 2006; Holleran & Snyder, 1990). According to Gana et al. (2013), hope is negatively correlated with negative affect and general forms of anxiety, such as anxious apprehension, physiological arousal, and panic-related anxiety. Hope also appears to be inversely associated with psychological distress and anxiety-related symptoms (Graham, 2006; Holleran & Snyder, 1990). As hope is associated with lower levels of trauma-related psychopathology, it is considered as a protective factor in the context of trauma (Long & Gallagher, 2018).

3.2.6.3 Hope as a protective factor in the context of trauma

Research findings suggest that hope plays a protective role in various traumatic situations, including natural disaster, war, life-threatening diseases, and physical disability (Elliott & Kurylo, 2000; Glass et al., 2009; Irving et al., 1998; Kasler, Dahan, & Elias, 2008; Levi et al., 2012a, 2012b; Moon & Snyder, 2000; Stanton, Danoff-Burg, & Huggins, 2002). For example, a study conducted with survivors of Hurricane Katrina found that individuals higher on hope, reported fewer PTSD symptoms (Glass et al.,

2009). Kasler et al. (2008) reported similar results among children from schools in an Israeli city affected by rocket attacks.

Levi and colleagues (2012a, 2012b) also suggested that hope plays a crucial role in assisting Israeli soldiers to cope during and after traumatic events. They conducted a qualitative study to explore the perceptions and experiences of hope among chronic PTSD veterans in Israel. Although veterans reported a sudden loss of hope immediately after the traumatic event, the majority experienced a more rational, mature form of hope as time lapsed. According to veterans, this form of hope was critical in their survival of the traumatic event as they described it as a source of life, which enabled them to maintain life and continue coping even in times of adversity. War veterans furthermore indicated that hope inspired them to turn to others who provided more hope (Levi et al., 2012a).

Hope may also play a beneficial role following a positive HIV/AIDS diagnosis (Moon & Snyder, 2000). In this context, high-hope people were more likely to adjust previous priorities, develop alternative methods to reach their goals, and utilise agentic and pathways thinking to pursue new life goals (Snyder, 1994). They also made use of active coping strategies to attain their goals and engaged in life-preserving behaviour. As a result, they experienced positive psychological adjustment and increased well-being, despite their diagnosis (Snyder et al., 1999). Hope in the context of HIV/AIDS can therefore help people deal more effectively with the associated challenges, protect them against negative psychological reactions, and possibly ignite psychological growth (Moon & Snyder, 2000).

The literature furthermore indicates that hope may assist people in coping with cancer (Irving et al., 1998; Jafari et al., 2010; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000; Stanton et al., 2002). For example, Irving et al. (1998) found that hopeful women, at risk for breast cancer, were more likely to conduct regular screenings, engage in preventative behaviour, utilise active coping responses, and view long-term health as an attainable goal. Upon diagnosis, high-hope women were also more likely to remain actively focused on their goal pursuits and had clearly defined pathways for dealing with treatment procedures (e.g. social support and relaxation techniques). It furthermore seemed that these individuals were more likely to adhere to medical regimens, despite associated challenges (Irving et al., 1998). Similarly, Stanton et al.

(2002) found that women with high levels of hope and who had received breast cancer treatment had positive perceptions about their health and reported high levels of positive emotions. They also experienced lower levels of psychological distress, fewer cancer-related physical complaints, and lower fear of recurrence, compared to women with low levels of hope (Stanton et al., 2002).

With regards to physical disability, studies have indicated that hope may facilitate adjustment (Affleck & Tennen, 1996; Elliott & Kurylo, 2000). According to Elliott and Kurylo (2000), hope was found to play an integral role in maintaining a positive self-image and protecting individuals against depressive behaviour and psychological impairment when faced with a physical disability. Hopeful people furthermore displayed more functional abilities when they entered rehabilitation programmes for physical disability (Elliott & Kurylo, 2000). This might be based on high-hope people remaining appropriately focused and motivated on what they need to do to recuperate. This is in stark contrast to the self-focus, self-pity, and anxiety that can overwhelm people with low levels of hope (Snyder et al., 2018). It is thus clear that hope not only facilitates effective coping and growth in the face of adversity, but may also play an important role in protecting trauma survivors against trauma-related psychopathology (Levi et al., 2012a, 2012b; Moon & Snyder, 2000). This supports the need to discuss hope's role in psychotherapy.

3.2.7 The role of hope in psychotherapy

Hope is acknowledged as a key component and common factor in psychotherapy, and it also plays an important implicit and explicit role in various therapeutic approaches (Blow & Sprenkle, 2001; Frank, 1971; Hubble, Duncan, & Miller, 1999; Lambert, 1992; Lambert, Shapiro, & Bergin, 1986). Hope-based interventions, such as hope therapy and SFBT, appear to be particularly effective at increasing hope (Bozeman, 1999; Cheavens, Feldman, Gum, Michael, & Snyder, 2006; Heiy & Cheavens, 2015; Klausner et al., 1998; Michael et al., 2000; Quick & Gizzo, 2007; Thornton et al., 2014). It is therefore valuable to consider the role of hope in psychotherapy.

3.2.7.1 Hope as a common factor in psychotherapy

A set of common factors which account for therapeutic change across different therapeutic modalities can be identified in the literature. These include extra-therapeutic factors, therapeutic techniques, the therapeutic alliance, and hope and expectancy. Studies suggested that hope and expectancy account for 15%–30% of therapeutic change (Blow & Sprenkle, 2001; Frank, 1971; Hubble et al., 1999; Lambert, 1992; Lambert et al., 1986). Researchers have also shown that patients at mental health centres have experienced increased levels of hope, irrespective of the theoretical approach that was used, even when hope was not a specific target of treatment (Harper-Jacques & Foucault, 2014; Irving et al., 2004; Ritschel, Cheavens, & Nelson, 2012). These findings suggest that engagement in a structured activity aimed at improving mental health functioning, regardless of the underlying psychotherapeutic approach, may positively impact the experience of hope, and therefore contribute to positive change through therapy (Cheavens & Guter, 2018).

Literature furthermore highlights the benefits of uncovering, instilling, and expressing hope in psychotherapy (Cooper, Darmody, & Dolan, 2003; Snyder, 2000). A hopeful stance in therapy not only facilitates more favourable psychotherapeutic outcomes, but is also associated with fewer psychopathological symptoms and greater psychological functioning following therapy. This could be explained by the fact that high-hope people are more likely to believe that therapeutic goals will be attained and that treatment will be successful (Cheavens et al., 2006; Cooper et al., 2003; Gilman et al., 2012; Irving et al., 2004). According to Snyder (2000), the belief that one can find ways to deal with problems (pathways thinking), and having the confidence that one can apply the necessary motivation to utilise those pathways (agency thinking), maintain therapeutic progress and prevent relapse in therapy. The general aim of psychotherapy, regardless of the intervention used, is thus to find motivation and ways to obtain desired goals (Frank, 1971; Snyder, 2000; Taylor, Feldman, Saunders, & Ilardi, 2000). However, hope may play a more explicit role in certain therapeutic approaches.

3.2.7.2 Hope in traditional therapeutic approaches

Different therapeutic approaches employ hope in different ways. For example, humanistic therapies, such as *person-centred therapy* and *gestalt therapy*, focus on building a therapeutic relationship characterised by acceptance, empathy, and

congruence that aims to inspire hope in the client (O'Hara, 2013; Rogers, 1980). Similarly, psychodynamic therapy places emphasis on the relationship between the client and the therapist, with the therapist not only sharing the client's emotional burden, but also containing hope until the client is in a position to do so themselves (O'Hara, 2013). In CBT, goal-setting, and skills training generate hope among clients. Specific CBT techniques may also amplify the different components of hope in a distinct manner (Cheavens & Guter, 2018; Taylor et al., 2000). Although hope is widely accepted as a central component in various psychotherapeutic approaches, little is known about the pragmatics of hope in clinical practice (Arnau, 2018; Courtnage, 2020; Long & Gallagher, 2018). However, interventions with a more explicit focus on increasing hopeful thinking may shed some light in this regard.

3.2.7.3 Hope therapy

3.2.7.3.1 *Hopeful principles and interventions*

Hope therapy, derived from Snyder's (2000) hope theory, refers to a system of specific intervention techniques to enhance hope in psychotherapy (Lopez et al., 2000). Hope therapy aims to help clients conceptualise optimal goals, and identify and evaluate possible pathways to obtain these goals. It also assists clients to muster the mental energy to initiate and maintain goal pursuits. Hope therapy furthermore guides clients in reframing overwhelming obstacles as challenges that can be overcome, and assists with anticipating and planning around these obstacles (Cheavens & Guter, 2018; Lopez et al., 2000). The focus of hope therapy is therefore on present goals, future possibilities, and past successes, rather than on problems or failures (Lopez et al., 2000).

The therapeutic relationship implicitly contributes towards change in hope therapy as therapists assume that all people have the capacity for hopeful thinking and that hope can be created in therapy (Coppock, Owen, Zagarskas, & Schmidt, 2010; Flesaker & Larsen, 2010; O'Hara, 2013). Sharing one's story with a neutral and objective listener may also be a source of hope for clients, as it influences their self-perception (Larsen & Stege, 2010; Lopez et al., 2000). Beside these implicit strategies, therapists also utilise various explicit hope-focused strategies to instil and increase hope. These include therapeutic techniques such as constructing of manageable approach-orientated sub-goals, conducting a cost-benefit analysis to identify the most

viable route to one's goals, and mentally rehearsing goal attainment. Therapists applying hope therapy furthermore encourage positive self-talk, self-care, and the cultivation of positive relationships which may contribute towards hope (Cheavens & Guter, 2018; Lopez et al., 2000).

In the face of impediments, hope therapy specifically focuses on finding alternative goals, emphasising positive domains of life, and recounting successful past goal pursuits. This appears to ignite hope within the present situation (Lopez et al., 2000; O'Hara, 2013). Although therapists acknowledge the client's hopelessness and pain during challenges, they also notice and highlight their strengths, abilities, and resources which contribute towards hope (Cheavens et al., 2006; Larsen & Stege, 2010; Lopez et al., 2000). This is supported by empirical evidence.

3.2.7.3.2 *Empirical studies on the effectiveness of increasing hope*

The literature shows that hope therapy influences self-reported levels of hope (Cheavens et al., 2006; Klausner et al., 1998; Snyder, 1994, 2002; Thornton et al., 2014). For example, Klausner et al. (1998) found that depressed adults who were exposed to goal-focused group psychotherapy, an intervention based on Snyder's hope theory, experienced increased levels of total hope and agency thinking. However, these increases were not significantly different when compared to the control group (Klausner et al., 1998). Clearer evidence was obtained by Cheavens et al. (2006) who developed and tested a comprehensive hope therapy model. Participants who attended this eight-week hope therapy group demonstrated large increases in total hope and agency scores. However, medium increases in pathways scores were observed when compared to the control group (Cheavens et al., 2006). Building on these findings, Thornton et al. (2014) integrated hope therapy with a mindfulness/biobehavioural intervention for a group of women with recurrent cancer. They found an increase from pre- to post-treatment hope scores, specifically pathways scores, that were being maintained seven months following the intervention (Thornton et al., 2014).

In addition to increasing hope, studies have suggested that hope therapy also reduces depression and anxiety in both clinical and nonclinical samples (Cheavens et al., 2006; Heiy & Cheavens, 2015; Klausner et al., 1998; Retnowati, Ramadiyanti, Suciati, Sokang, & Viola, 2015). In the context of trauma, Retnowati et al. (2015) found

that a hope intervention, delivered to Indonesian participants exposed to a natural disaster, led to a significant reduction in self-reported depressive scores. The literature furthermore shows that hope therapy increases well-being and optimal psychological functioning among various groups (Cheavens et al., 2006; Heiy & Cheavens, 2015; Klausner et al., 1998; Retnowati et al., 2015, Thornton et al., 2014). For example, Cheavens et al. (2006) found that hope therapy significantly increased participants' meaning in life and self-esteem, compared to a wait-list group. This may be attributed to the fact that hope therapy provided more opportunities for goal attainment and focused on goals that have personal value to participants (Cheavens et al., 2006).

Although these findings highlighted the value of hope therapy, it is not proposed as a stand-alone therapy and should be considered in conjunction with other therapeutic approaches (Heiy & Cheavens, 2015; Klausner et al., 1998). As research on hope therapy is still in its infancy, further studies are warranted (Gallagher et al., 2018). However, the role that other hope-based interventions, such as SFBT, play in enhancing hope should thus also be considered.

3.2.7.4 Hope in solution-focused brief therapy

3.2.7.4.1 *Hopeful principles and interventions*

As delineated in Chapter 2, SFBT is a post-modern strength-based therapeutic approach embedded in hopefulness. The hopeful tenets of SFBT, the stance SFBT therapists take, and the distinct SFBT techniques applied, conjointly contribute to the pragmatics of hope in this approach (Blundo et al., 2014; Michael et al., 2000; O'Hara, 2013; Reiter, 2010). The hopeful therapeutic relationship in SFBT also injects hope as therapists believe in the client's capacity to shift their lives in a positive direction. Therapists conducting SFBT furthermore utilise presuppositional language and solution-focused conversations to elicit hope in therapy. For example, the common opening SFBT question, *"What are your best hopes for the session?,"* is considered as the greatest driving force of change in this approach (Ratner et al., 2012). By working collaboratively with clients as experts and focusing on their best hopes, SFBT therapists therefore communicate a strong sense of hopefulness (Blundo et al., 2014; Courtnage, 2020; Michael et al., 2000; Reiter, 2010).

The literature suggests that pathways thinking emerges through a process of solution-building. In SFBT, this is accomplished by the client describing the presence

of their best hope, either in the past or the future. These detailed descriptions thus lead to the identification of potential pathways or solutions towards their desired outcome (De Jong & Berg, 2007; Froerer & Connie, 2016). Future-orientated questions in SFBT (e.g. the miracle question), in particular, help clients identify clear, concrete outcomes (goals), formulate solutions, and generate behavioural correlates to attain these goals (pathways thinking). The miracle question thus helps clients to think about pathways they may not have considered before (Michael et al., 2000; O'Hara, 2013; Reiter, 2010).

Clients' agency thinking is facilitated by SFBT as it assumes no problem happens all the time; SFBT thus aims to identify exceptions to problems. This highlights clients' own abilities to make things better, which motivates them towards further action (Blundo et al., 2014; Reiter, 2010). By identifying client strengths, past successes, and useful behaviour they are already engaging in, SFBT therapists furthermore foster agentic thinking and a positive expectancy for change (Michael et al., 2000). Additional SFBT techniques that may amplify agentic thinking include: highlighting pre-session change, using scaling questions to measure progress, focusing on what is better and how clients made this happen, and providing compliments and homework tasks (Reiter, 2010).

According to Snyder's hope theory, SFBT thus identifies and moves clients towards their desired outcome. It not only instils pathways and agency thinking, but may subsequently also contribute towards hope and positive feelings within clients (Courtnage, 2020; Reiter, 2010; Snyder et al., 1999, Snyder, Ilardi, Michael, & Cheavens, 2000). Frederickson's (2000) broaden-and-build theory of positive emotions furthermore suggests that these positive feelings make clients more creative in finding alternative routes to their desired outcomes. This ultimately facilitates therapeutic change and sparks more hope. A synergistic relationship thus exists between hope and positive feelings as they augment and build upon each other in the practice of SFBT (Reiter, 2010).

3.2.7.4.2 *Empirical studies on the effectiveness of increasing hope*

Despite SFBT's hopeful nature, only a few empirical studies have considered the effect of SFBT on clients' levels of hope (Bozeman, 1999; Michael et al., 2000; Quick & Gizzo, 2007). For example, Bozeman (1999) reported that clients involved in

SFBT experienced significantly higher expectations of realising their desired outcomes, than those participating in a pathology-orientated model. Michael et al. (2000) furthermore found that SFBT enhanced hope when compared to a problem-solving model. More recently, Quick and Gizzo (2007) indicated that participants involved in SFBT group therapy were more hopeful about obtaining their desired outcomes. This improvement was attributed to the SFBT techniques used in therapy. Participants specifically found it helpful to strive towards small everyday victories that are known, doable, and within their grasp (Quick & Gizzo, 2007). Although evidence is limited, SFBT may be effective in increasing hope and creating a positive expectancy in therapy. Unfortunately, no studies exploring this assumption could be found in the context of trauma. It is thus relevant to consider trauma interventions that may instil hope.

3.2.7.5 Instilling hope through trauma interventions

Sympson (2000) proposed that effective psychotherapy for trauma survivors should focus on increasing levels of hope. He highlighted the importance of establishing a trusting therapeutic relationship, setting realistic future goals, and deconditioning traumatic memories and responses when reclaiming hope for trauma survivors. Furthermore, he suggested that restructuring personal schemas, establishing social connections, and interpersonal efficiency, and reinvesting in alternative future goals may play an important role in instilling hope in the aftermath of trauma (Sympson, 2000). Snyder and colleagues thus proposed that hope-based trauma interventions should aim to regain clients' normalcy goals by identifying alternative pathways and mobilising them to use those paths (Snyder et al., 2002; 2018).

3.2.7.5.1 *Instilling hope through traditional trauma interventions*

Based on these recommendations, several therapeutic approaches are utilised to enhance hope among trauma survivors (Appelt, 2006; Gallagher & Resick, 2012; Gelkopf, Hasson-Ohayon, Bikman, & Kravetz, 2013; Gilman et al., 2012; Lala et al., 2014; Long & Gallagher, 2018). For example, CBT interventions, such as CPT and PE, are associated with increased hope and reduced hopelessness among trauma survivors (Gallagher & Resick, 2012; Gilman et al., 2012). These increased levels of hope also appear to correlate with reductions in PTSD severity and depression. Although studies suggested that hope is a potential mechanism of change in the

treatment of PTSD, few studies have been designed to explore ways to harness the beneficial effect of hope in the treatment of PTSD (Cheavens & Guter, 2018; Gilman et al., 2012; Long & Gallagher, 2018). It may therefore be valuable to consider how hope-based interventions instil hope among trauma survivors.

3.2.7.5.2 *Instilling hope though hope-based trauma interventions*

Irving et al. (2004) proposed that hope therapy may be effective in facilitating hope in the aftermath of trauma. One of the few studies on hope in the context of trauma, showed that hope therapy may be effective in reducing self-reported depressive scores among trauma survivors (Retnowati et al., 2015). Research also indicated that other hope-based interventions may be effective in increasing hope following exposure to trauma (Appelt, 2006; Gelkopf et al., 2013; Lala et al., 2014; Long & Gallagher, 2018)

For example, Gelkopf et al. (2013) found that *nature adventure rehabilitation therapy* enhanced hope and reduced post-traumatic stress symptomology among clients diagnosed with combat-related PTSD. This group therapeutic approach was specifically developed to enhance self-efficacy, hope and the ability to enjoy life, and improve social and emotional regulation skills among participants (Gelkopf et al., 2013). Narrative-orientated therapeutic approaches also appear promising for enhancing hope among trauma survivors (Appelt, 2006; Lala et al., 2014). Qualitative data and anecdotal evidence suggested that *Messages of Hope*, a narrative-orientated programme designed to assist survivors of the 1994 genocide in Rwanda, contributed positively to participants' experience of hope (Lala et al., 2014). In South Africa, a narrative therapeutic approach was also used to instil hope and dignity in the community of Lavender Hill where high levels of violence are experienced. This therapeutic approach not only created a safe therapeutic relationship and restored control, but also empowered participants to reconstruct their trauma story (Appelt, 2006).

Although previous studies have suggested that SFBT contributes towards hope in psychotherapy (Bozeman, 1999; Michael et al., 2000; Quick & Gizzo, 2007), no empirical studies concerning the role that SFBT plays in facilitating hope among trauma survivors could be found. However, SFBT shares various principles with the hope-based interventions mentioned above. Some of the similarities include: the focus

on present goals, future possibilities, and past successes; the collaborative therapeutic relationship; and the therapists' belief in the client's capability (Froerer et al., 2018; Lopez et al., 2000; Michael et al., 2000). It is therefore proposed that, similar to hope-based interventions, SFBT may also be applicable for enhancing hope among trauma survivors. The current study aims to explore this notion in the South African context.

3.2.8 Evaluative summary

Of the various theoretical perspectives concerning hope, Snyder's (2000) theory is considered the most influential in psychology. This conceptualises hope as a cognitive-motivational construct, stemming from an additive and iterative relationship between pathways- and agency thinking. However, this perspective is predominantly individualistic and urges the need to explore hope in a broader socio-cultural context (Chang & Banks, 2007; Daphne, 2011; L. M. Edwards & McClintock, 2018). In South Africa, hope is described as a multidimensional experience, influenced by contextual, personal, relational, and collective factors. Further studies concerning hope and hope-enhancing programmes in this particular context is thus warranted (Cherrington, 2018; Pretorius et al., 2008; Teodorczuk et al., 2019).

Although studies have indicated that traumatic events may temporarily reduce hope, hope may also be a protective factor in the aftermath of trauma. Hope was shown not only to facilitate effective coping and growth, but it also buffers against the development of trauma-related psychopathology (Irving et al., 1997, 1998; Levi et al., 2012a, 2012b; Moon & Snyder, 2000; Oskin, 1996). It is therefore relevant to consider the role that hope may play in the context of trauma interventions. Although the literature identified hope as a common factor in psychotherapy, few studies have specifically explored how trauma interventions can instil hope (Blow & Sprenkle, 2001; Cheavens & Guter, 2018; Gilman et al., 2012; Lopez et al., 2000). Based on SFBT's hopeful nature and previous studies supporting its effectiveness in increasing hope, the researcher proposes that SFBT may be a particularly valuable therapeutic approach to facilitate hope among trauma survivors (Blundo et al., 2014; Bozeman, 1999; Michael et al., 2000; Reiter, 2010).

3.3 Subjective Well-being

3.3.1 Defining well-being

For centuries, philosophers and social scientists have devoted their attention to understanding *the good life*. Well-being researchers have thus endeavoured to discover what happiness is, who is happy, and what makes people happy (Diener, 1984, 2000; Diener, Suh, Lucas, & Smith, 1999). In an attempt to answer these questions, various conflicting definitions of well-being have emerged. For example, well-being has been referred to as virtuous behaviour, a sense of contentment, freedom from suffering, and satisfaction with life (Diener, 1984, 2000; Tov & Diener, 2013). Consequently, well-being scholars have come to distinguish between two relatively distinct yet overlapping perspectives, namely eudaimonic and hedonic well-being (Ryff, 1989).

3.3.1.1 Eudaimonic and hedonic well-being

On the one hand, *eudaimonia* refers to self-actualisation, self-acceptance or commitment to socially meaningful goals which highlight the importance of optimal human functioning (Ryan, Huta, & Deci, 2008). In psychology, eudaimonia is usually measured in terms of *psychological well-being* consisting of autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryan & Deci, 2001; Ryff, 1989).

On the other hand, *hedonia* is described as the maximisation of pleasure and the minimisation of pain (Kahneman, 1999; Waterman, 2008). The hedonic perspective on well-being thus views well-being as living a happy and satisfying life, and having more pleasant emotional experiences than negative ones. However, this view goes beyond physical hedonism and focuses on subjective happiness, the experience of pleasure versus displeasure, and subjective judgements about what is good in life (Ryan & Deci, 2001). In psychology, hedonia is usually equated to *subjective well-being* (SWB) which encompasses the presence of positive affect and life satisfaction, and the absence of negative affect (Diener, 1984; Ryan & Deci, 2001).

Despite the popular distinction between hedonia and eudaimonia, it is reported in the literature that there is a substantial overlap between these two constructs (Fredrickson et al., 2013; Gallagher, Lopez, & Preacher, 2009; Keyes, Shmotkin, &

Ryff, 2002; Linley, Maltby, Wood, Osborne, & Hurling, 2009). The mental health continuum offers a more integrated perspective on well-being and operationalises well-being as a symptom of mental health. On one end of the continuum *flourishing in life* describes the presence of mental health, while on the other end of the continuum *languishing in life* refers to the absence of mental health (Keyes, 2002). In the current study, the researcher conceptualises and measures well-being from a hedonic or subjective perspective, while acknowledging the mental health continuum.

3.3.1.2 Subjective well-being

The concept of SWB is described as multidimensional, encompassing cognitive and affective evaluations of one's life (Diener, 1984, 2000; Tov & Diener, 2013). The subjective nature of this construct highlights that evaluations are made based on an individual's own expectations, previous experiences, goals, values, and the culture they belong to (Diener, Lucas, & Oishi, 2018). Satisfaction judgements usually result from discrepancies between *life as it is* and *life as it should be*. The smaller these discrepancies are, the higher an individual's satisfaction with life appears to be (Easterlin, 1974; Michalos, 1985). Colloquially SWB is often referred to as *happiness* as it describes those facets of life that make us feel good (Diener et al., 2017). In this thesis, the terms SWB, hedonia, and happiness are thus used interchangeably. Although SWB can be conceptualised from various theoretical perspectives, the focus of this study is on the psychological perspective of SWB.

3.3.2 A psychological perspective on subjective well-being

Ed Diener's (1984) tripartite model of SWB provides the most comprehensive conceptualisation of SWB in the field of psychology. The tripartite model describes SWB as comprising three distinct but related components, namely *life satisfaction*, high levels of *positive affect,* and low levels of *negative affect*. This model inspired extensive research concerning the theory, measurement, and practice of happiness which formed the scientific foundation for the inquiry into SWB (Diener, 1984; Diener & Diener, 1995). It is thus important to consider the different components of SWB.

3.3.2.1 Positive and negative affect

Diener's (1984) tripartite model refers to positive and negative affect as the affective component of SWB. This component reflects the number of pleasant and

unpleasant feelings people experience at a specific moment in time. Positive or pleasant emotions include joy, contentment, happiness, and love. In contrast, negative or unpleasant emotions refer to sadness, anger, and worry. In general, the presence of a larger number of positive emotions, rather than negative emotions, is associated with higher levels of SWB (Diener, 1984; Diener et al., 1999, Diener, Kesebir, & Tov 2009; Eid & Larsen, 2008). This may be explained by Fredrickson's (2001) broaden-and-build theory of positive emotions which assume that positive affect builds psychological resources and therefore enhances well-being.

However, the role of positive and negative affect concerning SWB is more complex and therefore one should also consider the intensity, stability, and context of emotions. For example, suppressing the experience and intensity of negative emotions may have a detrimental effect on well-being. This especially pertains to life satisfaction, as it is associated with less social support and more stress (McMahan et al, 2016; Tamir & Ford, 2012). Kuppens and Verduyn (2017) also suggested that relative stability in experiencing positive and negative emotions is important to well-being. In essence, it appears that when emotions match the context in which they are experienced, they contribute to SWB (Ford & Mauss, 2013).

3.3.2.2 Life satisfaction

Diener's (1984) tripartite model considers life satisfaction to be the cognitive component of SWB, and refers to it as global and evaluative beliefs, and judgements about one's life. These judgements stem from a process of qualitatively evaluating one's life against certain standards and values (Diener, 1984; Diener et al., 1999; Eid & Larsen, 2008). Diener et al. (1999) distinguish between two facets of cognitive SWB, namely general life satisfaction and domain-specific life satisfaction. On the one hand, general life satisfaction refers to one's satisfaction with life as a whole. According to Diener, Scollon, and Lucas (2009), non-hedonistic aspects such as fulfilment, meaning and purpose, and success in life may contribute to this facet of life satisfaction. On the other hand, domain-specific life satisfaction includes a positive evaluation of specific aspects of one's life such as health, work, marriage, and leisure (Diener et al., 1999, Diener, Scollon et al., 2009).

It is therefore clear that SWB entails more than constant euphoria. In order for a person to experience happiness, all three elements of SWB should be present.

Although empirical studies suggested a strong positive correlation between the different components of SWB, the cognitive and affective dimensions differ in their stability and variability over time. Different variables also have differential effects on these components (Delle Fave, Brdar, Freire, Vella-Brodrick, & Wissing, 2011; Diener et al., 1999; Luhmann, Hofmann, Eid, & Lucas, 2012; Ryan & Deci, 2001). Hence, the cognitive and affective components of SWB should be understood and measured independently (Tov & Diener, 2013). Despite some agreement between researchers regarding the conceptualisation and measurement of SWB, controversy still exists regarding the variables that cause or influence SWB (Diener, 1984; Headey, Veenhoven, & Wearing, 1991). It is therefore relevant to also consider this topic.

3.3.3 Causes of subjective well-being

Towards the end of the twentieth century, there has been an exponential growth in interest about the science of happiness and SWB, with researchers proposing various disparate theories regarding the cause of SWB (Easterlin, 1974; Frederick & Loewenstein, 1999; Headey & Wearing, 1989; Lykken & Tellegen, 1996; Michalos, 1985). These theoretical perspectives are generally distinguished as either being *top-down* or *bottom-up* approaches. For example, top-down approaches argue that happiness resides within the individual and is primarily influenced by internal causes such as inborn temperament, personality, and outlook on life. In contrast, bottom-up theories suggest that circumstances and external variables (e.g. material resources, social support, and life events) cause SWB to fluctuate and change (Diener, 2013). Prominent theories concerning the cause of SWB are described in more detail below.

3.3.3.1 Biological/temperament theories

Biological/temperament theories have described SWB as a stable, inborn trait; primarily determined by hereditary characteristics. This notion was supported by behavioural-genetic studies indicating that 30%–50% of variance in all components of SWB could be attributed to shared genes (Lykken & Tellegen, 1996; Roysamb, Harris, Magnus, Vitterso, & Tambs, 2002; Stubbe, Posthuma, Boomsma, & De Geus, 2005; Tellegen et al., 1988). Although these studies suggested that inborn biology plays at least some part in determining happiness, the description of the mechanism through which these genetic effects were transmitted remained vague (Diener et al., 1999; Lucas, 2008).

Throughout the literature, stable personality traits, such as extraversion and neuroticism seemed to be some of the strongest and most consistent predictors of SWB (Costa & McCrae, 1980; DeNeve & Cooper, 1998; Diener & Seligman, 2002; Lucas & Fujita, 2000). For example, Costa and McCrae (1980) found that extraversion correlated positively with SWB, as it was associated with more positive emotions. In contrast, neuroticism correlated negatively with SWB, as it was linked to more negative emotions. Several meta-analytic studies replicated these findings (DeNeve & Cooper, 1998; Lucas & Fujita, 2000). Other traits such as agreeableness, conscientiousness, self-esteem, optimism, and locus of control were also associated with SWB (DeNeve & Cooper, 1998; Diener et al., 1999).

Although a large body of literature supports the view that SWB is a stable, inborn trait, heritability studies indicated that up to 70% of SWB is attributable to environmental effects (Diener, Oishi, & Tay, 2018; Diener et al., 1999). For example, studies found a fair amount of variability in both affective well-being and life satisfaction across the life span, which could not be attributed to inborn personality traits (Diener, Lucas, & Scollon, 2006; Fujita & Diener, 2005; Luhmann, 2017; Lucas, Clark, Georgellis, & Diener, 2003). It is thus necessary to also consider other possible causes behind SWB.

3.3.3.2 Satisfaction of goal theories

Satisfaction of goal theories assumed that people are happy and satisfied with their lives when their key needs, desires, and goals are met. This view is consistent with the resource theory of SWB that proposed that if people have enough material, cognitive, spiritual, and/or relational resources to fulfil their personal needs and desires, they tend to be satisfied with their lives (Fujita & Diener, 2005; Judge, Bono, Erez, & Locke, 2005; Michalos, 1985). These needs appear to be universal, and cross-national studies have suggested that the fulfilment of basic and psychological needs is positively associated with SWB. For example, positive life evaluations were most strongly associated with the fulfilment of basic needs such as food and shelter, while positive feelings were most strongly associated with having social needs met and experiencing respect from others (Kenrick, Griskevicius, Neuberg, & Schaller, 2010; Ryan & Deci, 2000; Tay & Diener, 2011). Cognitive processes may also play a causative role in SWB.

3.3.3.3 Cognitive theories

Cognitive theories regarding SWB have highlighted the importance of cognitive and attentional processes (Diener, 1984; Robinson & Compton, 2008). For instance, wider attentional focus and attentional flexibility are associated with higher levels of SWB. Researchers have also found robust relationships between the tendency to selectively attend to positive information and positive affect; this suggests that positive attentional biases may positively contribute towards SWB (Compton, Wirtz, Pajoumand, Claus, & Heller, 2004; Gasper & Clore, 2002; Robinson & Compton, 2008). Robinson, Vargas, Tamir, and Solberg (2004) have furthermore found that faster negative evaluations of neutral or negative stimuli where associated with more negative appraisals of daily life, more negative affect, and lower levels of life satisfaction.

Although the above-mentioned theories conceptualised SWB as a stable, inborn trait, recent studies have suggested that happiness can indeed change (Diener et al., 2006; Lykken & Tellegen, 1996; Tellegen et al., 1988). This assumption was largely based on longitudinal studies suggesting long-term fluctuations in happiness and cross-national differences regarding SWB. It is thus possible that external factors may increase or lower SWB (Diener, Diener, & Diener, 1995; Fujita & Diener, 2005; Inglehart, Foa, Peterson, & Welzel, 2008; Lucas, 2005; Lucas 2007b).

3.3.4 Factors influencing subjective well-being

Diener et al. (2006) viewed SWB as an interactional product between stable hereditary factors and dynamic psychosocial factors. The literature therefore suggests that specific demographic factors such as age, gender, marital status, and income contribute towards individual differences concerning SWB (Diener et al., 1999; Pavot & Diener, 2013). Although much controversy exists concerning the long-term impact of significant life events, these events may also have an influence on SWB (Diener et al., 2006; Frederick & Loewenstein, 1999). The most relevant factors influencing SWB are considered below.

3.3.4.1 Demographic factors

Several demographic factors related to SWB have been investigated. Contrary to popular belief, life satisfaction seems to remain relatively stable across the life span.

Research suggests that life satisfaction follows an inverted U-shape, being lowest at mid-life and higher for younger and older people (Pavot & Diener, 2013). Males and females also do not substantially differ in terms of average levels of SWB (Geerling & Diener, 2018). However, with regards to affect, women experience both positive and negative emotions more frequently and intensely than men (Diener, Kesebir, & Tov, 2009; Pavot & Diener, 2013; Zuckerman, Li, & Diener, 2017). People who are married furthermore report higher levels of SWB in comparison to those who were never married or are divorced, separated, or widowed (Pavot & Diener, 2013).

The literature identifies that there is no significant relationship between intelligence, as measured by intelligence tests, and SWB. However, emotional intelligence is consistently linked to high levels of well-being (Furnham & Petrides, 2003; Schutte, Malouff, Simunek, McKenley, & Hollander, 2002). With regards to level of education, studies show a weak positive correlation between years of formal education and SWB (Witter, Okun, Stock, & Haring, 1984). However, employment and income may act as mediator variables in this relationship, because both are associated with well-being (Diener et al., 1999). Although income significantly affects well-being for those living in poverty, the strength of the association between wealth and life satisfaction decreases at higher levels of income (Diener & Biswas-Diener, 2002; Diener, Ng, Harter, & Arora 2010; Pavot & Diener, 2013). Besides demographic factors, the impact of significant life events on SWB should also be considered.

3.3.4.2 Significant life events

Various authors have supported the stance that life events do not have a significant impact on SWB over time, but have found that both positive and negative events may have a short-term effect on SWB (Brickman et al., 1978; Lucas, 2007b; Silver, 1982; Suh et al., 1996). For example, Brickman et al. (1978) found that major life events (e.g. winning the lottery or being a victim of a paraplegic accident) did not have any lasting effects on SWB and that people adapted quickly and completely to these events. Similarly, Silver (1982) found that people with spinal cord injuries were extremely unhappy immediately after the accident that caused their disability, but that their happiness returned rather quickly. Further studies supported these findings and indicated that people gradually adapt to life events such as disability, divorce, widowhood, and natural disaster (Calvo et al., 2015; Lucas, 2007b; Suh et al., 1996).

Although negative events produced relatively more and longer-lasting affective reactions, people adapted to both positive and negative events (Diener et al., 2006; Suh et al., 1996).

The ability to return to a neutral level of happiness following exposure to life events is commonly referred to as *hedonic adaptation* (Frederick & Loewenstein, 1999). However, contradictive studies found that life events may have a significant impact on SWB and that individuals do not fully adapt to all events (Bucciol & Zarri, 2017; Lucas, 2005, Lucas & Clark, 2006; Lucas et al., 2003). For example, the literature showed that people who lost their job or got divorced experienced long-lasting changes in life satisfaction. The death of a spouse also appears to have a detrimental impact on SWB which may persist up to eight years after the event (Lucas, 2005; Lucas et al., 2003). Lindqvist, Östling, and Cesarini (2018) furthermore found that large-prize lottery winners do indeed experience sustained increases in overall life satisfaction. This effect persisted for over a decade and showed no evidence of dissipating with time. These findings suggested that life events may indeed have a long- term impact on SWB.

Adaptation to life events may be influenced by various cognitive and contextual factors (Diener et al., 2006; Scheier et al., 1989). For example, goal flexibility, cognitive reappraisal, and finding meaning might be integral to restore SWB in adverse circumstances. Specific coping strategies, such as problem- and emotion-focused coping also appeared to be beneficial towards adaptation (Cantor & Sanderson, 1999; Emmons, 1986; Oishi, Diener, Suh, & Lucas, 1999; Tennen & Affleck, 2002). With regards to contextual factors, the type of event, the degree of exposure, and post-event resources and stressors tend to influence longitudinal levels of happiness (Calvo et al., 2015; Kimball, Levy, Ohtake, & Tsutsui, 2006; Rateau, 2009). It is thus apparent that various cognitive and contextual variables may determine how a specific life event influences a person's SWB. Despite these influences, SWB is associated with various benefits.

3.3.5 The benefits of subjective well-being

The emphasis on SWB in the past few decades can mostly be attributed to the various benefits associated with happiness and life satisfaction. According to the

literature, SWB predicts positive outcomes and life success across various domains (De Neve, Diener, Tay, & Xuereb, 2013; Lyubomirsky, King, & Diener, 2005; Pressman & Cohen, 2005). On an individual level, SWB is related to longevity and less physical impairment and illness (Diener & Chan, 2011). SWB is also associated with stronger and more satisfying interpersonal relationships, as well as socioeconomic success (e.g. higher education and income) (De Neve et al., 2013; Diener et al., 1999; Lyubomirsky et al., 2005; Pavot & Diener, 2013; Pressman & Cohen, 2005).

At a societal-level, studies have shown that nations with higher SWB are characterised by higher standards of living and economic prosperity, more positive population-health indicators, and greater peace, compared to nations with lower SWB (Diener, Kesebir, & Lucas, 2008; Diener & Lucas, 2000; Diener & Tov, 2007; P. Dolan & White, 2006). Societies with higher SWB also tend to have a longer life expectancy, lower divorce rates, more job security, more political stability, better records of civil liberty, and more gender equality (Diener & Lucas, 2000). As the majority of research on happiness and life satisfaction were conducted in western countries such as Europe and North America, a critical perspective on SWB is thus warranted (Tov & Diener, 2013).

3.3.6 A critical perspective on subjective well-being

Diener's (1984) tripartite model of SWB viewed happiness as being the result of personal efforts and achievements. It thus emphasised internal resources, potentials, and individual characteristics, while neglecting the benefits that a good society has at the level of the individual. However, critical analysis concerning this construct highlighted the necessity to shift from a subjective view of individual well-being to a more social and contextual approach (Arcidiacono & Di Martino, 2016; Oishi, 2018). For example, Critical Community Psychology (CCP) is an emerging psychological approach which studies and promotes happiness from a multidimensional perspective. This approach aims to link the psychological features of individuals with the contexts that surround them (Nelson & Prilleltensky, 2010).

The CCP perspective is centred around two key features. First, CCP considers happiness as a constant relationship between the resources and the opportunities provided by the context people live in and how they decide to use these. This takes

into consideration (both independently and reciprocally) the relational, organisational, cultural, economic, and political domains (Arcidiacono & Di Martino, 2016). Second, CCP acknowledges the role of power, liberation, and social justice in relation to SWB. For example, it is argued that power may uphold forms of oppression which reduce people's life opportunities and their chances of enjoying a satisfactory life (Nelson & Prilleltensky, 2010). Persisting conditions of injustice may also generate feelings of suffering which is detrimental to happiness. However, caring and reciprocal behaviours, ethics of care, and responsible togetherness may foster a sense of well-being (Arcidiacono & Di Martino, 2016). Thus, CPP provides a deeper understanding of how people's enjoyment of life is connected to the features of the environment, specifically focusing on their mutual interactions (Arcidiacono & Di Martino, 2016).

In agreement with this perspective, multidimensional approaches to assess happiness are proposed to obtain a more holistic picture of well-being. These encompass the use of divergent terms, assessing multiple concepts or multiple life domains, and using indigenous scales. They also consider informant reports, assessment of momentary moods, and analysis of social media data (Oishi, 2018). The use of qualitative approaches is furthermore considered valuable for shedding light on the concept of happiness. This may specifically be relevant in Africa, the Middle East, and South Africa where the notion of SWB is still relatively unknown (Cox, Casablanca, & McAdams, 2013; Dzokoto & Okazaki, 2006; Oishi, 2018). It is thus relevant to consider the socio-cultural context when studying SWB.

3.3.7 Subjective well-being in a socio-cultural context

Although the literature has considered happiness as a universal desirable state and identified common predictors of SWB across various demographic groups and regions, cross-national differences do exist (Diener & Diener, 1995; Diener, Suh, Smith, & Shao, 1995; Suh & Koo, 2008). These differences might be attributed to cultural, economic, and political factors which should be considered when describing SWB (Diener & Diener, 1995; Diener & Suh, 1999; Diener, Suh et al., 1995; Inglehart & Welzel, 2005; Loubser & Steenekamp, 2017; Tov & Diener, 2013). Taking into consideration the diverse context of South Africa, local literature regarding SWB is specifically highlighted in the following section (Boshoff et al., 2015; Van Zyl, 2012).

3.3.7.1 Socio-cultural differences in subjective well-being

Culture appears to play a prominent role in cross-national differences regarding SWB. Generally, individualistic nations tend to be happier than collectivistic countries. This may be ascribed to different cultural norms, values, practices, and central ideologies (Diener & Diener, 1995; Diener & Suh, 1999; Diener, Suh et al., 1995; Suh & Koo, 2008; Tov & Diener, 2013). For example, researchers have found that individualistic countries, such as Western Europe and North America, emphasise elements that promote, signify, and maintain an independent and agentic mode of living when referring to SWB. In contrast, collectivistic societies, such as Asia, Africa, and Latin America, highlight the importance of interconnectedness between the self and significant others when describing SWB (Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013). As can be expected, Asian Americans are more likely than European Americans to experience happiness after fulfilling goals directed at pleasing or receiving approval from others. However, by sacrificing their own desires to obtain social approval, collectivists may also sacrifice their personal happiness (Oishi & Diener, 2001; Oishi & Sullivan, 2005; Suh & Koo, 2008).

Cultural values thus influence both the cognitive and affective components of SWB. In individualistic cultures, life satisfaction correlates significantly with self-esteem and a sense of personal freedom (Diener & Diener, 1995). However, people in collectivist cultures are more likely to experience life satisfaction when they have harmonious relationships and spend time with important others (Oishi et al., 1999). The attainment of culturally valued goals is therefore more likely to contribute to life satisfaction, than less valued goals (Tov & Diener, 2013). The relationship between life satisfaction and emotional experiences furthermore appears to be weaker in collectivist countries, as compared to individualist countries. This may be because people in collectivist cultures disregard their personal feelings to a greater degree when evaluating the overall conditions of their life (Suh, Diener, Oishi, & Triandis, 1998).

In addition, cultural norms determining the appropriateness of a particular emotion may influence how often and intensely it is experienced and thus have an impact on the affective component of individuals' SWB (Tov & Diener, 2013). For example, individualistic cultures find it more desirable to feel and express positive

affect, while collectivistic cultures are more comfortable to experience and express negative affect (Diener & Suh, 1999; Diener, Suh et al., 1995). This might be due to the fact that collectivistic cultures believe that strong positive emotions (e.g. pride and happiness) may disrupt interpersonal harmony or lead to negligent behaviours (Suh & Koo, 2008). In collectivistic cultures, positive emotional experiences thus require a social component to contribute towards SWB. For example, researchers found that happiness was stronger associated with interpersonally engaging emotions (e.g. friendly feelings) than with interpersonally disengaging emotions (e.g. pride) among collectivists (Kitayama, Markus, & Kurokawa, 2000).

Cultural norms and values may therefore explain some of the cross-national differences reported by literature (Diener & Diener, 1995; Diener & Suh, 1999; Diener, Suh et al., 1995; Tov & Diener, 2013). However, Inglehart (1990) highlighted the fact that cultural orientations have important economic and political implications, and these may influence happiness across nations. Other factors influencing cross-national differences should thus also be considered.

3.3.7.2 Socioeconomic differences in subjective well-being

According to the literature, a country's material wealth and income correlate modestly and positively with SWB (Diener & Diener, 1995; Diener & Oishi, 2000; Diener & Suh, 1999; Diener et al., 1999). This might be explained by the fact that wealthy nations are more likely to fulfil citizens' basic human needs for food, shelter, and health (Diener, Diener et al., 1995). This is aligned with Maslow's (1954) basic needs theory which emphasised that basic physical needs must be satisfied before psychological fulfilment can be achieved. Inglehart and Welzel (2005) also proposed that economic development increases people's sense of existential security, which shifts their emphasis from survival values toward values that emphasise participation, freedom of expression, and quality of life. This consequently contributes towards SWB.

However, despite the rise in income and power in the United States over the past decade, life satisfaction and happiness remained stable (Diener & Seligman, 2004; Lane, 2000). This may be due to the observation that excessive materialism actually counters happiness and that the acquisition of material goods generally does not create lasting life satisfaction (Kasser & Kanner, 2004). As people also compare themselves to others in their cohort when making satisfaction judgements, their

happiness stays the same in the face of rising income. It is thus proposed that individuals' perceptions of relative financial standing may have a more important effect on SWB than absolute income (Inglehart et al., 2008; McBride, 2001; Posel & Casale, 2011). However, the majority of existing studies did not indicate a causal direction between wealth and happiness, suggesting a complex relationship between these variables (Diener, 2008). Other socio-contextual factors influencing wealth should thus also be considered when investigating cross-national differences in SWB.

3.3.7.3 Socio-political differences in subjective well-being

The literature indicates that a country's political history and beliefs play an important role when considering national levels of happiness. For example, stable democracies are more likely to experience happiness and life satisfaction as a democratic stand contributes to a sense of personal freedom (Inglehart, 1990; Inglehart & Welzel, 2005). This argument was supported by Loubser and Steenekamp (2017) who investigated well-being and democracy across a wide range of diverse countries. They found that democratic countries, such as Brazil, Sweden, and the United States, had the highest levels of life satisfaction. These findings corroborated the view that democratic legislation creates a sense of control and provides political, economic, and personal freedom. These in turn contribute towards life satisfaction (Inglehart et al., 2008; Veenhoven, 2008). The high levels of life satisfaction could furthermore be attributed to considerable socioeconomic achievements, good education systems, well-established social welfare systems, and a sense of progress associated with democratic countries (Loubser & Steenekamp, 2017).

However, these authors found that democratisation was often characterised by a history of rapid transition, civil rights violations, and social, political, and economic breakdown which could be detrimental to a country's happiness (Loubser & Steenekamp, 2017). This was evident in the low levels of SWB reported by citizens in South Africa, Rwanda, Russia, and India. Participants from these countries ascribed their unhappiness to serious economic and political challenges (e.g. income inequality and political corruption), and the associated sense of insecurity, uncertainty, and danger. In Rwanda, the low levels of SWB were specifically related to the country's history of violence, which not only destroyed its economy and infrastructure, but also led to psychological trauma and decreased well-being (Loubser & Steenekamp, 2017).

Similarly, South Africa is characterised by a violent political history and continues to experience an alarmingly high incidence of violence, crime, and trauma (Atwoli, 2015). Due to this unique history, it is therefore relevant to investigate SWB in the South African context.

3.3.7.4 Subjective well-being in the South African context

3.3.7.4.1 *Local prevalence and experience of subjective well-being*

According to the World Happiness Report released in 2020, South Africa ranked 109th out of a possible 156 countries (Helliwell, Layard, Sachs, & De Neve, 2020). This is similar to a cross-national study which indicated that South Africans' level of life satisfaction ranked in seventh place when compared to citizens from Brazil, Sweden, United States, Turkey, Singapore, China, Rwanda, Russia, and India (Loubser & Steenekamp, 2017). Although these figures provide valuable information concerning life satisfaction, they do not consider all components of SWB. However, the handful of studies investigating the national prevalence and experience of SWB in South Africa over the past few decades have revealed interesting findings (Botha & Booysen, 2014; Inglehart et al., 2008; Möller, 2001; Neff, 2007; Posel & Casale, 2011).

For example, shortly after the first democratic election held in South Africa in 1994, all races experienced unprecedented levels of life satisfaction and happiness. Unfortunately, the euphoria was only brief, and these levels decreased significantly for all groups after the election (Inglehart et al., 2008; Möller, 2001). However, 25 years later, levels of life satisfaction and happiness continued to reflect societal divides. Studies reported that the majority of black people (especially women) are comparatively unsatisfied with their lives, and white South Africans are the most satisfied. The well-being scores of other racial groups appeared to fall in the middle (Botha & Booysen, 2014; Inglehart et al., 2008; Möller, 2001; Posel & Casale, 2011).

These racial differences can primarily be attributed to a history of racial segregation and oppression, as well as prevailing poverty, inequality, high levels of HIV infection, and criminal violence among previously disadvantaged groups (Möller, 2001; Neff, 2007; Posel & Casale, 2011). Current dissatisfaction with service delivery and corruption, and recent xenophobic violence also negatively impact on the well-being of vulnerable populations in South Africa (Loubser & Steenekamp, 2017). In informal settlements, limited access to public amenities, and ineffective governance

and policing may furthermore negatively affect life satisfaction among South Africans (Bookwalter & Dalenberg, 2004; Richards, O'Leary, & Mutsonziwa, 2006). Beside these socio-political factors, the literature has identified other variables which influence individual levels of SWB in South Africa.

In agreement with international studies, female gender, employment, marriage, higher household income, higher levels of education, religious involvement, and personal health are associated with higher levels of life satisfaction and happiness among South Africans (Blaauw & Pretorius, 2013; Bookwalter & Dalenberg, 2004; Botha & Booysen, 2014; Delle Fave et al., 2011; Morton, Van Rooyen, Venter, & Andersson, 2018; Richards et al., 2006). Similar to global findings, local studies have also indicated that happiness increases slightly during the later life stages (Chirinda & Phaswana-Mafuya, 2019). Healthy family functioning (e.g. good family relationships, a greater level of attachment, and flexibility within the family) furthermore correlate positively with family members' happiness and satisfaction with life. These findings highlight the importance of social support and family relations concerning SWB among South Africans (Botha & Booysen, 2014).

Although previous studies considered the prevalence of SWB in South Africa, these findings need to be substantiated with more recent findings (Botha & Booysen, 2014; Möller, 2001; Posel & Casale, 2011). Local authors have specifically suggested that studies concerning SWB should focus on informal settlements and the factors contributing to well-being in these communities. The role that cultural norms and practices play regarding the experience of SWB is a relevant topic to consider in the South African context as it may guide practitioners in developing culturally appropriate therapeutic plans (Diener & Diener, 1995; Diener & Suh, 1999; Diener, Suh et al., 1995, 2017; Suh & Koo, 2008; Tov & Diener, 2013).

3.3.7.4.2 *Local interventions to enhance subjective well-being*

Literature concerning therapeutic interventions to facilitate SWB among South African adults is limited. Van Zyl (2012) conducted one of the few studies in this regard, as he developed and evaluated a positive psychology intervention to increase happiness among students at a tertiary educational institution. This intervention comprised self- and group-development workshops, and individual coaching sessions where participants were encouraged to become aware of and apply their signature

strengths. Results from this study showed that participants' levels of life satisfaction, and positive affect balance increased over eight months. The author thus concluded that positive psychology interventions may be effective in increasing overall levels of SWB among South African tertiary students (Van Zyl, 2012).

Boshoff et al. (2015) furthermore evaluated the efficacy of an equine-assisted therapy programme aimed at improving SWB and effective coping among boys with behavioural problems at an industrial school. In that study, horses were utilised in structured sessions to help the boys identify their strengths and learn different coping skills through experiential learning. This programme significantly improved participants' levels of SWB, and their levels of problem-focused and emotion-focused coping skills. However, it did not affect the participants' dysfunctional coping skills (Boshoff et al., 2015). Although these findings offer promising results concerning the effectiveness of positive psychology interventions to enhance SWB in South Africa, further studies are needed (Boshoff et al., 2015; Van Zyl, 2012). This may specifically be relevant in the context of trauma.

3.3.8 Subjective well-being in the context of trauma

In agreement with popular belief, a large body of literature suggested that adverse life events have a significant negative impact on SWB. However, the majority of these effects appear to be short-lived, as people have a remarkable capacity to adapt to life events (Bucciol & Zarri, 2017; Calvo et al., 2015; Davies & Hinks, 2010; Frederick & Loewenstein, 1999; Lucas, 2007a; Luhmann et al., 2012; Oswald, Proto, & Sgroi, 2015; Suh et al., 1996). Besides merely returning to a baseline level of well-being, studies also suggested that people may even experience increased happiness and life satisfaction following exposure to traumatic events. Post-traumatic growth specifically appears to play a role in this regard (Galea, 2018; Karlsen et al., 2006; Seery, 2011; Veronese et al., 2017; Wade et al., 2016; Whitelock et al., 2013). The experience of SWB in the context of trauma will thus be discussed in the following section.

3.3.8.1 The impact of trauma on subjective well-being

3.3.8.1.1 *Trauma and decreased subjective well-being*

According to the literature, traumatic events, such as the loss of a close relative, being diagnosed with a life-threatening illness, and exposure to accidents, serious physical assaults, and family tragedies have a negative impact on happiness (Bucciol & Zarri, 2017; Oswald et al., 2015). Studies have also found that exposure to disasters such as the 9/11 terrorist attacks, the tsunami in Indonesia, and hurricane Katrina decreased SWB among people who either personally experienced or witnessed these events (Back, Küfner, & Egloff, 2010; Calvo et al., 2015; Kimball et al., 2006; Metcalfe, Powdthavee, & Dolan, 2011).

Exposure to crime may furthermore have significant adverse consequences for the SWB of survivors, and society at large (Davies & Hinks, 2010; Mahuteau & Zhu, 2016; Powdthavee, 2005; Staubli, Killias, & Frey, 2014). For example, international studies have found that both the emotional and cognitive components of SWB decreased after exposure to violence, theft, or burglary (Davies & Hinks, 2010; Staubli et al., 2014). According to an Australian study, the adverse effects of violent crimes on happiness were felt most strongly by people at the lower end of the well-being distribution (Mahuteau & Zhu, 2016). Locally, Powdthavee (2005) also reported lower levels of happiness among crime victims in South Africa. However, the impact of crime on happiness was less intense for respondents who lived in a high crime region.

The negative impact trauma has on peoples' SWB may directly be attributed to increased negative affect and decreased positive affect resulting from traumatic exposure (Back et al., 2010; Calvo et al., 2015; Kimball et al., 2006; Metcalfe et al., 2011). For example, PTSD is often associated with persistent negative feelings (e.g. guilt, blame, anger) and an inability to experience positive emotions (APA, 2013). Furthermore, trauma survivors commonly struggle with comorbid conditions such as depression, anxiety, interpersonal problems, and poor self-image which may directly affect SWB (APA, 2013).

Besides the direct effect on emotions, trauma may indirectly influence SWB by shattering an individual's basic assumptions about themselves and the world. Exposure to trauma may also trigger avoidance-coping strategies which maintain negative feelings and decrease SWB (Janoff-Bulman & Frieze, 1983; Stickley,

Koyanagi, Roberts, Goryakin, & McKee, 2015; Van Dijk, Heller, & Seger-Guttmann, 2013). Furthermore, trauma has a detrimental impact on a person's health, personal safety, and their sense of control over their lives, all of which indirectly influence SWB (Möller, 2005). For example, traumatic events such as exposure to crime may result in changes in behaviour and lifestyle (e.g. staying in at night or changing residence or workplace) which are likely to lead to diminished feelings of life satisfaction. In addition, a perceived lack of social support (e.g. not being able to get help and support or being stigmatised) in the face of adversity may be detrimental to the well-being of trauma survivors (Janoff-Bulman & Frieze, 1983; Stickley et al., 2015). Traumatic events may thus directly or indirectly reduce SWB through several affective, cognitive, behavioural, and social paths.

3.3.8.1.2 *Trauma and hedonic adaptation*

Although the negative impact of trauma on well-being may be intense, it appears to be short-lived and dissipates over time. This can be ascribed to the process of hedonic adaptation discussed in Section 3.3.4.2 of this chapter (Frederick & Loewenstein, 1999; Mahuteau & Zhu, 2016; Van Dijk et al., 2013). For instance, Suh et al. (1996) proposed that the impact of most life events on SWB diminishes in less than 3 months. However, studies have shown that adaptation to negative events might take longer (e.g. 18 months to 8 years following the event), with people adapting faster to natural disasters than to divorce or the loss of a spouse (Calvo et al., 2015; Lucas, 2005; Lucas & Clark, 2006).

Despite evidence supporting the notion of hedonic adaptation, additional studies suggested that the effect of some traumatic events may persist over time and that people do not fully recover from all adverse events (Bucciol & Zarri, 2017; Lucas, 2005, 2007b). For example, Bucciol and Zarri (2017) argued that exposure to physical attacks and physical abuse during childhood may permanently scar survivors' general life satisfaction. Lucas (2005, 2007b) also found that individuals who experienced severe disability did not return to their initial levels of happiness. These findings only partially supported hedonic adaptation and suggested that some traumatic events may have a permanent negative impact on SWB. Further research concerning this topic is therefore warranted. Although the majority of past research on well-being and life

crises focused on negative consequences, recent studies have highlighted possible positive consequences related to traumatic events (Linley & Joseph, 2004).

3.3.8.1.3 *Trauma and increased subjective well-being*

Contemporary literature suggests that people can still experience well-being and life satisfaction, despite exposure to a traumatic event (Karlsen et al., 2006; Wade et al., 2016; Whitelock et al., 2013). For example, a large cross-sectional national survey conducted in the UK found that some adult survivors of CSA experienced average, or even above-average, levels of life satisfaction (Whitelock et al., 2013). This was especially noticed among young white females, who were employed, earned a high income, were highly educated, and were in intimate relationships. In this study, social support and education acted as valuable coping resources, while higher income protected survivors against additional stresses that could compound the adverse effects of CSA. Personality traits such as extraversion, agreeableness, and conscientiousness were also positively associated with life satisfaction as these traits predispose individuals to positive affect, a greater quantity and quality of social relationships, and greater achievement. However, exposure to additional traumatic events resulted in lower self-reported life satisfaction in adulthood, as it exacerbated the effects of CSA (Whitelock et al., 2013).

Wade et al. (2016) furthermore reported that prior experience of losing a spouse was associated with higher levels of SWB among a sample of patients suffering from a serious neurological illness. They proposed that the death of a loved one challenged participants' belief systems which fostered the development of new adaptive coping strategies, improvements in family relationships, and increased levels of compassion. This not only enhanced SWB among trauma survivors, but also made them less vulnerable to future stress (Wade et al., 2016). Similarly, Seery (2011) found that exposure to low-to-moderate levels of adversity predicted better outcomes concerning mental health and well-being. It was proposed that adversity might have generated individual toughness, created a sense of mastery, and fostered perceived control and belief in participants' ability to cope successfully. Adversity might also have enhanced coping skills and encouraged participants to establish effective social support networks (Seery, 2011).

Despite a few studies considering the experience of SWB in the context of trauma, this is still a relatively new topic which deserves further investigation (Karlsen et al., 2006; Seery, 2011; Wade et al., 2016; Whitelock et al., 2013). Although the above-mentioned studies did not deliberately investigate post-traumatic growth, it highlighted that well-being may be associated with positive psychological changes after exposure to trauma (Tedeschi & Calhoun, 2004). It is relevant to consider the role that post-traumatic growth play in relation to SWB.

3.3.8.1.4 *Post-traumatic growth and subjective well-being*

Researchers have found a positive correlation between post-traumatic growth and SWB, suggesting that post-traumatic growth may be a predictor of SWB (Galea, 2018; Karlsen et al., 2006; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2011; Veronese et al., 2017). Karlsen et al. (2006) found that exposure to traumatic events may both increase and decrease the level of SWB among UN veterans. Among veterans who experienced increased SWB, problem-focused coping and post-traumatic growth appeared to play an indirect role. The authors proposed that post-traumatic growth indirectly enhanced SWB by promoting resolution and meaning-making in the aftermath of trauma (Karlsen et al., 2006). A positive correlation between post-traumatic growth and SWB was also reported by Palestinian professional helpers from the Gaza Strip and West Bank who had experienced various traumatic events (Veronese et al., 2017). They suggested that the ability to attribute meaning to their lives helped them maintain a sense of integrity and conserve a self-perception of feeling subjectively well, despite the risky conditions they were working in (Veronese et al., 2017).

Post-traumatic growth may indirectly contribute towards SWB by providing an increased sense of meaning and purpose in life which leads to higher levels of life satisfaction and well-being (Triplett et al., 2011). Taking into consideration these positive psychological changes following adversity, it is thus relevant to consider the protective role SWB, and more specifically positive emotions, may play in the context of trauma.

3.3.8.2 Subjective well-being as a protective factor

3.3.8.2.1 *The broaden-and-build theory of positive emotions*

Research shows that positive emotions may promote adaptive human functioning (Fredrickson, 1998, 2000, 2013; Garland et al., 2010). As positive emotions form an integral part of Diener's (1984, 2000) tripartite model of SWB, it is thus relevant to consider the protective role these emotions may play. Emotions are usually described as brief cascades of changes in subjective feeling states, physiological responses, physical expressions, and thought–action repertoires which are triggered by the way people interpret their current circumstances (Fredrickson, 2000, 2013; Garland et al., 2010). For example, a perceived opportunity may give rise to distinct positive emotions which are associated with approach behaviour, while a perceived threat may give rise to distinct negative emotions which lead to avoidance behaviour (Frederickson, 2001).

Frederickson's (1998, 2000, 2001) broaden-and-build theory of positive emotions assumes that positive emotions such as joy, interest, contentment, hope, and love broaden people's momentary thought–action repertoires which build physical, mental, psychological, and social resources over time. These benefits seem to persist beyond the transient emotional state and serve as resources in later moments in life. This is frequently referred to as the *upward spiral* of positive emotions (Frederickson, 1998, 2000; Garland et al., 2010). This theory furthermore conceptualises positive and negative emotions as fundamentally incompatible, as positive emotions broaden an individual's thought–action repertoire, while negative emotions narrow the thought–action repertoire (Frederickson, 1998, 2000; Fredrickson & Levenson, 1998). It thus proposes that positive emotions and the associated upward spirals can undo the deleterious effects of negative emotions, potentially playing a protective role in the context of psychopathology (Fredrickson, 1998; Garland et al., 2010).

3.3.8.2.2 *Evidence for the protective role of positive emotions*

Psychopathological disorders such as depression and anxiety are usually associated with prominent negative emotions and a consequent *downward spiral* of defensive behaviour, threat focus, and feelings of inefficacy (Garland et al., 2010). However, according to the broaden-and-build theory, these downward spirals of

negative emotions may be countered by the upward spirals of positive emotions (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009; Keltner & Bonanno, 1997; Tugade & Fredrickson, 2004). For example, studies reported that positive emotions broaden people's attention, creativity, openness to new experiences, and desired actions in both personal and interpersonal domains (Fredrickson & Branigan, 2005; Gasper & Clore, 2002; Isen, Daubman, & Nowicki, 1987; Rowe, Hirsh, & Anderson, 2007; Waugh & Fredrickson, 2006). Research also found that, with time, positive emotions built durable personal resources such a resilience, resourcefulness, and social connectedness which can be considered protective factors against psychopathology (Fredrickson, Tugade, Waugh, & Larkin, 2003; Lyubomirsky et al., 2005; Mauss et al., 2011).

In the context of negative emotional experiences, positive emotions may restore autonomic latency and flexible thinking. Positive emotions not only attenuate attentional biases to negative information, but also facilitate cognitive reappraisal and effective coping (Cohn et al., 2009; Fredrickson & Levenson, 1998; Keltner & Bonanno, 1997; Tugade & Fredrickson, 2004). Recent brain-imaging and behavioural studies furthermore showed that positive emotions stimulate resilience which helps people to focus on the present moment; they therefore worry less about negative future consequences. In addition, researchers have found that psychotherapeutic interventions, intended to increase positive emotional experiences, trigger a neurochemical cascade, leading to neuronal growth and positive neurochemical changes (De Lange et al., 2008; Draganski et al., 2004; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004; Mitchell & Phillips, 2007).

It can thus be deduced that repeated induction of positive emotional states may gradually shift negative affective styles and potentially lead to broadened thought–action repertoires. This may not only increase individual and collective well-being, but may also lead to reductions in psychopathological symptoms (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Garland et al., 2010; Waugh & Fredrickson, 2006). For example, a randomised, controlled trial found that self-generating frequent positive emotions over the course of 7-weeks, reduced depressive symptoms within a nonclinical sample (Fredrickson et al., 2008). The experience of positive emotions furthermore assisted individuals with schizophrenia to envision and anticipate more

possible courses of action that contributed towards enhanced sociality and motivation (Fredrickson et al., 2008; Garland et al., 2010). It can thus be concluded that positive emotional states play a protective role in various clinical disorders. Despite this evidence, few studies have investigated the buffering effect of SWB in the context of trauma.

3.3.8.2.3 *Positive emotions in the context of trauma*

Exposure to traumatic events not only shatters deeply held assumptions about the self and the world as a whole, but is also associated with a narrowing of focus onto danger and survival (Bolton & Hill, 1996; Ehlers & Clark, 2000; Janoff-Bulman, 1992). People diagnosed with PTSD usually utilise inflexible behavioural (e.g. avoidance and safety behaviour) and cognitive (e.g. rumination and dissociation) coping strategies which maintain trauma-related distress (Nijdam & Wittmann, 2015). A broadened thought–action repertoire in the context of trauma may thus not only facilitate effective coping, but can also protect against the development of trauma-related psychopathology (Fredrickson, 1998; Garland et al., 2010). In addition, the building of personal resources such as resilience and social support in the aftermath of trauma may be valuable as it is associated with better adjustment and greater adversarial growth (Albuquerque et al., 2018; Bannink, 2008; Jayawickreme & Blackie, 2014; Joseph & Butler, 2010; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004).

Zanon, Hutz, Reppold, and Zenger (2016) conducted one of the few longitudinal studies that have investigated the protective role of positive emotions in the context of trauma. This study found that after a large-scale disaster, positive affect was negatively associated with rumination, anxiety, and PTSD. In contrast, negative affect correlated positively with these variables. Positive emotions may thus be key to optimising health and well-being, fostering resilience, and recovery and protecting against psychopathology in the face of adversity (Zanon et al., 2006). Although Fredrickson and colleagues acknowledged the protective role positive emotions play in relation to psychopathology, few studies have specifically focused on the buffering effect of SWB in the context of trauma (Cohn et al., 2009; Fredrickson et al., 2008; Tugade & Fredrickson, 2004; Zanon et al., 2006). Such studies may specifically be valuable, considering the role SWB plays in psychotherapy.

3.3.9 The role of subjective well-being in psychotherapy

Due to the recent shift in psychotherapy towards enhancing psychological functioning and well-being, several interventions to promote SWB have emerged (Seligman & Csikszentmihalyi, 2000). Research suggests that both traditional therapeutic approaches, and positive psychology interventions may be effective in increasing SWB (Bolier et al., 2013; Jazaieri, Goldin, & Gross, 2017; Safren, Heimberg, Brown, & Holle, 1997; Sin & Lyubomirsky, 2009). The focus of SFBT appears promising in this regard, as it builds on positive emotions, personal resources, resilience, and wellness (Grant, 2012; Green et al., 2006). Psychotherapeutic interventions that may contribute towards SWB are discussed below.

3.3.9.1 Subjective well-being and traditional therapeutic approaches

It has been found that CBT is not only effective for treating psychopathology, but may also contribute towards well-being. For example, positive reappraisal and relaxation exercises utilised in CBT may foster positive emotions and decrease negative emotions. It also promotes engagement in pleasant activities which may further increase positive affect (Folkman, 1997; Frederickson, 2000). Although limited empirical evidence concerning the effectiveness of CBT in promoting SWB could be found, a few studies suggested that CBT may be effective in enhancing life satisfaction (Jazaieri et al., 2017; Safren et al., 1997). For example, Jazaieri et al. (2017) reported that 16 weeks of individual CBT led to higher levels of life satisfaction in clients with social anxiety disorder, compared to a wait-list control group. Similar results were observed immediately following a course of cognitive behavioural group therapy for people with social anxiety disorder. These improvements were maintained for several months after treatment, suggesting that CBT may be used to enhance long-term adaptive functioning for people with social anxiety disorder (Jazaieri et al., 2017; Safren et al., 1997).

3.3.9.2 Subjective well-being and positive psychology interventions

Positive psychology interventions aim to increase clients' positive emotions and consequently enable them to survive, thrive, and flourish (Bolier et al., 2013). These interventions are generally brief, scripted, self-administered activities and include, but are not limited to; gratitude activities, mindfulness exercises, loving-kindness meditation, savouring positive experiences, practising random acts of kindness, and

visualising one's best possible future self. According to the literature, these interventions may contribute towards participants' experience of SWB (Bolier et al., 2013; Fredrickson, 2008; Mongrain & Anselmo-Matthews, 2012; Sin & Lyubomirsky, 2009; Seligman et al., 2005).

For example, Seligman et al. (2005) found that positive psychology exercises, delivered via the Internet over a period of one week, led participants to be happier and less depressed immediately after the study. Mongrain and Anselmo-Matthews (2012) replicated this pioneering study and found similar results. They proposed that positive psychology interventions boosted happiness by activating positive, self-relevant information. Although these studies suggested that brief, positive psychology interventions may enhance happiness, it did not investigate all components of SWB (Mongrain & Anselmo-Matthews, 2012; Seligman et al., 2005).

However, meta-analytic studies indicated that positive psychology interventions (e.g. mindfulness, life review therapy, and forgiveness therapy) not only decreased depressive symptoms, but also enhanced the well-being of depressed individuals (Sin & Lyubomirsky, 2009). Similarly, Bolier et al. (2013) reported that positive psychology interventions significantly enhanced SWB and reduced depressive symptoms among the general public, and people experiencing psychosocial problems. These effects were partly sustained over time, suggesting that positive psychology interventions may be an effective tool for promoting SWB in both clinically depressed and non-depressed clients (Bolier et al., 2013; Sin & Lyubomirsky, 2009). However, more recently White, Uttl, and Holder (2019) replicated these findings and found much smaller effect size estimates for both well-being and depression. This discrepancy was mainly attributed to the small sample size of initial studies and thus highlighted the need for more comprehensive meta-analytic studies (White et al., 2019).

Although evidence suggests that positive psychology interventions have the potential to enhance SWB, the majority of these studies have focused on clients pursuing therapy for reasons of personal growth (Bolier et al., 2013; Mongrain & Anselmo-Matthews, 2012; Seligman et al., 2005, Sin & Lyubomirsky, 2009). Future research is thus needed to examine whether positive psychology interventions can also be effective for people with mental illnesses. Studies to investigate whether these interventions may be effective in enhancing SWB among community-based samples

are specifically warranted (Bolier et al., 2013; Diener et al., 2017). Considering the evidence-base of SFBT (discussed in Chapter 2) the researcher proposes that this therapeutic approach be investigated.

3.3.9.3 Subjective well-being and solution-focused brief therapy

The solution-focused approach is strength-based and, future-focused; it utilises people's resilience, strengths, and resources to obtain purposeful positive change (Grant, 2012; Kim & Franklin, 2015). As outlined in Chapter 2, solution-focused conversations are key to SFBT and are used to create a context where the client and therapist collaboratively construct workable solutions for problems. Therapists selectively use language to amplify strengths and solutions, instead of problems. By formulating answers to solution-focused questions, clients are encouraged to turn their problem perceptions and negative emotions into positive formulations. Solution-focused language thus focuses on enhancing positive affect, motivation, and self-efficacy (Froerer et al., 2018; Kim & Franklin, 2015; McKergow & Korman, 2009). Specific SFBT techniques such as the miracle question, goaling questions, exception-finding questions, and providing compliments may also contribute towards positive emotions (Froerer et al., 2018).

Various authors have highlighted the integral role that positive emotions, such as expectancy, hope, faith, courage, and trust, play in the change processes of SFBT (Berg & Dolan, 2001; De Jong & Berg, 2007; De Shazer, 1985; De Shazer et al., 2007; Lipchik, 2011). According to Frederickson's (2000) broaden-and-build theory, SFBT's focus on strengths and solutions increases clients' positive emotions that subsequently help them to build durable resources. The positive emotions generated in therapy may also counteract the deleterious effect of negative emotions (Froerer et al., 2018; Kim & Franklin, 2015). It is thus proposed that SFBT may positively contribute towards SWB by increasing positive affect and decreasing negative affect.

Despite the integral role that positive emotions play in relation to SFBT, few studies explored how SFBT interventions contribute towards SWB (Frederickson, 2000; Grant, 2012; Green et al., 2006). However, in the context of life coaching, Grant (2012) reported that solution-focused questioning significantly increased participant's levels of positive affect, and reduced levels of negative affect compared to a problem-focused questioning approach. The author also discovered that solution-focused

questioning significantly increased self-efficacy, goal approach, and action planning that then contributed towards therapeutic change (Grant, 2012). These results correlated with previous studies, suggesting that solution-focused techniques may enhance positive affect (Grant & O'Connor, 2010; Wehr, 2010). Similar results were also obtained with a European, Spanish speaking nonclinical sample, suggesting that solution-focused questioning may be effective in increasing positive affect and decreasing negative affect across cultures (Neipp, Beyebach, Nuñez, & Martínez-González, 2016).

Taking into consideration both the affective and cognitive components of SWB, Green et al., (2006) found that a 10-week cognitive behavioural, solution-focused life coaching group programme significantly increased life satisfaction and positive affect, while decreasing negative affect among participants. This programme also contributed positively towards goal striving and hope, with all gains being maintained up to 30 weeks following the intervention. According to this study, the pursuit of desired goals contributed to positive emotions and increased well-being. It was thus proposed that hope may play a mediating role in increasing SWB in the context of SFBT (Snyder et al., 2002). These findings suggested that therapeutic programmes with an SFBT component may enhance and maintain SWB over time (Green et al., 2006). However, these findings should be replicated and expanded to other contexts in order to investigate the key SFBT processes involved in promoting well-being. Qualitative analyses may specifically be valuable in this regard (Grant, 2012; Green et al., 2006). Unfortunately, neither international nor local studies have considered how SFBT may instil SWB in the context of trauma; this highlights the relevance of the current study.

3.3.9.4 Enhancing subjective well-being through trauma interventions

Despite the evidence that therapeutic interventions may enhance SWB, literature concerning trauma interventions to promote SWB is limited (Demott, Jakobsen, Wentzel-Larsen, & Heir, 2017; Kerr, Donovan, & Pepping, 2015). However, a few positive psychology interventions appeared promising in this regard. For example, Kerr et al. (2015) found that self-administered gratitude and kindness interventions led to increased life satisfaction, higher levels of optimism and lower anxiety within a clinical sample where some of the participants were diagnosed with PTSD. More specifically, a five-week expressive arts programme named *EXIT*

appeared effective in enhancing life satisfaction and hope among a group of refugee boys exposed to complex traumatic experiences. This programme aimed to construct meaning and encourage connection with others by focusing on resources and creativity. These findings suggested that positive psychology interventions may not only help trauma survivors cope, but can also contribute towards their experience of hope and well-being (Demott et al., 2017). The relationship between hope and SWB was apparent in this chapter, and now receives focused attention in the next section.

3.3.10 Hope and subjective well-being

Literature suggests a close relationship between hope and SWB. A hopeful disposition not only makes one feel happier, but feeling good also increases one's hope for a better future (Bailey & Snyder, 2007). However, the majority of research focused on how hope enhances well-being. According to Snyder's hope theory (Snyder, 1994, 2002), hope contributes to SWB through successful goal attainment. Hopeful individuals tend to have a positive view of themselves and their future; this then increases their motivation (agency thinking) and leads to goal-directed actions (pathways thinking) (Hartley, Vance, Elliott, Cuckler, & Berry, 2008; Lyubomirsky et al., 2005; Park, Peterson, & Seligman, 2004). Successful goal attainment thus increases positive emotions. According to the broaden-and-build theory, these positive emotions foster personal and social resources that further contribute towards SWB (Fredrickson 2001; Snyder, 2002). As hopeful people tend to achieve success in specific life domains, they experience satisfaction with their lives (Snyder, 2002). In addition, hopeful individuals are more likely to establish positive interpersonal relationships and utilise their external resources, such as social support, which promote well-being (Snyder, Cheavens, & Sympson, 1997).

The type and structure of goals, the rate of progress toward one's goals and congruency between goals and needs, specifically seem to affect happiness and life satisfaction (Diener, 1984; Diener et al., 1999). For example, Tamir and Diener (2008) found that the pursuit and attainment of avoidance-orientated goals decreased SWB as it involved aversive psychological processes and resulted in a negative, undesirable end-state. In contrast, pursuing approach orientated goals was associated with positive psychological processes and provided individuals with a desirable end-state. The literature thus proposed that the process of moving toward one's aspirations may

be just as important to well-being as the end-state of goal attainment (Carver, Lawrence, & Scheier, 1996; Csikszentmihalyi, 1990). However, attainment of goals that are not congruent with a person's needs does not necessarily enhance SWB (Diener et al., 1999).

In the context of trauma and stressful life events, hope also appears to be a strong predictor of SWB (Bailey & Snyder, 2007; Ciarrochi et al., 2015; Gallagher & Lopez, 2009; Irving et al., 2004). For example, Jafari et al. (2010) suggested that hope correlated positively with life satisfaction and spiritual well-being among adults seeking cancer treatment. High levels of hope were also associated with positive affect, quality of life, and life satisfaction among individuals who sustained a spinal cord injury (Kortte, Gilbert, Gorman, & Wegener, 2010; Smedema, Chan, & Phillips, 2014). Smedema et al. (2014) highlighted that agency thinking increased individuals' motivation to pursue goals, which also predicted community participation and life satisfaction. These findings offered practical implications, as it suggested that interventions aimed at increasing hope can be used to simultaneously increase SWB, especially in the context of trauma (Kortte et al., 2010; Pleeging, Burger, & Van Exel, 2019; Smedema et al., 2014).

Although hope and SWB are related, this correlation may differ concerning the different components of hope and SWB. For example, studies found that hope is stronger associated with positive affect, compared to negative affect. The life satisfaction component of SWB appears to correlate more strongly with the agency component of hope than with the pathways component (Pleeging et al., 2019). However, cross-cultural differences do exist. For example, Chang and Banks (2007) found that life satisfaction is an important predictor of agentic thinking among European Americans, African Americans, and Latinos, but not Asian Americans. Additionally, positive affect predicted pathways thinking for all of the above-mentioned mentioned groups, except for Latinos (Chang & Banks, 2007). The relationship between hope and SWB in different socio-cultural contexts thus deserves further attention.

3.3.11 Evaluative summary

In accordance with the hedonic perspective of well-being, Diener's (1984) tripartite model described SWB as a multidimensional concept, encompassing life satisfaction, high levels of positive affect, and low levels of negative affect. Although initial theories viewed SWB as an inborn personality trait, recent theoretical perspectives assumed that SWB is an interactional product between stable hereditary factors and dynamic psychosocial circumstances (Diener et al., 2006). Cross-national studies highlighted the influence of cultural, economic, and political factors concerning SWB and emphasised the need for a critical perspective concerning this topic (Diener & Diener, 1995; Inglehart & Welzel, 2005; Loubser & Steenekamp, 2017). This is specifically warranted in the diverse South African context. Although previous research considered the prevalence and experience of SWB in South Africa, studies have not yet investigated this topic among trauma survivors (Botha & Booysen, 2014; Möller, 2001). The limited literature concerning therapeutic interventions to facilitate SWB among South African adults, especially in the context of trauma, should also be expanded on.

Studies undertaken to date suggest that life events, especially traumatic life events, have a significant, but short-term, negative effect on SWB (Calvo et al., 2015; Frederick & Loewenstein, 1999; Lucas, 2007a; Suh et al., 1996). However, people may also experience SWB and growth in the face of adversity (Seery, 2011; Wade et al., 2016; Whitelock et al., 2013). As positive emotions have the potential to broaden thought–action repertoires, build durable resources, and counter the downward spirals of negative emotions, it is proposed that SWB may play a protective role in the aftermath of trauma (Frederickson, 2000). Although studies have suggested that positive psychology interventions may be effective in increasing SWB, to date few studies have explored these findings in the context of trauma (Bolier et al., 2013; Sin & Lyubomirsky, 2009). This pertains particularly to SFBT. However, owing to the integral role positive emotions play in the SFBT change process, this approach may be effective for enhancing SWB among trauma survivors. This study thus aims to investigate the role SFBT may play in increasing SWB following trauma.

3.4 Conclusion

It is evident that trauma has a significant negative impact, both on hope and SWB. However, a small body of research has indicated that traumatic events may also contribute toward people's experience of hope and SWB (Levi et al., 2012a, 2012b; Whitelock et al., 2013). Taking into consideration the high prevalence of trauma in South Africa, and the influence of the socio-cultural context concerning hope and SWB, local research concerning these topics is needed. The current study therefore aims to provide in-depth information regarding the prevalence and experience of hope and SWB among trauma survivors in South Africa, a gap that was identified by previous studies.

Research furthermore suggested that hope and SWB play a beneficial role in psychotherapy, and that specific therapeutic approaches may be used to instil hope and SWB. As a strength-based therapeutic approach, SFBT appears particularly promising, as it focuses on building positive emotions, personal resources, resilience, and wellness. Although the literature has indicated that SFBT is effective at increasing hope and SWB in various other contexts, no studies concerning this experience in the aftermath of trauma are yet available (Grant, 2012; Green et al., 2006). The current study thus aims to address this gap in the literature by exploring how SFBT may contribute towards hope and SWB among trauma survivors in South Africa. The methodology used to answer this research question is discussed in the following chapter.

Chapter 4: Research Methodology

4.1 Introduction

A mixed methods research design was used in this study to examine hope and SWB among trauma survivors at community-based clinics in Gauteng; before, during, and after exposure to an SFBT intervention. The data were then used to develop an SFBT intervention which focused on facilitating hope and SWB. This chapter will provide an outline of the research paradigm, research design, and the research methods used in the quantitative and qualitative components of the study. The sampling process and therapeutic procedure, and data collection and data analysis are then explicated. The chapter concludes with a discussion of the measures taken to ensure rigour and trustworthiness, and the ethical considerations of the study.

4.2 Research Question and Objectives of the Study

Taking into consideration the problem statement outlined in Chapter 1, this study intends to investigate hope and SWB among trauma survivors at community-based clinics in Gauteng, to develop an SFBT intervention model which may facilitate these experiences. The objectives of this study are thus as follows:

- To investigate the incidence of hope and SWB, and psychopathology (as the absence of well-being) among trauma survivors at community-based clinics in Gauteng–a quantitative study;
- To implement and describe SFBT with trauma survivors at community-based clinics in Gauteng;
- To explore the experience of hope and SWB among trauma survivors at community-based clinics in Gauteng, during and after exposure to SFBT; with particular focus on the aspects of SFBT contributing to their experiences– a qualitative study; and
- To develop an SFBT intervention model facilitating hope and SWB among trauma survivors at community-based clinics.

4.3 Research Paradigm

A research paradigm or worldview refers to the researcher's general philosophical orientation about the world and the nature of research. It therefore informs the researcher's decision regarding the research design and methods that will

be used in a specific study (Creswell, 2014). Research paradigms can range from *postpositivism,* viewing reality as objective and predictable; to *social constructivism*, believing that reality is created and therefore subjective (Creswell, 2014; Creswell & Plano Clark, 2018). However, in this study, the researcher took a *pragmatic* stance*. Pragmatism* is a philosophical perspective that is not committed to one particular view of reality. It thus acknowledges the value of both objective and subjective knowledge, and recognises that the investigation of both leads to a richer understanding of the issue at hand (Barnes, 2012; Creswell, 2014; Creswell & Plano Clark, 2018; Tashakkori & Teddlie, 2010).

Hence, pragmatic researchers are free to choose the research methods, techniques, and procedures that fit best in answering the research question (Tashakkori & Teddlie, 2010). As they recognise the social, historical, and political contexts in which research is conducted, they are also reflective of social justice and political aims. Pragmatic studies therefore have transformative potential and may contribute to the development of locally relevant intervention models, often designed for previously disadvantaged contexts (Barnes, 2012; Creswell, 2014; Creswell & Plano Clark, 2018).

From a pragmatic point of view, and taking into consideration the research question and objectives of this study, a mixed methods research design was chosen for this study. The researcher thus accepted a *both– and* synthesis where objective quantitative data were sought and combined with qualitative data to create a rich and deep description of the experiences of hope and SWB among trauma survivors (Creswell, 2014; Creswell & Plano Clark, 2018). The mixed methods research design used in this study is discussed in further detail below.

4.4 Research Design

Research designs are procedures for collecting, analysing, interpreting, and reporting data in research studies. It thus guides the methods a researcher utilises and influences the interpretations they make at the end of a study. In this study, a *mixed methods research design* was used which can be described as mixing or combining elements of both quantitative and qualitative research approaches (e.g., viewpoints, data collection, analysis, inference techniques, and language) in a single

study to add to the depth of understanding, and for the purposes of corroboration (Johnsen, Onwuegbuzie, & Turner, 2007).

Mixed methods research designs are frequently used to clarify initial results, to explore a specific phenomenon before administering an instrument, to enhance an experimental study, to compare different cases, or to develop, implement, and evaluate a programme (Creswell & Plano Clark, 2018). In this study, a mixed methods research design not only allowed the researcher to investigate hope and SWB among trauma survivor before implementing an SFBT intervention, but also provided a rich description of the phenomenon during and after exposure to SFBT. It furthermore allowed the researcher to compare multiple cases and make use of different data sources which led to the development of an SFBT intervention model which could facilitate hope and SWB among trauma survivors.

A mixed methods research design offers numerous advantages (Creswell & Plano Clark, 2018). It not only provides more evidence for studying the research problem, than either quantitative or qualitative approaches alone, but the strength of one method may also offset the weaknesses of the other. Mixed methods research furthermore offers new insights by combining descriptive and exploratory information and provides a bridge across the divide between quantitative and qualitative researchers. Finally, mixed methods are both practical and intuitive and therefore allow for multiple perspectives of a research problem. However, the disadvantage of this design is that it requires multi-skilled researchers and is time- and resource-consuming (Creswell, 2014; Creswell & Plano Clark, 2018; Johnsen et al., 2007). Based on the various mixed methods designs that are available, this study followed a multiphase mixed methods design (Creswell, 2014).

4.4.1 Multiphase mixed methods design

Creswell (2014) describes a multiphase mixed methods design as an advanced research design which uses concurrent or sequential strategies through a series of steps to best understand or evaluate a programme or intervention. As the multiple phases of the study unfold, the researcher may thus build integrated conclusions about the implementation and outcomes of the programme. Mixed methods may fit into a single phase or multiple phases of the research process, with quantitative and qualitative results being integrated at any point (Creswell & Plano Clark, 2018). This

study was conducted in four sequential phases as illustrated in Figure 1. These phases are briefly outlined below, and a comprehensive description of the research methods used in each study phase is provided in Section 4.5.

Phase I was a cross-sectional survey design that provided information on the incidence of hope and SWB among trauma survivors. The purpose of such a design is to use sample results to generalise or draw inferences about the broader population (Creswell, 2014). This phase was conducted with 120 participants at community-based clinics in Gauteng (Ekurhuleni). Quantitative data were gathered from measuring instruments assessing hope, SWB, symptoms of PTSD, and depressive symptoms. Relevant biographical details were also obtained with the use of a self-constructed biographical questionnaire (see Appendix A). Based on the literature search, it was expected that this sample would experience low levels of hope and SWB, but a high incidence of psychopathology

In *Phases II and III*, an inductive multiple case study design was used to implement and describe SFBT, and to explore the experience of hope and SWB during and after exposure to SFBT (Miles, Huberman, & Saldaña, 2014). Seven trauma survivors identified during Phase I of the study, were included in the case study. During *Phase II*, therapy sessions were recorded, transcribed, and analysed to explore the participants' experiences of hope and SWB during the therapeutic process.

In *Phase III*, semi-structured individual interviews were employed to explore participants' experiences of hope and SWB after exposure to SFBT, with particular focus on the aspects of SFBT contributing to their experiences (Creswell, 2014). During this phase, measuring instruments were re-administered for the seven participants and quantitative data were compared to results from Phase I. Triangulating of the results was done to ensure rigour and trustworthiness of the findings (Creswell, 2014). During *Phase IV* of this study, quantitative and qualitative data were finally integrated into a multiple case study report. This informed the development of an SFBT intervention model that could facilitate hope and SWB among trauma survivors at community-based clinics.

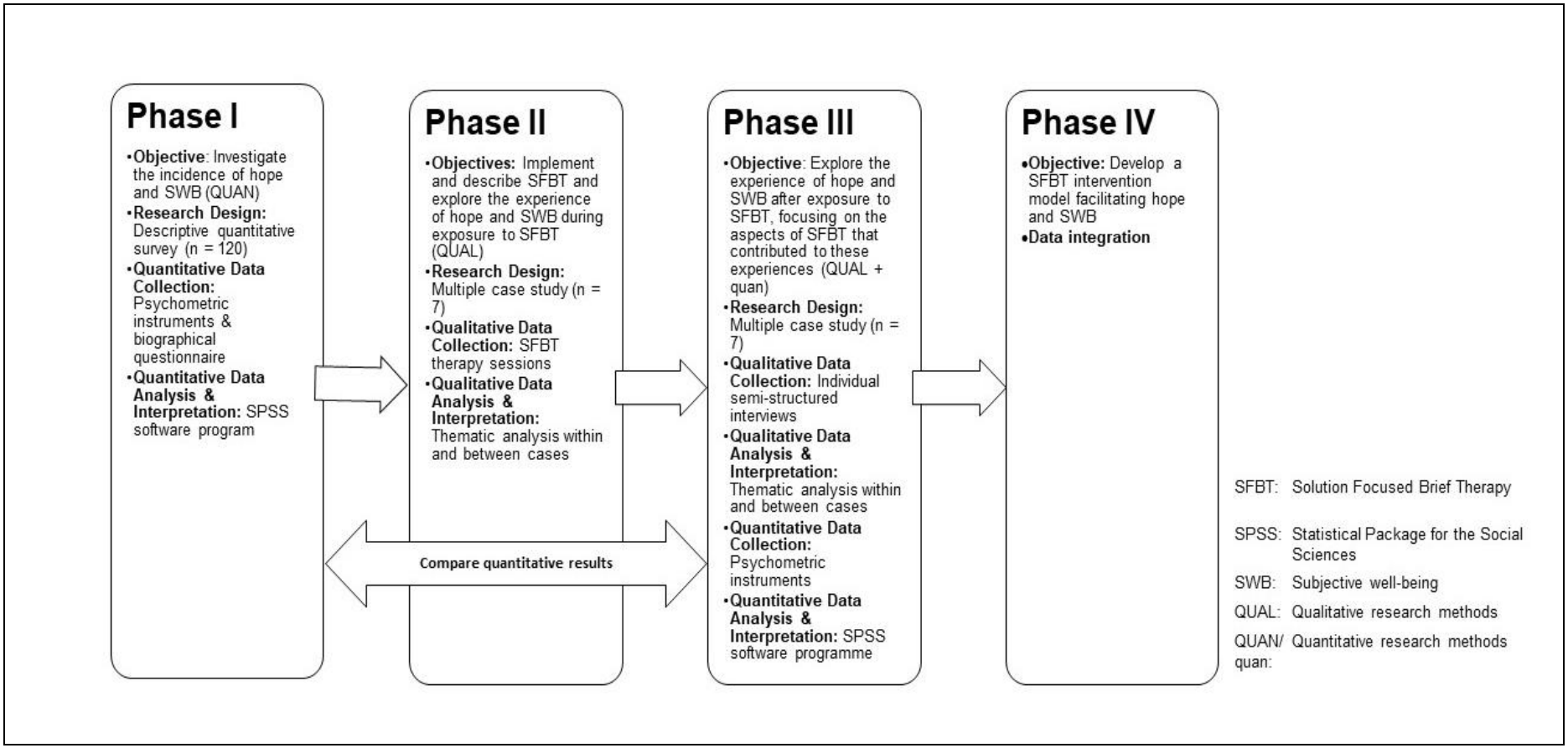

Figure 1. Outline of research design

4.4.2 Multiple case study design

As outlined above, Phases II and III of the study utilised a multiple case study design. Case study research is a qualitative approach in which researchers investigate a contemporary phenomenon in its real-life context over time, by making use of detailed in-depth data collection procedures and multiple sources of information (Creswell, 2014; Miles et al., 2014; Yin, 2009). Case study research recently gained support as a valued method in psychotherapy research, as it enables participants to tell their stories and assists researchers to better understand the participants' actions. It furthermore closes the research-practice gap by providing a contextual description of the therapist, the client, and the therapeutic process in a natural therapeutic setting (Baxter & Jack, 2008; McLeod, 2010; Miles et al., 2014).

In case study research, a *case* refers to a specific unit of analysis, delineated by clear boundaries. Cases may thus range from an individual or an organisation; to an intervention, or to a specific incident (Miles et al., 2014; Yin, 2009). In this study, a *case* was defined as each trauma survivor's experience of hope, SWB, and SFBT. Case study research may either explore a single case or compare a series of cases, as was done in this study (Creswell, 2014; Yin, 2009). The multiple case study design employed in this study thus allowed the researcher to explore similarities and differences within and between cases, and consequently allowed for the development of new insights regarding the phenomenon at hand. It also guided the researcher to draw conclusions based on replication, and therefore led to the development of an SFBT intervention model that could facilitate hope and SWB among trauma survivors (Miles et al., 2014; Yin, 2009).

However, the findings from multiple case study research are generally low in internal validity, and can therefore not be generalised to the broader population. Another disadvantage related to this approach is the fact that the researcher's subjectivity and integrity may influence the study outcomes (Baxter & Jack, 2008; Yin, 2009). In light of these shortcomings, D. J. A. Edwards (2019) proposes a systematic and pragmatic approach to conduct case study research, to enhance the trustworthiness of any conclusions drawn from the study. By following these steps in the present study, the researcher was thus able to collect, analyse, and integrate data

from both quantitative and qualitative sources to obtain a holistic understanding of the phenomenon being studied (D. J. A. Edwards, 2019; Yin, 2009).

4.5 Research Method

4.5.1 Sampling

4.5.1.1 Population and setting

The population of this study included patients at community-based clinics in Gauteng (Ekurhuleni) who had been exposed to one or more traumatic event during the past 5 years. The specific period was selected to accommodate delayed help-seeking after exposure to a traumatic event, and possible adaptation to stressful events (Calvo et al., 2015; Lucas, 2005; Lucas & Clark, 2006). As the researcher is a clinical psychologist employed by the Department of Health and who works at district health government clinics in Gauteng (Ekurhuleni), potential participants were sourced from these clinics. Patients from four different clinics, situated in both urban and semi-rural areas were considered.

The inclusion criteria for participants in the first phase of this study included: exposure to one or more traumatic event during the past 5 years; willingness to participate in the study; and a minimum age of 18 years. Participants of Phases II and III were identified from the first phase. In addition to the above-stated inclusion criteria, the following criteria were also considered: commitment to regularly attend therapy sessions; willingness to share their experiences during a semi-structured interview; consent for the therapeutic sessions and interviews to be recorded and transcribed; and comprehension and fluency in English and/or Afrikaans, as therapy at the clinics is predominantly conducted in these languages. The following exclusion criteria were also applied: acute presentation of trauma-related symptomology, psychosis, or suicidality; and mental impairment.

4.5.1.2 Sampling method and size

For the first phase of this study, non-probability purposeful sampling was used to identify patients at community-based clinics in Gauteng (Ekurhuleni) who had been exposed to one or more traumatic event during the past 5 years (Creswell, 2014; Creswell & Plano Clark, 2018). Participants either volunteered, were identified by the researcher, or were referred by qualified nurses at the clinics. The researcher used the following measures to inform patients about the study: distributing information

letters, displaying posters, and presenting information sessions at the clinics. In this phase, a convenience sample of 120 participants was used. According to Fowler (2009), this sample size is acceptable, assuming a margin of error of ± 9%, a confidence error of 95% and a 50/50 chance that the sample contains the inclusion criteria.

For Phases II and III, non-probability purposive sampling was again used to select participants who took part in the first phase and who met the additional inclusion criteria set out in Section 4.5.1.1. Onwuegbuzie and Collins (2007) refer to this as nested sampling, as the individuals in this sample are a subset of the individuals from the previous sample. As the researcher aimed to explore, understand, and obtain insight concerning hope and SWB during and after SFBT, a sample was selected that was best able to answer the research question (Miles et al. 2014). A convenience sample of seven participants was thus included in these phases. According to Creswell and Plano Clark (2018), this sample size is considered acceptable as case studies should preferably involve four to ten cases to gather in-depth information.

4.5.1.3 Participants

The participants in Phase I of this study were 120 adults, representative of patients at four clinics in Ekurhuleni (Gauteng). The sample comprised 25.8% from Alberton-North Clinic, 21.7% from Brackenhurst Clinic, 24.2% from Goba Clinic, and 28.3% from Dresser Clinic. The demographic information of the participants is shown in Table 1. The seven people participating in the later project phases were selected from this group.

Table 1 shows that the majority of the participants were females (83%) between the ages of 31 and 45 years. With regards to race, most (79%) of the participants were black. Highest participation by home language was by isiZulu speakers (35%), followed by Sesotho (27%), English (13%) and/or Afrikaans (13%). Of the participants, more than half (54%) were single and most (67%) had completed, at least, Grade 12. Just under half of the participants were unemployed (48%), although slightly more than half of them lived in a free-standing brick house (53%). Information concerning the trauma dynamics of the participants is provided in Chapter 5.

Table 1: *Demographic information of participants in Phase I*

Demographic Variable	n	%
Gender		
Female	100	83%
Male	20	17%
Age		
18–25 years	13	11%
26–30 years	29	24%
31–45 years	48	40%
46–60 years	20	17%
> 60 years	10	8%
Race		
Black	95	79%
White	21	18%
Indian/Asian	2	2%
Coloured	2	2%
Language		
isiZulu	41	35%
Sesotho	32	27%
English	16	13%
Afrikaans	15	13%
Other	15	13%
Marital status		
Single	65	54%
Married	18	15%
Living together	15	13%
Divorced/separated	13	11%
Partner deceased	9	8%
Highest level of education		
Primary school (Gr 1 - 7)	4	3%
Secondary school (Gr 8 - 11)	35	30%
Gr 12 certificate	47	39%
Tertiary qualification	33	28%
Other	1	1%
Employment status		
Unemployed	58	48%
Part-time employment	26	22%
Full-time employment	23	19%
Pensioner	5	4%
Self-employed	3	3%
Other	5	4%
Type of dwelling		
Free-standing brick house	64	53%
Room in a house	22	18%
Flat/apartment	18	15%
Informal dwelling (“shack”)	12	10%
Other	4	3%

The seven adults who participated in Phases II and III of this study were all black females between the ages of 29 and 54 years. Two of these women were single, two widowed, two divorced/separated from their respective partners, and one was married. Two participants had a secondary school education, two had completed Grade 12, and three had obtained a tertiary qualification. With regards to employment status, four were unemployed, one was employed on a part-time basis as a domestic worker, and two were employed by government institutions. More background information on each participant is provided in Chapter 5.

4.5.2 Data collection

4.5.2.1 Quantitative data collection

During Phases I and III of this study, quantitative data were collected using measuring instruments, and a biographical questionnaire presented to participants in a booklet format. This booklet was written in clear, understandable English and was administered by the researcher, either individually, or in a group format. Where necessary, a trained fieldworker (e.g. a mental health nurse or a health promoter at the clinic), fluent in the vernacular of the participants, assisted with administration and/or translation. The booklet contained instructions for the completion of the questionnaires and was accompanied by an information letter (see Appendices B and C) explaining the purpose of the study. A consent form was used to ensure participation for all participants was voluntary (see Appendices D and E).

Before administration of the questionnaires, a pilot study was conducted with six field workers who reported that the questionnaires were clear and user-friendly. According to the field workers, completion of the booklet took approximately 40 minutes, which is an acceptable length of time according to Brink (2006). The following questionnaires were included in the booklet:

A biographical questionnaire was designed by the researcher to gather socio-demographic information from the participants, and relevant trauma-related information (e.g. type of traumatic event, participants' responses to the traumatic event, and support/psychotherapy received after the traumatic event). Both closed-ended and open-ended questions were used to obtain this information (Creswell & Plano Clark, 2018).

The Adult State Hope Scale (AHS) (Snyder et al., 1996) is a 6-item instrument which measures participants' momentary hopeful thinking. This instrument conceptualises hope according to Snyder's (2002) hope theory and consists of three agency and three pathways items which participants respond to by using an eight-point Likert scale. This ranges from 1 (*definitely false*) to 8 (*definitely true*). For example, "*At the present time, I am energetically pursuing my goals*" is an item which measures agency thinking, while "*I can think of many ways to reach my current goals*" measures pathways thinking. The scores for each of these sub-scales are added and can range from 6 to 48, with higher scores representing higher hope levels. According to previous studies, Cronbach alpha coefficients ranged from 0.90 to 0.95 for the overall scale and 0.90 and higher for the agency and pathway factors which confirmed the reliability of this scale (Snyder et al., 1996). Internal consistency, as well as construct and discriminant validity, were also satisfactory (Snyder et al., 1996). Furthermore, Nel and Boshoff (2014) found the psychometric properties of this scale to be acceptable in the South African context. In the current study, a Cronbach alpha coefficient of 0.82 was obtained for the total scale.

The *Scale of Positive and Negative Experience (SPANE)* (Diener, Wirtz et al., 2009) was used to measure the affective components of SWB; respondents' positive (SPANE-P) and negative experiences (SPANE-N) were evaluated for the four weeks prior to the assessment. The SPANE is a 12-item questionnaire with two sub-scales, each including six items to respectively assess positive feelings and negative feelings on a 5-point Likert scale, ranging from 1 (r*arely never or never*) to 5 (*very often or always*). For example, feeling *good*, *happy* and *contented* are some of the items that measure positive feelings; while *unpleasant*, *afraid* and *angry* refers to negative feelings. The scores for each of these sub-scales are added to obtain a total score for positive and negative feelings which can range from 6 to 30, with higher scores indicating higher levels of either positive or negative feelings. The two scales can be combined by subtracting the negative from the positive scale total to derive an Affect Balance (SPANE-B) score. However, in this study, the positive and negative scales were used individually. The SPANE showed good psychometric properties with an internal consistency coefficient ranging from 0.81 to 0.90 (Diener, Wirtz et al., 2009). Du Plessis and Guse (2017) also found the SPANE to be a valid and psychometrically sound instrument for measuring positive and negative affect, as components of well-

being, among South African students. In the current study, a Cronbach alpha coefficient of 0.83 was obtained for the positive scale (SPANE-P), while a Cronbach alpha coefficient of 0.80 was measured for the negative scale (SPANE-N).

The *Satisfaction with Life Scale (SWLS)* (Diener, Emmons, Larsen, & Griffin, 1985) was used to measure the cognitive component of SWB. The SWLS is a 5-item scale designed to measure global cognitive judgements of life satisfaction on a 7-point Likert scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). For example, "*In most ways my life is close to my ideal*" and "*I am satisfied with my life*" are two items included in this scale. The scores for each item are added and can range from 5–35, with higher scores suggesting higher levels of life satisfaction. Reliability studies of the SWLS indicated a mean Cronbach alpha coefficient of 0.78 (Corrigan, Kalakowsky-Hayner, Wright, Bellon, & Carufal, 2013). The literature also indicated a test-retest correlation coefficient of 0.82 and confirmed a correlation between the SWLS and other measures of SWB (Corrigan et al., 2013). In South Africa, researchers have found the English version of the SWLS to be reliable among a multi-cultural sample, while the psychometric properties of the Setswana version have also been confirmed (M. P. Wissing & Van Eeden, 2002; J. A. B. Wissing, Wissing, Du Toit, & Temane, 2008; Wissing et al., 2010). In the current study, a Cronbach alpha coefficient of 0.83 was obtained for the SWLS.

The *Patient Health Questionnaire (PHQ-9)* (Kroenke, Spitzer, & Williams, 2001) was used to measure the presence of psychopathology, which can be conceptualised as the absence of well-being (Keyes, 2002). This instrument is a 9-item, self-administered scale which measures depression severity in the two preceding weeks. Each item is scored on a Likert scale, ranging from 0 (*not at all*) to 3 (*nearly every day*). For example, items such as *"Little interest or pleasure in doing things"* and "*Poor appetite or overeating"* are included in the scale. The scores for each item are added to obtain a severity scale, which can range from 0–27. A cut-off score ≥ 10 suggests a possible diagnosis of major depression. The PHQ-9 not only has the potential to establish depressive disorder diagnoses and severity in research and clinical practice, but can also screen for the presence and duration of suicidal ideation. Kroenke et al. (2001) found excellent test-retest reliability, and internal reliability for the PHQ-9 with a Cronbach alpha coefficient of 0.86. Researchers furthermore proposed that the PHQ-9 is valid to use in South African public health facilities as a tool for screening for

depression (Bhana, Rathod, Selohilwe, Kathree, & Petersen, 2015). In the current study, a Cronbach alpha coefficient of 0.86 was obtained for this instrument.

The *Post-Traumatic Stress Disorder Checklist for DSM-V (PCL-5)* (Weathers et al., 2013) was used to assess the presence and severity of PTSD symptoms among participants in the month leading up to the study. As with the PHQ-9, the PCL-5 was used in this study to measure the presence of psychopathology. The PCL-5 is a 20-item self-report measure which is scored on a 5-point Likert scale, ranging from 0 (*not at all*) to 4 (*extremely*). Items included in this scale are: "*Repeated, disturbing dreams of the stressful experience*" or "*Feeling jumpy or easily startled*". The scores for each item are added and can range from 0–80, with scores ≥ 33 suggesting a provisional PTSD diagnosis. Previous psychometric studies have confirmed satisfactory internal consistency, test-retest reliability, and convergent validity for this measure in various contexts (Ashbaugh, Houle-Johnson, Herbert, El-Hage, & Brunet, 2016; Cohen et al., 2014; Sveen, Bondjers, & Willebrand, 2016; Wortmann et al., 2016). Makhubela (2018) also provided evidence for the factorial validity and reliability of PCL-5 scores and support its research use in the South African context. Similar results were also obtained among a primary care population in Zimbabwe (Verhey, Chiband, Gibson, Brakarsh, & Seedat, 2018). In the current study, a Cronbach alpha coefficient of 0.91 was obtained for the PCL-5.

Although 136 questionnaires were circulated during the first phase of the study, only 120 (88%) were fully completed and received back. This was considered satisfactory as Szelenyi, Bryant, and Lindholm (2005) suggest that a response rate of 32% is acceptable in self-report surveys. During the third phase of the study, the seven participants who were involved in the therapeutic process again completed the questionnaires as soon as possible after the completion of therapy. For the majority of participants, post-test data were collected approximately two weeks after therapy was terminated. Although all seven returned the questionnaire, some participants did not fully complete the booklet.

4.5.2.2 Qualitative data collection

During Phases II and III of this study, qualitative data were collected both from *therapeutic sessions* (Phase II), and *individual semi-structured interviews* (Phase III). The researcher contacted participants who had taken part in the first phase of this

study, and who had met the additional inclusion criteria, to determine their willingness to be involved in Phases II and III of the study. Thirty participants from Phase 1 were contacted and 15 showed interest in attending therapy. However, only seven completed the therapeutic process and were included in Phases II and III of the study. The majority of participants attributed non-attendance and discontinuation of therapy to work-related responsibilities or relocation.

In Phase II, qualitative data were collected via the SFBT therapeutic process conducted with each of the seven participants. The process was implemented by the researcher and is outlined in more detail in Section 4.5.3. These sessions were audio-recorded and transcribed verbatim to explore participants' experience of hope and SWB during SFBT. Therapy was implemented at the clinics in a quiet, confidential setting, and the duration of sessions was approximately 60 minutes. The number of therapeutic sessions participants attended ranged from one to four, with the majority attending two or three sessions. This is in agreement with Courtnage (2020) who noted that single-session therapy is becoming more common. However, participants 3 and 4 requested a follow-up session after data collection was completed in order to monitor their progress.

During Phase III of the study, qualitative data were collected from individual semi-structured interviews with each of the seven participants. These interviews were conducted by the researcher, as soon as possible after the completion of the therapeutic process. The time interval between the last session and the interview ranged from two days to four months, with the majority of interviews conducted one to two weeks after completion of therapy. The interviews were audio-recorded and transcribed verbatim to explore participants' experience of hope and SWB after exposure to SFBT, specifically focusing on the aspects of SFBT that contributed to their experiences. An interview protocol (see Appendix F) consisting of open-ended, non-directive questions, introductory concepts, and concluding comments were used as a guide to ensure that the research objectives were addressed (Creswell, 2014; Creswell & Plano Clark, 2018).

To ensure rigour and trustworthiness, the researcher took on a stance of *not knowing* and prompted participants to provide examples or illustrations of experiences (Creswell, 2014). The interviews were held at the clinics in a quiet, confidential setting

and took approximately 60 minutes. Due to employment prospects and the possibility of not being able to continue therapy, the individual interview with participant 7 was held after she attended two therapeutic sessions. The impact this might have had on her experience should thus be considered. Throughout the process of qualitative data collection, the researcher noted observations, reactions, and impressions in a research journal to ensure reflexivity.

4.5.3 Solution-focused brief therapy process

During Phase II of this study, the researcher implemented an SFBT intervention with seven participants. To ensure rigour and trustworthiness, the researcher followed the SFBT assumptions and principles outlined in the *Solution-Focused Therapy Treatment Manual for Working with Individuals* (Bavelas et al, 2013). These assumptions and principles are also discussed in Chapter 2 of this thesis. Therapeutic sessions were specifically structured according to the *solution-focused art gallery metaphor* described by Froerer et al. (2018). These authors compare the SFBT session to a tour through an art gallery, with different rooms to visit and different pieces of art to explore. Although this metaphor implies a certain direction and purpose of travel, the client and therapist may spend more time in one room, may go back and revisit certain rooms, or may discover something else that is significant in the gallery. It is therefore not a recipe, but rather a guide that should be tailored to each therapeutic journey (McKergow, 2016). In this study, the researcher guided trauma survivors through the following art gallery rooms:

- The best hope/desired outcome room

In the first room of the art gallery, the researcher aimed to establish the client's desired outcome for the session. This was done by asking a goaling question such as: *"What do you hope to achieve from this session?"* (Von Cziffra-Bergs, 2018). The answer to this question served as a contract between the client and the researcher and guided them through the rest of the art gallery. If necessary, the researcher made use of additional questions to ensure the client's desired outcome was clear, specific, and positively framed (Bavelas et al., 2013). In this room, clients often described their trauma or problem. Although the researcher did not ignore these details or stop the client from talking about it, aspects that contributed to the client's desired outcome were rather amplified and reflected (Froerer et al., 2018).

- The resource talk room

The purpose of the second room in the art gallery was language expansion. The researcher therefore asked questions to get to know the client, instead of their problem (Von Cziffra-Bergs, 2018). This helped clients to step away from their trauma for a moment and talk about other aspects of their lives (e.g. *important people, talents, achievements, qualities, values* etc.) The researcher used the resources and strengths discovered in this room to guide towards the client's preferred future (Froerer et al., 2018).

- The preferred future room

This room is considered the most important room of the gallery as it is the place where change happens in the session (Froerer et al., 2018). In this room, the researcher elicited a detailed description of the presence of the client's desired outcome, either in the past or in the future. This was accomplished by making use of the following SFBT techniques and questions: *miracle question, coping questions, relational questions, scaling,* and *exception-finding* (Bavelas et al., 2013). These techniques are discussed in more detail in Chapter 2 of this thesis. After a clear description of the client's preferred future was obtained and their relevant resources had been elicited and amplified, the researcher entered the final room of the art gallery (Von Cziffra-Bergs, 2018).

- The session closing room

The goal of this room was to preserve the work that was done in the previous rooms and maintain the client's sense of authority (Froerer et al., 2018). In this room, the researcher thus refrained from providing psycho-education or homework, but rather encouraged clients to *notice signs of their preferred future* already being present and how they made it happen (Froerer et al., 2018). The researcher also helped clients to identify *what stood out* for them about the session and provided *positive feedback* by reflecting their strengths (Bavelas et al., 2013; Von Cziffra-Bergs, 2018). Finally, as the researcher viewed the client as the expert, the client was allowed to decide whether another therapy session should be scheduled (Connie & Froerer, 2020).

4.5.4 Data analysis

4.5.4.1 Quantitative data analysis

Quantitative data collected during Phase I of the study were analysed using the IBM SPSS (Version 26, 2019) computer software program. Biographical information was transformed into quantitative data so that the responses were categorised into discrete categories. Descriptive statistics, reliability of measuring instruments, and frequency distributions of biographical and trauma-related information were determined. Participants' mean scores of hope, SWB, and psychopathology; as measured using the instruments administered during Phases I and III of this study; were compared for the purposes of triangulation. The results are discussed in Chapter 5.

4.5.4.2 Qualitative data analysis

The researcher transcribed and analysed the qualitative data, collected using therapeutic sessions and semi-structured interviews. Thematic analysis was used as the method of data analysis (Braun & Clarke, 2006). According to Braun and Clarke (2014), thematic analysis provides a robust, systematic framework for coding qualitative data and then using that coding to identify patterns across the dataset concerning the research question. This method of analysis thus allowed the researcher to see and make sense of shared meanings and experiences. Thematic analysis is considered to be a method rather than a methodology and is therefore not tied to a particular epistemological or theoretical perspective, rendering it flexible and practical (Braun & Clarke, 2006, 2014). It specifically suits mixed methods research designs and offers potential in applied research projects as it is relatively easy to use (Braun & Clarke, 2012).

In the context of thematic analysis, a *theme* refers to patterns in the data that are important or interesting and that address the research question or say something about a specific issue (Braun & Clarke, 2006). In this study, themes were identified using deductive analysis which provided a detailed description of hope and SWB among trauma survivors during and after SFBT, focusing on the aspects of SFBT that contributed to these experiences. The analysis procedure was guided by the following six phases outlined by Braun and Clarke (2006, 2012, 2014):

- Step 1: Becoming familiar with the data

During the first step, the researcher read and re-read the transcripts of all the therapeutic sessions and the interviews. These were read actively, analytically, and critically. The aim of this step was for the researcher to familiarise herself with the content and to start making notes of potentially interesting items, meanings, or patterns.

- Step 2: Generating initial codes

Here, the researcher started to organise the data in a meaningful and systematic way by manually coding each segment of data that was relevant to the research question. Codes were identified and allocated a label for the most basic segment of the raw data that was of potential relevance. These codes were developed and modified during the coding process.

- Step 3: Searching for themes

In this phase, the researcher analysed and organised codes into broader themes by considering how different codes may combine to form an overarching theme. Codes were collapsed or clustered together to reflect and describe a coherent and meaningful pattern in the data. At the end of this phase, the researcher generated a table outlining candidate themes, possible sub-themes, and all coded data extracts. At this stage, the researcher did not abandon any codes and used a *miscellaneous* theme to manage codes that did not fit with a specific theme.

- Step 4: Reviewing themes

At this point, the researcher reviewed and refined preliminary themes concerning the coded data and the entire data set. The researcher thus ensured that themes were coherent, but distinct from each other. This was done by determining whether themes made sense, were supported by the data, and had clear boundaries. Any new themes emerging from the data were also identified. At the end of this phase, the researcher had a relatively strong knowledge of the different themes, how they fitted together, and the overall story they told about the data.

- Step 5: Defining and naming themes

In this step, the aim was to identify the essence of each theme and determine how sub-themes interact with each other and relate to the main theme. This was done by going back to the collated data extracts for each theme and organising them into a coherent and internally consistent narrative. At this point, the researcher also started thinking about informative and concise names for each theme.

- Step 6: Producing the report

The final step was to provide a concise, coherent, logical, non-repetitive, and interesting account of the story the data told, both within and across themes. In this study, the researcher followed the typical format for analysing multiple case studies. A detailed within-case report describing and discussing relevant themes for each case was thus provided; followed by a between-case analysis (Creswell, 2014; Miles et al., 2014). Regarding the between-case analysis, meta-matrices were drawn up to summarise the structured themes and sub-themes, and to highlight the similarities and differences between cases (see Appendix G) (Miles et al., 2014).

The between-case analysis contributed to the generalisability, relevance, and applicability of research findings as it allowed the researcher to produce sophisticated and valid explanations regarding trauma survivors' experiences of hope and SWB, during and after SFBT (Miles et al., 2014). Research findings were furthermore compared to the existing knowledge base on hope, SWB, and SFBT to discuss results in the context of what is already known. The literature thus validated the data and confirmed the findings of the study (N. Burns & Grove, 2005). At this point, quantitative and qualitative data as well and existing literature were integrated into a case study report which guided the development of an SFBT intervention model that could facilitate hope and SWB among trauma survivors.

4.5.5 Role of the researcher

In this study, the researcher not only collected, analysed, and interpreted data; but also implemented the SFBT intervention. The researcher was the only psychologist experienced in the field of SFBT and simultaneously employed at the relevant community-based clinics where the study was conducted. She thus took on the *dual role of psychologist and researcher*, and in this thesis, is referred to as both

the researcher and as the therapist. Consequently, the researcher was cognisant of how the dual role might influence participants' responses during the interviews and her interpretation of the results (Fleet, Burton, Reeves, & DasGupta, 2016; Henton, 2012; McLeod, 2010). To minimise the possible negative impact of this dual role, the researcher employed the following measures: providing no incentive or special treatment to participants, involving peer review, and incorporating role fluency during the research process. The researcher thus prioritised the role of therapist during the sessions and only started qualitative data analysis after the therapeutic process was completed (Fleet et al., 2016; Henton, 2012; McLeod, 2010).

Despite the possible limitations innate to the dual role of therapist-researcher, practice-based research also offers numerous advantages (Fleet et al., 2016; Henton, 2012; McLeod, 2010). This form of research, which includes case studies and process-orientated research, not only generates in-depth context-specific knowledge, but also contribute to the practice of psychology. Practice-based research furthermore provides participants with the opportunity to benefit personally from the research/therapy process. Dual role research is therefore considered to be a valid and applicable approach in the field of psychology, especially if the necessary steps are taken to ensure rigour and trustworthiness in a study (Fleet et al., 2016; Henton, 2012; McLeod, 2010).

4.6 Research Quality

Although rigour and trustworthiness differ in quantitative and qualitative research; for both approaches, it serves the purpose of ensuring the quality of the results and the researcher's interpretation of the data results (Creswell, 2014; Creswell & Plano Clark, 2018). In quantitative research, the researcher is specifically concerned with issues of *validity and reliability*. On the one hand, validity confirms that scores obtained in a study are meaningful indicators of the construct being measured; while on the other hand, reliability verifies that the scores obtained are consistent and stable over time (Creswell, 2014; Creswell & Plano Clark, 2018). In the quantitative phase of this study, validity was ensured by using measuring instruments. Reliability checks to determine the internal consistency of the scales were also conducted (see Section 4.5.2.1). When quantitative data from Phases I and III were compared, the researcher was furthermore cognisant of the possible threats to internal and external validity.

These findings were therefore only used to substantiate qualitative data (Creswell, 2014).

In qualitative research, validity is based on assessing whether the data obtained in a study is accurate from the standpoint of the researcher, the participants, or the readers. In this regard, validity is often referred to as *trustworthiness or authenticity* (Creswell, 2014; Creswell & Miller, 2000; Creswell & Plano Clark, 2018). According to Lincoln and Guba (1985), trustworthiness incorporates the credibility, transferability, dependability, and confirmability of research findings. Qualitative researchers therefore make use of different validity strategies to enhance the trustworthiness of their studies which allows them to draw well-founded and socially meaningful conclusions. Although reliability generally plays a minor role in qualitative research, researchers still have to ensure that their approach is consistent and stable across different researchers and projects (Creswell, 2014). As suggested by various authors, the following strategies were thus implemented to ensure rigour and trustworthiness in the qualitative phases of this study (Baxter & Jack, 2008; Creswell, 2014; Creswell & Plano Clark, 2018; Henwood & Pidgeon, 1992; McLeod, 2010; Miles et al., 2014):

- Triangulation

The researcher collected and analysed data from various sources (e.g. measuring instruments, transcripts of therapeutic sessions, and individual semi-structured interviews), and multiple cases, to explore hope and SWB in the context of SFBT from multiple perspectives. The collection and comparison of this data enhanced the quality of the information and assisted the researcher to build a coherent justification for the conclusions drawn from this study.

- Member-checking

At the end of each individual interview, the researcher summarised and shared the major themes identified by the participants to check whether the researcher had understood them correctly. Participants had the opportunity to discuss and clarify this information and were able to contribute any new or additional perspectives regarding their experiences.

- Rich, thick description

Using case study reports presented in Chapter 5, the researcher provided a thick description of the therapeutic process; the reports were further used to identify themes emerging from the individual semi-structured interviews. This was done not only to provide readers with a sense of shared experience, but also enriched the results and made them more realistic. Additionally, this chapter presented an in-depth description of the entire research process (e.g. data collection, analysis, and interpretation) which served as an audit trail and contributed towards the objectivity of the study.

- Reflexivity

As discussed in Section 4.5.5, the researcher was aware of how the dual role of researcher and therapist might influence the results. The researcher therefore kept a research journal and maintained ethical mindfulness to ensure beneficence. In the final chapter of this thesis, the researcher also acknowledge that the interpretation of research findings might be shaped by her socio-demographic background (e.g. gender, culture, history, and socioeconomic origin).

- Present negative and discrepant information

With the between-case analysis, the researcher highlighted and discussed cases that showed contrary information or did not support the general perspective of the theme. This not only added to the credibility of the account, but also made it more realistic because different perspectives can be expected in real life.

- Prolonged time in the field

The researcher has been working as a clinical psychologist at community-based clinics for more than three years and has consulted numerous clients who experienced trauma during this period. This allowed the researcher to develop an in-depth understanding of the phenomenon and contributed to the credibility of the narrative account. The researcher was also able to establish rapport and trust with participants during the therapeutic process which helped them to openly and honestly share their experiences during the interviews.

- Peer review

The results, interpretations, and conclusions drawn from this study were reviewed by both the researcher's supervisor, who is familiar with qualitative research, and another psychologist experienced in the field of SFBT. This ensured that the account resonated with people, other than the researcher, and therefore contributed to the accuracy of the account.

4.7 Ethical Considerations

Throughout the research process, the researcher was mindful of the need to conduct the research ethically to protect the rights of the participants, and to avoid potential breaches of those rights. The researcher therefore adhered to the ethical code of conduct for psychologists, as outlined by the Health Professions Council of South Africa (HPCSA, 2006). Before commencement of this study, the written proposal was submitted and approval was obtained from both the University of Pretoria's Research Ethics Committee (see Appendix H) and the Ekurhuleni Health District Research Committee (EHDRC) (see Appendix I).

Written informed consent was obtained from all participants before their involvement in the different phases of this study. They were provided with information letters (see Appendices B and C) explaining the purpose of the study, the research procedure, the researcher's role, privacy and confidentiality, and possible benefits or risks associated with the study. The participants were also informed that their participation was voluntary and that they could withdraw from the study at any time. It was also made clear that no incentive or special treatment was offered for participation. If participants agreed to these conditions, consent forms (see Appendices D and E) were signed. The researcher explained in detail the information letter, consent form, and the questionnaire to field workers who at times, assisted with the administration of the questionnaires. The researcher highlighted the ethical principles of the study and allowed an opportunity for questions and concerns to be clarified. However, the researcher was always present during data collection, should the field workers have experienced any challenges.

Participants' identity was protected by using a coding system, and quantitative data, audio recordings, and transcripts were stored in secured files on a password-protected computer. With regards to qualitative data analysis and reporting,

pseudonyms were used and identifying information was removed as far as possible. For archiving and research purposes, all information collected during this study will be safely stored for 15 years. The therapeutic intervention was provided by the researcher who is a registered clinical psychologist and has experience in the practice of SFBT. The researcher was thus equipped to conduct the research and was guided by other professionals in the field of psychology. Participants who experienced any distress as a result of participation in this study had the opportunity to continue therapy with the therapist (researcher) or be referred to another psychologist in the district, depending on their need or preference. A copy of the transcripts and research results was also available, should they have been requested by participants.

4.8 Conclusion

This chapter provided an outline of the pragmatic research paradigm and the multiphase mixed methods design (with emphasis on the multiple case study design) that was used in this study. The non-probability purposeful sampling procedure and the methods of data collection and data analysis that were utilised for both the quantitative and qualitative phases of this study were also discussed. The SFBT process, as guided by the SFBT art gallery metaphor, were furthermore outlined, and the researcher's dual role of psychologist and researcher was critically discussed. This chapter concluded with a description of the measures that were employed by the researcher to ensure rigour and trustworthiness, and the ethical considerations throughout the research process. The results of this study are presented and discussed in the following chapter.

Chapter 5: Results and Discussion

5.1 Introduction

The first part of this chapter will provide a description and discussion of the incidence of hope and SWB among a group of 120 trauma survivors at community-based clinics in Gauteng. This section will thus present and discuss the quantitative data results obtained during Phase I of this study. The second part of the chapter will offer a description and discussion of seven trauma survivors' experience of hope and SWB, during and after exposure to SFBT, at community-based clinics in Gauteng. This section will thus present and discuss the quantitative and qualitative results obtained during Phases II and III of this study.

5.2 Phase I: Incidence of Hope and Subjective Well-Being

5.2.1 Biographical information

5.2.1.1 Trauma-related experiences of participants

The biographical questionnaire provided valuable information on trauma-related experiences of the participants. The frequency distribution of trauma experiences of the participants is indicated in Table 2 and is discussed below.

From Table 2, it is evident that the most common traumatic events the participants had experienced were: the death of a loved one (49%), physical assault/abuse (32%), and a life-threatening illness/injury (24%). These findings concur with those of Atwoli (2015) who identified the unexpected death of a loved one, physical violence, and accidents as the most common traumatic events among South Africans. Compared to the SASH study, which found that 21% of the population is exposed to physical violence during their lifetime, this group reported a higher incidence of physical assault/abuse. This may reflect the criminal activities, gender-based violence and high-risk behaviour facing communities in South Africa (Atwoli et al., 2013; Jewkes & Abrahams, 2002; Schneider et al., 2016; Sibanda-Mojo et al., 2017; Van der Merwe & Kassan-Newton, 2007; Williams et al., 2007). The relatively high prevalence of life-threatening illness/injury among participants in this study may furthermore be ascribed to the clinical setting and possibly echo the high incidence of HIV/AIDS in the community (J. K. Burns, 2011; Schneider et al., 2016; Young, 2011).

Table 2: *Trauma experiences of the participants*

Trauma Variable	n	%
Type of traumatic event		
Experienced death of a loved one	59	49%
Experienced physical assault/abuse	38	32%
Experienced illness/injury	29	24%
Experienced transport accident	18	15%
Experienced sexual assault/abuse	18	15%
Number of traumatic events experienced in the past 5 years		
Ony 1	52	43%
2	27	23%
3	21	18%
4	5	4%
≥ 5	15	13%
Time of traumatic events		
≤ 1 month ago	9	8%
1–6 months ago	19	16%
7 months–1 year ago	14	12%
1–2 years ago	44	37%
3–5 years ago	81	68%
Impact of traumatic events		
Relationships	65	54%
Self-esteem	64	53%
Mental well-being	52	43%
Life satisfaction	45	38%
Hope	44	37%
Physical well-being	41	34%
Spiritual well-being	25	21%
Currently coping with trauma		
No	53	51%
Partially	27	26%
Yes	25	24%

With regards to the number of traumatic events, more than half (57%) of participants in this study had experienced more than one event in the past five years, and 13% were exposed to five or more events. These findings are supported by previous studies investigating the lifetime prevalence of traumatic events in the South African population (Atwoli, 2015; Kaminer & Eagle, 2010; Williams et al., 2007). For example, the SASH study found that 56% of South Africans are exposed to more than one traumatic event and 16% experience as many as four or five traumatic incidents (Williams et al., 2007). The results of the present study not only highlighted the high incidence of multiple traumatic events among South Africans, but also suggested continuous exposure to trauma. This is evident in the fact that the majority of

participants (68%) had experienced trauma in the previous 3–5 years, and almost one-quarter (24%) had also been exposed to a traumatic event in the preceding 6 months. It is therefore clear that for the majority of participants, exposure to potentially traumatic experiences is an inescapable part of daily life (Kaminer & Eagle, 2010).

Most participants indicated that exposure to traumatic events affected their relationships (65%), self-esteem (64%), and mental functioning (52%). According to the participants, the trauma predominantly had a negative impact on: their relationships; self-esteem; physical-, mental, and spiritual functioning; as well as their experience of hope and life satisfaction. This is supported by both local and international literature highlighting the negative consequences of trauma (APA, 2013; Atwoli et al., 2013; Kaminer & Eagle, 2010; Lowe et al., 2015; Scheiderer et al., 2015). Previous studies also found that hope and SWB are negatively associated with various traumatic events (Bucciol & Zarri, 2017; Chang et al., 2015; Irving, et al., 1997; Oskin, 1996; Oswald et al., 2015). This is mirrored by the fact that half (51%) of the participants indicated that they were not coping with the consequences of the trauma they had experienced.

5.2.1.2 Help-seeking behaviour of participants

The biographical questionnaire furthermore provided insightful information concerning participants' help-seeking behaviour following the traumatic event. The frequency distribution of the participants with regards to help-seeking is indicated in Table 3 and is discussed below.

Table 3 indicates that most participants (84%) in this study disclosed their trauma to someone, with a family member (57%) or a friend (38%) being the most likely people to confide in. This is in agreement with Walker-Williams (2012) who found that South African women exposed to CSA are most likely to disclose their trauma to a friend, a psychologist, or a family member, especially their mother. It thus appeared that, although women in South Africa do not always report gender-based violence to authorities, they often share the traumatic events they encounter with someone they trust (Appelt, 2006; Diale, 2014; Jewkes & Abrahams, 2002; Kaminer & Eagle, 2010; Sibanda-Mojo et al., 2017).

Table 3: *Help-seeking reported by participants*

Help-seeking Variable	n	%
Disclosure of traumatic event		
Family member	68	57%
Friend	45	38%
Spouse	26	22%
Spiritual/religious leader	20	17%
Never	19	16%
Professional help received		
Never	74	62%
Medical doctor/psychiatrist	20	17%
Psychologist	16	13%
Spiritual/religious leader	14	12%
Social worker	10	8%
Time professional help was received		
1–7 days after the event	5	11%
1–4 weeks after the event	9	20%
1–6 months after the event	11	24%
≥ 6 months after the event	21	46%
Effectiveness of professional help		
Helpful	20	49%
Partially helpful	9	22%
Not helpful	12	29%

In this study, the majority (62%) of participants did not receive any professional help following their traumatic experience. Only 17% received assistance from a medical doctor/psychiatrist and even less (13%) consulted a psychologist. This relatively low number may be ascribed to the various challenges community mental health services are faced in South Africa. For example, an insufficient number of community psychiatric clinics, poor accessibility of clinics, and limited mental health practitioners may hinder effective mental health service delivery in Gauteng (De Kock & Pillay, 2017; Moosa & Jeenah, 2008). Limited awareness of, and negative attitudes towards, government-based mental health services may furthermore have prevented participants from seeking professional help (Bezuidenhout, 2016; Kaminer & Eagle, 2010; Schneider et al., 2016).

However, those participants who did seek professional help, mostly (55%) did so less than 6 months after the traumatic event. This is unexpected as the traditional cultural and spiritual beliefs held by a large portion of the South African population often influence citizens to rather consult traditional or faith healers, before approaching formal psychiatric services (J. K. Burns, 2011; Eagle, 2015; Jalal et al., 2018).

Participants in this study seemed to hold a more accepting perspective regarding mainstream mental health services. Finally, the value of professional help was highlighted as the majority (71%) of participants who did seek help, felt that the professional input was helpful; or at least partially helpful. This concurs with local literature supporting the effectiveness of various interventions when working with trauma survivors (Eagle & Watts, 2002; D. J. A. Edwards, 2005, 2009; Jalal et al., 2018; Kaminer & Eagle, 2017).

5.2.2 Descriptive statistics

In addition to the biographical questionnaire, different measuring instruments were used to investigate the incidence of hope, SWB, and psychopathology among participants. Means, standard deviations, score ranges, and reliability for all scales used in this study are presented in Table 4.

Table 4: *Means (M), standard deviations (SD), score ranges, and reliability indices of scales*

Scale	*M*	*SD*	Observed range	Possible range	Cronbach's alpha coefficient
AHS	29.53	10.93	8–48	6–48	0.82
SPANE-P	18.78	4.78	8–30	6–30	0.83
SPANE-N	19.38	4.88	6–30	6–30	0.80
SWLS	16.92	7.76	5–33	5–35	0.83
PHQ-9	12.52	7.01	0–27	0–27	0.86
PCL-5	41.69	17.60	3–75	0–80	0.91

Note: AHS = Adult State Hope Scale; SPANE-P = Scale of Positive Experience; SPANE-N = Scale of Negative Experience; SWLS = Satisfaction with Life Scale; PHQ-9 = Patient Health Questionnaire; PCL-5 = Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V

5.2.2.1 Reliability of measuring instruments

As is evident in Table 4, the Cronbach alpha coefficients for all measuring instruments were equal to, or above 0.80, which suggests particularly good internal consistency (Steiner, 2003). These reliability indices correspond with values found in other comparable studies.

5.2.2.2 Incidence of hope, subjective well-being, and psychopathology

Mean scores (*M*) are generally used to summarise normal distributions of interval or ratio scores, and standard deviation (*SD*) is a measure of variability that

indicates how much the scores are spread out around the mean (Gravetter & Forzano, 2009). The mean scores presented in Table 4 were used to determine the incidence of hope, SWB, and psychopathology among the participants.

5.2.2.2.1 *Incidence of hope*

The mean score of the AHS was 29.53 (*SD* = 10.93) which is somewhat lower than the score obtained during the development and validation of this measure (33.99 < *M* < 37.15) (Snyder et al., 1996). This suggests that participants in this study experienced relatively low levels of hope.

This is supported by literature indicating that various traumatic events may erode trauma survivors' experience of hope. For example, studies found that hope is negatively associated with exposure to community violence, war, and sexual assault (Chang et al., 2015; Irving, et al., 1997; Oskin, 1996). Studies have also reported higher levels of hopelessness among people with a history of exposure to sexual abuse or interpersonal violence (Machado et al., 2010; Scher & Resick, 2005; Spokas et al., 2009). In South Africa, Isaacs and Savahl (2014) have furthermore found that violent perpetration is associated with a loss of hope for the future, specifically among adolescents residing in a high–violence community. According to Snyder (2002), variables such as violence, victimisation, loss, and non-supportive environments specifically contribute to diminished hope in the context of trauma. Considering the trauma dynamics observed in this sample, and the particular psychosocial challenges communities face, it thus makes sense that participants experienced low levels of hope.

Socio-demographic factors may also have influenced the experience of hope. The majority of participants were black females from disadvantaged communities, and it was found by Snyder et al. (1996) that females experience somewhat lower levels of hope, compared to males, on the AHS. With regards to race, Boyce and Harris (2013) also observed lower levels of hope among black South Africans. However, Guse and Vermaak (2011) found no statistically significant differences in the level of hope among a group of South African adolescents from various population groups. Similarly, Chang and Banks (2007) reported that minority groups in America did not have lower levels of hope when compared to other groups. It was proposed that the early experience or anticipation of goal-related obstacles may enable minority groups

to manage or circumvent exposure to goal-limiting barriers that ensure hope for the future (Chang & Banks, 2007). Although socio-demographic factors may have influenced the participants' experience of hope, trauma seemed to have a greater impact.

5.2.2.2.2 *Incidence of subjective well-being*

With regards to the affective component of SWB, the mean score of the SPANE-P was 18.78 (*SD* = 4.78) and *M* = 19.38 (*SD* = 4.88) was calculated for the SPANE-N. Compared to previous studies with groups of local (SPANE-P = 21.19; SPANE-N = 15.96) and international (SPANE-P = 22.05; SPANE-N = 15.36) students, the score of positive experience in this sample was comparatively lower; in contrast, the negative experience score was comparatively higher (Diener, Wirtz et al., 2010; Du Plessis & Guse, 2017). Although the mean score of the SPANE-P was similar to scores observed among Chinese participants who were divorced/widowed (SPANE-P = 19.90; SPANE-N = 14.80), the SPANE-N score for the present study was much higher (F. Li, Bai, & Wang, 2013). This suggests that participants experienced low levels of positive feelings and high levels of negative feelings.

Concerning the cognitive component of SWB, a mean score of 16.92 (*SD* = 7.76) was calculated for the SWLS. Based on the cut-off scores suggested by Diener et al. (1985), participants seemed slightly dissatisfied with their lives. Compared to South African students and adults ($23.33 < M < 24.8$), participants in the present study appeared to be less satisfied with their lives (Pretorius et al., 2008; J. A. B. Wissing et al., 2008). This was also true when compared to cross-cultural nonclinical samples ($20.09 < M < 26.23$) (Chang & Banks, 2007; Pavot & Diener, 1993). However, the results of this study were similar to those observed among a group of clinical clients at a psychological private practice ($14.4 < M < 18.3$) (Pavot & Diener, 1993). It can thus be concluded that participants in the present study experienced low levels of life satisfaction.

From the above findings, it is evident that participants in this study experienced low levels of both affective and cognitive SWB. This concurs with literature suggesting that traumatic events may negatively affect people's experience of SWB. For example, studies have shown that happiness is negatively impacted by the loss of a close relative, being diagnosed with a life-threatening illness, and exposure to accidents,

serious physical assaults, and family tragedies (Bucciol & Zarri, 2017; Oswald et al., 2015). The death of a spouse, divorce, losing one's job, or experiencing severe disability may also have a long-term detrimental impact on SWB (Lucas, 2005; 2007b; Lucas et al., 2003). International and local studies have furthermore reported that people exposed to violence or crime experienced decreased SWB (Davies & Hinks, 2010; Mahuteau & Zhu, 2016; Powdthavee, 2005; Staubli et al., 2014).

According to the literature, the type of traumatic event, the degree of exposure, as well as post-event resources and stressors may influence an individual's level of happiness following trauma (Calvo et al., 2015; Kimball et al., 2006; Rateau, 2009). Furthermore, a perceived lack of social support (e.g. not being able to get help and support, or being stigmatised) in the face of adversity may be detrimental to the well-being of trauma survivors (Janoff-Bulman & Frieze, 1983; Stickley et al., 2015). Considering the trauma dynamics and limited professional help received by participants in this study, it is therefore not surprising that they were experiencing low levels of SWB at the time of the study. However, various socio-demographic factors may also have influenced the participants' experience of SWB.

For example, the majority of participants in this sample were females who tend to experience both positive and negative emotions more frequently and intensely than men (Diener, Wirtz et al., 2010; Pavot & Diener, 2013; Zuckerman et al., 2017). Although gender may have influenced the higher levels of negative affect among participants, it does not explain the low levels of positive affect. Furthermore, most participants were black people who traditionally belong to a collectivistic culture. According to literature, people from collectivistic cultures find it more appropriate to experience and express negative affect as they tend to believe that strong positive emotions may disrupt interpersonal harmony or lead to negligent behaviours (Diener & Suh, 1999; Diener, Suh et al., 1995; Suh & Koo, 2008). Cultural norms may thus have influenced the higher levels of negative affect observed amongst the participants.

In the South African context, studies have also reported that black people (especially women) are less satisfied with their lives. These racial differences can primarily be attributed to a history of racial segregation and oppression, as well as prevailing psychosocial challenges experienced by previously disadvantaged communities (Botha & Booysen, 2014; Möller, 2001; Neff, 2007; Richards et al., 2006;

J. A. B. Wissing et al., 2008). In addition, the majority of the participants were single and unemployed; socio-demographic variables often associated with lower levels of well-being, both nationally and internationally (Blaauw & Pretorius, 2013; Bookwalter & Dalenberg, 2004; Botha & Booysen, 2014; Delle Fave et al., 2011; Diener et al., 1999; Pavot & Diener, 2013). Although the above-mentioned factors may have influenced participants' experience of happiness and life satisfaction, it is proposed that the low levels of SWB are not only ascribed to the demographics of the participants, but may also be attributed to the impact of trauma. This notion is supported by the high incidence of trauma-related psychopathology observed among the participants.

5.2.2.2.3 *Incidence of psychopathology*

The PHQ-9 and the PCL-5 were used to measure the presence of psychopathology, which can be conceptualised as the absence of well-being (Keyes, 2002). For the PHQ-9, *M* = 12.52 (*SD* = 7.01) was obtained. Based on the cut-off scores suggested by Kroenke et al. (2001), participants possibly experienced moderate to moderately severe depression. This score is slightly higher than the results found among a group of chronic patients with comorbid depression at primary health care clinics in South Africa *(M* = 9.4) (Bhana et al., 2015). However, it compared well to the mean score observed among American veterans at mental health clinics (*M* = 13.08) (Hassija et al., 2012). Participants in this sample therefore experienced prominent symptoms of depression.

For the PCL-5, *M* = 41.69 (*SD* = 17.60) was calculated for the sample. According to the suggested cut-off score (≥ 33), this indicates a provisional PTSD diagnosis (Weathers et al., 2013). This score is higher than that found by Ashbaugh et al. (2016) among a group of undergraduate students recruited from universities in Canada (*M* = 20.6). However, the findings concur with baseline scores measured from a group of military service members and recently retired veterans in the UK (*M* = 42.41) (Wortmann et al., 2016). In the African context, Verhey et al. (2018) also found that the majority of HIV positive patients at a primary health care clinic in Zimbabwe scored equal or above the cut-off score for PTSD. It can thus be concluded that participants in this sample experienced prominent symptoms of PTSD.

The high incidence of psychopathology among participants is supported by research highlighting the wide spectrum of adverse consequences associated with trauma. For example, PTSD is one of the most common psychiatric disorders diagnosed in the aftermath of trauma and causes significant distress and impairment in functioning (APA, 2013). Individuals with PTSD are also 80% more likely than those without PTSD to have a comorbid mental disorder; such as depression or anxiety (APA, 2013; Brady et al., 2000; Kaminer & Eagle, 2010; Lowe et al., 2015). In South Africa, studies have reported lower than anticipated levels of PTSD among trauma survivors; but they have also found that the survivors are commonly diagnosed with other psychiatric disorders, especially major depressive disorder (Atwoli et al., 2013; Eagle, 2015; Kaminer & Eagle, 2010; Subramaney, 2006; Williams et al, 2007). This might explain the high incidence of depression among participants in this study.

People exposed to multiple or continuous trauma, as is evident in this sample, may furthermore struggle with various emotional, behavioural, and interpersonal problems which tend to have a cumulative negative effect on a person's psychological health (Crawford-Browne & Benjamin, 2012; Herman, 1992; Jewkes & Abrahams, 2002; Kaminer & Eagle, 2010; Mahoney & Markel, 2016). In South Africa, research showed that citizens exposed to CTS often present with prominent hyperarousal and hypervigilance, somatic symptoms, concentration problems, irritability, feelings of guilt and despair, as well as self-destructive behaviour (Crawford-Browne & Benjamin, 2012; Eagle, 2015). This unique pattern of psychological symptoms is often referred to as sub-clinical PTSD, as it does not meet the full criteria for PTSD (Atwoli, 2015; Kaminer & Eagle, 2010). It is therefore possible that the incidence of trauma-related psychopathology may be even higher than that reported in the current study. As the mental health continuum conceptualises psychopathology as the absence of well-being, it can be concluded that participants in this study experienced low levels of SWB (Keyes, 2002).

5.2.3 Evaluative summary

The data obtained from the biographical and psychological questionnaires indicated that trauma had a significant effect on participants in this study. Not only had the majority of participants experienced multiple traumatic events in the past five years, but these events had also negatively impacted on their psychological

functioning. Participants specifically reported low levels of hope, positive affect, and life satisfaction respectively, as well as high levels of negative affect and psychopathology. Despite these experiences, most participants did not receive any professional help after the traumatic event. This highlighted the need for a therapeutic intervention that may facilitate hope and SWB among trauma survivors at community-based clinics.

5.3 Phases II & III: Experience of Hope and Subjective Well-Being

5.3.1 Description of case studies and within-case analysis

The experience of hope and SWB, during and after exposure to SFBT, is explored below via seven case studies. For each of the case studies, a description of the SFBT process, as guided by the solution-focused art gallery metaphor, is provided. Emphasis is placed on the SFBT tools the therapist used, expressions of hope and SWB, and unique or interesting responses by participants. A detailed within-case analysis of the themes emerging from both the therapy sessions (transcripts labelled S) and the semi-structured interviews (transcripts labelled I) is then described and discussed. Finally, for the purposes of triangulation, quantitative data results for each case are discussed.

5.3.1.1 Case Study 1

5.3.1.1.1 *Background information*

Participant 1 is a 30-year-old black female client who presented with grief symptoms after the traumatic death of her husband in March 2019. She indicated that he was involved in a motor vehicle accident. In concurrence with the assumptions of SFBT, no further details regarding the traumatic event were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). At the time of her husband's death, Participant 1 was eight months pregnant with their third child. She thus became a single mother of three young children, and at the time the study commenced they were aged eight years, three years, and five months. The participant had attended secondary school, but did not complete Grade 12. She was not officially employed, but did part-time domestic work to earn an income. Although Participant 1's first language is Shona (a native African language), therapy was conducted in English as the participant showed adequate comprehension and fluency in this language. Participant 1 attended three

SFBT sessions, whereafter a semi-structured interview was held for the participant to share her experience of therapy.

5.3.1.1.2 *Description of the Solution-Focused Brief Therapy process*

Session 1

The first session commenced with the therapist introducing herself to Participant 1 and explaining the collaborative, brief, and goal-orientated nature of SFBT. In the *desired outcome room*, the participant spoke about the death of her husband and expressed feelings of anger, pain, and hopelessness. The therapist acknowledged and validated these feelings, but made use of presuppositional language (Froerer et al., 2018) to elicit the participant's best hope for the session. Participant 1 indicated that she wants to feel like a better person and be happy again. This desired outcome thus guided the rest of the session.

In the *resource room,* the therapist got to know the participant, instead of her problems. The therapist inquired about the significant people in the participant's life, as well as her talents and strengths, and the things she previously enjoyed doing. Coping questions (Froerer et al., 2018) were furthermore used to explore how Participant 1 had coped with her loss until now. During this discussion, the participant highlighted the importance of her children and indicated that they motivate her to cope and carry on: "For now, I am working for my kids" (Participant 1, S1-202).

With the participant's resources in mind, the therapist entered the *preferred future room* to obtain a detailed description of the participant feeling better and happier, despite the death of her husband. Although the therapist focused on small signs of happiness, the participant had difficulty imagining this possibility. The therapist therefore made use of relational questions (Froerer et al., 2018) to identify what her children might notice when she is slightly happier. In response to this question, Participant 1 constructed a picture of herself smiling, talking politely to her children, and being playful. The therapist further expanded the participant's preferred future by exploring what friends, family, and her deceased husband's spirit would notice once she was a little bit happier. As the participant remembered a previous happy version of herself, a significant change in her mood was noticed. Not only did she express an expectation for a better future, but she also imagined strategies towards that future, as is evident in the following extract:

> I used to like talking to them [participant's friends] and sharing some ideas. Yes, just watching movies together, yeees. But for now, I am avoiding them—I think, if I start doing the same thing that I used to do, I think they'll notice [name of Participant 1] is happy—she is coming back again. (Participant 1, S1-350)

The therapist then asked a scaling question (Froerer et al., 2018) to measure the participant's progress towards her desired outcome and to identify what was already helping her. Participant 1 indicated that she was at *four* on this scale and specifically emphasised that the support of others is helping her to be at this point. Again, the participant indicated that her children give her hope and help her believe in her ability to progress further on this scale: "Jaaa [laughs] for my kids, I think I can [laughs]—close to ten. Jaaa, for my children's sake—close to ten" (Participant 1, S1-601).

With these positive emotions ignited, the therapist entered the *closing room* by asking the participant what her deceased husband would have complimented her on if he was able to witness how she is coping. Although the participant did not directly answer this question, she indicated that her husband would have encouraged her to be the happy, good mother she has always been. Respecting the participant's answer, the therapist ended the session by complimenting her for still working hard for her children, despite her pain and struggle. The therapist also encouraged the participant to notice moments of happiness in the coming weeks and specifically pay attention to what she is doing to make those moments happen. As requested by the participant, a follow-up appointment was scheduled for two weeks later.

Session 2

In accordance with the assumptions of SFBT (Bavelas et al., 2013; De Jong & Berg, 2007), the therapist started this session in the *resource room* by asking a presuppositional question to elicit what is better in the participant's life. Participant 1 indicated that she felt better as she now had peace of mind, was now sleeping better, and was also behaving better towards her children. The participant indicated that significant others had also noticed that she was happier: "My friends—and neighbours, they say 'ha [expresses surprise], your happy is coming back again' [laughs]" (Participant 1, S2-38).

This improvement was further amplified by the participant's response to the scaling question. She indicated that she moved to *six* (compared to *four* in the previous session) with regards to her desired outcome of being better and happy. According to Participant 1, thinking about her husband's spirit and her children motivated her to find steps forward. This is illustrated by the following extract:

> I was thinking 'I want to make my husband's spirit happy, I want to make my kids happy, I want to be a better mom—I don't want to put so much pressure on myself'...so I must do something else, for the sake of my kids jaa. (Participant 1, S2-150)

After amplifying the participant's progress and resources, the therapist entered the *desired outcome room* to establish the participant's best hope for the session. Although Participant 1 spoke about her husband's death and the impact it had had on her, the therapist did not explore this in detail. She rather focused on what would be a better way of coping with her husband's death and guided her towards a realistic desired outcome. The participant thus indicated that instead of feeling pain, she hoped to feel good when she remembers her husband. Hence, the therapist entered the *resource room* by eliciting positive memories of the participant's husband. Participant 1 highlighted that he was a loving, caring man who had a joy for life and worked hard for his family. Remembering her husband's legacy not only sparked positive emotions within the participant, but also created expectations for a better future. As a result, she mentioned ways towards that future: "Ja, I think he want to teach them [participant's children] love, to work hard—yes. So, I think if I do the same, I think my kids will learn from me—ja, I think it will help" (Participant 1, S2-412).

As the participant responded very well to relational questions in the first session, the therapist entered the *preferred future room* by asking her what her loved ones would notice if she remembered her husband in a good way. The participant indicated that others would notice that she was happy, working hard, and being a good mother to her children. In response to an exception-finding question, Participant 1 indicated that she knew she was capable of realising her preferred future as she had already noticed progress and was becoming aware of her strength: "I am proud to be strong—just I'm strong. I am now overcoming this stress, 'cos last time I was straining

myself, a lot of headache or something, but this time, at least I feel I'm strong" (Participant 1, S2-562).

On that note, the therapist stepped into the *closing room* and encouraged the participant to do more of what works (Von Cziffra-Bergs, 2018). It was also suggested that the participant try some of the strategies she spoke about to remember her husband's legacy and notice what difference it makes. The participant indicated that the session was helpful as it helped her to be strong. She thus requested that another session be scheduled for two weeks later.

Session 3

At the start of the session, the therapist noted significant improvement in the participant's mood as she appeared relieved and happy. As the therapist opened the door to the *resource room*, Participant 1 confirmed this happiness and also indicated that she was sleeping better, talking politely to her children, and doing things that made her feel good: "I was just sharing jokes [laughs], like their [the children's] father used to do—just dancing with them, talking" (Participant 1, S3-37).

This change was not only recognised by her family and friends, but also by her children. She attributed the improvement to remembering her husband's legacy and the advice the therapist gave her. As the participant had difficulty taking ownership of her progress, the therapist used relational questions to acknowledge the participant's strengths and consequently to empower her. As a result of this conversation, Participant 1 recognised her worth and expressed feeling good about herself, as she stated:

> Yes, I am proud of myself. I think if I see someone also in a situation, I think I will try to help... I think he [participant's husband] would say I'm a caring mother, I'm a hard worker also—I think she [sic, referring to husband] will say I am strong. (Participant 1, S3-263)

The participant's improvement was further emphasised as she reported being at a *ten* (compared to a *six* in the previous session) on a scale measuring progress. Participant 1 not only believed in her ability to maintain this progress, but also identified ways to accomplish this. She again emphasised that significant others in her life will motivate her to carry on, as is evident in the following extracts: "It is better for me if I keep on thinking 'if I do this, maybe I'm making my husband's spirit happy'... and focus

on taking care of my kids—yes."; and "Ja, if I keep on doing good things—yes, I will stay at ten" (Participant 1, S3-375).

In the *desired outcome room*, the participant indicated that there is nothing more she hoped to achieve from therapy as she reached her goal. The therapist therefore briefly walked through the *resource and preferred future rooms*, highlighting the participant's strengths and resources and constructing a picture of how the participant's life will look if she continues with what she is already doing. The participant painted a picture of a good, strong mother, as she indicated: "I think they [participant's children] will remember me as a good mother and a strong woman—yeees. They are going to be proud of me" (Participant 1, S3-483). In the *closing room*, the therapist thus encouraged the participant to continue with what is already helping her to be this woman. She was also complimented for her progress. Therapy was thus terminated and an appointment for the semi-structured interview was scheduled.

5.3.1.1.3 *Emerging themes*

A detailed within-case analysis of Participant 1's transcripts revealed three distinct themes, each with interrelated sub-themes (see Table 5).

Table 5: *Themes and sub-themes emerging from the within-case analysis of Case Study 1*

Theme	Sub-theme
Hope for a better future	Expecting a better future Believe I can be better Finding ways towards a better future Family gives me hope Therapy shows me how to be better
Feeling better	Feeling good Feeling good about myself Doing things that make me feel good Therapy encourages me to do good
What was good about therapy	Open and understanding relationship Encouraging words from the therapist Remembering the good things Not talking about the sad things

Theme 1: Hope for a better future

At the onset of therapy, Participant 1 expressed hopelessness as she felt her life will never be the same after her husband's death. According to her, she was unable to see a future for herself and her children. However, during the first session, she was

able to *envision a better future* and expected a positive therapeutic outcome: “So, I think if I keep up coming here and maybe sharing together, I think it will help” (Participant 1, S1-743). Although the participant did not recognise this as hope, her expectation for a better future reflected a glimpse of hope, as defined by hope theorists (Callina et al., 2018; Gallagher, 2018; Snyder, 2000). As therapy progressed, Participant 1’s positive expectation became stronger and she expressed motivation to create a better future for herself and her children. It was evident that she started to *believe she can be better* and expressed more confidence in her ability to maintain progress: “Ja, if I keep on doing good things—yes, I will stay at ten [highest point on progress scale]” (Participant 1, S3-399). According to Snyder’s hope theory (2000), the participant’s perceived energy to initiate and maintain movement towards her goal is considered to be agency thinking or the motivational component of hope.

Although the participant initially lacked a clear route towards her goal, she later found *ways towards a better future,* as shown in her statement: “If I sing and dance like he [participant’s deceased husband] used to do, if I make jokes with my kids or my neighbours or my friends—think it will change me” (Participant 1, S2-534). The participant not only started to share positive memories of her husband with her children, but also decided to socialise more with friends and family. She furthermore took on temporary work to generate an income for herself and her children. According to Snyder’s (2000) hope theory, the participant’s perceived capability to generate useable routes towards her goal can be considered as pathways thinking.

These pathways, in conjunction with agency thinking, led to successful goal attainment and increased hope (Snyder, 1994, 2002). This is evident in the following quote: “At least I have hope—yes, at least I have hope. Because I think about to take care of my kids... I have to be strong for my kids—I have to be a good mother for my kids” (Participant 1, I-165). It was clear that Participant 1’s *children and family gave her hope* for the future and strength to move forward. According to Bernardo (2010), this suggested an external locus-of-hope as external forces acted as agents of goal attainment cognitions. This form of hope is often associated with collectivistic cultures, such as the traditional African culture to which the participant belongs.

Participant 1 emphasised that *SFBT contributed to hope for a better future*, as it equipped her: “These sessions... taught me HOW to be strong“ (Participant 1, I-137).

According to her, therapy not only gave her strength, but also helped her find ways towards her desired outcome. Participant 1 noted that being reminded of her children was specifically helpful in this regard. SFBT potentially contributed to the participant's agency and pathways thinking. This echoed previous studies indicating that SFBT is relevant for increasing hope and creating a positive expectancy in therapy (Bozeman, 1999; Michael et al., 2000; Quick & Gizzo, 2007).

Theme 2: Feeling better

During the first session, Participant 1 indicated that she carries a burden in her heart and expressed pain, anger, and stress. However, as therapy progressed, she reported *feeling good*: "I am very happy—yes, I am very happy" (Participant 1, I-316). She not only expressed happiness and peace of mind; but also indicated that she was less stressed and irritable. Participant 1 seemed to start experiencing more positive, than negative emotions. According to Diener's (1984) tripartite model of SWB, these high levels of positive affect and low levels of negative affect reflected an increase in Participant 1's affective component of SWB.

Although Participant 1 initially felt as if she was not human and that there is something wrong with her, she later indicated that she was *feeling good about herself*. She specifically noted that others viewed her as good: "I think they [participant's children] will remember me as a good mother and a strong woman—They are going to be proud of me" (Participant 1, S3-483). She not only expressed pride, but also acknowledged her value as a mother and a woman. This positive evaluation Participant 1 made with regards to herself, especially in her family domain, may reflect the cognitive component of SWB. Recognising her purpose and meaning may also positively contribute to her experience of life satisfaction (Diener et al., 1999; Diener, Scollon et al., 2009). During the course of therapy, Participant 1 furthermore reported that she is starting to *do things that make her feel good*, such as socialising with friends and family and playing with her children. According to the literature, external factors such as social support and engagement in pleasurable activities contribute positively towards SWB, especially life satisfaction (Diener, Oishi, & Tay, 2018).

According to Participant 1, *therapy helped her to feel better* as it encouraged her to do good things. This is evident in the following quote:

> You were saying [asking]: 'if I keep on stressing myself, did [meaning is] my husband's spirit happy?' So, every time when I want to start straining myself, I think 'did this make my husband's spirit happy?'... These days, if I just want to start this then I say 'no, my therapist said I must be good with them to make my husband's spirit happy', so then I restrain myself. (Participant 1, I-89)

Therapy thus helped her to feel good as it reminded her of the pleasant things she used to do, and the significant people in her life. She highlighted that remembering her husband's legacy and the importance of her children in her life helped her to feel better. It is therefore suggested that SFBT contributed to Participant 1's experience of SWB by increasing her positive emotions and life satisfaction, building resources, and discovering new ways to resolve her problem (Froerer et al., 2018; Kim & Franklin, 2015).

Theme 3: What was good about therapy

Participant 1 experienced therapy as positive and she highlighted a few aspects that stood out for her. First, she emphasised the importance of an *open and understanding therapeutic relationship*, as it encouraged her to share her experience. This is echoed by previous studies which identified the therapeutic alliance, especially the respectful, curious, and non-judgemental stance of SFBT therapists, as an essential component in the SFBT change process (Carr et al., 2014; Franklin et al., 2017; Froerer & Connie, 2016; Lloyd & Dallos, 2008; Simon & Nelson, 2005). She specifically noted that it was useful to talk to a stranger, instead of someone she knows: "It is good to see someone that you don't know, not a family member or something. Because you'll be open to her—yes, you talk everything" (Participant 1, S3-128).

Second, Participant 1 found the *therapist's encouraging words* to be empowering. This not only helped her to be strong, but reminded her that she is a good mother: "Ja, that advise you give me... These encouraging words that you give me last time, it makes me strong" (Participant 1, S2-577). This reflects the positive nature of SFBT language. According to micro-analytic studies, SFBT therapists mostly use positive formulations during sessions and focus more on positive topics in clients' lives which have an overwhelmingly positive impact on clients (Froerer & Jordan, 2013; Jordan et al., 2013; Tomori & Bavelas, 2007). These encouraging words might

also refer to the compliments the therapist provided. Previous studies indicated that compliments help clients recognise their own strengths and ultimately lead them to view themselves as trauma survivors, instead of victims (Bannink, 2008).

Third, Participant 1 found it beneficial to *remember the good things in her life*. She specifically mentioned that therapy reminded her of the love she has for her children, her husband's legacy, and her past interests and strengths. This is illustrated in the following quotes: "Because we were sharing the things that I used to do, then I start. Yes, you are reminding me—[laughs]—yes, you are reminding me" (Participant 1, I-243); and:

> It helped me—like the words you teach me last time, that you ask me 'what did I learn from my husband?'. Then I told you love—'cos he used to do jokes and everything. And I also copy all these things and I do to my kids also. (Participant 1, S3-167)

According to Participant 1, this gave her strength and encouraged her to change her behaviour. This concurs with process-orientated research indicating that strength- and resource-orientated SFBT techniques (e.g. problem-free talk, exception-finding, and coping questions) direct clients to look for personal strengths and resources which contribute to the effectiveness of SFBT (Franklin et al., 2017; Lloyd & Dallos, 2006; McKeel, 2012). Fiske (2018) specifically noted that relationship questions, involving important people in the clients' lives, help them to recognise their own resources and strengths which elicits hope.

Fourth, Participant 1 indicated that it was *good not to talk about the details of her husband's death* as it "hurts to talk about the sad things*"*. This highlighted the criticism which has been directed at pathology-orientated approaches for potentially retraumatising clients (Paintain & Cassidy, 2018; Schottenbauer et al., 2008). It also emphasised the fact that SFBT therapists do not analyse traumatic experiences in detail, as they assume the client's problem is not necessarily related to the solution. They therefore rather focus on the client's desired outcome and resources which create an empowering therapeutic alliance where healing and growth can occur (Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004).

5.3.1.1.4 *Quantitative data results*

Participant 1's levels of hope, SWB, and psychopathology before and after exposure to SFBT were measured using various instruments (see Table 6), and the results were compared for the purpose of triangulation.

Table 6: *Hope, subjective well-being, and psychopathology experienced by the participant in Case Study 1*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	24	44
Scale of Positive Experience (SPANE-P)	21	26
Scale of Negative Experience (SPANE-N)	27	14
Satisfaction with Life Scale (SWLS)	7	23
Patient Health Questionnaire (PHQ-9)	13	2
Post-Traumatic Stress Disorder (PTSD) checklist for DSM-V (PCL-5)	48	18

Table 6 indicates that Participant 1 experienced an increase in *hope,* as measured using the AHS, after exposure to SFBT. She also experienced an increase in both the affective and cognitive components of *SWB*. According to scores from the SPANE, Participant 1 not only displayed an increase in positive affect (SPANE-P), but also reported a reduction in negative affect (SPANE-N) after therapy. She furthermore experienced heightened life satisfaction as measured by the SWLS. For example, prior to therapy, she indicated that she is extremely dissatisfied with her life; while she felt slightly satisfied with her life after therapy (Diener et al., 1985).

With regards to *psychopathology,* Participant 1 experienced a decrease in depressive and PTSD symptomology after exposure to SFBT. Before therapy, she showed moderate to moderately severe symptoms of depression as measured by the PHQ-9. However, according to this measure, she did not meet the diagnostic criteria for depression after therapy (Kroenke et al., 2001). Prior to therapy, Participant 1's score on the PCL-5 also suggested a provisional PTSD diagnosis. However, after exposure to SFBT, she scored below the suggested PTSD cut-off score (≥ 33) (Weathers et al., 2013). This reduction in psychopathology after therapy thus suggested an increase in Participant 1's experience of well-being (Keyes, 2002).

5.3.1.1.5 *Evaluative summary*

From the above-mentioned results, it can be concluded that SFBT contributed to Participant 1's experience of hope and SWB. Based on the qualitative data, therapy contributed to her sense of hope for a better future and helped her to feel better. She highlighted that an open and understanding relationship, encouraging words from the therapist, and remembering the good things, instead of the bad were particularly valuable in this regard. These findings were supported by quantitative data which indicated an increase in levels of hope, positive, affect and life satisfaction after exposure to SFBT. A reduction in negative affect and psychopathology were also observed after therapy.

5.3.1.2 Case Study 2

5.3.1.2.1 *Background information*

Participant 2 is a 31-year-old black female client who presented to therapy after exposure to multiple traumatic events. Not only was she diagnosed with a life-threatening, chronic disease; but she also had a miscarriage a few years ago. At the time of therapy, the participant was almost six months pregnant with her first child, and she gave birth three days prior to the semi-structured interview. In line with the assumptions of SFBT, no further details regarding the traumatic events were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). Although she was not married, she and the father of her child had a fair relationship. She was unemployed at the time of therapy and lived with her parents. Although her first language is Xhosa, therapy was conducted in English, as she is proficient in this language and had obtained a tertiary academic qualification. Participant 2 attended just one SFBT session, and due to unforeseen circumstances, did not adhere to the scheduled follow-up appointment. However, she agreed to the semi-structured interview to share her experience of therapy with the therapist.

5.3.1.2.2 *Description of the solution-focused brief therapy process*

Session 1

During the first session, the therapist introduced herself to Participant 2 and provided a brief explanation of SFBT, emphasising the collaborative, brief, and goal-orientated nature of the approach. In the *desired outcome room*, the participant indicated that she hopes to move forward and feel emotionally sound and healthy,

especially in light of being a mother soon. The participant not only expressed a desire to move forward, but also expected a better future: “I would like to heal so that I make sure that my child, obviously have a better upbringing than myself” (Participant 2, S1-51).

This desired outcome thus guided the therapist and participant through the rest of the session. Although Participant 2 mentioned that she experienced several challenges in her life, the therapist did not explore this in detail. The participant’s experience was acknowledged and validated, but the door to the *resource room* was rather opened by asking a coping question (Froerer et al., 2018) to elicit how the participant had coped with these challenges until now. Participant 2 highlighted that her spirituality, and the support of her family, helped her to cope and move forward: “But the truth is, if I didn’t have a support system like I have, I wouldn’t have been here” (Participant 2, S1-82).

In this room, the participant also remembered her strength as she mentioned how her resilience, confidence, and sense of responsibility helped her to deal with challenges in the past. Instead of dwelling on trauma-related concerns, the therapist amplified the skills and strengths the participant discovered during these challenges. Participant 2 indicated that trauma not only increased her confidence to move forward, but also equipped her as a mother: “I don’t think there is anything right now, that a baby can bring, that I wouldn’t be able to deal with, instead I have more to offer” (Participant 2, S1-269).

With the participant’s resources in mind, the therapist entered the *preferred future room* and asked an exception-finding question (Froerer et al., 2018) to elicit a description of the participant’s desired outcome already being present. During this discussion, Participant 2 acknowledged the steps forward she had already taken, and consequently expressed confidence to continue this movement, as she stated in the following two quotes: “So already just accepting that I’m HIV positive and that I’ll always have to take pills for the rest of my life. So that alone—was one way of [changing] my lifestyle” (Participant 2, S1-465); and “To hear myself—I think even hearing myself saying some of these things, is making me feel even more confident that ‘no, no, maybe I am on the right path’” (Participant 2, S1-662).

In response to this realisation, the therapist asked a scaling question (Froerer et al., 2018) to measure how far the participant had already walked on the path towards her desired outcome. Participant 2 indicated that she was at *three* on this scale. In response to follow-up questions by the therapist, she spoke about the differences she and others would notice when she took another step forward. She highlighted that she already felt better and that others would notice this change: “So, walking out of here, I feel better already—I can’t wait to tell people” (Participant 2, S1-703).

At that point, the therapist entered *the closing room* by amplifying the participant’s past coping and complimenting her on the steps forward she had already taken. Participant 2 was also encouraged to continue noticing what she was already doing to help her move forward. As requested by the participant, another session was scheduled for two weeks later. However, due to unforeseen circumstances, Participant 2 did not attend the scheduled follow-up session. She did nevertheless agree to share her experience of therapy and therefore a semi-structured interview was scheduled. During this interview, Participant 2 expressed an interest in continuing therapy, but indicated that she would do so at a more convenient time. The therapist thus encouraged the participant to approach her local clinic when she wished to schedule another appointment.

5.3.1.2.3 *Emerging themes*

A detailed within-case analysis of Participant 2’s transcripts revealed four distinct themes, each with interrelated sub-themes (see Table 7).

Theme 1: Moving forward

During the session, Participant 2 indicated that she is in the process of findings *ways to move forward* and prepare herself for motherhood: “I’m not blocking—but now, instead I’m preparing. I’m in your ‘what do I need to do?’ processes—mentally, physically” (Participant 2, S1-564). She not only decided to come for therapy, but also made lifestyle changes and was preparing for her child’s birth by doing research and getting the nursery ready. According to Snyder’s (2000) hope theory, the participant’s perceived ability to identify strategies or useable routes to obtain her desired outcome can be described as pathways thinking.

Table 7: *Themes and sub-themes emerging from the within-case analysis of Case Study 2*

Theme	Sub-theme
Moving forward	Finding ways forward
	Confident to move forward
	Others motivate me to move forward
	Expecting a better future
	Therapy increases confidence to move forward
Feeling good	Feeling relaxed
	Understanding and expressing feelings
	Feeling good about therapy
Coping with trauma	Surviving trauma
	Growth after trauma
	Therapy helps me cope
What about therapy works	Open and honest conversation
	Non-judgemental stance in therapy
	Positive feedback from the therapist
	Talking about coping instead of trauma

During the session, Participant 2 not only expressed *confidence in her ability to move forward*, but also appeared motivated to take steps forward. This became even more apparent during the interview: “I think even hearing myself saying some of these things, is making me feel even more confident that ‘no, no, maybe I am on the right path’” (Participant 2, S1-657). This perceived willpower to initiate and maintain movement along her desired pathway can be described as agency thinking or the motivational component of hope (Snyder, 1994, 2002). According to Participant 2, *external forces, such as her family and her spirituality, motivated her to move forward*: “But the truth is, if I didn’t have a support system like I have, I wouldn’t have been here” (Participant 2, S1-82). She highlighted that her unborn child motivated her to seek therapy and take steps forward. Bernardo (2010), describes this as an external locus-of-hope as external forces in the participant’s life act as agents of hope. This phenomenon is commonly observed in collectivistic societies, such as the African culture (Bernardo, 2010). In agreement with the participant’s experience, various researchers also considered spirituality and religiosity to be the roots of hope (Dufault & Martocchio, 1985; Farran et al., 1995; Isaacs & Savahl, 2014; Scioli et al., 2011).

At the end of the session, Participant 2 expressed a *positive future expectation*: “Because there should be—in seven days a lot happens—there should be a difference” (Participant 2, S1-677). She not only expected a positive therapeutic

outcome, but also appeared confident that she would be a good mother to her child. According to Snyder's (2000) hope theory, this positive expectation stems from an iterative and additive relationship between the participant's pathways and agency thinking. As Participant 2 moved closer to her goal, she thus experienced more hope.

Participant 2 highlighted that *therapy gave her the confidence to move forward*. This is illustrated by the following quote: "My confidence—I didn't lack confidence before—but now, after the therapy session, it made me realise I was on the right path" (Participant 2, I-339). Realising she was on the right path thus gave her confidence and motivation to move forward. SFBT seemed to contribute to Participant 2's experience of hope by increasing her agency thinking (Snyder 1994, 2002). This is supported by previous studies suggesting that SFBT increases clients' confidence to achieve future goals (Carr et al., 2014; Lloyd & Dallos, 2006, 2008).

Theme 2: Feeling good

During the session, Participant 2 indicated that she was nervous and apprehensive concerning her pregnancy and becoming a mother. On the one hand, she feared that she might "bleed" onto her child due to unresolved traumatic experiences, while on the other hand, she was concerned that she might be in denial concerning her situation. However, during the interview, Participant 2 indicated that she was *feeling more relaxed* after the therapeutic session and was not experiencing any panic symptoms: "And me not panicking—now, I don't panic anymore—so all of a sudden, I don't panic" (Participant 2, I-623). This was supported by the participant's relaxed demeanour and manner of speech. According to Diener's (1984) tripartite model of SWB, Participant 2's increased positive affect and decreased negative affect, reflected the affective component of SWB.

During the interview, Participant 2 reported having a *better understanding* of her own and others' feelings and being more confident to *express her emotions*: "When I am angry, being able to say 'no, listen, I am angry right now'. Or when I'm hurt—be confident enough to—so I found my voice" (Participant 2, I-339). She not only noted that she was more assertive, but also reported being more empathic and patient when responding to situations. According to literature, the ability to identify, understand, regulate, and harness emotions in oneself and others are associated with

SWB (Schutte et al., 2002). Participant 2's increased emotional awareness may thus have contributed to her experience of SWB.

After the first session, Participant 2 *expressed positive feelings regarding therapy*: "So, walking out of here, I feel better already—" (Participant 2, S1-703). She not only felt better and more confident after the session, but also experienced it as pleasant. According to the participant, therapy helped her to become more aware of her emotions and gave her the confidence to express her feelings. It is thus suggested that SFBT contributed to the affective component of the participant's SWB. Participant 2's experience reflects previous studies indicating that solution-focused approaches enhance positive affect and subsequently contribute towards SWB (Grant, 2012; Grant & O'Connor, 2010; Green et al., 2006; Wehr, 2010).

Theme 3: Coping with trauma

Participant 2 entered therapy not being sure whether she was coping with, or denying the trauma she experienced. However, during the therapy session, Participant 2 realised that she was *surviving trauma*. She not only became aware of the way she had coped until that point, but she also noticed that she was able to deal with challenges which occurred between the therapy session and the interview: "So, a lot happened, a lot just tumbled down and happened—but I was able to handle it. So, I saw it as—clearly it was the universe showing me that 'listen, you are ok'" (Participant 2, I-103). Participant 2 therefore concluded that she is "ok" and was also able to separate who she is from what she has (disease) and what she has been through (trauma). This led to the participant viewing herself as a trauma survivor, instead of a victim. This positive evaluation Participant 2 made regarding herself, especially in light of her trauma, may have contributed to her experience of life satisfaction and SWB (Diener, Scollon et al., 2009).

According to Participant 2, she *experienced growth after trauma* as these events prepared her for life, and more specifically motherhood: "I don't think there is anything right now that—a baby can bring—that I wouldn't be able to deal with, instead I have more to offer. I realised that—yes" (Participant 2, S1-266). Not only did the trauma enhance her purpose and meaning in life, but she also developed resilience, confidence, and responsibility as a result of these experiences. This growth may contribute to the participant's life satisfaction; as suggested in the literature, meaning

and purpose in life leads to higher levels of life satisfaction and well-being, especially in the context of trauma (Diener, Scollon et al., 2009; Karlsen et al., 2006; Triplett et al., 2011; Veronese et al., 2017).

During the interview, Participant 2 indicated that *therapy helped her to cope* with her trauma as it made her realise she is fine, despite the trauma she went through. It also helped her to accept that trauma and challenges are a part of life, but that she could decide how she wants to respond to these. This is evident in the following extract:

> Therapy made me realise that the [traumatic] experiences are life. So how I react and how I take my [traumatic] experiences, that's now going to impact—that's what's going to determine what's going to happen or that's going to determine how now I'm going to be moving forward. (Participant 2, I-380)

Participant 2's experience concurs with the literature, suggesting that SFBT goes beyond returning a client to their pre-crisis state of functioning as it views a crisis as an opportunity to develop new skills, strengths, and resources. SFBT also communicates that, although the traumatic past cannot be changed, the future can still be filled with success and satisfaction. This engenders feelings of hope and empowerment in the aftermath of trauma (Bannink, 2008; Froerer et al., 2009, 2018; Griffin, 2015; Hopson & Kim, 2004).

Theme 4: What about therapy works

Participant 2 experienced therapy as positive and mentioned certain aspects of the therapeutic process that worked for her. Participant 2 indicated that therapy was helpful as it felt like an *open and honest conversation* with someone who cares. This is evident in the following quote:

> So, you listened—it was a conversation... it didn't feel like a therapy session. It felt like I'm chit-chatting to a friend—and somebody who actually cares, somebody who actually wants to hear me out and help me sort this out. (Participant 2, I-203)

She highlighted that the therapist listened to her and showed interest and empathy. According to the participant, this was achieved by the therapist asking detailed questions pertaining to her life and using her own words when reflecting. This

made her feel comfortable to share more than what was asked. Participant 2's experience fits with literature identifying the collaborative language process between the client and the therapist as the key component of SFBT. It appears as if the therapeutic alliance is specifically fostered by the respectful and curious stance SFBT therapists take (Franklin et al., 2017; Froerer & Connie, 2016).

Previous qualitative studies have also emphasised the importance of a non-judgemental stance in SFBT (Carr et al., 2014; Lloyd & Dallos, 2008; Simon & Nelson, 2005). It is thus not surprising that Participant 2 noted the value of *not being judged* or interrogated in therapy: "You didn't sit there as a therapist and listened to me and just judged me for whatever—no, no, no, you felt what I was feeling—you were there" (Participant 2, I-175). Although the non-judgemental stance was unexpected, it allowed her to feel that the therapist accepted her and didn't try to analyse her according to a textbook.

Participant 2 also valued *positive feedback* from the therapist*,* as illustrated by the following quote:

> So, you gave me real feedback on what I gave you—on my truth to you. So, your feedback—it was honest and on top of that, it was professional. So, coming from a professional and honest and really from what I gave you—it really did help. It made me feel like 'ok, clearly, I've got something going right'—ja. (Participant 2, I-88)

According to her, the feedback was positive, honest, and based on what she shared with the therapist. She also indicated that the therapist's feedback highlighted her strengths and ability to cope. This not only empowered the participant, but also built her confidence. Participant 2's experience is supported by micro-analytic studies indicating that clients find positive formulations, preserving their exact words, extremely useful (Froerer & Jordan, 2013; Jordan et al., 2013; Korman et al., 2013; Tomori & Bavelas, 2007). Positive compliments provided by SFBT therapists may also help clients recognise their own strengths and guide them to view themselves as trauma survivors, instead of victims (Bannink, 2008; Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015).

Participant 2 furthermore highlighted the value of *talking about her ability to cope, instead of her trauma*. This is evident in these quotes: "You asking about the

coping helped more that you asking about the nitty gritties [of the trauma]" (Participant 2, I-466); and "It [coping questions] made me realise my sanity. Remember, I said to you, it made me aware that 'ok, clearly I've got some things under control'" (Participant 2, I-473). According to her, talking about coping helped her to realise her strength and notice the progress she had already made. The fact that the therapist did not deliberately ask about the details of the trauma, made the participant more comfortable to talk about the trauma and share what she thought was necessary. Previous studies echo the participant's experience as they suggest that coping questions guide clients to reflect on their past and identify what is already working. Coping questions also amplify clients' resilience which engenders a feeling of hope and empowerment (Bannink, 2008; Froerer et al., 2009, 2018; Ogunsakin, 2015; Von Cziffra-Bergs, 2018).

5.3.1.2.4 *Quantitative data results*

Participant 2's levels of hope, SWB, and psychopathology before and after exposure to SFBT were measured using various instruments and the results were compared for the purpose of triangulation.

Table 8: *Hope, subjective well-being, and psychopathology experienced by the participant in Case Study 2*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	25	48
Scale of Positive Experience (SPANE-P)	25	29
Scale of Negative Experience (SPANE-N)	22	10
Satisfaction with Life Scale (SWLS)	9	27
Patient Health Questionnaire (PHQ-9)	16	0
Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V (PCL-5)	57	-

Table 8 indicates that Participant 2's score of *hope,* as measured by the AHS, increased after exposure to SFBT. This is evident in the fact that, after therapy, she experienced the highest possible score on this scale (Snyder et al., 1996). She also experienced an increase in both the affective and cognitive components of *SWB.* According to scores from the SPANE, Participant 2 not only displayed enhanced positive affect (SPANE-P), but also reported fewer negative feelings (SPANE-N) after

therapy. Her scores on the SWLS also suggested an increase in life satisfaction after exposure to SFBT. For example, before therapy, she reported being extremely dissatisfied with her life, but after therapy, she felt satisfied with life (Diener et al., 1985).

With regards to *psychopathology*, Participant 2 experienced fewer depressive symptoms after exposure to SFBT. Before therapy, she displayed moderately severe symptoms of depression as measured by the PHQ-9. However, she reported no depressive symptomology after therapy (Kroenke et al., 2001). Participant 2's score on the PCL-5 also suggested a provisional PTSD diagnosis before the start of therapy (Weathers et al., 2013). Unfortunately, no conclusions regarding her experience of PTSD symptoms after therapy could be made, as the participant did not complete all items of this scale. However, Participant 2's improvement in depressive symptomology after exposure to SFBT suggested an increase in her experience of well-being (Keyes, 2002).

5.3.1.2.5 *Evaluative summary*

The above-mentioned findings suggest that SFBT contributed to Participant 2's experience of hope and SWB. According to the themes emerging from thematic analysis, therapy helped her to move forward, feel good, and cope with trauma. Participant 2 highlighted that the following aspects of therapy were specifically helpful in this regard: an open and honest conversation with the therapist, a non-judgemental stance in therapy, positive feedback from the therapist and talking about coping, instead of trauma. These qualitative results were supported by quantitative data which suggested an increase in levels of hope, positive affect, and life satisfaction after exposure to SFBT. A decrease in negative affect and depressive symptoms were also evident after therapy.

5.3.1.3 Case Study 3

5.3.1.3.1 *Background information*

Participant 3 is a 42-year-old black female client who presented with trauma-related concerns due to multiple miscarriages and the death of her three-day-old baby. According to the assumptions of SFBT, no further details regarding the trauma were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). However, it is known that she has no living children and has been married for the past 5 years. The participant had

completed Grade 12, but was unemployed at the time of therapy. Although her first language is Sesotho, the therapy sessions were conducted in English as the participant showed adequate comprehension and fluency in this language. Participant 3 attended three SFBT sessions, whereafter a semi-structured interview was conducted for the participant to share her experience of therapy. As requested by the participant, a follow-up session was scheduled three weeks after the interview to monitor her progress. However, this session was not considered for research purposes.

5.3.1.3.2 *Description of the solution-focused brief therapy process*

Session 1

The first session commenced with the therapist introducing herself to Participant 3 and providing a brief explanation of SFBT, emphasising the collaborative, brief, and goal-orientated nature of this approach. In the *desired outcome room*, the participant expressed a strong desire to move forward, accept, and heal as she felt stuck at that moment. This desired outcome thus guided the remainder of the session. In the *resource room,* the participant and therapist remembered the participant's past strengths, identified significant people in her life, and the strengths they noticed within her. Although Participant 3 referred to the trauma she experienced and the effect it had had on her, the therapist did not explore this in detail. The participant's response was acknowledged and validated, but coping questions (Froerer et al., 2018) were rather used to explore how she had coped until now. At this point, it became apparent that the participant believed in her ability to move forward, but lacked a solution or strategy to accomplish this: "And I know I can do better, I know that! But I just need that—there is something that I need, but I don't know what it is to push me—I don't know" (Participant 3, S1-158).

By using the participant's own words, the therapist guided the participant into the *preferred future room* to elicit a detailed description of how the participant's life would be different when she moved on or accepted. The therapist also made use of relational questions (Froerer et al., 2018) to identify what significant others would notice when this preferred future became a reality. Exception-finding questions (Froerer et al., 2018) were furthermore used to identify instances in the past when the participant had been able to move on or accept. The participant created a vivid picture

of herself realising her dreams and hopes and was able to identify how her past strengths, coping, and support system would contribute to this picture. In response to the scaling question (Froerer et al., 2018), the participant indicated that she was at *five* with regards to moving on/accepting.

This discussion not only generated positive emotions (e.g. pride, excitement) within the participant, but also led her to construct strategies or solutions that might help her move forward: “I think something that will help myself better in a way that—how to run a business, go to those seminars, learn how to cook better. I think those things will make me feel much better. Not staying at home” (Participant 3, S1-566). Participant 3 again expressed a strong belief in her ability to move forward, and an expectation for a better future: “I can do this—I CAN do this—I can do this!” (Participant 3, S1-628) and “It will take time, it’s not an overnight—but I think I will get there—ja, I think so!” (Participant 3, S1-659).

On this note, the therapist entered the *closing room* by asking the participant whether the session was useful and what she would take away from the session. In agreement with new directions in SFBT (Bavelas, et al., 2013; Connie & Froerer, 2020; Froerer & Connie, 2016; Froerer et al., 2018; McKergow, 2016), the therapist did not provide any feedback or homework, but rather suggested that the participant notice moments when she was just a little bit closer to moving on/accepting and specifically what she did to make that happen. The participant indicated that she would like to have another appointment, which was scheduled for two weeks later.

Session 2

In accordance with the assumptions of SFBT, the therapist started this session by asking a presuppositional question (Froerer et al., 2018) to elicit what is better in the participant’s life. The participant reported that she was moving forward and was feeling good. She specifically spoke about taking small steps forward, feeling happy, doing activities that she enjoyed, and thinking less about her problems. This is evident in the following quotes: “I’m making myself happy—slowly but suuurely—slowly, taking baby steps”; and “I socialised a lot—I was happy ‘cos I didn’t think much about my problems hey—I didn’t, no I didn’t. I didn’t have time to go back there!” (Participant 3, S2-216).

The participant's improvement was further highlighted as she indicated she moved (from *five* in the first session) to *seven* on a scale of moving on/accepting. After amplifying the participant's progress and the resources she used to accomplish this, the therapist entered the *desired outcome room* to establish the participant's best hope for the session. Participant 3 indicated that she wanted to focus on what she hoped for and needed, instead of thinking of the fact that she did not have children. In the *resource room,* the therapist and participant thus explored what the participant is still capable of doing, despite not having children. As the participant remembered and recognised her strengths, she came to the conclusion that she still has purpose: "I really have a purpose here. If I don't have a babies it means that I have this gift—let me say not a gift, I'm good at other things" (Participant 3, S2-299).

In the *preferred future room,* the therapist therefore elicited a description of how the participant's life would be different if she focused on this gift. The therapist also made use of relational and exception-finding questions (Froerer et al., 2018) to further expand the participant's description of her preferred future. During this discussion, the participant constructed a picture of a strong, worthy woman. She also shared that she had already taken steps towards her desired outcome as she enrolled for a cooking class. During this discussion, Participant 3 not only discovered her strengths, but also expressed a strong sense of pride and excitement for the future as she stated in the following two quotes: "I think I've discovered that I can live again, I can do things—other things than those, I can do other things better. Ja, I can do other things—I can still be me" (Participant 3, S2-556); and "Oh [expresses pride]—I'll be travelling the world, I think! [laughs]... Going places, doing things—ja!" (Participant 3, S2-636).

With that in mind, the therapist entered the *closing room* by announcing the end of the session and complimenting the participant on the progress she had already made. True to SFBT, the therapist asked the participant whether the session was useful and what stood out for her (Von Cziffra-Bergs, 2018). The participant again highlighted that she discovered her capability and worth as a woman. The therapist therefore suggested that the participant pay attention to what she is still capable of doing. As requested by the participant, another session was scheduled for two weeks later.

Session 3

In response to the therapist's question of what now was better, Participant 3 reported feeling free and happy as she was doing activities that she enjoyed. She expressed satisfaction with her life at that point, and was planning for the future. This is evident in the following extracts: "So, I think I must venture into other things that will keep me busy, that will keep my mind busy, and not focusing on other things [referring to trauma]" (Participant 3, S3-56); and

> I've been living this—is it hostile—life for nine years. So, it's only few weeks that I see I'm making changes. Ja, only for a few weeks—. So, I will get there, but right now, everything is good for now. (Participant 3, S3-26)

The therapist and participant explored the participant's progress in more detail, with the therapist asking relational questions to identify the changes her significant others had noticed. The participant not only mentioned the progress her husband had observed, but also indicated that she was reminded of some of her past strengths.

However, the participant also talked about the anniversary of her child's death and the impact it had on her. As SFBT is not problem-phobic, the therapist listened to the participant's story and acknowledged and validated her response (Von Cziffra-Bergs, 2018). However, the therapist focused on how the participant coped with the loss and how this year, she had responded differently to the anniversary of the trauma. Participant 3 specifically noted that she decided to focus on what she could control and the fact that she still had purpose. She repeatedly stated that she was a "woman" and a "mother" and wanted to remember that. As the participant stated her best hope for the session, the therapist and participant moved relatively quickly through the *desired outcome room*.

In the *resource room*, the participant and therapist explored past instances of the participant displaying qualities and values of a mother, and current behaviour that told her and others that she is a mother. The participant remembered her past strength, past coping, and well as the strengths others noticed within her. The discussion ended with her describing herself as a strong, competent woman who still had purpose and a drive to move forward: "I am good enough! In fact, I think I am more than good

enough—"; and "I think I'm going to do more—more than being a mother" (Participant 3, S3-456).

The participant reiterated this improvement when she indicated she was currently at *eight* (compared to *seven* in the previous session) on a scale of moving on/accepting. She also expressed a belief within herself of being capable of continuing her progress: "So, from here we'll see how I go from here, we'll see *eight* to *nine*, *ten* maybe; and "Because it doesn't end here at *eight*, there is still more to come" (Participant 3, S3-683).

At this point, the therapist opened the door of the *closing room* by announcing the end of the session and asking the participant whether she would like to schedule a follow-up session. Although Participant 3 indicated that she had reached her desired outcome, she requested a follow-up session so that her progress could be monitored. The therapist and participant therefore collaboratively decided to terminate therapy for research purposes, conduct the semi-structured interview, and schedule another appointment three weeks later. During this follow-up session, Participant 3 reported further improvement. Not only was she in the process of registering her fast-food business, but she was also selling clothes to family and friends. She indicated that she is at *ten* on the progress scale and reported no need for further therapy.

5.3.1.3.3 *Emerging themes*

A detailed within-case analysis of Participant 3's transcripts revealed four distinct themes, each with interrelated sub-themes (see Table 9).

Theme 1: Moving forward

Participant 3 entered therapy reporting that she had a *drive to move forward*, start a new life, and leave her traumatic past behind. As therapy progressed, this drive became more apparent and she also expressed confidence in her ability to move forward: "Because I have this drive in me—that I can do more, I can do more" (Participant 3, S1-344). This agentic self-talk possibly re-affirmed her perceived ability and increased her confidence in the decisions she made towards goal attainment (Snyder, 2002; Snyder et al., 1998). According to Snyder's (2000) hope theory, her perceived drive, or energy to initiate movement towards her goal demonstrates agency thinking which is considered to be the motivational component of hope.

Table 9: *Themes and sub-themes emerging from the within-case analysis of Case Study 3*

Theme	Sub-theme
Moving forward	Drive to move forward
	Finding and taking steps forward
	Positive future expectation
	Therapy helps me move forward
Feeling good	Feeling happy and free
	Making myself happy
	Doing things I enjoy
	Fulfilling relationships
	Therapy helps me feel better
Different mindset	Life is good
	Focus on what I can control
	I still have purpose
	Therapy changes my perspective
How therapy helped	Talking about my problem
	Empathy and acceptance in therapy
	Talking about my strengths

Despite this drive, Participant 3 initially felt stuck as she lacked a clear strategy to move forward and reach her goal. However, during the therapy, Participant 3 *found steps forward*: “I think something that will help myself better in a way that...how to run a business, go to those seminars, learn how to cook better. I think those things will make me feel much better. Not staying at home” (Participant 3, S1-566). Snyder’s (2000) hope theory describes this ability to identify steps or strategies towards one’s desired outcome as pathways thinking.

Due to an iterative and additive interaction between Participant 3’s pathways and agency thinking, she had started taking steps forward, as is evident below:

> I made an initiative and called. I called them and make an appointment. So that’s what I said to myself ‘today I am marking this right’. I did it—for the first time in nine years—this is what I did. (Participant 3, I-299)

Not only did she enrol for a cooking class, but she also started the process of registering her own business. As the participant started taking these steps, her motivation and drive were further enhanced and she reported a *positive future expectation:* “So from here we’ll see how I go from here. We’ll see eight to nine, ten maybe” (Participant 3, S3-679). According to hope theory, the participant’s movement

towards successful goal attainment possibly further enhanced her pathways and agency thinking, which resulted in hope (Snyder, 2000, 2002; Snyder et al., 2018).

According to Participant 3, *therapy helped her to move forward*, as is evident in these quotes: “But this therapy helped me to unlock something in me that I thought it will never happen” (Participant 3, I-63); and:

> It [this therapy] helped me—to do things as a person—to do things the way I want them to be. Because there is a lot of things I can’t change, but therapy helped me to focus and understand—and have future plans. (Participant 3, I-142)

Therapy not only ignited her drive, but also shifted her focus towards the future which helped her to find ways forward. SFBT thus enhanced her perceived ability to reach her goal (agency thinking) and assisted her to find routes towards her goal (pathways thinking). In agreement with previous findings, SFBT seemed to contribute to Participant 3’s experience of hope (Bozeman, 1999; Quick & Gizzo, 2007).

Theme 2: Feeling good

At the start of therapy, Participant 3 described herself as a “deflated balloon”; depressed, without energy, and not having an interest in anything. However, from the second session she indicated that she was now *feeling happy and free* and was now less depressed: “FREE—I’m free [laughs]. I’m free, ‘cos I don’t have that, too much burden on my shoulders” (Participant 3, S3-17). According to Diener’s (1984) tripartite model of SWB, Participant 3’s increased feelings of happiness and relaxation and decreased feelings of depression reflected the affective component of SWB.

These positive emotions seemed to primarily stem from an independent and an agentic mode of living, as Participant 3 indicated that she was now *making herself happy:* “You know what, I think I am making—you know what they say, when they say ‘happiness comes from you, don’t expect someone else to make you happy’—so I’m trying to do that” (Participant 3, S3-40). She highlighted that she was prioritising her own needs, spending quality time with herself, and spoiling herself. The participant’s experience may thus reflect a move towards western notions of happiness as independence and personal happiness contribute stronger towards SWB among individualistic cultures, as compared to collectivistic cultures (Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013).

Participant 3 also reported that she was now *doing things she enjoyed* such as socialising, sewing, cooking, reading, and watching television. According to her, these activities uplifted her spirit and contributed to her positive feelings. These pleasurable activities may thus have contributed towards the participant's experience of SWB, as hedonism views well-being as living a happy and satisfying life (Ryan & Deci, 2001). Participant 3 also noted that she experienced *more fulfilling relationships* with herself, her husband, and her family. She highlighted that she was now setting healthy boundaries, socialising more, and experiencing intimacy in her marriage again. According to the literature, social support and fulfilling marital relationships further contribute towards SWB (Diener et al., 1999).

Participant 3 stated that *therapy helped her to feel better* as it lessened her burden and made her feel less depressed. It furthermore encouraged her to do activities that she likes and to take care of herself: "I was always down—I think I was depressed. I had a lot on my shoulders and I carried everybody's burden.... But therapy helped me—eh, not to do those things, taking care of myself, doing what I like" (Participant 3, I-177). The participant used the metaphor of lighting a candle to describe the effect therapy had on her. It is thus proposed that therapy enhanced her positive emotions and decreased her negative emotions. This is supported by previous studies suggesting that a solution-focused approach increased SWB by increasing levels of positive affect and reducing levels of negative affect (Grant, 2012; Grant & O'Connor, 2010; Wehr, 2010).

Theme 3: Different mindset

At the start of therapy, Participant 3 only focused on her trauma and the fact that she did not have children. She thus had a negative perspective on life in general. However, as therapy progressed, Participant 3 reported that *life is good.* She not only accepted her past, but also started to notice the everyday blessings in her life. As a result, she realised that she still had a life to live and appeared excited do to so. "There is life to be lived. And I must live! ... And the past was in the past—and this is the present—and everything, bad or good, it had to happen to me" (Participant 3, I-130). Diener's (1984) tripartite model of SWB, describes this positive evaluation the participant made of her life as life satisfaction, which is considered to be the cognitive component of SWB.

Participant 3 attributed her new perspective to the fact that she started *focusing on what she can control,* instead of her past problems. This is illustrated below:

> No, there's nothing I can do, there's nothing I can do about it. So, I think I must focus on that one thing that will make my life—that will make me happy, that will make me prosper, that will make me—new challenges, you see. (Participant 3, S2-285)

The participant was thus able to shift her focus from a traumatic past to other aspects of her life over which she had control, such as her marriage, family, and business. This appeared to contribute to her satisfaction with life. The participant's experience is supported by literature suggesting that a wider attentional focus and attentional flexibility are associated with higher levels of SWB (Compton et al., 2004; Gasper & Clore, 2002).

Initially, Participant 3 felt worthless and described herself as a "manikin dressed in women's clothes", as she did not feel worthy without having children. However, as therapy progressed she realised *she still has purpose and worth*: "But I shift my mind from thinking about that [referring to trauma]—that I really have a purpose here. If I don't have a babies it means that I have this gift—let me say not a gift, I'm good at other things" (Participant 3, S2-298). The participant highlighted that she could still be a wife to her husband and a mother to other children. She also noted the gifts and talents she had to contribute towards society. At that point, Participant 3 referred to herself as a strong woman who is "more than good enough". This illustrates how the participant's shattered assumption of being worthy and competent was restructured as she reflected on the trauma (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). As the participant became aware of her meaning and purpose in life, it also contributed to her experience of life satisfaction and SWB (Diener, Scollon et al., 2009).

According to Participant 3, *therapy changed her perspective*. This is evident in the following quotes: "You showed me that I can, I can be me. I can be myself. And things that what happened is not my fault and that I am a human being—I am a human being" (Participant 3, I-267); and "The therapy helped me to looks things in a different way. That I am not living for now, I am living for—I must look to the future" (Participant 3, I-113).

Therapy not only shifted her focus towards the future, but also helped her to appreciate life again and rediscover her strengths. She specifically noted that therapy helped her to realise that she was, in fact, a woman and a mother. It is thus suggested that SFBT contributed to her experience of SWB by changing her perspective and improving her life satisfaction. This concurs with previous studies which suggested that SFBT, and more specifically solution-focused questions, turn clients' problem perceptions into positive formulations (Froerer et al., 2018). In the context of trauma, SFBT's future-focused orientation also shifts clients' focus towards a preferred future where the trauma is resolved. The emphasis on clients' strengths furthermore instils a sense of hope and confidence within themselves and ultimately assists them to view themselves as trauma survivors, instead of victims, as was evident in this participant's experience (Bannink, 2008; Griffin, 2015; Froerer et al., 2009, 2018; Hopson & Kim, 2004; Ogunsakin, 2015).

Theme 4: How therapy helped

Participant 3 experienced therapy as helpful and she highlighted how therapy had helped her. Although Participant 3 was satisfied with therapy, she had a desire to *talk about her problem* in more detail during the first session. This is evident in these extracts: "I wants to talk about what's really happening to me, what had happened to me—on our first visit here— I thought we would talk about what is the root of the problem [laughs]" (I-392); and "When we talk about my pregnancies... I felt something—that you care. And then—I must talk freely, because I haven't told anyone else—I must be free!" (Participant 3, I-530).

She specifically suggested that the therapist could have asked her: "'What brings you here?', or 'What really happened?'" in order for her to share her problem or traumatic experience during the first session. According to her, this would have allowed her to get rid of the burden she has been carrying for many years. However, she indicated that the therapist's empathic approach encouraged her to talk about her problems in subsequent sessions. Although SFBT is often criticised for being overly positive as it tends to focus on future possibilities and solutions, SFBT therapists are not problem-phobic. As is evident in Participant 3's experience, they empathically validate and acknowledge clients' problems (Bavelas et al., 2013; Froerer et al., 2018; Ratner et al., 2012).

As can be expected, Participant 3 also emphasised the value of *empathy and acceptance in therapy*. According to her, the fact that she felt listened to and accepted contributed to her positive experience of therapy. It also facilitated the positive perspective she developed of herself. This is echoed by qualitative studies highlighting the importance of the therapeutic alliance, specifically the therapist's non-judgemental stance (Carr et al., 2014; Lloyd & Dallos, 2008; Simon & Nelson, 2005).

Participant 3 furthermore indicated that *talking about her strengths and resources* (e.g. what she is good at, what she likes, and what makes her happy) stood out for her. This is illustrated below:

> Future plans—being positive. And possibility, possibility that things can be done, that I can be ok, I will be ok! So those are the things that stood out for me, because I was focusing on this thing [referring to trauma], but I am good at other things. (Participant 3, I-225)

> When I talk about being a woman... then I realised—when we talk, then I said 'NO, I am a woman, I am a mother. That's what also stood out for me, I should never look down on myself. (Participant 3, I-282)

Therapy not only reminded her of her past success, passions, and talents, but also created new possibilities. According to her, this made her aware of her capabilities and motivated her to reach her goal. This experience is supported by literature suggesting that strength- and resource-orientated techniques contribute to the value of SFBT as it directs clients to look for positive change, personal strengths, and resources (Franklin et al., 2017; Lloyd & Dallos, 2006; McKeel, 2012). In the context of trauma, SFBT's strength-based nature engenders feelings of hope and creates an empowering therapeutic alliance where healing and growth can occur (Bannink, 2008; Froerer et al., 2009, 2018).

5.3.1.3.4 *Quantitative data results*

Participant 3's levels of hope, SWB, and psychopathology were measured before and after exposure to SFBT. Various instruments were used for comparison, as shown in Table 10.

Table 10: *Hope, subjective well-being, and psychopathology experienced by the participant in Case Study 3*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	16	48
Scale of Positive Experience (SPANE-P)	16	30
Scale of Negative Experience (SPANE-N)	17	10
Satisfaction with Life Scale (SWLS)	7	32
Patient Health Questionnaire (PHQ-9)	12	0
Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V (PCL-5)	38	13

From Table 10 it is evident that Participant 3 experienced an increase in *hope,* as measured by the AHS, after exposure to SFBT. This is highlighted by the fact that, after therapy, she experienced the highest possible score on this scale (Snyder et al., 1996). Her experience of both affective and cognitive *SWB* also increased after exposure to SFBT. Participant 3 not only displayed the highest possible score of positive affect (SPANE-P) after therapy, but also reported less negative affect (SPANE-N), as measured by the SPANE. According to the scores from the SWLS, Participant 3 furthermore experienced enhanced life satisfaction after exposure to SFBT. For example, prior to therapy, she indicated that she was extremely dissatisfied with her life; while she felt extremely satisfied with life after therapy (Diener et al., 1985).

With regards to *psychopathology*, Participant 3 experienced an improvement in depressive and PTSD symptomology after exposure to SFBT. According to the PHQ-9, she showed moderate to moderately severe symptoms of depression before therapy. However, after therapy, she reported no depressive symptoms (Kroenke et al., 2001). Prior to therapy, Participant 3's score on the PCL-5 also suggested a provisional PTSD diagnosis. However, after exposure to SFBT, she scored below the suggested PTSD cut-off score (≥ 33) (Weathers et al., 2013). Participant 3's reduced psychopathological symptoms after therapy thus suggest an increase in her experience of well-being (Keyes, 2002).

5.3.1.3.5 *Evaluative summary*

From the above-mentioned results, it can be concluded that SFBT contributed to Participant 3's experience of hope and SWB. According to the qualitative data, therapy helped her to move forward, feel good, and have a different mindset. As noted by Participant 3, being able to talk about her problem, discovering who she is and the non-judgemental stance of the therapist specifically contributed to this experience. These findings were supported by quantitative data which indicated an increase in levels of hope, positive affect, and life satisfaction after exposure to SFBT. A decrease in negative affect and psychopathology were also evident after therapy.

5.3.1.4 Case Study 4

5.3.1.4.1 *Background information*

Participant 4 is a 29-year-old black female client who presented with depressive symptoms after exposure to multiple traumatic events. At the time of therapy, she was living in a place of safety due to recent physical and emotional abuse from her partner. In concurrence with the assumptions of SFBT, no further details regarding the trauma were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). Participant 4 has a tertiary qualification, but was unemployed at the time of therapy and lacked financial support from her family. She was taking care of her new-born son and his seven-year-old brother which contributed to her stress. Although her first language is Sesotho, therapy was conducted in English as the participant showed language proficiency. Participant 4 attended four SFBT sessions, whereafter a semi-structured interview was held for the participant to share her experience of therapy. As requested by the participant, therapy continued after the interview to monitor her progress. However, these sessions were not considered for research purposes.

5.3.1.4.2 *Description of the Solution-Focused Brief Therapy process*

Session 1

This session commenced with the therapist introducing herself to Participant 4 and highlighting the collaborative, brief, and goal-orientated nature of the therapeutic approach. In the *desired outcome room*, the participant indicated that she hoped to be her "old happy self" again, as she felt she had lost herself along the way. This desired outcome thus guided the rest of the session.

The therapist led the participant into the *resource room* by inquiring about the important people and the things she values in her life. Although the participant was depressed and hopeless at that time, she highlighted that her two sons were motivating her to stay alive, as she stated:

> I guess they [my children] are the reason I'm still alive right now. Because there's times that I will feel like 'give up' hey—then I will think of them. So, they are the most important things in my life right now. (Participant 4, S1-43)

The therapist further explored the participant's resources by identifying the strengths and skills she was drawing upon to stay alive. During this conversation, the participant mentioned that she still had future dreams and a desire to accomplish them, as she indicated:

> I had these dreams and I still wanna see them come true, yeah—as much as there were hiccups along the way, but there's this thing inside of me that says 'you still need to—you still have to live this life you've always wanted'. (Participant 4, S1-125)

With the participant's resources in mind, the therapist entered the *preferred future room* by eliciting a description of the participant's old happy self which she referred to as her ideal self. Participant 4 responded very positively to this question and created a vivid picture of a happy, confident, content woman with a sparkle in her eye. The therapist expanded this picture by asking relational questions (Froerer et al., 2018), specifically focusing on what difference her sons would notice when she is this version of herself. Participant 4 mentioned that they were already seeing glimpses of this version and that it has a positive impact on them. As the participant identified instances of her ideal self already being present, the therapist amplified these exceptions by focusing on small steps the participant was already taking towards her ideal self and eliciting the skills she employs to accomplish this. During this conversation, it became apparent that Participant 4 lacked a strategy towards her desired outcome, but had confidence that she would achieve this. This is illustrated in the following two quotes: "I feel that I'm in this dark pit—yeah. Even though I don't know how will I get out, but there's that part of me that still wants that picture that I made in my mind" (Participant 4, S1-624); and "There's times when I know—there's

times when I feel ‘you’ve been through worse and you’ve made it, you can still do it’” (Participant 4, S1-437).

With this hopeful thinking ignited, the therapist guided the participant into the *closing room*. The participant was encouraged to notice small steps with her ideal self being present, specifically paying attention to how she makes the steps happen. The participant indicated that the session was helpful, as it reminded her of her ideal self and made her aware of the small steps she already had taken forward. Participant 4 thus indicated that she would like to have another appointment, which was scheduled for two weeks later.

Session 2

Believing in the participant’s ability to find a way towards her desired outcome, the therapist entered the *resource room* by inquiring about what had improved in the participant’s life since the last session. Although the participant initially responded by saying “nothing much”, the therapist used presuppositional language (Froerer et al., 2018) to identify small changes in the participant’s life. In response to these questions, Participant 4 noted glimpses of hope and small steps she had taken forward: “So now at least I have that hope, that even though I might not have...nothing yet, but I’m gonna keep on and at least there’s something that I’m doing. Even if it’s not much, but it is something” (Participant 4, S2-51).

The therapist amplified this change by inquiring about the difference significant others have noticed. According to Participant 4, they noticed a change in her mood and behaviour as she stated:

> I don’t snap like I would normally snap—I think I’m more relaxed. Even though I keep on receiving bad news, I don’t react the way I would normally react. I think there’s something—I can’t say what—but there’s that something keeping me calm. (Participant 4, S2-65)

The therapist specifically explored the skills and strengths she used to create this change. As the therapist and participant collaboratively discovered her self-discipline, confidence, rational thinking, and conflict management and distress tolerance skills, Participant 4 expressed astonishment and pride towards herself. At that point, the therapist used a scaling question (Froerer et al., 2018) to measure the progress she made towards her ideal self. The participant indicated that she is at

seven and a half on this scale and believed in her ability to progress further: “I might be here right now, but I’ve overcame a lot of things that most people wouldn’t have overcome...that means I am good, whatever I want to achieve, it’s still possible” (Participant 4, S2-474).

In the *desired outcome room* Participant 4 indicated that she wants to boost her confidence even more. The therapist thus entered the *preferred future room* to obtain a detailed description of a more confident version of the participant. The therapist also used relational questions (Froerer et al., 2018) to identify what significant others will notice when she is more confident. Participant 4 described herself as being happy, calm, loving, and playful towards her sons and feeling secure and content with herself. As the participant had mentioned signs of confidence, the therapist used an exception-finding question (Froerer et al., 2018) to inquire about moments in the past when she chose to be more confident. Remembering these times not only affirmed her confidence to obtain her goal, but also created a positive future expectation: “I’m looking forward to what the future holds, because I know, I know what I’m capable of and I know.... I have this confidence that whatever comes my way, I’ll overcome it and whatever I want, I’m gonna achieve that” (Participant 4, S2-702).

In the *closing room,* the therapist complimented the participant on her drive and determination and suggested that she notice moments of being more confident. As requested by the participant, another session was scheduled for the following week.

Session 3

As the participant and therapist entered the *resource room*, the therapist noticed a positive change in the participant’s mood and appearance. In response to the “what is better?” question, Participant 4 confirmed improvement: “Emotionally, physically—I just feel better! [laughs] I think the glow that I wanted, it’s coming [laughs]” (Participant 4, S3-21). The participant also reported that she now had more energy, slept better, and was feeling happy, positive, and confident. In response to relational questions, Participant 4 indicated that her children noticed that she had recently been smiling, laughing, and was being more playful, and others observed contentment within her. The therapist specifically inquired about the strengths the participant used to effect this change and whether she discovered any new skills in the past week.

Participant 4 highlighted her ability to achieve whatever she wanted, and expressed a hopeful perspective regarding her future, as she indicated:

> My future—it looks bright—because I would be able to do more things that, back then, I wouldn't have done, yeah. Try new things that would change my life for the better and on the—also seeking employment, I think it's gonna be easier now. (Participant 4, S3-237)

In response to the scaling question, Participant 4 spoke about being one step closer towards her ideal self and was now at *eight and a half*. The therapist thus opened the door to the *desired outcome room* to determine the participant's best hope for the session. Participant 4 indicated that she would like to deal better with disappointment and not allow it to pull her down. As the participant mentioned instances of coping with disappointment in the previous few weeks, the therapist entered the *preferred future room* by asking a coping question (Froerer et al., 2018). A detailed description of what was different in the way the participant recently coped with disappointment, as compared to the past, was obtained. Participant 4 spontaneously identified several skills and strategies that were now helping her to cope with challenges. She highlighted that she had recently developed a positive, solution-focused perspective, as she stated:

> So now, instead of saying 'why me?'—I'm telling myself 'it had to happen and because it happened, I have the potential to deal with it' ... Now I have solutions, I ask questions that will bring solutions, not more stress. (Participant 4, S3-663)

At that point, the therapist guided the participant into the *closing room* by complimenting her on the way she had coped with disappointment in the past few weeks. In this room, Participant 4 indicated that the session was useful as it made her realise that she was already dealing with disappointment and she had been empowered to deal with future challenges. She also requested that another session be scheduled for a week later.

Session 4

In concurrence with the hopeful assumptions of SFBT (Bavelas et al., 2013; De Jong & Berg, 2007), the therapist started this session in the *resource room* by inquiring about what was better since the last session. Although Participant 4 had experienced

disappointment in the intervening week, she indicated that she was feeling positive, coping better with challenges, and still had a hopeful perspective regarding her future. She also highlighted an improvement in her physical health and her satisfaction with life: “I’m more happy, no more headaches, and each day to me it’s a blessing. I don’t know how to explain it, but I see myself doing more and achieving more, through the ups and downs still” (Participant 4, S4-64). After eliciting and amplifying the strengths the participant drew upon to enact this change, the therapist asked a scaling question to measure Participant 4’s progress towards her desired outcome. The participant indicated that she was now at *ten* on this scale as she fulfilled her ideal self. Consequently, Participant 4 expressed satisfaction with herself as she described herself as an “experienced, die hard, conqueror, strong-willed, good mother!”.

On that note, the therapist entered the *desired outcome room* where the participant indicated that she wanted to discuss her future plans, as these would provide her with a sense of purpose and help her create security and stability for her sons. This desired outcome thus guided the participant and therapist through the rest of the session. In the *preferred future room*, the therapist obtained a detailed description of how Participant 4’s life would be different once she had purpose, security, and stability. The participant constructed a picture of an ambitious, happy woman who uplifts her community and provides for her sons’ needs. The therapist briefly walked back to the *resource room* to explore how her current situation prepared her for this role and what recently discovered skills she might draw upon to make this desired outcome a reality. Participant 4 highlighted that she had discovered a hopeful future perspective and a strong internal locus of emotional control, as she stated:

> I’ve learned is that there’s still light at the end of the tunnel. And we are stronger—more than we can ever think... , hence we can even change how we feel, even when things around us, they don’t change, but you still decided that ‘I’m gonna feel this way—even if I’m still in that bad situation, even if I faced bad things, but I’m gonna be happy’.” (Participant 4, S4-431)

Moving back to the *preferred future room*, the therapist elicited what the participant was now already doing to move closer to her desired outcome. Relational questions were also used to identify the signs of stability and security the participant’s sons were already noticing. Participant 4 not only identified numerous strategies she

was applying, but also expressed confidence in her ability to achieve her desired outcome, as she stated:

> I know for sure hard work pays off, so I am working hard to achieving that—I am working hard and I know definitely it's gonna pay off; ... I won't give up. I'll still push and work hard on achieving that. (Participant 4, S4-744)

At that point, the therapist guided the participant into the *closing room* by inquiring whether the session had been useful. Although Participant 4 indicated that she had reached her desired outcome, she requested a follow-up session to allow her to monitor her progress. The therapist and participant therefore collaboratively decided to terminate therapy for research purposes, conduct the semi-structured interview, and schedule another appointment two weeks later. After the interview, Participant 4 attended three more sessions over a period of two months. She maintained her progress and stayed at *ten* on the progress scale; these sessions were not considered for data analysis.

5.3.1.4.3 *Emerging themes*

A detailed within-case analysis of Participant 4's transcripts revealed four distinct themes, each with interrelated sub-themes (see Table 11).

Theme 1: My ideal self

Participant 4 entered therapy with a clear picture of her ideal self and was *motivated to be her ideal self*. As therapy progressed, her motivation and confidence to reach her goal became even stronger. This is evident in the following extracts: "Even though I don't know how will I get out, but there's that part of me that still wants that picture that I made in my mind" (Participant 4, S1-621); and "And I know that if I put my mind onto something—now, I definitely do that, yeah. So, the will is there" (Participant 4, S4-549). According to Snyder's (2000) hope theory, Participant 4's motivation and willpower to obtain her goal can be described as agentic thinking which is the motivational component of hope.

Table 11: *Themes and sub-themes emerging from the within-case analysis of Case Study 4*

Theme	Sub-theme
My ideal self	Motivation to be ideal self
	Ways toward ideal self
	Things pushing me to be ideal self
	Hopeful to be my ideal self
	Therapy helps me to become ideal self
Positive perspective	Confident perspective of self
	Positive perspective on life
	Therapy shifts my perspective
I am better	Feeling good
	Happiness starts with me
	In control of my feelings
	Improvement in physical health
	Better relationships
What was good about therapy	Visualising ideal future self
	Focusing on small steps forward
	Identifying strengths
	Not analysing problem
	Collaborative therapeutic relationship

Although she initially lacked a strategy to reach her desired outcome, she later identified numerous *ways to become her ideal self*. For example, she started looking for employment and alternative housing, and also researched further studies she could undertake. Not only did she believe in her ability to find solutions, but she was also able to change these plans in the face of impediments: “So instead of me asking ‘why me?’ —[now the participant asks herself] ’how do I fix this—can this be fixed; how do I move past this?’” (Participant 4, S3-735). Participant 4’s perceived ability to identify and adjust strategies towards her desired outcome refers to pathways thinking which is considered to be a component of hope (Snyder, 1994, 2002).

Initially, Participant 4 indicated that her children were the reason she was still alive and they *push her to be her ideal self*. According to Bernardo (2010), this reflects an external locus-of-hope as the participant’s goal attainment cognitions were driven by external agents, such as her family. However, as therapy progressed, Participant 4 attributed her motivation to the progress that she was making towards her goal: “I was starting to do like those small things—I was starting to reach that picture that I always had. So yeah, it motivated me to like push forward and still wanna do more” (Participant 4, S1-394). It thus appeared that the participant experienced a stronger

internal locus-of-hope towards the end of therapy as her pathways and agency thinking were internally derived (Bernardo, 2010).

Noticing progress not only motivated her, but also made her *hopeful of being and maintaining her ideal self in future*: “So even in the future, I still see myself as happy and—yeah, maintaining whatever that I have now, maintaining it, and growing whatever” (Participant 4, S4-523). This might be explained by the iterative and additive relationship between pathways and agency thinking. According to Snyder’s hope theory, progress towards goal attainment increases hope, which then reinforces pathways and agency thinking (Snyder, 2000; Snyder et al., 2018).

Participant 4 highlighted that *therapy helped her to become her ideal self* and contributed to her experience of hope. This is evident in the following extracts:

> But when we spoke and we discussed the person I want to be and then I thought about things that I’ve overcame—then that confidence started to grow that ‘uh-uh [expresses disagreement], I might be here right now, but I’ve overcame a lot of things that most people would’ve overcome—that means I am good, whatever I want to achieve, it’s still possible’. (Participant 4, S2-472)

> So now, the therapy helped me—even though things might fall apart, I have the solution in me;—I need to solve it, then move forward—yeah. So now I have hope that ‘yes, I will face setbacks, but I have the solution in me’ and in the end I’m gonna achieve the goal. Now I am hopeful. (Participant 4, I-444)

Therapy not only reminded her of who she wanted to be and what she had overcome in the past, but also made her aware of the steps she already had taken towards her goal. As a result, her confidence about finding solutions towards her goal and her motivation to achieve this goal was enhanced. It is thus conceivable that SFBT not only reminded the participant of her goal, but also sparked her pathways and agency thinking which contributed to her experience of hope. The literature supports this finding by suggesting that SFBT engenders feelings of hope and empowerment in the aftermath of trauma. It assists clients to set clear future goals and shifts their focus towards a preferred future where the trauma is resolved. SFBT furthermore instils confidence within clients and creates an expectancy of change (Bannink, 2008; Froerer et al., 2009, 2018; Hopson & Kim, 2004; Ogunsakin, 2015).

Theme 2: Positive perspective

At the start of therapy, Participant 4 viewed herself as a failure and blamed herself for past mistakes. She lacked confidence and needed other peoples' approval to feel worthy. However, as therapy progressed, Participant 4 developed a *confident perspective of herself*, irrespective of her circumstances. This is evident in the following extract:

> So now I've got self-confidence, so regardless of my surroundings or of what other people might say, I still have that confidence that 'I can do this'. So, I no longer need someone to say 'you can do this or you can't do this', I know I have it within me. (Participant 4, I-474)

Later in therapy, she was also able to recognise her strengths and skills and described herself as a "strong-willed conqueror". According to her, this confidence helped her to be more assertiveness in dealing with life challenges and looking for employment. It is thus conceivable that Participant 4's agentic self-talk re-affirmed her perceived ability and increased her confidence in the decisions she took towards goal attainment (Snyder et al., 1998; Snyder, 2002). This confidence may also have contributed towards her satisfaction with life, as the literature proposes that self-efficacy, self-esteem, and optimism are associated with SWB (DeNeve & Cooper, 1998; Diener et al., 1999).

Initially, Participant 4 also viewed her life as dark and worthless. She specifically felt that the trauma she went through shattered her dreams of being a successful woman and mother. This accords with the theory of shattered assumptions, which assumes that traumatic events shatter deeply held assumptions about the world as being benevolent, meaningful, and predictable and the self as being worthy and competent (Bolton & Hill, 1996; Janoff-Bulman, 1992). However, as therapy progressed and she reflected on the trauma, she developed a *positive perspective on life*, despite the trauma she faced. This is illustrated by the following quotes: "I now know that it had to happen to me for a purpose and for me to grow. So those challenges—they actually taught me something—that I can use even in the future" (I-304); and "The setbacks—they are actually there to make life more worth living. Because the more you overcome—because if everything was just simple, I don't think life would be meaningful" (Participant 4, I-407).

She not only viewed challenges as adding meaning and purpose to her life, but also identified how she could use her traumatic experience to support and encourage others. The participant furthermore noticed small blessings in her life and referred to her life as an adventure she was now excited about. In concurrence with previous studies, it is thus proposed that finding meaning and purpose in her trauma contributed towards her life satisfaction and SWB (Diener, Scollon et al., 2009; Triplett et al., 2011; Veronese et al., 2017).

According to Participant 4, *therapy shifted her perspective* to be more positive. This is evident in the following two quotes: “I no longer dwell in the past. I now have this mindset—and I know that it’s something I got from therapy: I have this mentality that what happened, it had to happen” (Participant 4, I-241); and “So now the therapy made me realise the setbacks—all those things that I didn’t want in my life—they are actually the reason to live for [laughs]. Because they make life more interesting—like a challenge—you know?” (Participant 4, I-407).

It is clear that therapy shifted her perspective from past problems, towards a future filled with opportunities. She specifically noted that therapy helped her to recognise the skills she learned through her trauma and how she would be able to use these skills in the future. According to her, therapy had also contributed to a more confident perspective of herself, as it made her aware of her worth and strengths. Participant 4’s experience is supported by previous studies suggesting clients’ shattered assumptions about the self can be restructured by reflecting on the trauma (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). Research specifically indicated that SFBT increases feelings of self-efficacy, empowerment, pride, and confidence to achieve future goals. SFBT furthermore shifts clients’ focus from a traumatic past which cannot be changed, towards a future that can still be filled with success and satisfaction (Carr et al., 2014; Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004; Lloyd & Dallos, 2006, 2008).

Theme 3: I am better

At the start of therapy, Participant 4 was noticeably depressed and overwhelmed. Although she did not verbalise any suicidal thoughts, she reported that she sometimes felts like giving up. At that point, she described herself as being in a “dark pit”. However, during the course of therapy, Participant 4 indicated that she was

now *feeling good.* This is evident in the following quotes: “I’m happy most of the time, yeah—I’m just always in a good mood [laughs]” (Participant 4, S4-17); and “I just feel this contentment inside, I feel content” (Participant 4, S3-188). She not only expressed feeling happy, content, excited, and joyful; but also indicated that she is more relaxed and less frustrated. According to Diener’s (1984) tripartite model of SWB, Participant 4’s experience of increased positive affect and decreased negative affect can be described as the affective component of SWB.

Participant 4 specifically noted that she was *finding happiness within herself* and was now prioritising her own feelings, above those of others: “But I need to start with me, I need to be happy first, I need to be—how do I explain it—it has to start with me, before I can say my sons and say my siblings” (Participant 4, S1-421). The participant’s experience may reflect a move towards a western notion of happiness where independence and personal happiness contribute more towards SWB, than interconnectedness and satisfying the needs of others (Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013). The participant’s focus on her own happiness may have contributed to her experience of SWB.

Participant 4 also indicated that she was now more *in control of her feelings*, irrespective of the situation she finds herself in: “I cannot change what has happened, but I can change how I react. And—like they say, you’re responsible for how you feel and I’m choosing to be happy and look at the bright side” (Participant 4, S4-115). This strong internal locus of control may have contributed to her experience of SWB, as studies have suggested that locus of control is associated with SWB (DeNeve & Cooper, 1998; Diener et al., 1999). According to the literature, the ability to identify, understand, regulate, and harness emotions in oneself and others also correlates with SWB (Schutte et al., 2002).

Participant 4 furthermore reported *improvement in physical health and interpersonal relationships.* According to her, she was sleeping better, had more energy, and no longer experienced headaches. She specifically noted that her relationship with her sons was more fulfilling as she and her sons now laughed, played, and read together. Participant 4 also indicated that her interaction with the women she resides with was now more positive and less conflictual: “So I think, since I’ve changed my attitude and became more positive, I even attract positive responses from people

around me" (Participant 4, S4-231). Both the participant's improvement in physical health and interpersonal relationships may have contributed to her satisfaction with life and SWB. Other studies have highlighted the importance of social support and healthy interpersonal relationships concerning SWB (Diener et al., 1999; Tov & Diener, 2013).

Theme 4: What was good about therapy

Participant 4 identified several aspects of the therapeutic process that were beneficial. First, she found it helpful to vis*ualise and describe her ideal future self* during the first session. This is illustrated by the following extracts: "Speaking about—me in the future and where do I see myself... it also gave me that oomph" (Participant 4, S4-754); and "I started making change. So, whenever I was sad—immediately that picture came back and I said 'is this the person you want to be?'... then in my mind I was like 'I need to change this, I need to reach that goal'. So, the session—it really helped me to think of who I want to be and also how do I get there (Participant 4, I-41).

According to her, this picture served as a reminder of who she wants to be and thus gave her a goal to work towards. This picture not only evoked positive emotions and motivation in the session, but also guided her to make changes and find ways towards her ideal self. Participant 4's experience is supported by previous process-orientated research indicating that future-focused questions assist clients to set clear future goals, shift their focus towards a hopeful future, and contribute towards goal attainment (Hopson & Kim, 2004; McKeel, 2012; Ogunsakin, 2015).

Second, she indicated that it was beneficial to *focus on the small steps* she is taking towards her ideal self, as is evident in the following quote:

> When I came here I felt like—I felt defeated. I felt there is nothing that I am doing that is good. And then just talking about the little things—because I took the little things that I was doing for granted—just talking about those little things—like holding on and not doing drugs—it's also contributing to that bigger picture. Thinking about those small things. I felt empowered that at least there is something that I am doing—then I had that power and courage to want to do more. (Participant 4, I-109)

It is thus conceivable that talking about the small steps she had already taken towards her goal (and how she coped in the past) had empowered her, and motivated her to do more. The participant also highlighted that it gave her hope to realise that at least she was now doing something right.

Third, Participant 4 found it useful to *identify the strengths and skills* she used to cope with trauma and overcome current challenges. This is evident in the following extracts: “Whenever you asked me ‘what skill did you use, what strength do you think you have?’—then I realised ‘hey, I’m actually the answer to all this problems around me’ [laughs]” (Participant 4, I-452); and “So, speaking about the good things—like focusing on the good things, it made me have that hope—it brought back the hope that I’ve lost” (Participant 4, I-121).

According to her, this not only made her aware of her strengths, but it also empowered her to utilise these skills in other situations. Talking about her strengths and skills also contributed to her experience of hope. Similar to Participant 4’s experience, the literature suggests that solution-focused questions, especially exception-finding questions, shift problem-orientated conversations towards solution-focused talk. Such questions thus direct clients to look for positive change, personal strengths, and resources which engenders feelings of hope and empowerment, especially in the aftermath of trauma (Bannink, 2008; Froerer et al., 2009, 2018, Lloyd & Dallos, 2006; McKeel, 2012; Ogunsakin, 2015).

Fourth, Participant 4 indicated that she found it useful *not to analyse the problem* or dwell on the past, as she stated:

> I think maybe if we were going to speak about it [problem], I wouldn’t have achieved the results that I have now. Because as much as we didn’t speak about it, but whatever we spoke about, it actually solved what happened and how I looked at what happened. So—ja! So, I think that speaking about it and you asking, it would have been a waste of time. (Participant 4, I-571)

The participant indicated that talking about her problems would not necessarily have yielded solutions and highlighted that it would have been painful to relive the past. She specifically noted that talking about the details of her trauma would have made her feel helpless. According to her, therapy provided her with solutions that she can apply to all aspects of her life, not only the trauma. She therefore experienced

therapy as brief and effective. This echoes the assumption of SFBT that the solution is not always related to the problem and it is therefore not necessary to explore the past or the cause of the problem (Bavelas et al., 2013; De Jong & Berg, 2007). Her experience also highlights the possibility of retraumatising clients when reliving the traumatic experience (Paintain & Cassidy, 2018; Schottenbauer et al., 2008).

Finally, Participant 4 emphasised the value of a *collaborative therapeutic relationship*. Although she initially found it frustrating to be actively involved in therapy, it empowered her and enabled her to take ownership of the therapeutic progress. According to her, collaboration in therapy forced her to use her mind and consequently contributed to her progress, as is evident in this quote:

> In this one [this therapy], with every answer that I am saying, I am using a lot of my mind.... Now I had to use my mind—and when you asked me questions, I have to actually put myself in that picture and think about it—and really think about it and find the answer. (Participant 4, I-524)

She also indicated that the collaborative conversation made her more comfortable with sharing her experience in therapy. Participant 4's experience is supported by studies identifying the collaborative language process between the client and the therapist as the central and key component of SFBT (Froerer & Connie, 2016). Viewing the client as an expert and collaboratively involving them during the therapeutic process also creates an empowering therapeutic alliance where healing and growth can occur (Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004).

5.3.1.4.4 *Quantitative data results*

Participant 4's levels of hope, SWB, and psychopathology before and after exposure to SFBT were measured using various instruments (see Table 12). These results were compared, for the purpose of triangulation.

Table 12: *Hope, subjective well-being, and psychopathology experienced by the participant in case study 4*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	-	48
Scale of Positive Experience (SPANE-P)	12	25
Scale of Negative Experience (SPANE-N)	22	10
Satisfaction with Life Scale (SWLS)	5	30
Patient Health Questionnaire (PHQ-9)	20	1
Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V (PCL-5)	65	17

Table 12 indicates that Participant 4 experienced the highest possible score of *hope*, as measured by the AHS, after exposure to SFBT (Snyder et al., 1996). Unfortunately, no conclusions concerning her experience of hope before therapy could be made, as the participant did not complete all items of this scale. Participant 4 also experienced an increase in both the affective and cognitive components of *SWB*. According to scores from the SPANE, she not only displayed more positive affect (SPANE-P), but also reported a decrease in negative affect (SPANE-N) after therapy. Participant 4's scores on the SWLS also suggested enhanced life satisfaction after exposure to SFBT. Before therapy, she reported being extremely dissatisfied with her life; while she felt satisfied with life after therapy (Diener et al., 1985).

With regards to *psychopathology*, Participant 4 experienced a decrease in depressive and PTSD symptomology after exposure to SFBT. Before therapy, she displayed severe symptoms of depression as measured by the PHQ-9. However, she reported almost no depressive symptoms after therapy (Kroenke et al., 2001). Participant 4's score on the PCL-5 also suggested a provisional PTSD diagnosis before the start of therapy (Weathers et al., 2013). However, after exposure to SFBT, she scored below the suggested PTSD cut-off score (≥ 33) (Weathers et al., 2013). Participant 4's improvement in psychopathological symptoms after therapy thus suggested an increase in her experience of well-being (Keyes, 2002).

5.3.1.4.5 *Evaluative summary*

The above-mentioned findings suggest that SFBT contributed to Participant 4's experience of hope and SWB. According to the themes emerging from thematic analysis, therapy not only helped her to become her ideal self, but also shifted her perspective to be more positive. She also experienced an improvement in her feelings, health, and relationships. According to Participant 4, visualising her ideal future self, identifying strengths, focusing on small steps, not analysing the problem, and the collaborative nature of SFBT contributed to this experience. These qualitative results were supported by quantitative data which suggested an increase in levels of hope, positive affect, and life satisfaction after exposure to SFBT. A reduction in negative affect and psychopathology were also observed after therapy.

5.3.1.5 Case Study 5

5.3.1.5.1 *Background information*

Participant 5 is a 54-year-old black female client who presented with trauma-related concerns after exposure to multiple traumatic events. Not only had she witnessed the traumatic death of her brother, but she had also experienced an abusive marriage which ended in divorce. One of her close friends also passed away during the participants' therapy. However, in agreement with the assumptions of SFBT, no further details regarding the trauma were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). At the time of therapy, Participant 5 was employed as a cleaner at a government institution. She lived with and supported her two adult sons, as they were unemployed. Although her first language is isiZulu, therapy was conducted in English as the participant showed language proficiency and had a secondary school level of education. Participant 5 attended two SFBT sessions, but failed to adhere to a third scheduled appointment. However, when contacted, the participant reported no need for further therapy as she was doing much better. A semi-structured interview was thus scheduled for the participant to share her experience of therapy.

5.3.1.5.2 *Description of the Solution-Focused Brief Therapy process*

Session 1

The first session commenced with the therapist introducing herself to Participant 5 and providing a brief explanation of SFBT, emphasising the collaborative, brief, and goal-orientated nature of the approach. In the *desired outcome room*,

Participant 5 indicated that she hoped to live a better life in which she could be happy and trust others. This desired outcome thus guided the participant and therapist through the SFBT art gallery.

The therapist entered the *resource room* to get to know the participant's strengths and significant people in her life. Although Participant 5 referred to past trauma and current challenges in this room, the therapist did not explore or analyse this in detail. Consistent with the assumptions of SFBT (Bavelas et al., 2013; De Jong & Berg, 2007), the therapist validated and acknowledged these experiences; however, the therapist also amplified the participant's desire to get better. This shifted the conversation towards an elaborative discussion of the participant's interests, talents, and strengths. The therapist also made use of relational questions (Froerer et al., 2018) to elicit the strengths others notice within her. As a result, the participant was reminded of her skills and capabilities, as she stated:

> You know, the other thing that I like the most, but I didn't realise this is the best thing to me—I like to counsel people. If a person comes to me with a problem, I know how to solve that problem. (Participant 5, S1-262)

With the participant's resources in mind, the therapist guided the participant into the *preferred future room* by asking a miracle question (Froerer et al., 2018). The participant responded positively to this question and painted a picture of a miracle day where her desired outcome is present. She highlighted that she would be happy, and would be doing things she usually does not do; she would furthermore be engaging with others. In response to a relational question, she indicated that her sons would also notice her happiness, and that this would have a positive effect on them. As the participant previously mentioned times when she was happy, the therapist asked an exception-finding question (Froerer et al., 2018) to identity moments of the miracle day already being present. During this conversation, the participant not only remembered past moments of happiness, but also expressed happiness in the present moment: "I'm telling you everything and that thing makes me happy" (Participant 5, S1-589).

At that point, the therapist made use of a scaling question (Froerer et al., 2018) to identify Participant 5's progress towards her desired outcome of being happy and trusting others. The participant indicated that she is at an *eight* on this scale. In response to follow-up questions, she not only expressed a positive expectation

regarding progress, but also had clear plans on how to move forward on this scale. This is evident in the following extract:

> From eight to a nine—I think I need to change a lot of things in my life—I must learn to forgive fully, and then after that I'll be strong and I'll be able to face things so that I can be on my way. And then I know how to move them from this steps to the other. (Participant 5, S1-721)

The therapist thereafter opened the door to the *closing room* by encouraging the participant to notice glimpses of her miracle day being present in the following weeks, specifically paying attention to what she was doing to make those moments happen. Participant 5 indicated that the session was useful as she felt free after talking to the therapist. The participant thus requested another appointment, which was scheduled for two weeks later.

Session 2

In line with the hopeful assumptions of SFBT (Froerer et al., 2018), the therapist led the participant to the *resource room* by asking what was now better in the participant's life since the previous session. Participant 5 mentioned that she was feeling relieved, free, and happy after the previous session: "At that time I was relieved and free. I was happy" (Participant 5, S2-114). She also indicated that her sons noticed she is less angry and expressing her feelings openly, but politely towards them.

However, Participant 5 reported that her close friend had died in the two-week interim since the previous session. Despite this loss, the participant indicated that she was being strong and was coping fairly well. Although the therapist expressed empathy, the strengths and resources the participant relied on during this difficult time were amplified. Participant 5 specifically indicated that her spirituality, her loved ones, a positive mindset, and remembering past instances of coping gave her the strength to move forward. In response to further coping questions (Froerer et al., 2018), the participant indicated that coping with this experience not only made her aware of her strength, but also gave her hope regarding the future. This is evident in the following quotes: "Because the other thing that makes me strong, I tell myself that 'my problem is not bigger than me—I am bigger than my problem'" (Participant 5, S2-292); and "That thing tells me that my life is BRIGHT—there is brightness in my future, I can see the light and I can see where I'm going!" (Participant 5, S2-306).

At that point, the therapist asked a scaling question, to measure the participant's progress towards her desired outcome of being happy and trusting others. Although the participant had not moved higher on this scale, the therapist amplified the fact that she was able to stay at that point, despite the loss she was experiencing (loss of her friend). The therapist thus entered the *desired outcome room* by eliciting the participant's best hope for the session. Participant 5 stated that, instead of being afraid, she wanted to trust herself more. Without analysing or confronting this desired outcome, the therapist used this best hope to guide the remainder of the conversation.

In the *preferred future room,* the therapist thus asked a future-focused question (Froerer et al., 2018) to elicit a detailed description of what would be different in the participant's life once she was trusting herself more. Participant 5 constructed a picture of talking freely to others, having the confidence to express her feelings, being independent, and doing things that she enjoyed. Based on the resources the participant identified in the first session, the therapist asked an exception-finding question to inquire about past instances where she had trusted herself. The participant remembered a twelve-year-old version of herself who was free, fearless, talkative, and outgoing. The therapist asked detailed questions to obtain a clear description of her twelve-year-old self. A relational question was also used to inquire about what this younger version of the participant would have told her if she was present during the session. In response to this question, Participant 5 enthusiastically shared steps that would help her move towards this version of herself as she indicated:

> The first thing that I'm going to do, I'll put a smile on my face. After putting a smile on my face, then I'll invite happiness to come to my life, I'll invite the trust to come to my life and I will invite the respect to come into my life—because I have to respect myself first, before I can respect you. (Participant 5, S2-681)

With this in mind, the therapist entered the *closing room* by suggesting that the participant keep her eyes open for her twelve-year-old self being present. The therapist also complimented the participant on the way she was coping with the loss of her friend and the strengths she was applying in this situation. Participant 5 indicated that therapy was useful and therefore requested that a follow-up session be scheduled for a week later. Unfortunately, the participant did not attend this appointment. However, when contacted telephonically, she indicated that she is doing well and did

not require further sessions. An appointment for the semi-structured interview was thus scheduled for the participant to share her experience of therapy.

5.3.1.5.3 *Emerging themes*

A detailed within-case analysis of Participant 5's transcripts revealed four distinct themes, each with interrelated sub-themes (see Table 13).

Theme 1: Moving forward

Participant 5 expressed a *positive future expectation* that she had felt since the first session, as she stated:

> But now this thing [this therapy] is going to help me, because now I have to change myself of this anger—I want to be out of this dark room of anger. You know as soon as I can be out of this darkness of a room, things will be fine. (Participant 5, S1-853)

She not only expected a positive therapeutic outcome, but was also able to envision a better future where she achieved her goal of being happy and trusting others. This positive expectation for goal attainment can be interpreted as the bare-bones conception of hope referred to by early theorists (Callina et al., 2018; Gallagher, 2018; Snyder, 2000).

Early in therapy, Participant 5 was also able to *find steps forward*: "Because I can't climb the next step, while I leave the mess behind. I have to fix that mess. Then after fixing that mess, then I must take another step and then move forward" (Participant 5, S1-702). She specifically mentioned that she needed to make peace with the past, forgive herself and others, and start trusting herself. According to Snyder's (2000) hope theory, Participant 5's perceived ability to identify strategies or useable routes to obtain her desired outcome resembled pathways thinking which is considered to be a component of hope.

Table 13: *Themes and sub-themes emerging from the within-case analysis of Case Study 5*

Theme	Sub-theme
Moving forward	Positive future expectation Finding steps forward Motivation to move forward Others motivate me to move forward Therapy helps me move forward
Feeling better	Feeling happy and free Happiness starts with me Expressing my feelings Therapy helps me feel better
Seeing the light	I am strong Life is still good Therapy opens my mind
How therapy helped	Talking about good things Not talking about bad things Open conversation Acceptance in therapy

Although Participant 5 expressed *motivation to take steps forward* and reach her goal at the start of therapy, this became more apparent as therapy progressed. This is illustrated in the following quote:

> I'm just looking forward for my life. I want to move on with my life, I don't want to stand in one place—so I want to see my feet go forward. They say backwards never, forward ever—so I don't want to go backwards. (Participant 5, I-670)

She not only expressed confidence to reach her goal, but also compared her willpower to that of a baby starting to walk. According to her, she would not give up trying to take steps forward, despite falling and experiencing obstacles. Snyder's (2000) hope theory describes the participant's motivation to initiate and maintain movement towards her goal as agency thinking, considered to be the motivational component of hope.

According to Participant 5, *others motivate her to move forward*: "Because I can't move from step number one until the top one, without getting the encouragement from people…without getting the strength, without hearing people telling me 'you are strong'" (Participant 5, S2-306). She highlighted that support from friends and prayer would give her the strength to reach her goal. Bernardo (2010) refers to this as an external locus-of-hope, because family, peers, and spiritual forces were acting as

agents of goal attainment cognitions. This form of hope is frequently observed among collectivistic cultures, including the African culture to which the participant belongs. Various researchers also considered spirituality and religiosity to be the roots of hope (Dufault & Martocchio, 1985; Farran et al., 1995; Isaacs & Savahl, 2014; Scioli et al., 2011). In the African context, studies have also suggested that pathways thinking is strongly influenced by an individual's faith and belief in a higher power which enables them to achieve their goals (Asamoah et al., 2014; R. Li et al., 2010).

Participant 5 furthermore emphasised that *therapy helped her move forward.* This is illustrated by the following quotes: "But it [this therapy] helps me and it opened my mind. Because I did tell myself that 'you know man, let me move forward'—ja it helped me a lot, because I did move forward" (Participant 5, I-67); and "I can talk [in therapy] and then at the end of the day, I can get the right answers—and then I will get the clue, I will know from here where to" (Participant 5, S1-598).

Therapy not only assisted her to find ways forward, but also encouraged her to take these steps. It is thus suggested that SFBT contributed to the participant's pathways and agency thinking. This is supported by literature that suggests that SFBT gives clients hope by fostering both pathways and agency thinking (Blundo et al., 2014; Michael et al., 2000; O'Hara, 2013; Reiter, 2010).

Theme 2: Feeling better

At the start of therapy, Participant 5 expressed anger towards herself and others and that made her feel depressed and irritable. According to her, she carried a heavy stone in her heart and mind. However, as therapy progressed, she not only expressed *feeling happy and free*, but also stated that she is less angry: "Ja—at that time [after the session] I was relieved and free. I was happy" (Participant 5, S2-114). According to Diener's (1984) tripartite model of SWB, Participant 5's experience of increased positive feelings and decreased negative feelings could be considered as the affective component of SWB.

Participant 5 specifically noted that she is feeling better as she realised that *happiness starts with her* and therefore decided to prioritise her own feelings above those of others: "But now I tell myself that 'no, I myself, I must be happy—happiness must come first to me, before it goes to the next person'—because how can I make people happy, if I'm not happy" (Participant 5, I-570). The collectivistic cultures

(including the African culture to which Participant 5 belongs), tend to sacrifice their own desires to obtain social approval; in the process, they may then sacrifice their personal happiness. Taking this context into consideration, the decision by the participant to prioritise her own happiness was an unexpected action (Oishi & Diener, 2001; Oishi & Sullivan, 2005; Suh & Koo, 2008). Participant 5's decision to prioritise her own happiness might thus reflect a move towards western notions of happiness and may have contributed towards her experience of SWB.

Initially, Participant 5 either suppressed her feelings which exacerbated her depression, or aggressively expressed her emotions which led to interpersonal conflict and guilt. However, as therapy progressed, she indicated that she was more assertive and now had the confidence to *express her feelings appropriately*. This is evident in the following extract:

> I was so shy to take a stand, but now I'm open—wide open. If I don't want a thing, I will tell you that 'I don't like this'—ja, because at that time it was like I'm sacrificing with my own life. (Participant 5, I-76)

The participant also started communicating more politely and respectfully, especially with her sons. According to the literature, suppressing emotions, especially negative emotions, may have a detrimental effect on well-being. It is not only associated with lower levels of life satisfaction and social support, but may also increase levels of stress (McMahan et al., 2016; Tamir & Ford, 2012). It is thus suggested that Participant 5's ability to openly express her emotions, contributed towards her experience of SWB.

According to Participant 5, *therapy helped her to feel better* as it not only made her feel "happy and free", but also encouraged her to prioritise her own happiness: "So, it [this therapy] teaches me that the first person that must be happy is me" (Participant 5, I-47). Therapy furthermore gave her the opportunity to express her feelings which empowered her to be more assertive in other contexts. Similar to Participant 5's experience, previous studies suggested that SFBT-orientated approaches increased clients' levels of positive affect, and reduced levels of negative affect (Grant, 2012; Grant & O'Connor, 2010; Green et al., 2006; Wehr, 2010). According to Frederickson's (1998, 2000, 2001) broaden-and-build theory, these

positive emotions may also build resources that can be used in other contexts, as seen in the participant's case.

Theme 3: Seeing the light

At the start of therapy, Participant 5 doubted herself and felt as if she was in a dark room. She described herself as a shy person who was sensitive to criticism and she felt that she was not good enough. However, as therapy progressed, she forgave herself for past mistakes and started to *view herself as a strong, competent woman*: "You know what other people they learn about me, they learn that I'm a strong woman" (Participant 5, S2-266). She not only realised that she is "bigger than her problems", but also noted that she still had worth and purpose. The participant highlighted her ability to support and encourage other people who experience problems. This illustrates how the participant's shattered assumption of being worthy and competent was restructured as she reflected on the trauma (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). Realising her strength and worth also added a sense of meaning to Participant 5's life which possibly contributed to her experience of life satisfaction and SWB (Diener, Scollon et al., 2009).

As therapy progressed, Participant 5 also considered her *life to be good*, despite the trauma she had experienced. This is evident in the following extracts: "Because everything has got its own time—it was the time for those things to happen to me and it was the time for my friend to pass away" (Participant 5, S2-207); and "So let me live—as I'm still here, alive in this world" (Participant 5, S2-171).

Participant 5 not only accepted trauma as a part of life, but also concluded that she still has a life to be lived, despite the trauma she had been through. She furthermore recognised several things that were good in her life, such as her family and work. She also noted that she still received fulfilment from singing, praying and nature, and was thus able to see the light in her life. This illustrates how the participant's shattered assumption of the world being benevolent, meaningful and predictable were restructured during therapy (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). According to Diener et al. (1999), Participant 5's positive evaluation of specific life domains (e.g. work, leisure, and family) may also reflect life satisfaction, considered to be the cognitive component of SWB.

According to Participant 5, therapy *opened a window in her mind and heart* which helped her to *see the light* again. This is illustrated by the following quote:

> You helped me while I was in my dark room, while I was closing myself in that dark room—so you made me to come out from that dark room that I was in. You made me realise that, me also—I'm a human being, I am a person, I am me. I must know what I want, I must know who I am. (Participant 5, I-563)

Therapy specifically made her feel like a human being which helped her to recognise her strength and worth. It is thus suggested that therapy contributed to Participant 5's experience of SWB by highlighting her sense of purpose and meaning (Diener, Scollon et al., 2009). Participant 5's experience was supported by qualitative studies suggesting that SFBT increases feelings of self-efficacy, empowerment, and hope (Carr et al., 2014; Lloyd & Dallos, 2006, 2008). According to the literature, this not only contributes towards positive therapeutic change, but also increases positive emotions and well-being in therapy (Grant, 2012; Green et al., 2006).

Theme 4: How therapy helped

Participant 5 experienced therapy as positive and highlighted a few aspects regarding the therapeutic process that stood out for her. She found it helpful to *talk about the good things in her life*, such as her strengths, resources, and things that make her happy. This is evident in the following extracts:

> The other thing that was good about therapy—I remember the time we talk, you asked me 'what makes me happy?'....So this thing [question about what makes me happy] it makes me okay, then it even gave me strength and then it made me to stand up for myself, ja. (Participant 5, I-171)

> You know the other thing, I remember the time you asked me [about] when I grew up—what kind of a girl I was—and I tell you . . . that's why I am still standing now, I'm still strong . . . It reminded me of the good things only, not the bad things. (Participant 5, I-328)

The participant specifically noted that it was helpful to remember her past success and talk about the strong, confident, younger version of herself. According to her, this motivated and empowered her, as it reminded her of who she is and who she wants to be. Consequently, she found answers within herself and was able to counsel

herself between and after therapy sessions. Talking about the good things in her life furthermore shifted her perspective from the negative towards the positive aspects of her life. Participant 5's experience concurs with literature suggesting that resource-orientated questions contribute towards positive outcomes in SFBT sessions. It specifically appears to engender feelings of hope and empowerment in the aftermath of trauma (Bannink, 2008; Froerer et al., 2009, 2018; Froerer & Jordan, 2013; Jordan et al., 2013; McKeel, 2012; Tomori & Bavelas, 2007).

Participant 5 also stated that it was good for her *not to talk about the bad things* (trauma) in her life as it would have caused more pain and anger. This is illustrated by the following quote:

> I didn't want to talk about it [bad things], because now, I'm fine. Because if I can go back…oh, it will be a disaster, because hey, they will hurt me badly, badly, badly. So I don't want to talk about them. (Participant 5, I-607)

According to her, talking about the trauma would not have been conducive for healing, as it is better to bury the bad things in your life. Participant 5's experience supports the assumption of SFBT that the focus of therapy should be on the client's desired outcome, instead of past problems or current conflicts (Bavelas et al., 2013; De Jong & Berg, 2007). It furthermore amplified the criticism of pathology-orientated approaches for potentially retraumatising clients by recollecting the traumatic event (Paintain & Cassidy, 2018; Schottenbauer et al., 2008).

Participant 5 furthermore benefitted from having an *open conversation* with the therapist. According to her, the therapist's attentive and respectful stance contributed to her being open and free in therapy. This is evident in the following quote:

> I found a person who can give me time to think about what I'm going to say—and then a person who makes me to open my mind and my heart, a person who makes me free so that I can talk. (Participant 5, I-192)

She also noted that the confidential and private nature of the conversation encouraged her to be open and to feel free to talk. According to the participant, the open conversation allowed her to release her burden and pain. Participant 5's experience was supported by the literature which highlighted the importance of the therapeutic alliance in the SFBT process. This alliance is specifically fostered by the

respectful and curious stance SFBT therapists take (Franklin et al., 2017; Froerer & Connie, 2016).

Unsurprisingly, Participant 5 also highlighted the value of *being accepted in therapy.* She noted that the therapist did not judge her or try to change her. This is evident in the following statements: “You know, you didn’t change me—you didn’t say ‘no stop doing this, do this’—no, you never change me” (Participant 5, I-299); and

> And then the way you accepted me—and then the way you were a good listener. When I talk about my problems, you never said ‘ag [expresses disinterest], the same story every time’—you didn’t say that, you did listen to my problem! (Participant 5, I-544)

This not only made her feel like a human being, but also, through positive modelling, encouraged her to trust and accept other people in her life. Previous qualitative studies echoed Participant 5’s experience and emphasised the value of SFBT therapists’ non-judgemental stance (Carr et al., 2014; Lloyd & Dallos, 2008; Simon & Nelson, 2005).

5.3.1.5.4 *Quantitative data results*

For the purpose of triangulation, Participant 5’s levels of hope, SWB, and psychopathology before and after exposure to SFBT were compared by the use of measuring instruments. These results are presented in Table 14.

Table 14: *Hope, subjective well-being, and psychopathology experienced by the participant in Case Study 5*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	37	41
Scale of Positive Experience (SPANE-P)	28	27
Scale of Negative Experience (SPANE-N)	17	8
Satisfaction with Life Scale (SWLS)	33	35
Patient Health Questionnaire (PHQ-9)	-	3
Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V (PCL-5)	53	23

Table 14 shows that Participant 5 experienced greater *hope,* as measured by the AHS, after exposure to SFBT. She also experienced an increase in both the affective and cognitive components of *SWB*. Although Participant 5's score of positive affect (SPANE-P), measured using the SPANE remained relatively stable; she reported less negative affect (SPANE-N) after therapy. Participant 5 felt extremely satisfied with her life before the start of therapy, and this satisfaction was maintained after therapy. At that point, she also obtained the highest possible score on this scale (Diener et al., 1985).

Regarding *psychopathology*, Participant 5 experienced less PTSD symptoms after exposure to SFBT. Before therapy, Participant 5's score on the PCL-5 suggested a provisional PTSD diagnosis. However, after exposure to SFBT, her score was below the suggested PTSD cut-off score (≥ 33) (Weathers et al., 2013). According to her scores measured using the PHQ-9, she did not meet the diagnostic criteria for depression after therapy (Kroenke et al., 2001). However, no conclusions regarding depressive symptomology before therapy could be made, as the participant did not complete all items of this scale. Nevertheless, Participant 5's improvement in PTSD symptoms after exposure to SFBT suggested an increase in her experience of well-being (Keyes, 2002).

5.3.1.5.5 *Evaluative summary*

From the above-mentioned results, it can be concluded that SFBT contributed to Participant 5's experience of hope and SWB. Qualitative data suggested that therapy not only helped her to move forward and feel better, but also assisted her to see light again. Participant 5 highlighted that talking about the good things instead of the bad, having an open conversation, and being accepted in therapy contributed to her experience. These findings were supported by quantitative data which indicated an increase in the participant's levels of hope and life satisfaction after exposure to SFBT. Lower negative affect and psychopathology were also observed in the participant after therapy.

5.3.1.6 Case Study 6

5.3.1.6.1 *Background information*

Participant 6 is a 43-year-old black female client who presented with depressive symptoms after the death of both her parents and her husband. In line with the

assumptions of SFBT, no further details regarding the trauma were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). At the time of therapy, Participant 6 was employed as a part-time community care worker at a government institution. Following the death of her parents, she had taken care of her three younger siblings and her own son, which contributed to additional stress. Therapy sessions were conducted in English, as the participant indicated this was her first language and she had obtained a Grade 12 level of education. Participant 6 attended two SFBT sessions, whereafter a semi-structured interview was held for the participant to share her experience of therapy.

5.3.1.6.2 *Description of the Solution-Focused Brief Therapy process*

Session 1

At the start of the first session the therapist introduced herself to Participant 6 and explained the collaborative, brief, and goal-orientated nature of the SFBT approach. The therapist immediately thereafter opened the door to the *desired outcome room*, to establish the participant's best hope for the session. However, instead of sharing her desired outcome, the participant relayed her problem to the therapist. The therapist acknowledged and validated the participant's problem, and then used strategic questions to help the participant identify what she wanted to experience instead of the pain and suffering. As a result, Participant 6 expressed a wish to be happy, which guided the participant and therapist through the remainder of the SFBT art gallery.

In the *preferred future room*, the therapist used presuppositional language (Froerer et al., 2018) to obtain a detailed description of what the participant would notice in future when, waking up one morning and she was feeling slightly happier. Participant 6 provided a vivid picture of herself smiling, making jokes, singing a gospel song in the shower, and having the energy to do her household chores. In response to relational questions (Froerer et al., 2018), the participant indicated that her son and siblings would notice her happiness and would respond positively to this. As the participant imagined this picture of herself and her family, she became emotional as she recognised the importance of her family. Discovering the participant's values, the therapist continued to ask relational questions to elicit what her deceased parents would notice when she was happier. This question evoked several positive emotions

as the participant imagined what her parents in heaven would tell each other when they saw her on a morning when she was feeling happy.

As Participant 6 previously alluded to moments of happiness that were already visible, the therapist asked an exception-finding question (Froerer et al., 2018) to explore these moments in more detail. The therapist focused on eliciting specific examples and amplifying the strengths and skills the participant utilised during these moments. During this conversation, the participant not only identified small things that make her feel happy and worthy; but also emphasised that her family pushed her to move forward. This is illustrated by the following extracts: “Hence I’m saying I’m living for them [participant’s family]—they are the reason…they are the one’s pushing me” (Participant 6, S1-303); and “For the fact that I wake up in the morning, bathing myself, going to work...at least I do have a job, at least. So, I can afford to put a bread on the table for them [participant’s family]” (Participant 6, S1-273).

At that moment, the therapist asked a scaling question (Froerer et al., 2018) to measure the participant’s progress towards her desired outcome of being happy. Participant 6 indicated that she was at *nine* on this scale due to the strength she gets from her family and faith. The therapist also inquired what would be different if she moved half a step higher. The participant did not answer this question directly and rather stated the situational changes that needed to occur for her to move a step higher; the therapist respected and accepted the participant’s answer.

The therapist then entered the *closing room* by suggesting that the participant notice herself being happy, despite these situational changes not being present yet. The therapist also asked the participant what she would like to compliment herself on, after reflecting on the session. Participant 6 responded to this question, by acknowledging her purpose and worth: “I’m a mother—that’s what I would tell myself. I’m a mother; I’m a woman who can raise, not only my son, not only my siblings, but even the society as well, ja—that’s me” (Participant 6, S1-631). The participant furthermore indicated that she found therapy useful and wanted another appointment, which was scheduled for two weeks later.

Session 2

This session started in the *resource room* with the therapist asking a presuppositional question to elicit what was better in the participant’s life. The

participant reported that she was now not only feeling better, but also had hope: “Now, as we spoke, I can see there is bright, there is hope—I don’t know, but I just feel so free, so relieved” (Participant 6, S2-31).

In response to relational questions to amplify the changes she had experienced, Participant 6 indicated that her son, friends, and deceased parents had noticed that she was now happy and bright. The therapist specifically explored how the participant created this change and what personal skills or strengths she discovered in the process. During this conversation, the participant not only indicated that she surprised herself, but also expressed motivation and confidence to move forward: “I’ve noticed that—ja, I think I have the power that I didn’t know where it comes from—I can do whatever that can come now. From now on, going on—nothing that can stop me or hurt me—ja, like before” (Participant 6, S2-165).

At that point, the therapist used a scaling question to measure the participant’s progress towards her desired outcome of being happy. The participant enthusiastically indicated that she was at *ten* on this scale (compared to *nine* in the previous session). The therapist congratulated the participant on her progress and entered the *desired outcome room* by asking the participant whether there is anything more she hopes to achieve from the session. The participant indicated that she is satisfied and has no further therapeutic needs. The therapist therefore guided the participant back to the *resource room* and spent the rest of the session on amplifying the participant’s progress. As Participant 6 found it difficult to take ownership of her progress, the therapist specifically elicited the personal resources that helped her move from a nine to a ten on the progress scale of happiness.

The therapist also briefly stepped into the *preferred future room* by asking the participant what she and her family would see if she continued to utilise her strengths and resources in future. Participant 6 again expressed hope for a better future: “In future, I’ll be more than now—MORE, more than now, ja. Maybe I’ll be a matron somewhere at the hospital—you know [laughs]... up, up there—that’s where you’ll see me, you’ll find me there” (Participant 6, S2-307). On that note, the therapist opened the door to the *closing room* by inquiring whether the participant has anything more to share or ask. The participant indicated that the sessions were beneficial and that she would approach the therapist if she needed further therapy in future. The participant

and therapist thus collaboratively decided to terminate therapy and an appointment for the semi-structured interview was scheduled.

5.3.1.6.3 *Emerging themes*

A detailed within-case analysis of Participant 6's transcripts revealed four distinct themes, each with interrelated sub-themes (see Table 15).

Theme 1: A better future

Participant 6 entered therapy with *motivation or push to move forward* and create a better future for herself, her siblings, and her child: "I don't know, it's just a courage that I don't know where it comes from—but I do have that thing that says 'I cannot give up now'" (Participant 6, S1-298). However, as therapy progressed, her motivation and courage to move forward and obtain her goal became even stronger. Snyder's (2000) hope theory refers to Participant 6's perceived energy to initiate and maintain movement along an identified pathway as agency thinking or the motivational component of hope.

Participant 6 attributed her motivation mostly to external sources because her *family and faith pushed her forward*. She felt that her desire to create a better life for her siblings and child was motivating her not to give up. This is illustrated below:

> I'm living for them [participant's family]. So that give me a courage to say 'whatever that I'm facing, whatever that I've been through, but then I have to wake up, I have to push—by all means being me, so that I can try to live a better life'. (Participant 6, S1-282)

The participant also indicated that praying and fasting gave her strength to carry on. Bernardo (2010) refers to this as an external locus-of-hope as her family and spiritual forces were acting as agents of the participant's goal attainment cognitions. This form of hope is commonly observed among collectivistic cultures, such as the African culture to which the participant belongs. In agreement with Participant 6's experience, researchers have identified spirituality and religiosity as the roots of hope (Dufault & Martocchio, 1985; Farran et al., 1995; Isaacs & Savahl, 2014; Scioli et al., 2011). In the African context, studies specifically suggested that an individual's faith and belief in God strongly influences pathways thinking (Asamoah et al., 2014; R. Li et al., 2010).

Table 15: *Themes and sub-themes emerging from the within-case analysis of Case Study 6*

Theme	Sub-theme
A better future	Push towards a better future
	Others push me forward
	Taking steps forward
	Hope for a better future
	Therapy helps me move forward
Feeling good	Feeling happy and relieved
	Family makes me happy
	Therapy helps me feel good
Life goes on	I must live
	My family is good
	I am good
	Therapy opens my eyes
How therapy helped	Talking about past
	Imagining a happy self
	Empathy and acceptance in therapy

As therapy progressed, Participant 6 utilised her energy and started to *take steps forward*: “I just left everything behind now. I’m going forward, I am going forward” (Participant 6, S2-329). She not only decided to leave her past behind, but also started socialising more and made plans. According to Snyder’s (2000) hope theory, the participant’s perceived ability to identify strategies or useable routes to obtain her desired outcome can be described as pathways thinking, which reflects a component of hope.

As Participant 6 started taking these steps forward, she also expressed a *positive future expectation and hope for a better future*: “But now, as we spoke, I can see there is bright, there is hope” (Participant 6, S2-28). She not only visualised herself as being a successful matron, but also believed that she will maintain the progress she made. Participant 6’s expression of hope reflected the outcome of an iterative and additive interaction between her pathways and agency thinking, as described by hope theory (Snyder, 1994, 2002).

Participant 6 highlighted that *therapy helped her to move forward*. This is illustrated by the following quotes: “I wasn’t so sure that it’s enough, that I’m doing it enough—am I right, am I good—but then after, that’s when I was like ‘ja, I’m on the right track—ja, so let me do it more’” (Participant 6, I-162); and “It [this therapy] was

helpful, because each and every day it makes me being a new person...it pushes me to a point where I need to be me, I need to do this" (Participant 6, I-204).

According to her, she was unsure about her route towards a better future, but therapy gave her direction and confirmed that she was on the right path. This realisation not only motivated her to continue pushing forward, but also gave her hope concerning her future. It is thus suggested that SFBT contributed to the participant's experience of hope by enhancing her pathways and agency thinking. Participant 6's experience was supported by the literature, suggesting that SFBT contributes towards clients' expectations of realising their desired outcomes, and therefore enhances their levels of hope (Bozeman, 1999; Michael et al., 2000; Quick & Gizzo, 2007).

Theme 2: Feeling good

During the first session, Participant 6 reported feeling depressed, stressed, and tense. She was emotional during the session and appeared overwhelmed. However, during the second session, she reported that a burden had been lifted from her shoulders and that she was no longer feeling tearful. Not only was she experiencing fewer negative emotions (e.g. feeling upset, down, and sad), but she also *felt relieved, free, and happy*: "I was so relieved, I felt so, so relieved! You know last time I was so upset, down, crying, and all that; but then after—I was so relieved, I'm relieved even now" (Participant 6, S2-12). Participant 6's experience of decreased negative affect and increased positive affect reflected the affective component of SWB, as defined by Diener's (1984) tripartite model.

During therapy, it became apparent that Participant 6's *happiness is primarily rooted in supporting her family* and seeing them prosper. According to her, working for them and improving their lives would make her the happiest person alive: "If I can see them [participant's family] —you know, working for them, improving their lives—ja, that is the only thing that's in my heart. That one can make me happy, happy, happiest in my life" (Participant 6, S2-365). Her experience concurs with cross-cultural studies suggesting that collectivistic societies emphasise interconnectedness between the self and significant others when describing SWB. These cultures are thus more likely to experience happiness after fulfilling goals that are directed at pleasing or receiving approval from others (Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013).

Participant 6 highlighted that *therapy helped her to feel good*, as she stated:

> After we spoke, then that's when I started to be happier—even more. Because just I poured little bits of my heart to someone—someone try to listen to me, then I was a bit relieved. But as time goes, coming here, attending these sessions, then it made me feel free—more and more. (Participant 6, I-169)

According to the participant, therapy allowed her to talk and express her feelings and therefore made her feel relieved, free, and happy. It is thus proposed that therapy positively contributed to Participant 6's experience of SWB by increasing her positive feelings and decreasing her negative feelings. In agreement with this proposal, the literature highlights that SFBT increases clients' levels of positive affect and reduces levels of negative affect as it focuses on strengths and solutions (Grant, 2012; Grant & O'Connor, 2010; Green et al., 2006; Wehr, 2010).

Theme 3: Life goes on

Participant 6 entered therapy being stuck in her past and not feeling satisfied with her current situation. Despite this negative evaluation she made concerning her life, Participant 6 indicated that her *family is an important part of her life*. This is illustrated below:

> He's [participant's brother is] not smoking, he's not drinking—he is focused. Ja, when he's at home—when I'm from work, I can see that ok, there was a person in the house—cleaning the house, cooking—you know, he's so, so supportive. (Participant 6, S1-601)

She not only mentioned that she is proud of her siblings, as they are well-behaved and respectful, but also noted how much they support her. The participant's positive judgement about her family domain reflected a glimpse of life satisfaction and SWB (Diener et al., 1999).

As therapy progressed, Participant 6 also realised that life would go on and that she *still had a life to live*, despite the trauma she had experienced: "Ok, what happened it happened—but it doesn't mean it's the end of the world or the end of my life'. Yes, I still need to live a happier life, even after everything" (Participant 6, I-187). She not only made peace with her past, but also expressed a greater appreciation for life and recognised new possibilities. For example, for the first time since her husband's death,

she was excited to enter a new romantic relationship. Noticing the meaning in her life probably enhanced her life satisfaction and SWB. This is supported by the literature which indicates that finding purpose and meaning in life contributes towards life satisfaction and SWB, especially in the context of trauma (Bannink, 2008; Jayawickreme & Blackie, 2014; Tedeschi & Calhoun, 2004; Triplett et al., 2011).

A significant change in the participant's perception of herself was also noted. At the start of therapy, Participant 6 viewed herself as a failure as she felt she was not doing enough for her siblings and son. She doubted herself and lacked confidence in various contexts. However, as therapy progressed, she r*ealised that she was a good person and was worthy*: "I'm a mother—that's what I would tell myself. I'm a mother; I'm a woman who can raise, not only my son, not only my siblings, but even the society as well, ja—that's me" (Participant 6, S1-631). She not only discovered her worth and purpose, but also became aware of her strengths and the small things she was already doing for her family. The participant specifically noted that she was working and providing for her family, setting a good example, and was supporting them to finish school. Consequently, she referred to herself as a "brave, strong woman". It is thus conceivable that the participant's shattered assumption of being worthy and competent was restructured during the therapy (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). According to Diener, Scollon et al. (2009), finding purpose and meaning in life also contributes to the cognitive component of SWB. It is also therefore plausible that Participant 6's positive evaluation of herself might have enhanced her life satisfaction and SWB.

Participant 6 emphasised that *therapy opened her eyes* as it not only made her realise life goes on, but also gave her courage to face the world and live again. This is evident in the following extract:

> But after we spoke, ja—that's when I opened my eyes—that's when my eyes was starting to open and I could see that there is life, even after what happened, ja. I can still live longer, ja—it's not the end of the world. (Participant 6, I-132)

Therapy furthermore changed the view she had of herself, as it made her aware of her strength and competence. It is thus suggested that SFBT contributed to Participant 6's experience of life satisfaction and SWB. The participant's experience echoed previous studies which indicated that SFBT contributes towards healing and

growth by communicating that although the traumatic past cannot be changed, the future can still be filled with success and satisfaction (Froerer et al., 2009, 2018; Griffin, 2015; Hopson & Kim, 2004).

Theme 4: How therapy helped

Participant 6 experienced therapy as positive and highlighted how it helped her. First, she indicated that it was beneficial for her to *talk about her past trauma*. This is illustrated by the following quote:

> It [talking about participant's past] was helpful, because I think—at that time, I feel that pain—but I feel that pain for good, for once and for good. And then I'm no more feeling the pain at all. Now I'm facing the world, ja—trying to build up my life. (Participant 6, I-105*)*

Talking about her trauma not only relieved her pain, but also helped her to make peace with the past to start building her future. She also noted that being able to talk about her problem made her feel accepted. Although SFBT is often criticised for being overly positive, optimistic, and dismissive of clients' problems, Participant 6's experience highlighted that SFBT is not problem-phobic. Rather, SFBT therapists empathically validate and acknowledge clients' problems, while shifting the focus of the conversation towards solutions (Bavelas et al., 2013; Froerer et al., 2018; Ratner et al., 2012).

Second, she found it useful to imagine and *talk about a happy version of herself*, because it reminded her of past happiness and encouraged her to become that person: "It [imagining a happy self] helps me to gain the strength again to say 'yes, I am doing it—but then I have to do it more', ja" (Participant 6, I-157). Being asked about her happiness also made the participant feel that the therapist was genuinely concerned about her well-being. Furthermore, talking about a happy version of herself sparked positive emotions and motivated her to do more things that make her happy. Participant 6's experience echoed the literature indicating that strength- and resource-orientated questions contribute towards positive outcomes in SFBT as it directs clients to look for positive change and personal strengths and resources (Carr et al., 2014; Lloyd & Dallos, 2006, 2008; McKeel, 2012; Simon & Nelson, 2005). In the context of trauma, this specifically instils a sense of hope and confidence within clients regarding their future (Froerer et al., 2009, 2018; Ogunsakin, 2015).

Finally, Participant 6 highlighted the value of an e*mpathic and non-judgemental stance in therapy*. She specifically experienced the therapist as being kind, friendly, and attentive. She was surprised by the empathy and acceptance she received in therapy, but it nevertheless helped her to trust the therapist and be open in therapy. This is evident in the following extract: “The way we spoke and the way you just accepted me, ja. You were just—you were so kind, you were so friendly—so that I can be freely too, talking more and more” (Participant 6, I-59).

Being accepted in therapy also made her feel like a human being, which enhanced her confidence. In addition, it made her realise that she is on the right path towards her goal. This empowered her to take additional steps forward. In agreement with Participant 6’s experience, the literature identifies the therapeutic alliance between the client and the therapist as the central and key component of SFBT. It highlighted that this process is fostered by the respectful and non-judgemental stance SFBT therapists take (Carr et al., 2014; Froerer & Connie, 2016; Lloyd & Dallos, 2008; Simon & Nelson, 2005).

5.3.1.6.4 Quantitative data results

For the purpose of triangulation, Participant 6’s levels of hope, SWB, and psychopathology before and after exposure to SFBT were compared using various measuring instruments. These results are presented in Table 16.

Table 16: *Hope, subjective well-being, and psychopathology experienced by the participant in Case Study 6*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	30	41
Scale of Positive Experience (SPANE-P)	10	12
Scale of Negative Experience (SPANE-N)	15	6
Satisfaction with Life Scale (SWLS)	10	22
Patient Health Questionnaire (PHQ-9)	10	0
Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V (PCL-5)	48	14

Table 16 indicates that Participant 6’s score of *hope,* as measured by the AHS, was higher after exposure to SFBT. She also experienced an increase in both the

affective and cognitive components of *SWB*. According to scores measured using the SPANE, Participant 6 displayed more positive affect (SPANE-P) and less negative feelings (SPANE-N) after therapy. Her scores on the SWLS also suggested enhanced life satisfaction after exposure to SFBT. Before therapy, she had reported being dissatisfied with her life; but she felt relatively satisfied with life after therapy (Diener et al., 1985).

Considering *psychopathology*, Participant 6 experienced a decrease in depressive and PTSD symptoms after exposure to SFBT. Before therapy, she displayed moderate symptoms of depression, as measured using the PHQ-9. However, she reported no depressive symptomology after therapy (Kroenke et al., 2001). Participant 6's score on the PCL-5 also suggested a provisional PTSD diagnosis before the start of therapy. However, after exposure to SFBT, she scored below the suggested PTSD cut-off score (≥ 33) (Weathers et al., 2013). Participant 6's improvement in psychopathological symptoms after therapy thus suggests an increase in her experience of well-being (Keyes, 2002).

5.3.1.6.4 *Evaluative summary*

The above-mentioned findings suggest that SFBT contributed to Participant 6's experience of hope and SWB. According to the themes emerging from thematic analysis, therapy helped her move towards a better future and to feel good. Therapy also opened her eyes and made her realise life goes on. Participant 6 specifically noted that the following aspects of therapy contributed towards her experience: imagining a happy self, talking about her past, and experiencing empathy and acceptance in therapy. These qualitative results are supported by quantitative data which suggest higher levels of hope, positive affect, and life satisfaction after exposure to SFBT. A decrease in negative affect and psychopathological symptoms was also evident after therapy.

5.3.1.7 Case Study 7

5.3.1.7.1 *Background information*

Participant 7 is a 41-year-old black female client who presented with depressive symptoms after experiencing several traumatic events. She not only had lost her father a few years ago, but had also recently lost her job and separated from her life partner. However, according to the assumptions of SFBT, no further details regarding the

trauma were obtained (Bavelas et al., 2013; De Jong & Berg, 2007). At the time of therapy, Participant 7 was unemployed and took care of her two young daughters which contributed to additional stress. Although her first language is isiZulu, therapy was conducted in English as the participant showed adequate language proficiency and has a tertiary qualification. Participant 7 attended two SFBT sessions, whereafter a semi-structured interview was held for the participant to share her experience of therapy. Although the participant attended a follow-up session after the interview, this session was not considered for research purposes.

5.3.1.7.2 *Description of the Solution-Focused Brief Therapy process*

Session 1

This session started with the therapist introducing herself to Participant 7 and providing a brief explanation of SFBT, emphasising the collaborative, brief, and goal-orientated nature of the approach. Thereafter, the therapist immediately entered the *desired outcome room* by establishing the participant's best hope for the session. Participant 7 indicated that she hoped to find the light within herself again and gain perspective. This desired outcome thus guided the participant and therapist through the remainder of the session.

The therapist opened the door to the *resource room* to get to know the participant's resources and strengths, instead of her problem. Participant 7 instantaneously lit up as she started talking about her passion for helping others, and community upliftment projects she is involved in. The therapist showed specific interest in this, by inquiring about the personal strengths and skills the participant utilises to successfully implement these projects. During this conversation, the participant indicated that these projects not only give her joy and remind her of her purpose in life, but also motivate her to move forward, as she indicated:

> So that [community projects], at the moment, is what's keeping me going—waking me up in the morning... ja, I think, basically I know that I've been put on this earth to be a giver of sorts—and that's what I basically do every day of my life. (Participant 7, S1-37)

Participant 7 also highlighted that her children motivated her to keep going, despite the challenges she experienced. The therapist therefore amplified the participant's ability to cope amidst the challenges by inquiring about the strengths

which helped her to cope. During this conversation, Participant 7 noted that the challenges not only empowered her, but also instilled a sense of gratitude within her: “I have a lot of gratitude—I feel very grateful for this situation, ja, it’s been an eye opener” (Participant 7, S1-258).

With the participant’s resources in mind, the therapist entered the *preferred future room* by asking a scaling question (Froerer et al., 2018) to measure the participant’s progress towards her desired outcome. Participant 7 indicated that she was at *five* on this scale, but appeared motivated to move higher: “And ja—enough of the pity party and let’s get up and get going again” (Participant 7, S1-106). The therapist thus obtained a description of what would be different when she moved another step higher on this scale. Participant 7 painted a picture of herself being relaxed and happy, sleeping better, being more productive, and having pride within herself. In response to relational questions (Froerer et al., 2018), Participant 7 also indicated that others, especially her daughters, would notice that she was more relaxed, playful, and engaging.

Taking into consideration the progress the participant had already made, the therapist asked an exception-finding question (Froerer et al., 2018) to identify moments in the past when she noticed herself being higher on this scale. Participant 7 identified this as an “aha moment” as she noticed the steps she was taking forward. This further enhanced her motivation to move forward and gave her some hope: “So now that I can do small things that give me simple pleasures again, I can see that I’m on my way again” (Participant 7, S1-468). At that point, the therapist entered the *closing room*, by suggesting that the participant should notice when she is one step higher on the scale. Participant 7 indicated that the question about her best past self, was particularly useful, as it sparked introspection. She thus requested that another appointment be scheduled for a week later.

Session 2

Concurrent with the hopeful principles of SFBT (Bavelas et al., 2013; De Jong & Berg, 2007), the therapist started this session in the *resource room* by asking the participant what is better since the last session. Participant 7 indicated that she was more relaxed and focused and that she had gained perspective regarding the challenges she was facing at that stage: “It’s made my current situation a little bit

better—in realising it's just a season in my life, it's not life-defining and it's not what my life will plan out to be for the rest of my days" (Participant 7, S2-42).

In response to relational questions, the participant also indicated that her daughters and best friend had noticed she was more relaxed and playful, which had a positive effect on them. The therapist amplified this change by inquiring how the participant made it happen and what strengths she relied on. According to Participant 7, remembering her past self then sparked a drive within her which not only made her realise her worth, but also motivated her to make changes: "That little fire—just that little fire in me, that was still burning—very low, but still there. That made me realise there's more to me and there's more that I have to offer" (Participant 7, S2-158).

At that point, the therapist asked a scaling question to measure the participant's progress towards her desired outcome of having light and perspective. Participant 7 reported that she had moved to *five and a half* (compared to a *five* in the previous session). The therapist acknowledged the small steps she had taken forward and entered the *desired outcome room*, by asking the participant what they should talk about to make the session worthwhile. In this room, Participant 7 shared some of the relationship challenges she was busy facing and the effect this difficulty had on her. Although the therapist validated and acknowledged the participant's experience, strategic questions were asked to elicit the participant's desired outcome. Participant 7 indicated she hoped to remain calm when she faced her ex-partner.

This desired outcome thus guided the participant and therapist into the *preferred future room*. Here, the therapist asked an exception-finding question to identify moments in the past where the participant had remained calm, irrespective of her partner's behaviour. As Participant 7 had difficulty recalling moments like this and continued to highlight her partner's wrongdoings, the therapist inquired about other stressful situations where she was able to stay calm. The participant reported that she remained surprisingly calm at a time when she and her (since deceased) father had experienced conflict. She also mentioned being calm before competing in swim galas at school. The therapist therefore asked questions to obtain a detailed description of these moments, focusing on the strengths and resources the participant relied on to remain calm. Participant 7 mentioned specific communication and distress tolerance skills, and the ability to stay focused and in control. After this conversation, the

participant not only expressed a strategy to accomplish her desired outcome, but appeared hopeful concerning the outcome of her plan: “And I’m just saying to myself ‘ok, I’m going to keep calm, say as little as possible, try and stay on [the] message’—and hopefully not get worked up” (Participant 7, S2-671).

On that note, the therapist opened the door to the *closing room,* by announcing the end of the session. In line with the new directions in SFBT (Bavelas, et al., 2013; Connie & Froerer, 2020; Froerer & Connie, 2016; Froerer et al., 2018; McKergow, 2016), no feedback or suggestions were provided by the therapist. As requested by the participant, another appointment was scheduled for a week later. However, before the start of the third session, the therapist and participant collaboratively decided to rather conduct the semi-structured interview and continue therapy thereafter, due to the possibility of the participant finding employment and not being able to continue therapy. After the interview, Participant 7 was consulted for another session where she reported further improvement. Not only was she more relaxed, focused, and productive, but also reported having better relationships with her family and friends. She furthermore reported being at *six* on the progress scale. However, this session was not considered for data analysis.

5.3.1.7.3 *Emerging themes*

A detailed within-case analysis of Participant 7’s transcripts revealed four distinct themes, each with interrelated sub-themes (see Table 17).

Theme 1: Rebuilding my life

Participant 7 entered therapy with a *drive to rebuild her life*: “So, ja—I’m willing to fight hard again and rise again” (Participant 7, S2-219). Although she had experienced a slump in her life over the preceding three years, she had recently decided to “get up and get going again” based on her belief that she is capable of more. She referred to this drive as a “small fire” within her that refuses to die. According to Snyder’s (2000) hope theory, Participant 7’s perceived energy to initiate and maintain movement along a specific pathway can be described as agency thinking which is the motivational component of hope.

Table 17: *Themes and sub-themes emerging from the within-case analysis of Case Study 7*

Theme	Sub-theme
Rebuilding my life	Drive to rebuild my life External sources of motivation Finding steps to rebuild my life Therapy helps me to rebuild my life
Feeling better	Feeling relaxed In control of emotions Connections make me feel good
Different perspective	I still have worth and purpose Life is still good Seeing the bigger picture Therapy gives me perspective
How therapy helped	Therapeutic conversation Collaborative nature of therapy Non-judgemental stance in therapy Remembering strengths instead of pain

Participant 7 *attributed her drive primarily to external sources* such as her family and friends, as well the community projects she is involved in. She reported that looking at her children sparked her motivation to rebuild her life. This is evidenced in the following quote:

> Towards the end of the year, I woke up one night and I looked at my kids in the bed and I said 'you deserve better—I need to be a better me, so that I can give you a better chance in life'. And I think that's where the light came on—sparked back again. (Participant 7, S1-113)

Bernardo (2010) describes this as an external locus-of-hope because external forces act as agents of goal attainment cognitions. According to Bernardo, collectivistic cultures, such as the African society, are more likely to experience this form of hope.

Before therapy, Participant 7 had already taken *steps to rebuild her life* as she assisted children in her community with homework and was in the process of opening her own swimming school. As therapy progressed, Participant 7 took further steps to rebuild her life. She not only socialised more and engaged in pleasurable activities, but also pursued other business opportunities. The participant was also able to alter her steps when her initial plan towards her goal was blocked: "You know when you are accustomed to a certain lifestyle and things don't happen that way anymore, you

know—and you have to find [other] ways" (Participant 7, S1-220). The participant not only adjusted her lifestyle, but also found creative ways to implement her community projects, despite financial challenges. Participant 7's perceived ability to identify strategies or useable routes to obtain her desired outcome, and the ability to change these routes in the face of impediments, reflected pathways thinking (Snyder, 1994, 2002).

Participant 7 furthermore highlighted that *therapy had helped her to rebuild her life* as it provided her with tools and strategies to tackle her current situation and move forward. This is evident in the following quote: "And [through therapy] learning that, without certain things in life…how to then manoeuvre my way forward again" (Participant 7, I-91). Therapy also helped her to stay focused and motivated, which encouraged her to fight harder for herself. It is thus suggested that SFBT enhanced the participant's experience of hope as it contributed both to pathways and agency thinking. Participant 7's experience was supported by literature that indicates that SFBT helps clients identify clear, concrete outcomes; formulate solutions; and generate behavioural correlates to attain these outcomes. By highlighting clients' abilities to make things better, SFBT also motivates clients towards further action (Blundo et al., 2014; Michael et al., 2000; O'Hara, 2013; Quick & Gizzo; 2007; Reiter, 2010).

Theme 2: Feeling better

Prior to therapy, Participant 7 noticed an improvement in her mood and other depressive symptoms (e.g. anhedonia, appetite, insomnia, and energy level). However, at the start of therapy, she still felt slightly depressed and emotional. She also reported feeling tense, irritable, and angry, especially towards her ex-partner. As therapy progressed, she indicated that she is *feeling more relaxed*, calm, and focused. According to her, other people also noticed that she was now less stressed and uptight: "I think a more relaxed me—ja, I think she [participant's daughter] could sense that I'm not as uptight as I normally have been over the past months" (Participant 7, S2-61). Participant 7's experience of increased positive affect and decreased negative affect can be described as the affective component of SWB (Diener, 1984).

Participant 7 also noted that she was now more *in control of her feelings*, despite external influences. She indicated that she took ownership of her emotions

and no longer allowed other people to dictate how she felt. According to literature, the participant's ability to maintain relative emotional stability may have contributed to her experience of affective well-being. Studies also suggested that locus of control is associated with SWB (DeNeve & Cooper, 1998; Diener et al., 1999; Kuppens & Verduyn, 2017).

Participant 7 reported that *connecting with others and/or a higher power allowed her to feel good*. She specifically noted that she obtained joy from giving and helping others: "It gives me the ultimate joy—to be able to put a smile on someone's face means everything to me" (Participant 7, S1-46). Initially, she had neglected these connections and described herself as living in a cave. However, she later broke down her walls and started socialising, networking, praying, and meditating again, and this made her feel better. Participant 7's investment in her connections and/or relationships may thus have contributed to her experience of SWB. This notion is supported by studies highlighting the importance of social support and healthy interpersonal relationships in relation to SWB (Tov & Diener, 2013). As expressed by Participant 7, collectivistic societies specifically experience happiness by fulfilling goals that are directed at pleasing or receiving approval from others (Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013).

Theme 3: Different perspective

Participant 7 entered therapy viewing herself as worthless. She also felt that she had disappointed herself, her family, and her children. She was thus overwhelmed by the situation she found herself in and struggled to look beyond her challenges. However, as therapy progressed, she *realised that she still had worth and purpose*: "I wake up and I look at myself and tell myself 'your beautiful, your valuable, you have a lot to contribute—keep going'" (Participant 7, S2-112). She specifically noted that she finds purpose and meaning in the community projects she is involved in. This illustrates how the participant's shattered assumption of being worthy and competent were restructured during the course of therapy (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). Participant 7 also found it deeply satisfying to impart a skill to somebody. Her experience thus concurs with Diener, Scollon et al. (2009) who argued that meaning and purpose contribute towards life satisfaction.

Participant 7 also started to *view her life as good*, despite the trauma she had experienced: “I just realised that it’s important to... nurture the good that is there—and to appreciate and be grateful for the good that is there and not always look on the dark side” (Participant 7, I-371). She specifically expressed being grateful for her upbringing, the support she continued to receive from her family and friends, and for her children. According to Diener’s (1984) tripartite model of SWB, Participant 7’s positive evaluation of her life may have contributed to the cognitive component of SWB, namely life satisfaction.

According to Participant 7, this new positive perspective concerning herself and her life stemmed from the fact that she started *seeing a larger perspective*. She realised, in particular, that her current situation was not life-defining; but rather a season in her life. She also discovered that her income or financial status did not equate to her worth and value. This is evident in the following quote:

> I think it’s given me a different perspective on life...that you can be someone, even if you don’t have the financial backing. It doesn’t mean that if that changes, that completely alters who I am as a person. (Participant 7, S2-28)

It is suggested that Participant 7’s ability to see the bigger positive picture of her life may have contributed to her experience of SWB. The literature shows broader attentional focus and flexibility are associated with higher levels of SWB. The tendency to selectively attend to positive information specifically appears to contribute positively towards SWB (Compton et al., 2004; Gasper & Clore, 2002; Robinson & Compton, 2008).

Participant 7 furthermore highlighted that *therapy gave her perspective* as it not only reminded her of her resilience and purpose, but also encouraged her to look differently at life: “It [the therapy] helped me to look more positively at my situation and wanting me to fight harder for myself” (Participant 7, I-204). According to the participant, therapy sparked introspection which helped her to notice things she previously did not pay attention to. Therapy also made her pause, step back, and think about the outcome she desires before responding to people and situations. This not only helped her to see the bigger picture, but also assisted her to deal more effectively with current challenges. Participant 7’s experience echoed research indicating that SFBT shifts clients’ focus towards a better future and instils confidence within

individuals. This in turn motivates and empowers clients towards further progress (Froerer et al., 2009, 2018; Ogunsakin, 2015).

Theme 4: How therapy helped

Participant 7 experienced therapy as positive and described several ways of how it helped her. First, she highlighted the importance of the *therapeutic conversation*. According to her, this not only allowed her to honestly express her feelings, but also sparked introspection. The participant indicated that the conversation between herself and the therapist gave her homework to think about, which resulted in therapeutic change. This is evident in the following quote:

> I think it starts here. And then—you know, in my quiet moments, when I reflect on my day or my daily progress, my daily checklist—that's when I've noticed the change. But it's always from the conversation—our conversations that linger on in my head afterwards. (Participant 7, I-322)

Participant 7 specifically mentioned that relational questions involving her children were beneficial as it gave her perspective. She furthermore noted that having a conversation with an objective professional made it easier for her to express herself. Participant 7's observation concurs with the literature identifying the collaborative language process between the client and the therapist as the central and key component of SFBT. Studies specifically identified the co-construction of meaning as a linguistic method that is useful for building solutions with clients (Franklin et al., 2017; Froerer & Connie, 2016).

Second, as can be anticipated, the *collaborative nature of therapy* also stood out for the participant. Although she did not expect collaboration in therapy and, initially, found it a bit frustrating; she got more comfortable with the approach and ultimately experienced it as positive. According to her, it pushed her to start thinking for herself again and therefore empowered her to find answers within herself. The participant also noted that, because she knows herself best, she would probably have shown some resistance if the therapist had instructed her on what to do. This is evident below:

> I think maybe—being very stubborn natured. I would have had some resistance, you know—because I might not have necessarily thought this is the right answer for me. But I think me working through, with you, to get to the answers myself, has been more helpful. (Participant 7, I-446)

Participant 7's experience reflected the assumption of SFBT that clients are the experts of their own life and have the resources, skills, and competencies to resolve their own problems. The role of the therapist is merely to help clients identify what they want and move closer to that desired outcome (Bavelas et al., 2013; De Jong & Berg, 2007). Previous qualitative studies have also suggested that collaboratively involving clients during the therapeutic process and allowing them ownership of the therapeutic change is a useful aspect of SFBT (Carr et al., 2014; Lloyd & Dallos, 2008; Simon & Nelson, 2005).

Third, Participant 7 noted the value of a *non-judgemental stance in therapy* as it made her feel comfortable to express her feelings: "So I think that's been helpful in that sense—being able to just voice myself, without fear of judgement and criticism" (Participant 7, I-71). The participant specifically described the therapist as relaxed and welcoming and indicated that she did not feel judged for thinking or feeling the way she did. Participant 7's experience concurs with the literature emphasising the importance of the non-judgemental, respectful, and curious stance in facilitating therapeutic change in the SFBT process (Carr et al., 2014; Froerer & Connie, 2016; Lloyd & Dallos, 2008; Simon & Nelson, 2005).

Finally, Participant 7 indicated that it was helpful to *remember her past and present strengths, instead of the pain and trauma* she had experienced. Focusing on her strengths not only reminded her of who she is, but also guided and motivated her to rebuild her life. Remembering past instances of coping furthermore provided her with tools to tackle current challenges: "Just remembering the old me and wanting to get back to that person again made me realise when I did those things, it did me the world of good" (Participant 7, S2-128). According to the literature, strength- and resources-orientated language contributes towards positive outcomes in SFBT sessions. It not only shifts problem-orientated conversations towards solution-focused talk, but also emphasises clients' strengths and instils a sense of hope in therapy (Franklin et al., 2017; Froerer & Jordan, 2013; Froerer et al., 2009, 2018; Lloyd &

Dallos, 2006; Jordan et al., 2013; McKeel, 2012; Ogunsakin, 2015; Tomori & Bavelas, 2007).

According to Participant 7, it would have been painful to remember her past trauma: “Sometimes it’s just painful to relive experiences—so I think it would have been a bit difficult, a bit challenging to relive certain things” (Participant 7, I-489). She observed that since she cannot change the past, it was more useful to focus on her response to the trauma and how she wants her trauma story to end, instead of talking about the trauma details. Participant 7’s experience also highlighted that dwelling on the details of adverse events may amplify clients’ deficits, which is counterproductive for growth (Von Cziffra-Bergs, 2018).

5.3.1.7.4 *Quantitative data results*

For the purpose of triangulation, Participant 7’s levels of hope, SWB, and psychopathology before and after exposure to SFBT were compared using measuring instruments. These results are presented in Table 18.

Table 18: *Hope, subjective well-being, and psychopathology experienced by the participant in Case Study 7*

Scale	Pre-test score	Post-test score
Adult State Hope Scale (AHS)	36	43
Scale of Positive Experience (SPANE-P)	18	23
Scale of Negative Experience (SPANE-N)	26	14
Satisfaction with Life Scale (SWLS)	10	21
Patient Health Questionnaire (PHQ-9)	24	2
Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-V (PCL-5)	44	22

Table 18 shows that Participant 7 experienced more *hope,* as measured by the AHS, after exposure to SFBT. She also experienced an increase in both the affective and cognitive components of *SWB*. According to scores measured using the SPANE, Participant 7 not only displayed higher positive affect (SPANE-P), but also reported a decrease in negative affect (SPANE-N) after therapy. She furthermore experienced enhanced life satisfaction as measured by the SWLS. Prior to therapy, she indicated

that she is was dissatisfied with her life; while she felt slightly satisfied with life after therapy (Diener et al., 1985).

With regards to *psychopathology*, Participant 7 experienced fewer symptoms both for depression and PTSD after exposure to SFBT. Before therapy, she showed severe symptoms of depression as measured by the PHQ-9. However, according to this measure, she did not meet the diagnostic criteria for depression after therapy (Kroenke et al., 2001). Before therapy, Participant 7's score on the PCL-5 also suggested a provisional PTSD diagnosis. However, after exposure to SFBT, she scored below the suggested PTSD cut-off score (≥ 33) (Weathers et al., 2013). Participant 7's improvement in psychopathological symptoms after therapy thus suggested an increase in her experience of well-being (Keyes, 2002).

5.3.1.7.5 *Evaluative summary*

From the above-mentioned results, it can be concluded that SFBT contributed to Participant 7's experience of hope and SWB. According to qualitative data, therapy helped her to rebuild her life and gave her perspective. Consequently, she also felt better. Participant 7 highlighted that the therapeutic conversation; remembering strengths, instead of pains; the collaborative nature; and the non-judgemental stance of therapy specifically contributed to this experience. These findings were supported by quantitative data which indicated higher levels of hope, positive affect, and life satisfaction after exposure to SFBT. A decrease in negative affect and psychopathology was also evident after therapy.

5.3.2 Between-case analysis

The above-mentioned section provided a detailed description and discussion of the experience of hope and SWB for each of the seven case studies, emphasising the aspects of SFBT that contributed to this experience. The following section aims to provide a detailed between-case analysis of the seven cases, highlighting and discussing case similarities and differences. The analysis allows the researcher to generalise research findings across cases and provides an in-depth understanding of the experience of hope and SWB among this group of trauma survivors (Miles et al., 2014). The information is aimed at guiding and informing the development of an SFBT intervention model that facilitates hope and SWB among trauma survivors at community clinics.

The between-case analysis revealed four distinct themes, each with interrelated sub-themes. These themes and their interrelated sub-themes are summarised in Table 19 and are described below. Meta-matrices for each of these themes, highlighting the differences and similarities between cases, are provided in Appendix G (Miles et al., 2014).

Table 19: *Themes and sub-themes emerging from between-case analysis of all case studies*

Theme	Sub-theme
Moving towards a goal	Motivation and confidence to move towards goal Source of motivation Steps towards goal Hope for a better future Therapy helps me move towards goal
Feeling good	More positive than negative feelings Controlling and expressing feelings Feeling good starts with me Relational factors make me feel good Therapy helps me feel good
Life is good	Life after trauma Grateful for things in life I am good and worthy Therapy changes my perspective on life
How therapy helped	Therapeutic conversation Empathy and acceptance in therapy Visualising a better future Focusing on strengths Talking about trauma

5.3.2.1 Theme 1: Moving towards a goal

Most participants entered therapy with *motivation and confidence to move towards a goal* they envisioned for themselves: “I have this drive in me…that I can do more” (Participant 3, S1-344). Initially, Participant 1 lacked motivation, which may be ascribed to the depressive symptoms and hopelessness she was experiencing (Ritschel & Sheppard, 2018). However, as therapy progressed, she gained motivation and confidence in her ability to initiate and maintain movement towards her goal: “If I keep on doing good things—yes, I will stay at ten” (Participant 1, S3-399). This increase in motivation and confidence were observed among all participants, except Participant 7. The fact that the semi-structured interview with this participant was conducted before the therapeutic process was completed, might have influenced her

experience. The participants seemed to perceive energy to initiate and maintain movement towards their respective goals. For the majority of participants, this perception became stronger as therapy progressed, which suggests an increase in agency thinking or the motivational component of hope (Snyder, 1994, 2002).

Most participants attributed their *source of motivation* to external factors, such as friends, family, and their children: “Then I’ll think of my sons—for them, let me—even if I’m just pulling myself, but I have to, I can’t give up” (Participant 4, S1-442). Some participants (2, 5, and 6) also noted that their spirituality gave them strength to move towards their goal, while another mentioned involvement in community projects as a source of motivation: “Currently I’m working at opening a swimming school. So that, at the moment, is what’s keeping me going—waking me up in the morning” (Participant 7, S1-36). Bernardo (2010) describes this as an external locus-of-hope as family, peers, and spiritual forces acted as agents of goal attainment cognitions. According to Bernardo, this form of hope is frequently observed among collectivistic cultures, such as the African culture the participants belong to. Participants’ experiences also concurred with the literature that highlights the importance of spirituality, religiosity, and building connections to something bigger than oneself, when conceptualising hope (Dufault & Martocchio, 1985; Farran et al., 1995; Isaacs & Savahl, 2014; Peterson & Seligman, 2004; Scioli et al., 2011). Studies conducted in Africa have suggested that pathways thinking is strongly influenced by an individual’s faith and belief in God, as it enables them to achieve their goals (Asamoah et al., 2014; R. Li et al., 2010).

Although Participant 4 initially referred to her children as a source of motivation, she later attributed her drive to the progress she was making: “I was starting to do like those small things—I was starting to reach that picture that I always had. So yeah, it motivated me to like push forward and still wanna do more” (Participant 4, S1-394). According to hope theory, this can be explained by the fact that successful goal attainment and the resultant positive emotions enhanced her agency thinking through an interrelated system of positive feedback (Snyder, 2000, 2002; Snyder et al., 2018). As therapy progressed, this participant seemed to show a stronger internal locus-of-hope as her agency thinking was anchored in her own capabilities and actions (Bernardo, 2010). This might be explained by the autonomous perspective she

acquired, as people with an independent self-construal are more likely to display an internal locus-of-hope (Du & King, 2012).

Before therapy, some participants (2 and 7) had already taken *steps towards their goal* and they continued this movement during the therapeutic process. This might be explained by the improvement in their depressive symptomology before therapy had commenced. According to the literature, depression is often associated with cognitive deficits, such as impaired executive functioning and slower processing speed which may restrict an individual's ability to follow a stepwise plan to achieve a goal (Ritschel & Sheppard, 2018). Depressed individuals are also inclined to be more pessimistic regarding the possibility of achieving their goals, feel that they have less control over the outcome of their goal pursuits and have lower intrinsic motivation towards approach-orientated goals (Dickson et al., 2011; 2013; Winch et al., 2015). This might also be the reason why other participants initially lacked a clear way or strategy to move forward. However, as therapy progressed, all participants found and took steps toward their goal: "I think something that will help myself better in a way that—how to run a business, go to those seminars, learn how to cook better. I think those things will make me feel much better. Not staying at home" (Participant 3, S1-566).

Amidst financial and situational challenges, participants 4 and 7 were also able to alter their initial plans and identified alternative steps towards their goal: "You know when you are accustomed to a certain lifestyle and things don't happen that way anymore, you know—you have to find [other] ways" (Participant 7, S1-220). According to Snyder's (2000) hope theory, the participants' perceived ability to identify strategies or useable routes to obtain their desired outcome and the ability to alter these routes in the face of impediments can be described as pathways thinking. As all participants were able to identify and take steps towards their goal, it thus appeared that their pathways thinking was enhanced during therapy.

As therapy progressed, participants expressed *hope for a better future*. They not only expected a positive therapeutic outcome: "Because there should be—in seven days a lot happens—there should be a difference" (Participant 2, S1-677), but also had a positive future expectation: "My life is BRIGHT—there is brightness in my future, I can see the light and I can see where I'm going" (Participant 5, S2-306). According

to Snyder's (2000) hope theory, the participants' experience of hope may thus be attributed to their movement towards successful goal attainment. As Participant 7 was the only participant who did not mention hope for a better future, this might be attributed to the fact that her interview was conducted before the therapeutic process was completed. It is thus proposed that therapy contributed towards participants' experience of hope.

This is evident in participants' notion that *therapy helped them to move towards their goal.* According to them, therapy helped them find solutions within themselves, which contributed to their experience of hope:

> So now, the therapy helped me—even though things might fall apart, I have the solution in me—I need to solve it, then move forward—yeah. So now I have hope that 'yes, I will face setbacks, but I have the solution in me' and in the end I'm gonna achieve the goal. Now I am hopeful. (Participant 4, I-444)

Participants also mentioned that therapy unlocked their motivation and confidence to move towards their goal which created a positive expectation regarding the future: "Coming here helped me a lot. That no, I can do the things—and I'll be better—and there's going to be a change" (Participant 3, I-569). Some participants specifically mentioned that realising they are on the right path towards their goal sparked their motivation and confidence: "My confidence—I didn't lack confidence before—but now, after the therapy session, it made me realise I was on the right path" (Participant 2, I-339). Similarly, being reminded of their goal and remembering past success increased their motivation and confidence to move towards their goal. They furthermore noted that therapy reminded them of their respective sources of motivation, such as their children, which gave them hope: "But after that therapy—you said I must be strong for my kids... that gave me hope—my kids" (Participant 1, I-187).

It is plausible that SFBT not only helped participants move towards their goal, but also contributed to their experience of hope by enhancing their agency and pathways thinking. This was facilitated by clarifying their goal, reminding them of past success, helping them find solutions within themselves, and improving their confidence and motivation. This is supported by Snyder's (2000) hope theory which suggests that hopeful thinking emerges in the presence of a meaningful goal which activates an iterative and additive interaction between pathways and agency thinking.

Positive feedback regarding past and present goal pursuits furthermore reinforces pathways and agency thinking which in turn leads to successful goal attainment and ultimately results in hope.

Findings from this study concur with the literature suggesting that SFBT builds clients' hope and creates a positive expectancy for realising their desired outcomes (Blundo et al., 2014; Bozeman, 1999; Michael et al., 2000; Quick & Gizzo, 2007; Reiter, 2010; J. A. Wilson, 2015). For example, studies found that solution-focused questions assist clients to generate action-orientated steps towards their respective goals, which then lead to successful goal attainment and enhanced pathways thinking (Grant, 2012; Green et al., 2006; Neipp et al., 2015). J. A. Wilson (2015) furthermore highlighted that hope is built through a relational process relying on the hopeful SFBT tenants and techniques. In the aftermath of trauma, research suggested that SFBT engenders feelings of hope and empowerment as it assists clients to set clear future goals and shift their focus towards a preferred future where the trauma is resolved. As a result, clients experience confidence to find solutions towards their goals (Bannink, 2008; Froerer et al., 2009, 2018; Hopson & Kim, 2004; Ogunsakin, 2015).

5.3.2.2 Theme 2: Feeling good

During therapy, all participants reported *more positive, than negative feelings.* They not only noted that they were feeling happy, free, and relaxed; but also indicated that they experienced less stress, depression, and anger: "I was so relieved, I felt so, so relieved! You know last time I was so upset, down, crying and all that; but then after—I was so relieved, I'm relieved even now" (Participant 6, S2-12). They furthermore mentioned feeling excited and content, instead of anxious: "I just feel this contentment inside, I feel content. It's no really about leaving the shelter. Yes, I'm excited I'm gonna be leaving the shelter, but I believe the 'old me' would have been nervous about the unknown" (Participant 4, S3-188).

The literature highlights the relationship between positive affect and physical health (Diener & Chan, 2011); similarly, some participants (1, 4, and 7) also noted improvement in their health. Not only did they sleep better and had more energy, but they also experienced fewer headaches: "I am now overcoming this stress. 'Cos last time I was straining myself—a lot of headache or something, but this time, at least I feel I'm strong" (Participant 1, S2-562). Participants seemed to experience more

positive emotions, compared to negative emotions during the therapy process. According to Diener's (1984) tripartite model of SWB, this can be conceptualised as an increase in the affective component of SWB.

As therapy progressed, most of the participants (2, 4, 5, and 7) reported that they were now better able to *control and express their feelings*. For example, they were able to manage conflict and tolerate distress better and developed an internal locus of emotional control: "I think it's taking ownership—taking back ownership of my life and my emotions, and not allowing other people to dictate how I feel" (Participant 7, I-361). Some also indicated that they were now more assertive and confident to express their feelings which made them feel good: "When I am angry, being able to say 'no, listen, I am angry right now'. Or when I'm hurt, be confident enough to [say it]—so I found my voice" (Participant 2, I-339). This may suggest that participants had successfully recovered from their trauma, as trauma exposure is often associated with emotional regulation difficulties, such as reduced emotional awareness, higher levels of emotional suppression, and poor impulse control (Ehring & Quack, 2010).

It is thus proposed that the participants' improved ability to appropriately control and express their feelings contributed to their experience of affective SWB. This is supported by the literature indicating that emotional intelligence (defined as the ability to identify, understand, regulate, and harness emotions in oneself and others) is associated with positive mood (Schutte et al., 2002). The ability to maintain relative emotional stability also appears to be important to well-being. Research furthermore indicated that an internal locus of control, and a tendency to attribute outcomes to oneself rather than to external causes, is related to happiness (DeNeve & Cooper, 1998; Diener et al., 1999; Kuppens & Verduyn, 2017). Studies have also suggested that suppressing emotions, especially negative emotions, may have a detrimental effect on well-being. Not only is this suppression associated with lower levels of life satisfaction and social support, but it may also lead to increased levels of negative feelings such as stress (McMahan et al, 2016; Tamir & Ford, 2012).

Three participants (3, 4, and 5) highlighted that *feeling good starts with themselves*. They not only decided to prioritise their own feelings above those of others, but also started to make themselves happy by setting healthy boundaries. It appears that this independent and agentic mode of living contributed towards their

happiness and well-being: “But now I tell myself that ‘no, I myself, I must be happy—happiness must come first to me, before it goes to the next person’—because how can I make people happy, if I’m not happy” (Participant 5, I-570).

Taking into consideration the collectivistic African culture to which these participants belong, their experience is unexpected. According to the literature, collectivists tend to sacrifice their own desires to obtain social approval (Oishi & Diener, 2001; Oishi & Sullivan, 2005; Suh & Koo, 2008). However, as alluded by the participants, they may consequently sacrifice their personal happiness. The participants’ experience may thus reflect a move towards a western notion of happiness as independence and personal happiness contribute more to SWB among individualistic cultures, compared to collectivistic societies (Diener & Diener, 1995; Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013). However, therapy may also have facilitated these agentic thoughts by encouraging self-expression, self-improvement, and the pursuit of individual goals.

Aside from the consideration of a western notion of happiness, most participants indicated that *relational factors make them feel good*. They highlighted that socialising, spending time with their loved ones and having more fulfilling relationships increased their positive feelings: “I socialised a lot—I was happy!” (Participant 3, S2-50). Some participants also mentioned that their hobbies provide them pleasure, while others noted that they gain happiness from spiritual activities such as prayer and meditation. Participants furthermore emphasised that altruistic behaviour gives them joy: “It gives me the ultimate joy—to be able to put a smile on someone’s face means everything to me” (Participant 7, S1-46). It is thus suggested that social support and engagement in spiritual activities and altruistic behaviour also contributed towards their experience of affective SWB.

This concurs with cross-cultural studies suggesting that collectivistic societies emphasise interconnectedness between the self and significant others when describing SWB. These cultures are thus more likely to experience happiness after fulfilling goals that were directed to pleasing or receive approval from others (Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013). People in collectivist cultures also tend to experience life satisfaction when they have harmonious relationships and spend time with important others (Oishi et al., 1999). The

participants' experiences are further supported by literature that suggests that social support and fulfilling interpersonal relationships contribute towards SWB across cultures (Diener et al., 1999; Tov & Diener, 2013). Diener, Scollon et al. (2009) also reported that participation in religious services, a strong religious affiliation, having a relationship with a higher power, and practising of prayer are associated with higher levels of happiness. It thus appears that although participants valued independence and personal agency, they continued to recognise the importance of interconnectedness when describing happiness.

The majority of participants noted that *therapy helped them feel good.* They emphasised that therapy allowed them to express their feelings during the session: "After we spoke, then that's when I started to be happier—even more. Because, just I poured little bits of my heart to someone—someone try to listen to me, then I was a bit relieved" (Participant 6, I-169). They not only highlighted that therapy empowered them to be more assertive, but also noted that therapy helped them to prioritise their own happiness: "So, it [this therapy] teaches me that the first person that must be happy is me" (Participant 5, I-47). Participants furthermore indicated that therapy reminded them of the things that previously made them feel good, which motivated them to do more of this and consequently enhanced their happiness.

Participants 4 and 7 were the only participants who did not mention that therapy made them feel good. The fact that Participant 7 had experienced an improvement in depressive symptoms before therapy might explain why she did not attribute feeling good to the therapeutic process. For this participant, data were collected before therapy was completed, which could have influenced her experience. Participant 4 reported more positive than negative feelings during therapy, and it is plausible that therapy played an indirect role in increasing positive feelings as it had given her control over her thoughts. This is evident in the following extract:

> So right now, most of our conversation is based on my mind. Yes, there is emotions, but what I think. And I feel the mind it's stronger than the emotions. So ja, I quickly corrected the mind and how the mind thinks—and it was easy for me to control the emotions. (Participant 4, I-580)

It is thus conceivable that therapy contributed towards the affective component of participants' SWB as it increased their positive emotions and decreased negative emotions. This was achieved by helping them gain control over their emotions and encouraging them to express their feelings. Therapy furthermore facilitated well-being by empowering participants to prioritise their own happiness and reminding them of past pleasures.

Previous studies have also suggested that solution-focused questions and techniques increased clients' SWB by increasing positive affect and reducing negative affect (Grant, 2012; Grant & O'Connor, 2010; Green et al., 2006; Neipp et al., 2015; Wehr, 2010). For example, Green et al., (2006) found that, in the context of solution-focused life coaching, the unimpeded pursuit of desired goals led to positive emotions and thus increased clients' well-being. However, Kim, and Franklin (2015) highlighted that SFBT directly elicits positive emotions by assisting clients to describe their goal, envisioning steps towards their goal, and identifying personal strengths and resources to reach their goal. Amplifying exceptions and providing compliments and reflections concerning the client's competent behaviours furthermore generates positive feelings and subsequently contributes towards SWB (Kim & Franklin, 2015).

5.3.2.3 Theme 3: Life is good

As therapy progressed, most participants realised that there is *life after trauma*. They not only accepted trauma as a part of life, but also started looking towards the future for new possibilities: "No, there's nothing I can do, there's nothing I can do about it. So I think I must focus on that one thing that will... make me happy, that will make me prosper, that will make me—new challenges" (Participant 3, S2-285). They also reported personal growth as a result of trauma and were able to find meaning and purpose in their traumatic experiences: "So—as bad as they [challenges] were—they were actually a university for me [laughs]. Because—ja, I learned a lot" (Participant 4, I-313). Participants also realised that their past trauma is not life-defining and therefore concluded that they still have a life to live, despite what they went through: "What happened it happened—but it doesn't mean it's the end of the world or the end of my life. Yes, I still need to live a happier life, even after everything" (Participant 6, I-187).

Participant 1 was the only one who did not refer to life after trauma. This might be explained by the nature of her traumatic experience (death of a spouse) and the

relatively short duration since the event had taken place (less than 8 months). Literature regarding hedonic adaptation suggests that people take 3 months to 8 years to adapt to negative life events. However, the death of a spouse may have a long-term detrimental impact on SWB (Calvo et al., 2015; Lucas, 2005; Lucas & Clark, 2006; Lucas et al., 2003; Suh et al., 1996). Studies furthermore showed that post-traumatic growth, characterised by the recognition of new possibilities following trauma, gradually increases after trauma (Albuquerque et al., 2018; Bannink, 2008; Jayawickreme & Blackie, 2014; Joseph & Butler, 2010; Linley & Joseph, 2004; Reinecke, 2017; Tedeschi & Calhoun, 2004). The majority of participants thus seemed to realise that there is life after trauma as they recognised the bigger picture, shifted their focus towards the future, and found meaning and purpose in their traumatic experience. It is suggested that this new perspective concerning their trauma contributed to their experience of life satisfaction.

This is supported by the literature which indicates that finding a sense of meaning and purpose in life contributes to higher levels of life satisfaction, especially in the context of trauma (Bannink, 2008; Diener, Scollon et al., 2009; Jayawickreme & Blackie, 2014; Karlsen et al., 2006; Tedeschi & Calhoun, 2004; Triplett et al., 2011; Veronese et al., 2017). Researchers have also suggested that a wider attentional focus and attentional flexibility are associated with higher levels of SWB. The tendency to selectively attend to positive information specifically appears to contribute towards SWB (Compton et al., 2004; Gasper & Clore, 2002; Robinson & Compton, 2008). Positive emotions may thus play an integral role in restoring flexible thinking in the context of negative emotional experiences. Studies have shown that positive emotions not only attenuate attentional biases to negative information, but also facilitate cognitive reappraisal, and effective coping (Cohn et al., 2009; Fredrickson & Levenson, 1998; Keltner & Bonanno, 1997; Tugade & Fredrickson, 2004).

Similarly, hope shifts people's attention from fixating on the traumatic event to problem-solving and adaptation (Affleck & Tennen, 1996; Ai et al., 2011; Ciarrochi et al., 2015; Kaye-Tzadok & Davidson-Arad, 2016; Snyder et al., 2002). The literature has also suggested that people with high levels of hope tend to view impediments as useful resources towards attaining their goals and focus on successes, despite failures (Reff et al., 2005; Snyder, 1994; Snyder et al., 2006). Recognising life after trauma

may thus also reflect hope among the participants. As the majority of participants spoke about finding meaning in their lives again, it is plausible that participants' shattered positive assumptions of the world were restructured during therapy (Bolton & Hill, 1996; Janoff-Bulman, 1992).

As therapy progressed, participants also expressed *gratitude for several things in their lives*. They not only noticed everyday blessings, but also reported being grateful for their family: "Because every time I keep on thanking God for giving me such children—my children doesn't give me problem—they are good children" (Participant 5, S2-96). According to Participant 4, gratitude contributed towards a positive evaluation of her life, particularly motherhood: "I don't see motherhood as being difficult, now it's an adventure that I'm looking forward to doing. Now I'm looking forward to waking up and spending time with my kids" (Participant 4, S3-266). As Participant 2 was the only participant who did not refer to gratitude, this may be explained by the fact that she was pregnant at the time of therapy and gave birth three days before the interview. According to researchers, pregnancy and childbirth have a significant impact on life satisfaction. Women of advanced maternal age (32–37 years), such as the participant, may specifically experience altered life satisfaction (Aasheim, Waldenström, Rasmussen, Espehaug, & Schytt, 2014; Luhmann, et al., 2012).

It was observed that most participants seemed to possess a sense of gratitude. This, in turn, led to a positive evaluation of important domains in these participants' lives. This accords with literature suggesting that gratitude is associated with life satisfaction, as it causes people to feel better about their lives (Emmons & McCullough, 2003; Watkins, 2004; Wood, Froh, & Geraghty, 2010). For example, Watkins (2004) found that practising gratitude increases one's enjoyment of blessings and consistently reminds one of how good life is. It also reduces the negative impact of social comparison, as it shifts people's attention from the things they do not have, towards appreciation of the things they do have in life. Furthermore, grateful people tend to make use of effective coping strategies when solving problems; these strategies then help them to successfully deal with problems (Wood et al., 2010).

Participants furthermore started to *view themselves as good and worthy*. Some expressed being proud of themselves for the way they coped with the trauma, while

others noted that they are bigger than their problems: “I tell myself that ‘my problem is not bigger than me—I am bigger than my problem’” (Participant 5, S2-291). Most participants recognised their strengths, worth, and purpose; despite the challenges they encountered: “I really have a purpose here. If I don’t have a babies it means that I have this gift... I’m good at other things” (Participant 3, S2-298). As a result, they viewed themselves as trauma survivors, instead of trauma victims which contributed towards their self-confidence: “I wake up and I look at myself and tell myself ‘your beautiful, your valuable, you have a lot to contribute—keep going’” (Participant 7, S2-112).

Participants thus appeared to develop a positive view of themselves by recognising their ability to cope and discovering their worth and purpose. This illustrates how participants’ shattered assumptions about themselves being worthy and competent were restructured during therapy (Bolton & Hill, 1996; Brewin & Holmes, 2003; Janoff-Bulman, 1992). Believing they are good and worthy may also be indicative of hope, as literature has suggested that high-hope people have a sense of self-efficacy and confidence in their capacity to adapt to difficulties and losses (Ai et al., 2007; Snyder, 1994, 2000, 2002).

It is proposed that participants’ positive self-evaluation contributed to their satisfaction with life. This concurs with Diener, Scollon et al. (2009) who indicated that meaning, fulfilment, and success in life positively contribute to peoples’ global life judgements. The literature furthermore suggests that optimism, self-efficacy, and self-esteem are associated with SWB (DeNeve & Cooper, 1998; Diener et al., 1999). The relationship between self-esteem and life satisfaction specifically appears strong among individualistic countries. However, self-esteem plays a weaker role in satisfaction judgements among members of collectivist cultures, as they tend to value the group above the individual (Diener & Diener, 1995). The participants’ experiences thus reflected a more individualistic view of life satisfaction.

The majority of participants indicated that *therapy changed their perspective* on life. According to them, therapy helped them realise that trauma is a part of life, but that they still have control over their responses: “Therapy made me realise that the [traumatic] experiences are life. So how I react and how I take my [traumatic] experiences, that’s now going to determine what’s going to happen or how now I’m

going to be moving forward" (Participant 2, I-380). Other participants also indicated that therapy helped them shift their focus from their traumatic past towards a future filled with possibilities: "Therapy helped me to look things in a different way. That I am not living for now, I am living for—I must look to the future" (Participant 3, I-113).

Furthermore, most participants indicated that therapy made them aware of their strengths and helped them to discover their worth and purpose in life: "I think the sessions have also reminded me of my resilience—reminded me that I have a purpose and reminded me that I still have a lot that I want to achieve" (Participant 7, I-118). As a result, they developed confidence, and pride within themselves and realised that they are good enough: "You asking me 'what skills [does the participant have]?'—It made me feel 'yeah! I am actually worth more—I am powerful' ... It boosted my confidence! [laughs] ... I am now confident of myself, I am proud of myself" (Participant 4, I-381).

The majority of participants indicated that therapy changed their perspective of their trauma, their lives, and themselves, respectively. This suggests that SFBT contributed towards participants' experience of life satisfaction by instilling a positive perspective. This is supported by literature suggesting that solution-focused questions turn clients' problem perceptions into positive formulations (Froerer et al., 2018). For example, SFBT views a crisis as an opportunity to develop new skills, strengths, and resources and therefore goes beyond returning a client to their pre-crisis state of functioning. SFBT also communicates that, although the traumatic past cannot be changed, the future can still be filled with success and satisfaction that engenders feelings of empowerment in the aftermath of trauma. The emphasis on clients' strengths furthermore instils feelings of self-efficacy, empowerment, pride, and confidence to achieve future goals. This ultimately assists clients to view themselves as trauma survivors, instead of victims (Bannink, 2008; Carr et al., 2014; Griffin, 2015; Froerer et al., 2009, 2018; Green et al., 2006; Hopson & Kim, 2004; Lloyd & Dallos, 2006, 2008; Ogunsakin, 2015).

5.3.2.4 Theme 4: How therapy helped

Participants experienced therapy as helpful, and they identified several aspects that stood out for them. First, they highlighted the importance of the *therapeutic conversation*. They compared therapy to having an open and honest conversation with

someone they know as the therapist listened to them and asked detailed questions about their lives. This authentic nature of the conversation made participants comfortable to express their feelings: “We had a conversation, you know—I relaxed, I spoke, and I was free and I was open.... It didn’t feel like I’m in a session” (Participant 2, I-215).

Some participants (4 and 7) also noted the value of collaboration in the therapeutic conversation. Although initially, this was both unexpected and slightly frustrating to them, it empowered them to find answers within themselves: “It actually trained my mind... even though it frustrated me, but at the end it actually helped” (Participant 4, I-603). Participant 7 also noted that, as she knows herself best, she would probably have shown resistance and not experienced the same therapeutic outcome, if the therapist had told her what to do. Participants furthermore highlighted the value of the therapist’s feedback. According to them, it was positive, honest, based on what they shared with the therapist, and highlighted their strengths and skills. Receiving positive feedback not only reminded them of their worth and purpose, but also made them feel accepted and built their confidence: “As I said, I’ll go back to your feedback—you being honest. Your feedback showed me that you listened to me, so that build my confidence” (Participant 2, I-328).

Second, participants mentioned the importance of *empathy and acceptance in therapy*. Most participants highlighted the value of not being judged, interrogated, or analysed by the therapist. They also noted that the therapist accepted them for who they are and did not try to change them: “You know, you didn’t change me—you didn’t say ‘no stop doing this, do this’—no, you never change me” (Participant 5, I-299). Instead, the therapist displayed empathy by listening and respecting them as well as by showing interest. According to them, the therapist’s kind, friendly, relaxed, and welcoming stance further contributed to the empathic experience: “The way we spoke and the way you just accepted me, ja. You were just—you were so kind, you were so friendly—so that I can be freely too, talking more and more” (Participant 6, I-59).

Experiencing empathy and acceptance in therapy allowed them to feel comfortable about expressing their feelings, and also played a role in the positive perspective they developed of themselves: “You never looked down on me or asked me those [judgemental] questions. If you have asked those questions, I think I would

have felt otherwise about myself" (Participant 3, l-496). Positive modelling, and being accepted and respected in therapy, also encouraged participants to trust and accept other people in their lives. Acceptance furthermore confirmed that they are on the right path towards their goal, which empowered them to take additional steps forward.

It is conceivable that the therapeutic conversation, grounded on acceptance and empathy, played a significant role during the SFBT process. It not only allowed participants to express themselves, but also made them aware of their worth. It furthermore helped them find steps towards their goal and increased their confidence and motivation to reach their goal. The participants' experiences are supported by studies identifying the collaborative language process between the client and the therapist as the key component of SFBT (Carr et al., 2014; Franklin et al., 2017; Froerer & Connie, 2016; Lloyd & Dallos, 2008; Simon & Nelson, 2005). According to Froerer and Connie (2016), this process is synonymous with the therapeutic alliance and is fostered by the respectful and curious stance SFBT therapists take.

Researchers have also suggested that viewing clients as experts and collaboratively involving them during the therapeutic process creates an empowering therapeutic alliance where healing and growth can occur. It specifically increases clients' confidence, and helps them find solutions within themselves (Carr et al., 2014, Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004). Micro-analytic studies have furthermore indicated that positive formulations, preserving clients' exact words, are extremely useful (Froerer & Jordan, 2013; Jordan et al., 2013; Korman et al., 2013; Tomori & Bavelas, 2007). In the context of trauma, positive reflections and compliments help clients to alter the perspective they have of their trauma. Such reflections also assist clients to recognise their own strengths. Clients are thus guided to viewing themselves as trauma survivors, instead of victims (Bannink, 2008; Carr et al., 2014; Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015). Additionally, compliments may amplify client's agentic thinking and therefore increase hope in therapy (Reiter, 2010).

Third, some participants (3, 4, and 6) emphasised the benefit of talking about and *visualising a better future* in therapy. These participants noted that describing their ideal future self, reminded them of who they wanted to become, and further made them aware of their capabilities, and future possibilities. Talking about their preferred

future also motivated them to identify and take steps towards this future: “It [question about the participant’s preferred future] helps me to gain the strength again to say ‘yes, I am doing it...but then I have to do it more’” (Participant 6, I-157). Talking about their ideal future self not only allowed them to feel that the therapist was genuinely concerned about their well-being, but also evoked positive emotions during the session: “When we said my ideal self—then you started asking me what would the ideal self be, then I started pointing out. Then immediately speaking about it made me happy—I started remembering all these things that I want to be” (Participant 4, I-59).

The above-mentioned three participants initially presented with depressive symptoms and hopelessness which possibly made it difficult for them to envision a better future (Ritschel & Sheppard, 2018). It is thus proposed that visualising a better future might be of particular value to clients who present with hopelessness. Such visualising not only created a concrete picture of their goal, but may also have motivated them to identify and take steps towards that goal. It furthermore evoked positive emotions during the session. This notion concurs with previous studies indicating that future-focused questions assist clients to: set clear future goals; shift their focus towards a hopeful future; formulate solutions; and generate behavioural correlates for attaining their goals (Hopson & Kim, 2004; McKeel, 2012; Ogunsakin, 2015). The literature also shows that conversations about what people want lead to increased hope; these conversations help clients to identify potential pathways or solutions towards hope (Courtnage, 2020; De Jong & Berg, 2007; Froerer & Connie, 2016). Lloyd and Dallos (2006, 2008) found that visualising one’s preferred future in detail led to conversations characterised by possibility, change, hope, and self-efficacy.

Fourth, the majority of participants highlighted the benefit of *focusing on strengths* in therapy. They found it helpful to talk about their talents, interests, skills, and passions as it reminded them of their capabilities and worth. It also gave them confidence and motivation to reach their goal: “Whenever you asked me ‘what skill did you use, what strength do you think you have?’—then I realised ‘hey, I’m actually the answer to all this problems around me’ [laughs]” (Participant 4, I-452). Likewise, remembering past success provided them with tools to tackle current challenges and encouraged them to take steps towards their goal: “Because we were sharing the

things that I used to do—then I start. Yes, you are reminding me—[laughs]" (Participant 1, I-243).

Identifying exceptions to the problem, such as the small steps they had already taken towards their goal, also made them aware of their strengths and empowered them to do more: "Also talking about the little things that I'm already doing—it kind of like motivated me to say 'ja, your hard work, it's something' [laughs]" (Participant 4, S4-754). Similarly, questions concerning their ability to cope helped them to acknowledge the progress they had already made, which contributed towards them viewing themselves as capable*:* "It [coping questions] made me realise my sanity. Remember, I said to you, it made me aware that 'ok, clearly I've got some things under control'" (Participant 2, I-473).

Participants furthermore highlighted that relational questions, involving important people in their lives, reminded them of the good things in their respective lives (e.g. their family and children). This not only shifted their perspective towards the positive aspects of life, but also motivated them to take steps towards their individual goal and gave them hope: "So, speaking about the good things—like focusing on the good things, it made me have that hope—it brought back the hope that I've lost" (Participant 4, I-121). Moreover, it reminded them of their worth and purpose: "A reminder of who I am to them [my children] and how much they still need me—it made me strong" (Participant 7, I-154). Focusing on participant's strengths seemed to contribute towards their experience of hope and life satisfaction. Taking into account the positive emotions expressed in the above-mentioned extracts (e.g. laughter), talking about strengths seemed to spark positive feelings.

This concurs with research indicating that strength- and resource-orientated SFBT techniques (e.g. problem-free talk, exception-finding, and coping questions) direct clients to look for positive change, personal strengths, and resources which facilitates therapeutic change. It not only shifts problem-orientated conversations towards solution-focused talk, but also instils a sense of hope in therapy. Highlighting clients' capabilities and recognising past successes foster agentic thinking and a positive expectancy for change (Blundo et al., 2014; Carr et al., 2014; Franklin et al., 2017; Froerer et al., 2009, 2018; Froerer & Jordan, 2013; Lloyd & Dallos, 2006; Reiter, 2010; McKeel, 2012; Michael et al., 2000).

In the context of trauma, both coping and exception-finding questions engender a sense of hope and empowerment as it guides clients to reflect on their past, and identify what is already good in their lives (Bannink, 2008; Froerer et al., 2009, 2018; Hopson & Kin, 2004; Ogunsakin, 2015). Fiske (2018) noted that relationship questions involving important people in their lives helps clients to recognise their own resources and strengths, and this in turn then elicits hope. This may specifically be valuable in enhancing hope and well-being in collectivistic societies who value interconnectedness. In South Africa, Diale (2014) furthermore highlighted the value of problem-free talk, exception-finding, and complimenting when applying SFBT with trauma survivors.

Finally, participants expressed different opinions concerning *talking about their trauma* or past problems. Participants 3 and 6 found it useful to talk about their trauma as it allowed them to release their pain and make peace with their past: “It [talking about participant’s trauma] was helpful, because I think—at that time, I feel that pain—but I feel that pain for good, for once and for good. And then I’m no more feeling the pain at all” (Participant 6, I-105). Being able to talk about their problems also made them feel heard and accepted in therapy. Participant 3 specifically expressed a desire to talk about her problem in more detail during the first session. She made the following suggestions as to how the therapist could have started this session: “‘What really brings you here? What are you facing right now?’... ‘Ok, tell me just a little bit about yourself—ok—tell me what really happened?’ Then we take it from there” (Participant 3, I-613).

However, she indicated that the therapist’s empathic approach encouraged her to talk about her problem in subsequent sessions. This highlighted that, although SFBT is often criticised for being overly positive, SFBT therapists are not problem-phobic. They empathically validate and acknowledge clients’ problems, while shifting the client’s focus to future possibilities and solutions (Bavelas et al., 2013; Froerer et al., 2018; Ratner et al., 2012). Nevertheless, the participant’s need to talk about her trauma in more detail during the first session and the suggestions she made should be considered. As both these participants experienced grief symptoms, it is suggested that talking about trauma may be useful to decrease negative feelings and increase positive feelings among bereaved clients. According to previous studies, re-narration of the loss promotes mastery of difficult material and helps counteract avoidance-

coping among clients who lost a loved one (Neimeyer, Burke, Mackay, & Van Dyke Stringer, 2009). Re-narration may, in turn, enhance SWB (Janoff-Bulman & Frieze, 1983; Stickley et al., 2015; Van Dijk et al., 2013).

All other participants indicated that it was good not to talk about their trauma in detail, as it would have been painful to relive their experiences: “Sometimes it’s just painful to relive experiences...so I think it would have been a bit difficult, a bit challenging to relive certain things” (Participant 7, I-489). Some participants also indicated that talking about the trauma would probably have made them feel hopeless and might not have yielded solutions:

> Being asked about my past... I would end up crying—yes, sometimes it’s good to cry. But how do I solve it when it comes back, when this happens? So now, our conversation—I have the solution—when this comes, this is how I react. (Participant 4, I-593)

Participants therefore felt that talking about ones’ response to the trauma, rather than dwelling on the past, was more valuable to healing. Not directly focusing on the trauma also provided them with tools and skills which they could apply to other contexts, rendering therapy brief and effective. They furthermore noted that, not specifically being asked about the details of their trauma made them more comfortable to share what they felt was necessary: “So, you let me be open about my trauma, instead of you wanting details of it” (Participant 2, I-429).

For the majority of participants, talking about their trauma would conceivably have increased negative feelings (including feelings of hopelessness). This highlighted criticism against pathology-orientated approaches that potentially retraumatise clients (Paintain & Cassidy, 2018; Schottenbauer et al., 2008). It also emphasised the fact that SFBT therapists do not analyse traumatic experiences in detail, as they assume the client’s problem is not necessarily related to the solution. They therefore rather focus on the client’s desired outcome and resources which create an empowering therapeutic alliance where healing and growth can occur (Bavelas et al., 2013; De Jong & Berg, 2007; Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004).

5.3.2.5 Evaluative summary

From the between-case analysis, it can be concluded that SFBT contributed towards participants' experience of hope and SWB. According to participants, they experienced hope as they moved towards their goal. It is thus plausible that therapy enhanced both their agency and pathways thinking (Snyder, 1994, 2002). During therapy, participants also reported feeling good and viewing life as good. It is thus proposed that therapy contributed towards both the affective and cognitive components of participants' SWB (Diener,1984; Diener et al., 1999). They noted that the following aspects of therapy facilitated their experience of hope and SWB: the therapeutic conversation; empathy, and acceptance in therapy; visualising a better future; and focusing on their strengths. Being given the opportunity, but not being forced to provide details regarding their trauma also appeared beneficial in this regard.

These qualitative findings were supported by quantitative data obtained by using various measuring instruments. For example, participants in this study experienced increased levels of hope, positive affect, and life satisfaction after exposure to SFBT. They also displayed a decrease in negative affect, and improvement in depressive- and PTSD symptomology after therapy. Triangulation thus supported the notion that SFBT contributed towards participants' experience of hope and SWB (see Tables 6, 8, 10, 12, 14, 16, and 18). Consequently, the researcher proposes that SFBT may be an appropriate intervention to facilitate hope and SWB among trauma survivors at community-based clinics.

5.4 Conclusion

Results from the first phase of this study indicated that trauma survivors at community-based clinics in Gauteng experienced low levels of hope, positive affect, and life satisfaction, as well as high levels of negative affect and psychopathology. This highlighted the need for a therapeutic intervention that may facilitate hope and SWB in this context, and thus informed the subsequent phases of the study. During and after the implementation of SFBT, participants reported increased levels of hope and SWB. They specifically noted that the therapeutic conversation; empathy and acceptance in therapy; visualising a better future; and focusing on their strengths instead of their trauma, facilitated these experiences. Based on these results, the final phase of this study involved the development of an SFBT intervention model. In the

following chapter, this model is presented and the researcher proposes how the model may facilitate hope and SWB among trauma survivors at community-based clinics.

Chapter 6: A Solution-focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-being among Trauma Survivors

6.1 Introduction

Based on the findings from the current study, this chapter proposes an SFBT intervention model to facilitate hope and SWB among trauma survivors at community-based clinics in the South African context. A brief description of the theoretical framework, principles on which this proposed model is grounded, and the rationale for this model is provided. A detailed description of the model, based on a journey metaphor, is also outlined. For each component of the model, findings from the current study, existing literature, and practical guidelines are highlighted. This chapter concludes with suggestions regarding the implementation of the proposed model.

6.2 Background on the Proposed Model

Quantitative results from this study highlighted the need for a therapeutic intervention which can facilitate hope and SWB among trauma survivors. Based on existing literature and qualitative data obtained during Phases II and III of this study, the researcher thus proposes an SFBT intervention model that can facilitate hope and SWB among trauma survivors at community-based clinics in the South African context. As discussed in Chapter 3, this model defines hope according to Snyder's (2000) hope theory and conceptualises SWB in accordance with Diener's (1984) tripartite model. Although the findings from the current study have primarily guided the development of this model, it is grounded on SFBT principles and existing literature. The theoretical foundation and the rationale for the proposed model are explained below.

6.2.1 Theoretical foundation of the proposed model

6.2.1.1 Principles and assumptions of solution-focused brief therapy

Strong philosophical influences underpin SFBT, and this approach is therefore based on various principles and assumptions regarding solutions, therapy, and clients (Bavelas et al., 2013; De Jong & Berg, 2007; De Shazer, 1985; De Shazer et al., 2007; Proudlock & Wellman, 2011; Ratner et al., 2012; Von Cziffra-Bergs, 2018). The proposed SFBT model is informed by the basic tenets of SFBT (see Section 2.3.1.2 of Chapter 2). For example, the model assumes that the solution is not always related to the problem and therefore exploring or retelling the problem is not necessary to

build solutions. As the future is creatable, the model puts forward that the therapeutic focus should be on the client's desired outcome, rather than on past problems or current conflicts. What the client wants to be different in their future is thus more important than the trauma the client experienced in the past. The model also assumes that solutions are co-constructed between the client and the therapist, during the therapeutic conversation. The language used to build solutions is therefore different from that used to diagnose and treat problems. As a result, solution-building conversations are pragmatic, empowering, and filled with possibility, instead of being analytical and exploratory.

The proposed model furthermore supposes that no problem happens all the time and that there are always exceptions that can be utilised to show clients how they have coped or managed before. In this regard, clients are encouraged to do more of what now (or did) work well. This model also assumes that small changes can lead to bigger change. The goal of the therapy is therefore not to fix problems, but to empower clients to start the process of change, one step at a time. Moreover, the model assumes that all clients are motivated towards change and have the resources, skills, and competencies to resolve their own problems. As a result, clients are viewed as co-experts who courageously survived trauma, instead of trauma victims. With this model, the therapist's role is thus merely to help clients identify what they want and elicit the necessary strategies to move closer to that desired outcome.

6.2.1.2 Collaborative therapeutic dialogue

Anchored on the above-mentioned assumptions, the proposed SFBT model is primarily guided by new directions in SFBT (Froerer & Connie, 2016; Froerer et al., 2018; McKergow, 2016). Recent developments in SFBT have shifted the focus from asking questions to gather information and devise interventions, to strategically using the collaborative communication process. The purpose of the shift is to expand the descriptions of what clients want to be different in their lives. Through a process of listening, selecting, and building, the therapist guides the client towards describing a detailed desired outcome which constructs new versions of reality, and ultimately creates change (Bavelas, et al., 2013; Froerer & Connie, 2016; Froerer et al., 2018; McKergow, 2016). Although various authors have referred to the collaborative SFBT dialogue, the proposed SFBT model is specifically inspired by the solution-focused art gallery metaphor outlined by Froerer et al. (2018).

6.2.1.3 The solution-focused art gallery

Froerer et al. (2018) compare the SFBT session to a *tour* through an art gallery, with different rooms to visit and different pieces of art to explore. According to these authors, the SFBT art gallery has four rooms that are visited during the session. First, the therapist and client enter the *best hopes room* to establish the client's desired outcome for the session. Thereafter, they walk through the *resource talk room* to step away from the client's problem for a moment and to expand the therapist's language. The therapist and client then enter the *preferred future room* where the presence of the client's desired outcome is described in detail. This room is considered to be the most important room of the gallery, as it is the place where change happens. Finally, they conclude the session in the *closing room* where the therapist is cautious not to ruin the work that was done in the previous rooms (Froerer et al., 2018). Although this metaphor implies a certain direction and purpose of travel, it is not a recipe, but rather a guide to each individual therapeutic process (McKergow, 2016).

6.2.2 Rationale for the proposed model

The quantitative results obtained in the first phase of this mixed methods study suggested relatively low levels of hope and SWB, and high levels of psychopathology in a sample of trauma survivors at community-based clinics in Gauteng (Ekurhuleni) (see Section 5.2.2.2 of Chapter 5). These results highlighted the need for a therapeutic intervention which can facilitate hope and SWB among trauma survivors at community-based clinics in South Africa. Although the solution-focused art gallery metaphor provides valuable insight regarding SFBT with trauma survivors, it is a relatively unfamiliar concept to the majority of South Africans. Furthermore, the confined, silent, and secluded nature inherent in an art gallery specifically conflicts with a vibrant, social country renowned for its vast open landscapes, sunny weather, and outdoor lifestyles. Based on the results from this study, adaptations to the existing art gallery metaphor were also deemed necessary to facilitate hope and SWB among trauma survivors at community-based clinics in South Africa. These adaptations are outlined in more detail in Section 6.3. Inspired by the participants of this study, the researcher therefore proposes an SFBT model illustrated by a *journey* metaphor as most South African's are familiar with a journey, either by foot, car, or public transport.

The journey metaphor also allows for more flexibility and cooperation during the SFBT session which is relevant in the diverse South African context.

6.3 Description of the Proposed Model: "Journey of Possibilities"

Based on the results of the multiple case studies, the researcher proposes an SFBT intervention model which can facilitate hope and SWB among trauma survivors at community-based clinics in South Africa. This model is referred to as *"Journey of Possibilities" as* it intends to guide trauma survivors towards hope and SWB which, according to the participants of this study, unlocks possibilities. The proposed SFBT model focuses on eliciting the client's desired outcome, describing the presence of the desired outcome, and utilising clients' resources to move towards the desired outcome. This model strategically incorporates language tools and more traditional SFBT techniques and questions (Bavelas et al., 2013; De Jong & Berg, 2007; De Shazer et al., 2007; Froerer et al., 2018; Ratner et al., 2012; Von Cziffra-Bergs, 2018). The different components of this model are depicted in Figure 2.

6.3.1 Therapeutic relationship: Co-travellers in conversation

6.3.1.1 Findings from the current study

Participants in this study highlighted the importance of the therapeutic relationship in facilitating hope and SWB. The proposed SFBT model thus compares the therapeutic relationship to co-travellers who meet each other along a journey and start a deep, meaningful conversation. As a result of the participants' trauma, they often find themselves feeling like they are in a dark pit, and that they have lost their way (or are stuck at a specific point along their journey). As a result, they would typically be unable to see the light at the end of the journey. The therapist's role is thus to help clients rediscover this light and find their way forward. Participants in this study specifically noted that: acceptance and empathy, collaboration, and an open and honest conversation, helped them to experience hope and SWB.

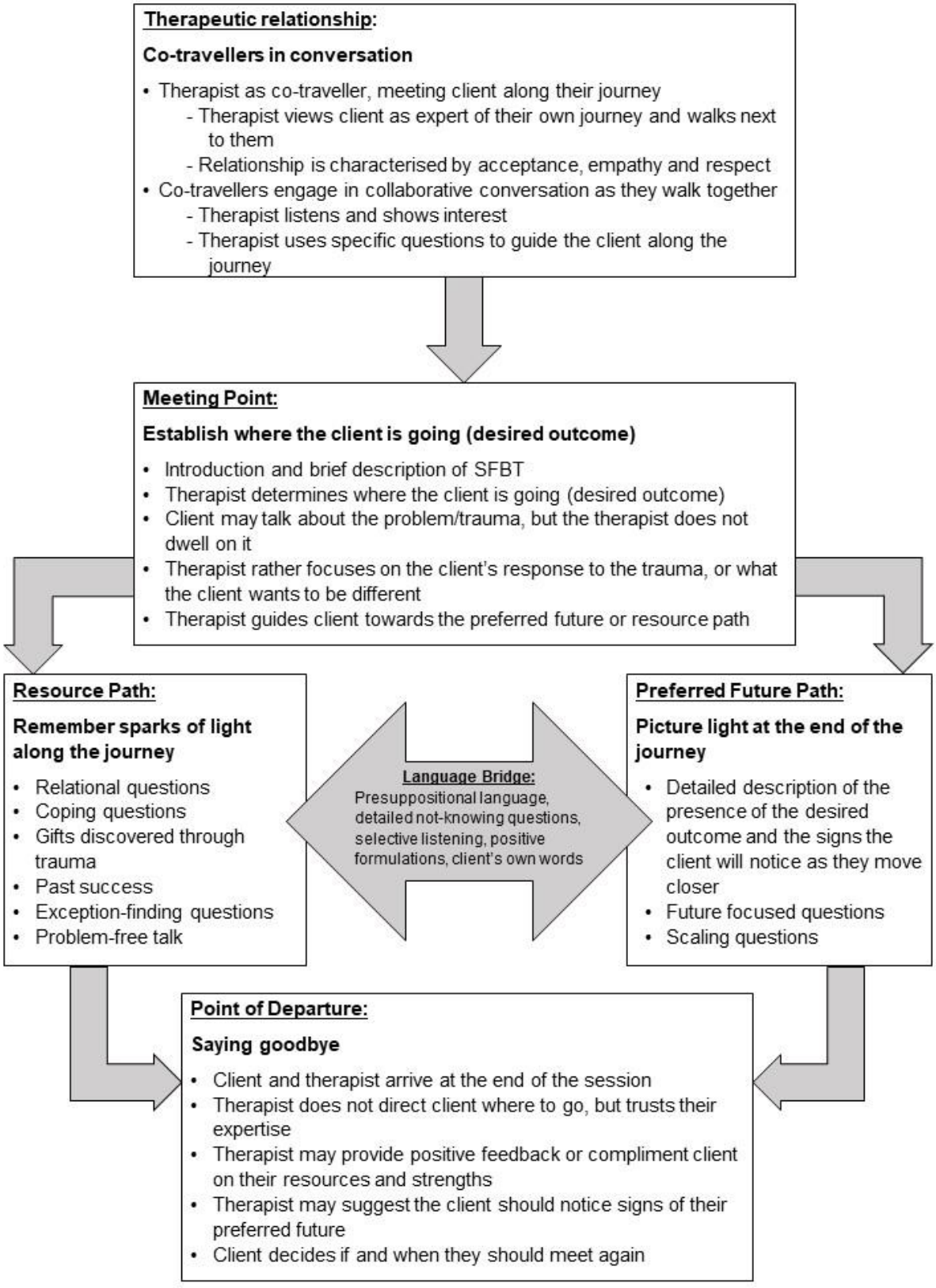

Figure 2. Outline of proposed Solution-Focused Brief Therapy (SFBT) model: "Journey of Possibilities"

First, participants from this study emphasised the importance of having an *open and honest conversation* with a therapist who is attentive and respectful. This allowed them the opportunity to release their burden and consequently enhanced their happiness. Second, participants indicated that *acceptance and empathy* in therapy made them comfortable to express their feelings, which further contributed to the affective component of SWB. Not being judged in therapy also made them feel worthy and reminded them of their purpose. This facilitated life satisfaction among participants. Acceptance and empathy in therapy furthermore confirmed that they are on the right path, which increased their experience of hope, and especially agency thinking. Third, participants noted that *collaboration in therapy* empowered them and helped them find answers within themselves. It also sparked introspection which shifted their perspective to be more positive. This not only enhanced their levels of hope, but also contributed towards life satisfaction.

6.3.1.2 Existing literature

The participants' experiences are supported by studies identifying the collaborative language process as the key component of SFBT. This process is considered synonymous with the therapeutic alliance which is fostered by the respectful and curious stance SFBT therapists take (Carr et al., 2014; Franklin et al., 2017; Froerer & Connie, 2016; Lloyd & Dallos, 2008; Simon & Nelson, 2005). According to previous studies, collaboratively involving clients during the therapeutic process also empowers them and helps them find solutions within themselves (Carr et al., 2014, Froerer et al., 2009; Griffin, 2015; Hopson & Kim, 2004). Although the literature shows the importance of the therapeutic relationship in SFBT, the art gallery metaphor, and other contemporary SFBT models, do not explicitly include this as part of their conceptualisation (Connie & Froerer, 2020; Froerer & Connie, 2016; Froerer et al., 2018). However, the importance of the therapeutic relationship in facilitating hope and SWB among this sample, urged the researcher to incorporate it as an essential component of the proposed SFBT model.

The prominent role the therapeutic relationship played for these participants might be ascribed to their demographic background and presenting problem. For example, collectivistic African cultures tend to value interconnectedness, social support, and interpersonal relationships when describing hope and SWB (Bernardo, 2010; Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013). Similarly,

women usually have more frequent contact with network members and value intimacy, emotional disclosure, and empathy in relationships (Turner, 1994). Various therapeutic approaches have furthermore highlighted the importance of providing a supportive and containing therapeutic relationship when working with trauma survivors (Cusack et al., 2016; Kaminer & Eagle, 2010; Krupnick, 2002; Paintain & Cassidy, 2018). The focus of SFBT on collaboration and creating a sense of community, which is an inherent part of the African philosophy of Ubuntu, may specifically be valuable for trauma survivors in South Africa (Diale, 2014; Von Cziffra-Bergs, 2018).

6.3.1.3 Practical guidelines

Based on participants' experiences and existing literature, the SFBT model proposes the following guidelines regarding the therapeutic relationship in order to facilitate hope and SWB in therapy:

- The therapist views the client as the expert of their life and thus walks next to the client along the journey, allowing them to lead the way;
- The therapist trusts the client's ability to find the right path, and therefore accepts and respects the client, without trying to change them;
- The therapist therefore actively involves the client throughout the therapeutic process, even though clients might initially find this unexpected or frustrating;
- The therapist shows empathy by taking on a kind, friendly, and welcoming stance along the journey;
- The therapist shows interest in the client by asking detailed questions, using the client's own words, and listening attentively; and
- The therapist uses strategic questions throughout the conversation, to guide clients along the journey.

6.3.2 Meeting point: Where the client is going

6.3.2.1 Findings from the current study

Results from this study point to the importance of establishing a desired outcome at the onset of therapy to build hope and SWB. The proposed SFBT model views this as the point along the journey where the client and therapist meet. At this point, the therapist, as curious and respectful co-traveller, introduces themself to the client, and inquires where the client is going. As the client often finds themselves in a

dark pit as a result of their trauma, they might have difficulty envisioning their end destination and is more likely to describe the darkness they find themselves in. The role of the therapist is thus to respectfully determine what the client wants, despite the trauma or problem they have encountered. To facilitate hope and SWB, participants in this study noted that; at times, it is good to share the trauma or problem, but that one should not dwell on it.

According to the participants, *talking about their trauma or problem* at the onset of therapy made them feel heard and helped them to release the pain they have been carrying. It also allowed them to make peace with the past and move forward on their journey. This not only contributed to their SWB, especially the affective component; but also gave them hope. However, participants emphasised that it is *not good to dwell on the trauma or problem*, as it cannot be changed. Talking about the trauma details may not only decrease affective SWB, but can also leave clients feeling hopeless. Participants therefore indicated that it was more useful to talk about their response to the trauma or problem and discuss where they are going, despite what they had encountered along their journey. This not only gave them hope, but also contributed towards SWB.

6.3.2.2 Existing literature

SFBT therapists assume the client's problem is not necessarily related to the solution, and the therapist therefore does not analyse traumatic experiences in detail (Bavelas et al., 2013; De Jong & Berg, 2007). They rather focus on the client's desired outcome and communicate that, although the traumatic past cannot be changed, the future can still be filled with success and satisfaction. This engenders feelings of hope and empowerment in the aftermath of trauma (Bannink, 2008; Carr et al., 2014; Griffin, 2015; Froerer et al., 2009, 2018; Green et al., 2006; Hopson & Kim, 2004; Lloyd & Dallos, 2006, 2008; Ogunsakin, 2015). Rather than being problem-phobic, SFBT therapists empathically validate and acknowledge client's problems, while shifting the client's focus to future possibilities and solutions (Bavelas et al., 2013; Froerer et al., 2018; Ratner et al., 2012). This is important as the suppression of emotions (especially negative emotions) may have a detrimental effect on the client's well-being (McMahan et al., 2016; Tamir & Ford, 2012).

In terms of the gallery metaphor of Froerer et al. (2018), determining the client's desired outcome is the very first question that should be asked in an SFBT session. This not only serves as a contract between the client and the therapist, but also guides the conversation for the rest of the session. Clients are allowed to talk about their trauma or problem, but the therapist should remain focused on the client's desired outcome (Froerer et al., 2018). In line with the art gallery metaphor, the proposed SFBT model thus suggests that the client's desired outcome should be established at the onset of therapy, and that the focus should be on the client's desired outcome. Although existing SFBT models do not mention any introductory statement or explanation of the SFBT approach at the onset of therapy; the researcher found it useful to highlight the collaborative, brief, and goal-orientated nature of SFBT for clients. This might be relevant as many South Africans have lost their voice; in the process, they falsely believe that the therapist is the only expert, and that they themselves do not have expertise in their own lives. They might therefore assume that they need extensive professional help (Von Cziffra-Bergs, 2018).

6.3.2.3 Practical guidelines

Based on participants' experiences and existing literature, the SFBT model proposes the following guidelines concerning the meeting point to facilitate hope and SWB in therapy:

- The therapist introduces him/herself to the client and provides a brief description of SFBT, highlighting the collaborative, brief, and goal-orientated nature of the approach;
- Immediately thereafter, the therapist establishes the client's desired outcome for the session by asking a *direction question* (where the client is going), such as:
  - What do you hope to achieve from the session?
  - What do you want to be different after the session?
  - What do you want to talk about, so that the conversation is useful?
  - What do you want to feel/do instead of [the problem]?
- The therapist allows the client to talk about the trauma or problem, if they have the need, but does not dwell on the details of the trauma;

- The therapist empathically validates and acknowledges the client's trauma or problem, and listens with an attentive ear for the details that contribute towards the client's desired outcome;
- The therapist therefore focuses on the client's strength and resilience related to the trauma, and how the client wants the trauma journey to end; and
- Once the client's desired outcome for the journey is determined (e.g. "I just want to feel happy", "I hope to be my old self again" or "I need to become better"), the therapist either directs the client towards the preferred future, or the resource path. However, throughout the journey, they will continuously cross between these two paths using a language bridge.

6.3.3 Preferred future path: Picture light at the end of the journey

6.3.3.1 Findings from the current study

Participants from this study noted the value of describing the presence of their desired outcome (the preferred future) in detail. The proposed SFBT model describes this as the client and therapist collaboratively walking along the preferred future path and picturing the light at the end of the client's journey. Most journeys end at a beautiful destination or a place the traveller has been dreaming about for some time. However, due to the trauma the client has experienced, they may not be able to see this light anymore. On this path, the therapist's role is thus to help client's picture the light at their end destination and help them move closer to it. Participants in this study specifically noted that visualising their preferred future and scaling their progress towards their preferred future were useful in building hope and SWB.

Participants indicated that *visualising their preferred future* reminded them of what they want, helped them to construct strategies or solutions towards their goal, and motivated them to move forward. It also shifted their focus towards the future and made them aware of future possibilities which facilitated hope. Being asked detailed questions about their preferred future furthermore elicited positive emotions during the session and reminded them of the things that make them happy. This contributed to a subjective experience of happiness. Measuring progress towards their preferred future using *scaling questions* also enhanced their level of hope. Not only did these questions create a positive expectation regarding progress, but it also motivated participants and elicited clear plans to move forward.

6.3.3.2 Existing literature

The participants' experiences are supported by literature suggesting that future-focused questions assist clients to set clear goals, shift their focus towards a hopeful future, and help clients to reach their goals (Hopson & Kim, 2004; McKeel, 2012; Ogunsakin, 2015). Lloyd and Dallos (2006, 2008) specifically found that visualising one's preferred future in detail leads to conversations characterised by possibility, change, hope, and self-efficacy. By assisting clients to describe their goal and envision steps towards that goal, SFBT also elicits positive emotions (Kim & Franklin, 2015). The wider attentional focus and attentional flexibility required to visualise one's preferred future may furthermore lead to higher levels of SWB. The tendency to selectively attend to positive information specifically appears to enhance SWB (Compton et al., 2004; Gasper & Clore, 2002; Robinson & Compton, 2008).

The art gallery metaphor of Froerer et al. (2018) considers the description of the client's preferred future as the most important component of therapy. These authors suggest that clients are empowered as they are asked specific, detail-orientated questions about the presence of their desired outcome. According to Connie and Froerer's (2020) Diamond Model of SFBT, the client's desired outcome can also be described using resource talk, scaling questions, and inquiring about past instances of the desired outcome being present. The proposed SFBT model thus borrows from both these conceptualisations as it incorporates future-focused and scaling questions to describe the client's preferred future.

6.3.3.3 Practical guidelines

Based on participants' experiences and existing literature, the SFBT model proposes the following guidelines regarding the preferred future path to facilitate hope and SWB in therapy:

- The therapist elicits a detailed description of the presence of the client's desired outcome (preferred future);
- The therapist focuses on the small signs and the difference the client will notice once they move closer to their preferred future;
- The client's preferred future is elicited through specific future-focused questions, such as:

- A *personalised miracle question* (e.g. Suppose that one night, while you were asleep, a miracle happened [the client's desired outcome is present]. How would you know? What is the first sign that will tell you something is different?);
- *Scaling questions* (e.g. On a scale *from 0 to 10*, where *10* resembles your desired outcome and *0* the exact opposite, where are you today? How would you know when you move one step higher on this scale?);
- *Presuppositional questions* (e.g. Suppose this session is useful and within the next few days you start to move closer to [presence of the client's desired outcome]. What will be different?); and

- To further expand the preferred future, the client and therapist continuously cross between the preferred future and resource paths using a language bridge.

6.3.4 Resource path: Remember sparks of light along the journey

6.3.4.1 Findings from the current study

With regards to building hope and SWB, results from this study have emphasised the importance of eliciting and amplifying clients' resources and strengths. The proposed SFBT model compares this process to the client and therapist collaboratively walking along the resource path and remembering sparks of light along the client's journey. Most journeys are filled with highlights and memorable moments, and important people who encourage or support travellers along the way. Travellers often also collect various gifts along their journey that they treasure. However, due to the trauma the client has experienced, they often forget about these sparks of light. On this path, the therapist's role is thus to remind the client of their resources and empower them to move forward. Participants in this study specifically noted that resource-orientated questions contributed towards hope and SWB.

First, *relational questions*, involving important people in their lives, gave participants hope. These questions not only created a positive future expectation, but also helped participants find strategies towards their goal, and unlocked their drive to move forward. These questions also contributed towards participants' SWB as it elicited positive emotions, gave them perspective, and made them aware of their strengths and worth. The importance of relationships in the context of hope and SWB was furthermore highlighted by participants as they indicated that external factors

motivated them and made them feel good. Second, *coping questions* made participants realise they are on the right path and increased their confidence and motivation to move forward. Such questions thus gave participants hope because they enhanced the latter's pathways and agency thinking. These questions also made participants aware of what they had learned through their trauma. The questions thus contributed to participants' SWB by making them feel good and reminding the participants of their strength and purpose.

Third, participants found it useful to talk about *past success and exceptions* to the problem. Talking in this manner gave participants hope because this not only highlighted the steps they already had taken forward, but also helped them identify strategies and motivated them to continue this movement. It also contributed towards SWB as talking about mastery and success generated positive emotions and made them realise their strength and worth. Finally, *problem-free talk,* discussing participants' skills, interests, and talents, encouraged them to move forward. Talking about these topics thus enhanced participants' experience of hope, especially their agency thinking. Additionally, *problem-free talk* contributed towards their SWB because it made them feel good and reminded them of the good things in their lives, and their own purpose and worth.

6.3.4.2 Existing literature

The participants' experiences concur with research indicating that strength- and resource-orientated SFBT techniques (e.g. problem-free talk, exception-finding, and coping questions) direct clients to look for positive change, personal strengths, and resources which facilitate therapeutic change (Carr et al., 2014; Franklin et al., 2017; Froerer et al., 2009, 2018; Froerer & Jordan, 2013; Lloyd & Dallos, 2006; McKeel, 2012). Coping and exception-finding questions, in particular, engender a sense of hope and empowerment in the aftermath of trauma because these questions remind clients of previous successes. Identifying personal strengths and resources also generates positive feelings and assists clients to view themselves as trauma survivors, instead of victims. This positive perspective ultimately contributes towards clients' SWB (Bannink, 2008; Carr et al., 2014; Griffin, 2015; Froerer et al., 2009, 2018; Green et al., 2006; Hopson & Kim, 2004; Kim & Franklin, 2015; Lloyd & Dallos, 2006, 2008; Ogunsakin, 2015).

According to the solution-focused art gallery metaphor, the resource room is a vital part of the SFBT session, because the room allows the therapist to become familiar with the client's language (who the client is and what they value in life). This knowledge may then be used in the preferred future room (Froerer et al., 2018). Similarly, Connie and Froerer's (2020) Diamond Model of SFBT suggests that resource talk is used to describe the client's desired outcome. Although both these models acknowledge the value of asking clients about important people in their lives, they do not view this as essential to therapy (Connie & Froerer, 2020; Froerer et al., 2018). However, based on the findings from this study, the proposed SFBT model considers relational questions to be a fundamental tool for building hope and SWB. This might be explained by participants' demographic background and presenting problem. Collectivistic African cultures, as well as females, tend to prioritise interconnectedness, social support, and interpersonal relationships (Bernardo, 2010; Kitayama & Markus, 2000; Lu & Gilmour, 2004; Tov & Diener, 2013; Turner, 1994). Relational questions may furthermore be specifically useful in the context of trauma as these questions give clients perspective and hope (Fiske, 2018).

In contrast to existing SFBT models, the model proposed in this study views the resource and preferred future paths as equally important for creating hope and SWB. The client and therapist thus continuously cross between the resource and preferred future paths using a language bridge (see Section 6.3.5). According to the researcher, the resource path may be particularly valuable when clients are not yet able to describe their preferred future. The SFBT model thus proposes that the resource path, and specifically relational questions, is used to expand the client's preferred future. This is a unique contribution of the proposed model, as the SFBT literature seldom explicitly refers to the use of relational questions in therapy.

6.3.4.3 Practical guidelines

Based on participants' experiences and existing literature, the SFBT model proposes the following guidelines concerning the resource path to facilitate hope and SWB in therapy:

- The therapist helps the client to step away from their trauma or problem for a moment and remember the best version of themselves;

- The client's resources and strengths are elicited using specific resource-orientated questions, such as:
  - *Relational questions* (e.g. Who are the most important people in your life? Who supports or motivates you in life? What will they notice as you move closer to your desired outcome? How would they respond to this?);
  - *Coping questions* (e.g. How have you coped until now? How did you overcome obstacles in the past? What skills have helped you to survive?);
  - *Gifts discovered through trauma or problem* (e.g. What strengths or skills did you discover through your trauma? What did you learn as a result of your trauma? How did your trauma equip you for the future?);
  - *Exception-finding questions* (e.g. What signs of your preferred future are already visible? What steps have you already taken towards your preferred future? How did you do that? What qualities did you use?);
  - *Past success questions* (e.g. When in the past was your preferred future present? What are your biggest achievements or proudest moments in your life? How did you achieve that? Which skills did you use?);
  - *Problem-free talk* (e.g. What is important to you in life? What are your special talents? What makes you happy? What are your best qualities?)
- These resource-orientated questions should be used strategically, as relevant to the conversation, and not in a formulaic way; and
- The therapist utilises the client's resources and strengths to expand their preferred future and therefore continuously cross between the preferred future and resource paths via a language bridge.

6.3.5 Language bridge

6.3.5.1 Findings from the current study

According to participants from this study, specific components of the therapeutic conversation were useful for developing hope and SWB. The proposed SFBT model considers these language components to be a bridge between the preferred future and resource paths. To overcome obstacles, or truly appreciate the scenery along a journey, travellers often have to cross between different paths. In this regard, a bridge helps travellers navigate the best route forward. The language bridge proposed by this SFBT model thus allows the client and therapist to strategically cross between the preferred future and resources paths, to move towards the client's desired

outcome. Participants in this study specifically noted that presuppositional language, positive formulations, and the therapist's manner of listening and asking questions contributed towards hope and SWB.

For example, participants indicated that *presuppositional language;* implying they are better, have coped, or will make progress; made them feel motivated and hopeful. It also made them aware of their strengths which enhanced their life satisfaction. Participants also noted that the therapist's *positive formulations*, summaries, or paraphrases, highlighting their strengths and resources, empowered them and made them realise their worth. This furthermore contributed to the cognitive component of SWB. In addition, the fact that the t*herapist listened, asked detailed questions, and used participants' own words* made them feel comfortable and encouraged participants to be open in therapy. Expressing their feelings openly consequently increased their affective SWB.

6.3.5.2 Existing literature

Froerer and Connie (2016) identified the collaborative language process between the client and the therapist as the central and key component of SFBT. According to micro-analytic studies, SFBT conversations are characterised by therapists providing positive formulations and preserving the client's exact words (Froerer & Jordan, 2013; Jordan et al., 2013; Tomori & Bavelas, 2007). Froerer et al. (2018) therefore suggest that language components such a lexical choice, grounding, positive formulations, *'not knowing'* questions, and presuppositional language should be used with deliberation and precision in SFBT sessions. In the South African context, Von Cziffra-Bergs (2018) noted that SFBT therapists listen to their clients with *soulution ears* and speak with *solution-focused tongues* as they selectively listen for and reflect clients' strengths and resilience. This not only empowers clients, but also creates hope and possibility.

Despite the importance of the therapeutic dialogue, none of the contemporary SFBT models explicitly include the dialogue in their conceptualisation (Connie & Froerer, 2020; Froerer & Connie, 2016; Froerer et al., 2018). However, the proposed model considers solution-focused language as an essential component for building hope and SWB. It thus proposes that the language process is used as a bridge

between the preferred future and resource paths, offering a unique contribution to the practice of SFBT.

6.3.5.3 Practical guidelines

Based on participants' experiences and existing literature, the SFBT model proposes the following guidelines regarding the language bridge, to facilitate hope and SWB in therapy:

- The therapist listens with an attentive and selective ear to the client's resources and strengths, what is important to them, and what they want;
- The therapist shows interest in, and asks detailed questions about, the client's resources and strengths, instead of their trauma or problem;
- The therapist amplifies the client's resources and strengths when summarising or paraphrasing;
- The therapist empathically acknowledges and validates the client's trauma or problem, but does not amplify these details;
- The therapist incorporates the client's words (e.g. metaphors, descriptions, or slang words) when asking questions and providing formulations;
- The therapist makes use of *presuppositional language* (e.g. suppose, different, yet, however, at the moment, currently, despite) when asking questions and providing formulations; and
- The therapist asks *not knowing* questions (e.g. What do you hope to achieve from this session? What will be different once your desired outcome is present?) that lead clients towards a description of their desired outcome, instead of their trauma or problem.

6.3.6 Point of departure: Saying goodbye

6.3.6.1 Findings from the current study

Findings from this study, suggested that the way the session is ended also contributes towards hope and SWB. The proposed model compares the end of the session to the point where the client and therapist depart. Travellers often meet each other along a journey; travel together for some time, but then get to a point where their paths separate, and they have to say goodbye. Similar to travellers going their separate ways; the therapist does not direct the client where to go, but trusts they will

find their way. The therapist rather leaves the client with words of encouragement they can ponder, as their journey continues. Participants in this study specifically emphasised that positive feedback, compliments, and suggestions at the end of the session were useful in building hope and SWB.

Participants noted that *positive feedback* from the therapist, highlighting their strengths and resources, was valuable. Honest feedback, based on what they shared with the therapist, not only reminded them of their worth and purpose, but also built their confidence. This consequently increased their hope, especially agency thinking, and life satisfaction. Similarly, *compliments* concerning their ability to cope gave participants strength and made them realise their worth. Participants furthermore indicated that *suggestions* to notice signs of their desired outcome being present or *encouragement* from the therapist to do more of what works, motivated them, and gave them hope.

6.3.6.2 Existing literature

The participants' experiences are supported by literature suggesting that positive reflections and compliments concerning clients' competent behaviours generate positive feelings. This subsequently contributes to SWB (Kim & Franklin, 2015). In the context of trauma, positive reflections, and compliments help clients to alter the perspective they have of their trauma, and to recognise their own strengths. It thus guides clients to view themselves as trauma survivors, instead of victims (Bannink, 2008; Carr et al., 2014; Griffin, 2015; Hopson & Kim, 2004; Ogunsakin, 2015). Compliments specifically appear to be valuable in resource-poor countries, such as South Africa. In this context, it not only validates and acknowledges clients' efforts, but also empowers them to find answers within (Diale, 2014; Von Cziffra-Bergs, 2018).

New directions in SFBT place less emphasis on providing compliments and homework tasks or suggestions (McKergow, 2016). For example, the art gallery metaphor closes the session by asking clients to notice the signs of their preferred future being present (Froerer et al., 2018). Similarly, the SFBT Diamond Model suggests that the session should be closed in a manner which honours the work that was done during the session and leaves the client with authority. The therapist thus ends the session by indicating that the time has come to an end, and by asking the

client whether they want to schedule another session (Connie & Froerer, 2020). To build hope and SWB, the proposed SFBT model incorporates aspects from both classic SFBT and more contemporary models to close the session.

6.3.6.3 Practical guidelines

Based on participants' experiences and existing literature, the SFBT model proposes the following guidelines concerning the departure point to facilitate hope and SWB in therapy:

- After eliciting a clear description of the client's preferred future and strategically amplifying their resources, the therapist announces that the session has come to an end;
- At this point, the therapist does not direct the client where to go, but trusts their ability to find the way;
- Being careful not to ruin the work that was done in the session, the therapist makes use one of the following strategies to end the session:
  - Provides *positive feedback or compliments* the client on their resources and strengths (based on what the client shared during the session);
  - Asks the client what *compliments significant others (or they themselves)* could give them;
  - Suggests that the client *notice signs of their preferred future* being present, paying specific attention to how they made it happen;
  - Encourages the client to *do more of what works*; and
- The therapist asks the client if and when they should meet again and schedules a follow-up meeting, as indicated.

6.4 Implementation of the Proposed Model

Taking into consideration the above-mentioned description and proposed guidelines, the researcher provides suggestions regarding the implementation of this SFBT model. The structure of follow-up meetings, and the intended clients and context for the model are also discussed below.

6.4.1 Follow-up meetings

The proposed SFBT model allows the client to decide if and when a follow-up session should be scheduled. The therapeutic process may thus consist of one or

multiple sessions, depending on the needs of the client. For example, De Shazer, as cited by Ratner et al. (2012), emphasised that SFBT's duration is "as long as it takes and not one session more" (p. 29). If the client decides that no further sessions are necessary, the therapist thus respects their decision and trusts their expertise. However, if the client requests that a follow-up session should be scheduled, the proposed SFBT model recommends that the same guidelines are followed for each subsequent session.

In accordance with various authors (Froerer et al., 2018; Ratner et al., 2012, Von Cziffra-Bergs, 2018), the proposed SFBT model suggests that the therapist commence the follow-up meeting by asking a presuppositional question (e.g. What is better since our last session? What is different from the last time we met?). The therapist may also make use of resource-orientated questions, especially eliciting what significant others have noticed is better or different in the client's life. Once the therapist has amplified the client's progress, resources, and strengths, the client's desired outcome for that session is again determined. During a follow-up meeting, the travellers thus meet each other at a new meeting point, talk about the sparks of light since they last met each other, and establish where they are going from here.

6.4.2 Traveller and terrain criteria

The implementation of the proposed model requires consideration of the travellers (clients) and the terrain (context) it is intended for. The proposed SFBT model is based on the experiences of black, female adults who were exposed to one or more traumatic event during the past 5 years. Although the respective first languages of the majority of the participants was one of the native South African languages, all the participants showed strong comprehension and fluency in English. The seven participants did not display acute presentation of trauma-related symptomology, psychosis, or suicidality, and furthermore, none of them was mentally impaired. For this study, therapy was conducted in individual format at urban and semi-rural Ekurhuleni district health government clinics in Gauteng. Although these criteria should be noted, it is of the researcher's opinion that the proposed SFBT model may be relevant to a broader scope of trauma survivors in South Africa. However, further research concerning its application in other contexts is recommended.

Despite the proposed SFBT model's value to possibly facilitating hope and SWB among trauma survivors in South Africa, the researcher noted the following special considerations when implementing the model:

- Clients with *depressive symptoms* specifically found it useful to describe their preferred future. It not only gave them hope, but also evoked positive emotions during the session which contributed towards SWB. This is supported by literature suggesting that depression is often associated with cognitive deficits, which may restrict an individual's ability to follow a stepwise plan to achieve a goal (Ritschel & Sheppard, 2018).
- *Clients who experienced bereavement* found it valuable to talk about their trauma or problem at the onset of therapy. Expressing their grief reduced their negative feelings which contributed towards SWB. According to previous grief studies, re-narration of the loss promotes mastery of difficult material and helps counteract avoidance-coping. Approach coping strategies in turn enhances SWB (Janoff-Bulman & Frieze, 1983; Neimeyer et al., 2009; Stickley et al., 2015; Van Dijk et al., 2013).
- The *duration* and *type of trauma* a client has been exposed to may influence their experience of SWB in therapy. This is supported by literature indicating that people do not fully adapt to all negative life events, and that certain traumatic events may have a long-term detrimental impact on SWB (Bucciol & Zarri, 2017; Calvo et al., 2015; Lucas, 2005, 2007b; Lucas & Clark, 2006; Lucas et al., 2003; Suh et al., 1996).

6.4.3 Map instead of GPS

The proposed SFBT model is intended to be used as a metaphorical map, guiding travellers on their journey; instead of being a global positioning system (GPS) that dictates where they should go. Similar to a real map, this model views the traveller as the expert, considers the broader context of the journey, and allows for deviations from the planned route. The trauma recovery process is often complex and multidimensional; with every trauma survivor following a unique path, at their own pace. In implementation, the guidelines suggested by this model should thus be kept flexible to suit each client's journey towards hope and SWB. The dynamic relationship between hope and SWB, and its interrelated components, also makes it difficult to

clinically dissect these two constructs and provide distinct guidelines to facilitate each in therapy. The proposed SFBT model thus inevitably offers an oversimplification of a complex process and should be applied with sensitivity and good clinical judgement. However, this model offers valuable SFBT guidelines that can facilitate hope and SWB among trauma survivors at community clinics in the South African context.

6.5 Conclusion

This chapter described the proposed SFBT model, *"Journey of Possibilities",* that can facilitate hope and SWB among trauma survivors in South Africa. The researcher not only highlighted the theoretical framework and existing literature upon which it is grounded, but also noted adaptations for the unique South African context. Practical guidelines, suggestions, and special considerations regarding implementation of the model were furthermore provided. This is intended to serve as a map for other SFBT therapists aiming to facilitate hope and SWB among trauma survivors in South Africa. The contribution of this model, further recommendations, and final conclusions are discussed in the last chapter.

Chapter 7: Conclusions and Recommendations

7.1 Introduction

Although the international literature has noted the impact of trauma on hope and SWB, no South African studies have investigated this topic to date. Furthermore, research concerning trauma interventions that may facilitate hope and SWB is limited, especially in the South African context. The aim of this study was thus to investigate hope and SWB among trauma survivors at community-based clinics in Gauteng to develop an SFBT model which may facilitate hope and SWB. Earlier chapters of this thesis provided a literature review concerning the research question, and outlined the methodology that was used to answer this question. The research results were also discussed, followed by a description of the proposed SFBT intervention model. This chapter gives a summary of the research findings and highlights the contributions, as well as the limitations of the study. Recommendations regarding clinical practice and future research are also considered. The chapter concludes with the researcher's personal reflection and final remarks.

7.2 Summary of Research Findings

This study utilised a multiphase mixed methods research design to address the research objectives. Both quantitative and qualitative data were thus collected, analysed and interpreted across different phases. The main research findings emanating from this study are summarised below.

7.2.1 The incidence of hope, subjective well-being, and psychopathology

The first research objective was to investigate the incidence of hope, SWB and psychopathology, as the absence of well-being, among trauma survivors at community-based clinics in Gauteng. Considering the trauma dynamics of the participants, the death of a loved one, physical assault/abuse and a life-threatening illness/injury were the most common traumatic events participants had experienced. More than half of the participants had experienced more than one traumatic event over the past five years, and a small percentage had been exposed to five or more events. These findings concurred with previous studies concerning trauma in South Africa (Atwoli, 2015; Williams et al., 2007). Although most participants in the present study had disclosed their trauma to someone (with a family member or a friend being the

most likely people to confide in), the majority had not received any professional help following their traumatic experience. This may be related to the various service delivery challenges facing community mental health services (Bezuidenhout, 2016; De Kock & Pillay, 2017; Kaminer & Eagle, 2010; Moosa & Jeenah, 2008; Schneider et al., 2016).

However, the majority of participants indicated that exposure to traumatic events affected their relationships, self-esteem, and mental functioning. According to them, the trauma had a predominantly negative impact on the participants': relationships; self-esteem; physical, mental, and spiritual functioning; as well as their experience of hope and life satisfaction. It was therefore not surprising that about half of the participants indicated that they are not coping with the consequences of the trauma. This was supported by descriptive statistical findings obtained from questionnaires measuring hope (AHS), positive and negative experiences (SPANE), life satisfaction (SWLS), and psychopathology (PCL-5 and PHQ-9).

The mean scores on these measuring instruments suggested relatively low levels of hope, positive affect, and life satisfaction among the participants before exposure to SFBT. High levels of negative affect and psychopathology, especially symptoms of depression and PTSD, were also observed. The mean scores of positive affect, life satisfaction, and psychopathology were similar to previous studies involving clinical samples, particularly in the context of trauma. However, the mean score of negative affect was much higher for this sample (Hassija et al., 2012; F. Li et al., 2013; Pavot & Diener, 1993; Wortmann et al., 2016). This may be because the majority of participants were females; as indicated in the literature, women tend to experience and express negative emotions more frequently and intensely than men do (Diener, Diener, Kesebir et al., 2009; Diener & Suh, 1999; Pavot & Diener, 2013; Suh & Koo, 2008; Zuckerman et al., 2017).

Although socio-cultural variables may have influenced participants' experiences; it is plausible that the increased incidence of hope and SWB in this sample can rather be ascribed to the impact of trauma. These findings are supported both by local, and international literature emphasising the adverse effect traumatic events may have on people's experiences of hope and SWB (Chang et al., 2015; Isaacs & Savahl, 2014; Lucas, 2005; 2007b; Lucas et al., 2003; Powdthavee, 2005).

Findings from this phase of the study thus highlighted the need for a therapeutic intervention that can facilitate hope and SWB among trauma survivors at community-based clinics.

7.2.2 Implementing and describing solution-focused brief therapy

The second research objective was to implement and describe SFBT with trauma survivors at community-based clinics in Gauteng. Seven females participated in this phase of the study. An account of the therapeutic process for each participant was presented in Chapter 5 (see Section 5.3.1), using a case study approach. This process was guided by the solution-focused art gallery metaphor (Froerer et al., 2018). The researcher also made use of specific SFBT questions and techniques. Verbatim transcripts of these therapeutic sessions were used to address the subsequent research objective.

7.2.3 The experience of hope and subjective well-being, during and after exposure to therapy

The third objective of the study was to explore trauma survivors' experience of hope and SWB, during, and after exposure to SFBT. Particular focus was placed on the aspects of SFBT which contributed to participants' experiences. A multiple case study design was used to accomplish this aim. The main qualitative findings from the therapeutic sessions and individual interviews with the seven participants and the quantitative data collected from the measuring instruments are summarised below.

Themes and sub-themes emerging from, both within- and between-case, thematic analyses indicate that participants experienced hope and SWB during and after exposure to this approach. The following main themes reflect these experiences. First, the theme of *moving towards a goal* reflected hope as participants not only reported motivation and confidence to move forward (agency thinking), but also took steps towards their goal (pathways thinking). Participants' locus-of-hope primarily appeared to be external; as family, peers, and spiritual forces acted as agents of goal attainment cognitions. This is commonly observed in collectivistic societies, including African cultures to which participants belonged (Bernardo, 2010). As found in previous studies conducted by other researchers, participants also noted that therapy helped

them to move towards their goal (Blundo et al., 2014; Bozeman, 1999; Michael et al., 2000; Quick & Gizzo, 2007; Reiter, 2010; J. A. Wilson, 2015).

Second, the theme *feeling good* suggested affective SWB as participants experienced more positive than negative feelings. This was attributed to participants' ability to: control and express their feelings; find happiness within themselves; and have relationships that make them feel good. Although participants valued western notions of well-being, they continued to recognise the importance of interconnectedness when describing happiness. They also indicated that therapy helped them feel good, which concurred with literature suggesting that SFBT increases positive affective and decreases negative affect (Grant, 2012; Grant & O'Connor, 2010; Green et al., 2006; Neipp et al., 2015; Wehr, 2010).

Third, the theme *life is good* indicated cognitive SWB or life satisfaction. Not only did participants realise that there is life after trauma and expressed gratitude for several things in their lives, but they also started to view themselves as good and worthy. Participants' experiences of increased self-esteem may thus reflect a more western view of life satisfaction (Diener & Diener, 1995). They also noted that therapy changed their perspective on life. This was supported by research indicating that SFBT assists clients to view themselves as trauma survivors, instead of victims (Bannink, 2008; Carr et al., 2014; Griffin, 2015; Froerer et al., 2009, 2018; Green et al., 2006; Hopson & Kim, 2004; Lloyd & Dallos, 2006, 2008; Ogunsakin, 2015).

Finally, participants indicated *how therapy helped* them to experience hope and SWB. They highlighted that the therapeutic conversation, empathy, and acceptance in therapy, visualising a better future, and focusing on their strengths were valuable. Being given the opportunity, but not being forced, to provide details regarding their trauma also appeared beneficial in facilitating hope and SWB. This was supported by the literature identifying the collaborative language process between the client and the therapist, and strength- and resource-orientated questions as key components of SFBT (Franklin et al., 2017; Froerer & Connie, 2016; Froerer et al., 2009, 2018; McKeel, 2012).

These qualitative results were supported by quantitative data. For the purpose of triangulation, individual participants' levels of hope, SWB, and psychopathology before and after exposure to SFBT were compared based on various measuring

instruments. These results indicated that participants experienced an increase in hope, positive affect, and life satisfaction as well a decrease in negative affect and psychopathology, after exposure to SFBT. It can thus be concluded that SFBT may be an appropriate intervention to facilitate hope and SWB among trauma survivors at community-based clinics.

7.2.4 A proposed model to facilitate hope and subjective well-being

The fourth and final research objective was to develop an SFBT intervention model that could facilitate hope and SWB among trauma survivors at community-based clinics. Findings from Phases II and III, as well as existing literature, were integrated to achieve this aim. The main principles and guidelines of the proposed SFBT model, as outlined in Chapter 6, are highlighted below.

The proposed SFBT model was informed by the basic tenets of SFBT (Bavelas et al., 2013; De Jong & Berg, 2007; De Shazer, 1985; De Shazer et al., 2007; Ratner et al., 2012; Von Cziffra-Bergs, 2018). It therefore focuses on the future, instead of past trauma. It also assumes that solutions are co-constructed between the client and the therapist, during the therapeutic conversation. This model furthermore posits that clients are motivated towards change and have the resources, skills, and competencies to resolve their own problems. As a result, clients are viewed as co-experts in therapy. The therapist's role is therefore not to fix problems, but merely to help clients identify what they want and empower them to move closer to that desired outcome. The proposed SFBT model was primarily guided by new directions in SFBT, especially the art gallery metaphor outlined by Froerer et al. (2018).

Inspired by participants' own metaphors, the researcher named this model: *"Journey of Possibilities".* It intends to guide trauma survivors towards hope and SWB that can unlock possibilities. The proposed SFBT model is intended to be used as a metaphorical map guiding travellers on their journey, rather than a GPS that dictates where the travellers should go. On this journey, the therapist and client are considered to be *co-travellers* engaging in a collaborative conversation. According to this model, the client and therapist start the session at a *meeting point* where the client's desired outcome is elicited. Thereafter, the therapist guides the client towards *the preferred future path* to obtain a detailed description of the presence of the client's desired

outcome. Future-focused and scaling questions may specifically be useful along this path.

The therapist and client may also step onto the *resource path* to identify and amplify the client's resources to move towards their desired outcome. Relational-, coping-, and exception-finding questions as well as problem-free talk may be helpful along this path. The client and therapist can continuously cross between the preferred future and resource paths using a *language bridge,* making use of solution-focused language tools (such as presuppositional language, selective listening, and positive formulations). After eliciting a clear description of the client's preferred future and strategically amplifying their resources, the session ends at the *departure point*. Here the therapist may provide positive feedback, compliment the client on their resources and strengths, or make a relevant suggestion. However, the therapist does not direct the client on where to go, but rather trusts they will find their way.

The proposed model is distinct from other SFBT models, as it explicitly identifies the therapeutic relationship and collaborative language process as essential components of building hope and SWB. This model furthermore considers relational questions as an important tool for building hope and SWB. Contrary to new directions in SFBT, this model also highlighted the importance of providing positive reflections and compliments in therapy.

7.3 Contribution of the Study

This study has contributed to the theory and practice of psychology, specifically positive psychology and SFBT. First, on a theoretical level, this study is one of few that have considered the application of SFBT with trauma survivors, both nationally and internationally. It has thus contributed to new knowledge in this field. Not only do these findings add to outcome- and process-orientated literature regarding SFBT with trauma survivors, but they also shed light on the cross-cultural applicability of SFBT. This study furthermore has expanded the existing knowledge base of positive psychology and traumatology, particularly regarding the prevalence and experience of hope and SWB among trauma survivors at local community-based clinics. The mixed methods research approach utilised in this study specifically has provided in-depth, context-specific information regarding this topic.

This study has also led to the development of an SFBT intervention model that may facilitate hope and SWB among trauma survivors at community-based clinics. This model is unique and the first of its kind, both locally and internationally. The model's inclusion of the therapeutic relationship and collaborative language process, as well as the emphasis on relational questions for building hope and SWB appears to be especially distinct. This study has thus contributed to the literature concerning the application of positive psychology interventions in the context of trauma.

Second, on a practical level, the results of this study may inform psychological practice at community-based clinics in South Africa. Not only can it overcome some of the limitations inherent to traditional pathology-orientated trauma interventions, but it also appears promising for addressing the challenges related to community mental health services. This intervention model may thus contribute to more effective service delivery, and has the potential to relieve the burden on local psychologists. This is specifically relevant considering the potential implementation of National Health Insurance, which may place additional pressure on the public health sector in South Africa (De Kock & Pillay, 2017). The application of this model could also be expanded to the practice fields of clinical and counselling psychology in other contexts such as government departments (including social development and correctional services), non-profit organisations, community trauma clinics, and private practices.

Finally, the knowledge generated regarding the application of SFBT with trauma survivors may contribute to the training of psychologists, social workers, and trauma counsellors. In South Africa, this may be particularly relevant considering the high prevalence of trauma and the demand for brief and effective, strength-based trauma interventions (Diale, 2014; Kaminer & Eagle, 2010; Van der Merwe & Kassan-Newton, 2007; Von Cziffra-Bergs, 2018).

7.4 Limitations of the Study

Despite the theoretical and practical contribution this study makes towards the field of psychology, some limitations were identified. First, the findings of this study are based on a relatively small, homogenous sample, and can therefore not be generalised to the broader population. For example, all seven participants involved in Phases II and III were black women between the ages of 29 and 54 years. However, as this was primarily a case study design, the goal was not to generalise findings, but

rather to obtain a detailed description of participants' experiences in a specific context (Creswell, 2014; Miles et al., 2014; Yin, 2009).

Second, both data collection and therapy were conducted in English, which was not the participants' first language. The questionnaires used in this study also measured hope and SWB according to a western conceptualisation and may have neglected the multidimensional perspective of these constructs. This could thus have influenced the quality and accuracy of findings. However, with regards to quantitative data collection, field workers fluent in the vernacular of the participants were available to assist with administration and/or translation. During qualitative data collection, the researcher also asked questions in an easily understandable manner and requested participants to elaborate if any of their answers were not clear. The researcher thus endeavoured to obtain a thick, culturally-relevant description of participants' experiences of hope and SWB.

Third, the researcher took on the dual role of psychologist and researcher which may have influenced participants' responses during the interviews. The researcher also worked independently and was primarily responsible for data collection, analysis, and interpretation which may have influenced her own perception of results. However, to minimise the possible negative impact of this dual role; the researcher provided no incentive or special treatment to participants, prioritised the role of therapist during the therapy sessions and only commenced qualitative data analysis after the therapeutic process had been completed. To promote research quality, the researcher furthermore made use of: member-checking during data collection; providing thick, rich descriptions of participants' experiences; presenting negative and discrepant information; and maintaining reflexivity by keeping a research journal (Baxter & Jack, 2008; Creswell, 2014; Creswell & Plano Clark, 2018; Henwood & Pidgeon, 1992; McLeod, 2010; Miles et al., 2014).

Fourth, this study mainly focused on the short-term experience of hope and SWB as the majority of interviews were conducted within a few days to a maximum of four months after therapy was provided. No conclusions regarding the long-term experience of hope and SWB after exposure to SFBT could thus be made. It is therefore proposed that long-term effects of the therapy warrant further investigation.

Finally, as this study did not involve a control group, various internal or external factors could have influenced the quantitative results obtained after therapy was provided (Creswell, 2014). For example, external events (such as participants finding employment or giving birth), the time interval between pre- and post-test data collection, and participants becoming familiar with questionnaires might have affected results. Common therapeutic factors, not specific to SFBT, could also have influenced participants' experiences (Creswell, 2014). However, as the researcher collected and compared data from various sources, triangulation contributed to data quality.

7.5 Recommendations

Based on the research findings and the above-mentioned limitations, the following recommendations regarding clinical practice and further research are made:

7.5.1 Recommendations for clinical practice

- Clinicians should be encouraged to incorporate positive psychology trauma interventions into their current practices to amplify trauma survivors' strengths, instead of only repairing weaknesses or fixing problems.
- From the research findings, it is evident that trauma has a significant impact on survivors' experience of hope and SWB. Trauma interventions should thus aim to (directly or indirectly), facilitate these experiences in therapy.
- This study highlighted the importance of the therapeutic relationship and the collaborative dialogue in building hope and SWB among trauma survivors. SFBT therapists could thus focus on creating an open and honest conversation with clients, characterised by empathy, acceptance, and collaboration. Specific language tools (e.g. presuppositional language, selective listening, positive formulations, etc.) may also be valuable in this regard.
- In this study, resource questions (specifically relational questions) appeared to be an important tool for creating hope and SWB among trauma survivors. It is thus suggested that SFBT therapists may utilise these questions to expand the client's preferred future.
- In the South African context, SFBT therapists may find it useful to highlight the collaborative, brief, and goal-orientated nature of SFBT at the onset of therapy to clarify clients' expectations.

- Similarly, in this context, positive reflections, compliments, and suggestions may be useful at the end of therapy to engender hope and SWB among trauma survivors.

7.5.2 Recommendations for further research

- Similar research studies concerning SFBT with trauma survivors could be conducted, but with a larger sample and in different contexts.
- Further evidence-based studies regarding the application of SFBT with other population groups in South Africa could be valuable.
- Longitudinal research regarding the prevalence of hope and SWB among trauma survivors is recommended.
- Moderator variables influencing the relationship between hope and SWB in the context of trauma could also be investigated.
- The questionnaires used in this study could be translated into African languages to obtain more accurate data concerning the prevalence of hope and SWB in African cultures.
- Although the researcher recognised and acknowledged the significance of socio-cultural factors in participants' experience of hope and SWB, this was not explored. Further qualitative research concerning this topic may thus be valuable.
- The proposed SFBT intervention model to facilitate hope and SWB among trauma survivors could furthermore be implemented and validated. It is recommended that the application of this model be assessed and/or adapted for use with different populations (e.g. children/adolescents), in different contexts (e.g. private practice) and in different formats (e.g. group therapy).
- Finally, the personal experience of therapists utilising the proposed model with trauma survivors may be explored. Qualitative studies investigating positive psychology constructs, such as hope, SWB, and vicarious growth among therapists may particularly be valuable.

7.6 Personal Reflection

My personal journey with SFBT started when I was working as a clinical psychologist at a correctional centre in the country. The high incidence of trauma

among this population, both as victims and perpetrators, was particularly striking. However, in this problem-saturated environment, SFBT encouraged me to view offenders as competent and capable individuals with the potential of having a better future, despite their adverse histories. In this regard, SFBT protected me from vicarious traumatisation, as I did not have to listen to the details of offenders' trauma histories. I thus noticed that SFBT not only sparked hope and happiness within my clients, but also contributed to my own well-being in a context which is often described as dark and dire.

As I started working at community-based clinics in Gauteng (Ekurhuleni) the high prevalence of trauma among community members became even more apparent. Not only did most of my clients experience multiple forms of trauma during their lifetime, but many of them lived in constant fear due to interpersonal violence, community unrest, or xenophobia. However, practising from a solution-focused stance, I explored and amplified trauma survivors' ability to cope and survive amidst these challenges. As a result, they not only reported feeling empowered and confident, but also appeared to be more hopeful about their future. Many of them even reported psychological growth and "being stronger" as a result of the trauma they had experienced. This resilience I observed among trauma survivors thus ignited my interest in the research topic and inspired to me to further my studies.

I believe that my PhD journey has equipped me to be a more confident and skilled SFBT therapist. It has not only confirmed clients' expertise and capability of thriving, despite challenges; but has also encouraged me to fully trust my clients and do more of what works in therapy. Witnessing participants' remarkable strength has also ignited hope, happiness, and satisfaction within me, which has contributed towards personal growth. Not only do I now believe in people's resilience, but I also tend to seek the opportunity that is hidden in every adversity. This study furthermore developed my academic and research skills; especially as a qualitative researcher, as I had no prior experience in this field. Although there were challenging and frustrating times along the research path, I believe this has amplified my own strengths, including my patience, creativity, and persistence. These challenges have also evoked more empathy for my participants' struggles and allowed me to appreciate the light at the end of the research journey even more. I thus hope this study will inspire and empower other therapists and trauma survivors, both in South Africa and internationally.

Throughout this study, I was aware that my socio-demographic background, personal worldview, and belief system may have influenced the research process. As a white psychologist from a privileged background, I differed from my participants, most of whom were black people from disadvantaged communities. However, despite these differences, I believe that my past work experience has equipped me to work in culturally diverse contexts. I also trust that my ability to view and treat all human beings as equal, allowed participants to be open and honest, both in therapy and during the interviews. Furthermore, as participants in Phases II and III of this study were all women, I consider my gender to be an advantage as it enabled participants to share sensitive information. In addition, both SFBT and qualitative research acknowledge participants' expertise, and they aim to elicit rich and thick descriptions of their personal experiences. I therefore believe that, even though my background differed from that of the participants, their voices were given preference in this study.

7.7 Final Conclusion

It can be concluded that the objectives of this research study were met. The low incidence of hope and SWB observed among trauma survivors at community-based clinics in Gauteng highlighted the need for a trauma intervention that could facilitate hope and SWB. By implementing and describing SFBT in this context, it became apparent that trauma survivors may experience hope and SWB during and after exposure to this approach. The aspects of SFBT that contributed to these experiences were identified and led to the development of an SFBT intervention model that could facilitate hope and SWB among trauma survivors at community-based clinics. The outcome of this study has grown the body of research on SFBT with trauma survivors, and can also inform psychological practise, both locally and internationally. Further research in this regard is therefore recommended.

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Appendix A: Biographical Questionnaire

RESEARCH STUDY

A Solution Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-Being among Trauma Survivors at Community Clinics in Gauteng: A Mixed Methods Study

Participant Name: _____

Contact Number:_____

Name of Clinic: __

Researcher: Jolize Joubert

Email address: jolizejoubert@yahoo.com

University of Pretoria

Please read the instructions carefully before responding

Please turn over

A. INFORMATION ABOUT YOURSELF

Please read the following questions carefully and make an X in the column most applicable to you.

1. **How old are you?**

18–25	26–30	31–45	46–60	61–75	Older than 75

2. **What is your gender?**

Male	Female	Other

If other, please specify: _____

3. **What is your race?**

Black African	Coloured	Indian/Asian	White	Other

If other, please specify: _____

4. **What is your first language/mother tongue?**

English	Afrikaans	isiZulu	Sesotho	Other

If other, please specify: _____

5. **What is your marital status?**

Single	Married	Living Together	Divorced	Partner Deceased	Separated

6. **What is the highest level of education you completed?**

Primary School Level (Gr R–7)	High School Level (Grade 8–11)	Gr 12	Tertiary Qualification	Other

If other, please specify:_____

7. **What is your work status?**

Unemployed	Full-Time Employment	Part-Time Employment	Other

If other, please specify: _____

Please turn over

8. In what kind of home do you stay?

Free-standing house/brick structure	Flat/Apartment	Room in a house	Informal dwelling (shack)	Traditional dwelling/hut	Other

If other, please specify: _____

Please turn over

B. INFORMATION ABOUT THE TRAUMA

The following questions are about the traumatic event/s you experienced or witnessed in the past 5 years. Please read carefully and answer as honest as possible. You are allowed to mark more than one item.

1. **Type of traumatic event. Please make an X next to the traumatic event/s that you experienced or witnessed in the past 5 years.**

Type of Trauma	Personally Experienced	Witnessed
Natural disaster (e.g. flood, lightning)		
Fire/Explosion		
Transport accident (e.g. car, taxi, bus, train)		
Serious accident at work, home or during leisure activity		
Physical assault (e.g. attacked, hit, beaten up)		
Assault with a weapon (e.g. shot, stabbed, threatened with gun/knife)		
Sexual assault (e.g. rape, attempted rape, molestation)		
Other unwanted/uncomfortable sexual experience (e.g. forced to watch pornography)		
Captivity (e.g. being kidnapped, abducted, held hostage)		
Community violence (e.g. gang fights, protest, unrest)		
Life-threatening illness/injury (e.g. cancer, HIV)		
Sudden, unexpected death of a loved one		
Any other stressful event or experience		

If other, please specify: _____

2. **When did the traumatic event/s happen? Please make an X in the column most applicable to you.**

Less than 1 month ago	1-6 months ago	7 months–1 year ago	1–2 years ago	3 - 5 years ago

Please turn over

3. **Did the traumatic event/s change your life? Please make an X next to those areas the traumatic event changed and explain.**

Area of life	Traumatic event changed my:	Explain/clarify: Why do you say it changed your life?
Relationships		
Self-esteem (how I feel about myself)		
Physical health		
Mental health		
Spirituality/religion		
Hope for the future		
Satisfaction/happiness with life		
Other		

4. **Did you ever tell anyone about the traumatic event? Please make an X next to the column most applicable to you.**

I told:	
No one	
My spouse	
A family member	
A friend	
A spiritual/religious leader	
A professional (e.g. doctor, social worker, psychologist)	
Other	

If other, please specify: _____

5. **Did you ever see a professional to help you cope with the traumatic event? Please make an X next to the column most applicable to you.**

I consulted:	
No one	
A medical doctor/psychiatrist	
A social worker	
A psychologist	
A counsellor/therapist	
A spiritual/religious leader (e.g. pastor)	
Other	

If other, please specify: _____

Please turn over

6. **How long after the traumatic event did you consult a professional (e.g. doctor, social worker, psychologist, counsellor, pastor)? Please make an X next to the column most applicable to you**.

I consulted a professional:	
Never	
1–7 days after the event	
1–2 weeks after the event	
2–4 weeks after the event	
1–6 months after the event	
7 months–1 year after the event	
1–2 years after the event	
More than 2 years after the event	

If you did consult a professional, do you feel that helped you? Please explain your answer.

_____
_____
_____

7. **At this moment, do you feel you successfully coped/dealt with the traumatic event? Please explain your answer.**

_____
_____
_____

Please turn over

Appendix B: Information Letter for Phase I of the Study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

INFORMATION LETTER

REQUEST TO PARTICIPATE IN PHASE I OF THE RESEARCH ENTITLED:

A Solution-Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-Being among Trauma Survivors at Community Clinics in Gauteng: A Mixed Methods Study

Dear prospective participant,

I am a clinical psychologist currently working for the Gauteng Department of Health. I provide psychological services at government clinics in Ekurhuleni, Gauteng and am currently also registered for a PhD degree at the University of Pretoria. I am doing research on the above-mentioned topic and would like you to participate in this study.

Please take time to read the following information carefully before you decide to participate or not. You are welcome to ask if anything is not clear or if you would like more information.

What is the purpose of this study?

Many people in South Africa experience trauma (e.g. accidents, crime, abuse, violence etc.) that has an influence on their mental well-being. Psychologists at community clinics can, however, help people to recover from trauma and lead satisfying lives. I would therefore like to investigate trauma survivors' mental well-being, before and after receiving psychotherapy. I would also like to know what parts of therapy are most useful to clients. This information will then be used to develop a model that can be applied by psychologists who work with trauma survivors at community clinics.

What will be expected of me?

You were selected to take part in this study because you experienced trauma in the past 5 years. This study will be done in different phases and you are requested to take part in the first phase. You might, however, be contacted to take part in the next phases of the study.

During the first phase, you will be asked to complete a questionnaire which will be given by the researcher or a qualified nurse at the clinic. The questions will be about your background information (e.g. age, gender etc.), the trauma you experienced and your mental well-being. This questionnaire will not take more than 30 minutes to complete.

What more should I know to make an informed decision?

- This research has been approved by the Ethics Committee of the University of Pretoria as well as the Gauteng Department of Health.
- The researcher is registered as a clinical psychologist with the Health Professions Council of South Africa (HPCSA) and is expected to act in an ethical and professional manner.
- Participation in this study is completely voluntary and you have the right to withdraw at any time. Your decision not to continue with this study, will not disadvantage you in any way. If you decide to withdraw, your information will be destroyed.
- All your information will be kept confidential and private. Your name will not be mentioned anywhere and identifying information will be removed as far as possible.
- The information obtained from this study will be published in a thesis and/or article format and might be shared with other professionals.
- All information collected during this study will be safely stored for at least 15 years for archiving and research purposes.
- No significant risks are expected, but sensitive topics might be addressed that can be distressing. If you experience any distress due to your participation in this study, you will have the opportunity to continue therapy with the researcher or be referred to another psychologist in the district.
- This study may give you the opportunity to resolve trauma-related distress and potentially increase your mental well-being. Participation in this study may also benefit other trauma survivors at community-based clinics, as the research will guide other psychologists to provide effective therapy in future. You will, however, NOT receive any reward (e.g. money/gifts/rewards) for your participation.

Thank you for considering to participate in my study. If you decide to participate, please sign the attached consent form.

_____

Ms Jolize Joubert
Clinical Psychologist/Researcher
Gauteng Department of Health
jolizejoubert@yahoo.com

Prof. Tharina Guse
Supervisor
Faculty of Humanities
University of Pretoria

Appendix C: Information Letter for Phases II & III of the Study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

INFORMATION LETTER

REQUEST TO PARTICIPATE IN PHASES II & III OF THE RESEARCH ENTITLED:

A Solution-Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-being among Trauma Survivors at Community Clinics in Gauteng: A Mixed Methods Study

Dear prospective participant,

I am a clinical psychologist currently working for the Gauteng Department of Health. I provide psychological services at government clinics in Ekurhuleni, Gauteng and am currently also registered for a PhD degree at the University of Pretoria. I am doing research on the above-mentioned topic and would like you to participate in this study.

Please take time to read the following information carefully before you decide to participate or not. You are welcome to ask if anything is not clear or if you would like more information.

What is the purpose of this study?

Many people in South Africa experience trauma (e.g. accidents, crime, abuse, violence etc.) that has an influence on their mental well-being. Psychologists at community clinics can, however, help people to recover from trauma and lead satisfying lives. I would therefore like to investigate trauma survivors' mental well-being, before and after receiving psychotherapy. I would also like to know what parts of therapy are most useful to clients. This information will then be used to develop a model that can be used by psychologists who work with trauma survivors at community clinics.

What will be expected of me?

You were selected to take part in this study because you experienced trauma in the past 5 years. This study will be done in different phases and you are requested to take part in the second and third phase.

During the second phase, you will be requested to attend ±6 (or less) individual therapy sessions with the psychologist at the clinic. These sessions will specifically focus on how you coped with/survived the trauma. As soon as possible after these sessions, you will be asked to share your experience of the therapeutic process with the researcher during an interview. This will be

the third phase of the study. Both the therapy sessions and the interviews will be recorded on a digital voice recorder.

What more should I know to make an informed decision?

- This research has been approved by the Ethics Committee of the University of Pretoria as well as the Gauteng Department of Health.
- The researcher is registered as a clinical psychologist with the Health Professions Council of South Africa (HPCSA) and is expected to act in an ethical and professional manner.
- Participation in this study is completely voluntary and you have the right to withdraw at any time. Your decision not to continue with this study, will not disadvantage you in any way. If you decide to withdraw, your information will be destroyed.
- All your information will be kept confidential and private. Your name will not be mentioned anywhere and identifying information will be removed as far as possible.
- The information obtained from this study will be published in a thesis and/or article format and might be shared with other professionals.
- All information collected during this study will be safely stored for at least 15 years for archiving and research purposes.
- No significant risks are expected, but sensitive topics might be addressed that can be distressing. If you experience any distress due to your participation in this study, you will have the opportunity to continue therapy with the researcher or be referred to another psychologist in the district.
- This study may give you the opportunity to resolve trauma-related distress and potentially increase your mental well-being. Participation in this study may also benefit other trauma survivors at community-based clinics, as the research will guide psychologists to provide effective therapy in future. You will, however, NOT receive any reward (e.g. money/gifts/rewards) for your participation.

Thank you for considering to participate in my study. If you decide to participate, please sign the attached consent form.

_____

Ms Jolize Joubert
Clinical Psychologist/Researcher
Gauteng Department of Health
jolizejoubert@yahoo.com

Prof. Tharina Guse
Supervisor
Faculty of Humanities
University of Pretoria

Appendix D: Consent Form to Participate in Phase I of the Study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

CONSENT TO PARTICIPATE IN RESEARCH:

PHASE I

Research Entitled:

A Solution-Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-Being among Trauma Survivors at Community Clinics in Gauteng: A Mixed Methods Study

I_____ hereby agree to participate voluntary in the above-mentioned research project. I have read the attached information letter and I understand the implications of participation. I am willing to complete a questionnaire about my background information, the trauma I experienced as well as my mental well-being.

_____ _____

Participant's Signature Date

_____

Ms Jolize Joubert
Clinical Psychologist/Researcher
Gauteng Department of Health
jolizejoubert@yahoo.com

Prof. Tharina Guse
Supervisor
Faculty of Humanities
University of Pretoria

Appendix E: Consent Form to Participate in Phases II and III of the Study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

CONSENT TO PARTICIPATE IN RESEARCH:

PHASES II & III

Research Entitled:

A Solution-Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-Being among Trauma Survivors at Community Clinics in Gauteng: A Mixed Methods Study

I _____hereby voluntarily agree to the following:

- To complete a questionnaire about my background information, the trauma I experienced as well as my mental well-being;
- To attend 6 (or less) one-hourly individual therapeutic sessions with the researcher at the clinic;
- To take part in an individual interview with the researcher at the clinic, as soon as possible, after I completed the therapeutic sessions. During this interview, I will be asked to share my experience of the therapeutic process;
- For the therapeutic sessions as well as the interview to be recorded on a digital voice recorder;
- For the information I provided, to be used and published by the researcher. This information will, however, be treated confidentially and my identity will be protected;
- To inform the researcher if I experience any mental discomfort or distress during or as a result of my participation in this study, in order to receive the necessary support;
- To have read the attached information letter and to understand the implications of participation.

_____ _____

Participant's Signature Date

_____

Ms Jolize Joubert
Clinical Psychologist/Researcher
Gauteng Department of Health
jolizejoubert@yahoo.com

Prof. Tharina Guse
Supervisor
Faculty of Humanities
University of Pretoria

Appendix F: Interview Protocol

Proposed Interview Schedule

These questions serve as a proposed outline for the qualitative (interview) phase of the study entitled:

A Solution-Focused Brief Therapy Intervention Model to Facilitate Hope and Subjective Well-Being among Trauma Survivors at Community Clinics in Gauteng: A Mixed Methods Study

(Please note that this is a selection of questions which will guide the researcher, it may be that all questions and prompts are not used for all participants. It will depend on the nature of the interview.)

The interview will commence with the researcher explaining the purpose and procedure to the participants. Participants will be encouraged to answer in as much detail as possible and they will be prompted to provide examples where applicable.

A. Introductory Questions

1. What was the reason you came for therapy? /What was your goal for therapy?

2. How many therapeutic sessions did you attend?

3. How long ago was therapy ended?

4. Have you ever attended therapy before?

B. General Experience of the Therapeutic Process

1. How did you experience the therapeutic sessions?

1.1. How did you experience the techniques and questions used in therapy?

1.2. What stood out for you?

1.3. What impressed you about the approach?

2. What was most useful/valuable? What was not useful/valuable?

2.1. What worked for you? What did not work?

C. Experience of Trauma, Hope and Subjective Well-being

1. How did the therapeutic process impact you (if at all)? /How did therapy affect you?

1.1. What changes have you noticed since you attended therapy?

1.2. What changes have other people noticed within you, since you attended therapy?

1.3. What part of therapy contributed to this change?

2. How did therapy influence your view of the traumatic event (if at all)?

2.1. How did therapy influence the way you live/cope with the trauma?

2.2. What part of therapy contributed most?

3. How did therapy influence your view of life (if at all)?

3.1. How did therapy influence your view of yourself?

3.2 How did therapy influence your view of the future?

3.3. What part of therapy contributed to this?

4. How did therapy influence your experience of hope?

4.1. How did therapy influence the goals that you have for yourself?

4.2. How did therapy influence your motivation to achieve these goals?

4.3. What part of therapy contributed to this?

5. How did therapy influence your experience of well-being?

5.1. How did therapy influence your satisfaction with life?

5.2. How did therapy influence the feelings you experience?

5.3. What part of therapy contributed to this?

D. Concluding Questions

1. What did you achieve from attending therapy?

2. What would you remember/take away from this experience?

3. What would you have wanted to be done differently?

4. Is there anything more you want to add regarding your experience during therapy?

The interview will be concluded by thanking the participants for their participation and summarising the most prominent themes mentioned by the participant in order to serve as a credibility check.

Appendix G: Meta-Matrices of Between-Case Analysis

META-MATRIX OF BETWEEN-CASE ANALYSIS

Table G1: Theme 1: Moving towards a goal

Participant	Motivation and confidence to move towards goal	Source of motivation	Steps toward goal	Hope for a better future	Therapy helped me move towards goal
Participant 1	Not apparent at the start of therapy, gradually started to believe she can reach her goal.	External: family (especially children).	Initially lacked a way forward, found steps towards goal as therapy progressed.	• Expected a positive therapeutic outcome at the start of therapy; and • Expressed hope as therapy progressed.	• Reminded of source of motivation (children); • Gained motivation to reach goal; and • Found steps towards goal.
Participant 2	Motivation and confidence to reach goal present during the session, more apparent during interview.	External: family (especially unborn child) and spirituality.	Took steps toward goal prior to therapy, continued finding ways forward.	Expected a positive therapeutic outcome and a better future since the start of therapy.	• Gained confidence to reach goal; and • Realised she is on right path towards goal.
Participant 3	Drive to reach goal present at the start of therapy and gradually became stronger.	-	Initially lacked a way forward, found and took steps towards goal as therapy progressed.	Developed a positive future expectation as therapy progressed.	• Gained motivation to reach goal; and • Found steps towards goal.
Participant 4	Motivation to reach goal present at the start of therapy, confidence gradually became stronger.	• Initially, external: children; and • Later, internal: noticing progress towards goal.	Initially lacked a way forward, but took steps towards goal and was able to alter steps as therapy progressed.	Expressed hope to reach and maintain goal as therapy progressed.	• Reminded of goal and past success; • Found steps toward goal; and • Gained motivation and confidence to take steps toward goal.
Participant 5	Motivation to reach goal present at the start of therapy and gradually became stronger.	External: family, friends, and spirituality.	Plan to move forward present early in therapy, took steps towards goal as therapy progressed.	Expected a positive therapeutic outcome since the start of therapy.	• Gained motivation to reach goal; and • Found steps towards goal.

Participant	Motivation and confidence to move towards goal	Source of motivation	Steps toward goal	Hope for a better future	Therapy helped me move towards goal
Participant 6	Push to reach goal present at the start of therapy and gradually became stronger.	External: family (especially child and siblings) and spirituality.	Initially lacked a way forward, but took steps towards goal as therapy progressed.	Developed hope as therapy progressed.	• Gained confidence to reach goal; and • Realised she is on right path towards goal.
Participant 7	Drive to reach goal present at the start of therapy.	External: family (especially children and siblings) and community projects.	Took steps toward goal prior to therapy and was able to alter steps as therapy progressed.	-	• Gained motivation to reach goal; and • Found steps towards goal.

Table G2: Theme 2: Feeling good

Participant	More positive than negative feelings	Controlling and expressing feelings	Feeling good starts with me	Relational factors make me feel good	Therapy helped me feel good
Participant 1	• Feeling happy and at peace, less stressed and irritable; and • Sleeps better, has fewer headaches.	-	-	• Socialising; and • Spending time with children.	• Reminded of external factors that make her feel food; and • Encouraged to do good things.
Participant 2	Feeling relaxed, no panic.	More assertive, empathic, and patient.	-	-	• Became aware of emotions; and • Gained confidence to express feelings.
Participant 3	Feeling happy and free, less depressed.	-	Prioritise own needs, makes herself happy, and set healthy boundaries.	• Socialising; • Relationships; and • Hobbies.	• Provided opportunity to express feelings; • Encouraged to do things she likes; and • Encouraged to prioritise self.
Participant 4	• Feeling happy, content, excited, more relaxed, and less frustrated; and • Sleeps better has fewer headaches and more energy.	More assertive, able to manage conflict and emotions better.	Prioritise own feelings and makes herself happy.	• Socialising; and • Relationships.	-
Participant 5	Feeling happy and free, less angry.	More assertive, communicates better.	Prioritise own feelings and makes herself happy.	• Socialising; • Hobbies; and • Spiritual activities.	• Provided opportunity to express feelings and practice assertiveness; and • Encouraged to prioritise self.
Participant 6	Feeling happy, free, and relieved, less depressed.	-	-	Helping others	Provided opportunity to express feelings.

Participant	More positive than negative feelings	Controlling and expressing feelings	Feeling good starts with me	Relational factors make me feel good	Therapy helped me feel good
Participant 7	• Feeling relaxed, calm, and focused. less stressed; and • Less sleepless nights.	More in control of emotions.	-	• Connections (socialising, spiritual activities); and • Helping others.	-

Table G3: Theme 3: Life is good

Participant	Life after trauma	Grateful for things in life	I am good and worthy	Therapy changed my perspective on life
Participant 1	-	Alluded that she is grateful for her children, and loves them.	• Proud of herself; and • Recognised her value as mother.	-
Participant 2	• Experienced growth after trauma; Trauma gave purpose and meaning to life; and Trauma gave her strength.	-	• Realised she is more than her trauma; and • Realised she is surviving.	• Made her realise she is surviving and coping; and • Helped her accept trauma as part of life and take control of how she responds.
Participant 3	• Accepted trauma; • Realised she still has a life to live; and • Focused on future she can control.	Appreciated everyday blessings in life.	• Recognised her worth and purpose as a woman and mother; and • Gained self-confidence.	• Shifted her focus towards future possibilities; and • Helped her rediscover her strengths.
Participant 4	• Trauma gave purpose and meaning to life; and • Trauma gave her strength.	• Appreciated everyday blessings in life; and • Grateful for her circumstances and what it taught her.	Recognised her strengths and skills.	• Shifted focus towards future possibilities; • Made her recognise the skills she learned through her trauma; and • Helped her to became aware of her worth.
Participant 5	• Accepted trauma; and • Realised she still has a life to live.	• Thanked God for her children; and • Noticed everyday blessings in life.	• Forgave herself for past mistakes; • Realised she is bigger than her problems; and • Became aware of her worth and purpose.	• Opened her mind to see the light; and • Helped her to recognise her strength and worth.
Participant 6	• Accepted trauma; and • Realised she still has a life to live.	Thanked God for her family.	• Discovered her worth and purpose; and • Became aware of her strengths.	• Made her aware of her strength and competence; and • Helped her to realise life goes on.

Participant	Life after trauma	Grateful for things in life	I am good and worthy	Therapy changed my perspective on life
Participant 7	• Seeing the bigger picture; and • Realising current situation is not life defining.	• Grateful for her circumstances and what it taught her; and • Appreciate her upbringing and her family.	Recognised her worth and purpose in relation to her community projects.	• Reminded her of her resilience and purpose; and • Helped her to see the bigger picture.

Table G4: Theme 4: How therapy helped

Participant	Therapeutic conversation	Empathy and acceptance in therapy	Visualising a better future	Focusing on strengths	Talking about trauma
Participant 1	• Talking to a stranger; and • Encouraging words from therapist.	-	-	• Remembering the good things in her life (e.g. loved ones); and • Talking about past interests and strengths.	Painful to talk about trauma.
Participant 2	• Open and honest conversation; • Positive feedback from therapist; and • Therapist asking detailed questions; and • Therapist using client's own words.	• Not being judged or analysed; and • Therapist showing interest and empathy.	-	Taking about coping.	• Better to talk about coping, then details of trauma; but • Comfortable to share what she felt was necessary.
Participant 3	Therapist listening.	Therapist accepting her.	Talking about future plans and new possibilities.	• Talking about strengths and resources (e.g. talents, interests, hobbies etc.); and • Remembering past success, passions, and talents.	• Desire to talk about problem in more detail during the first session; but • Empathic approach encouraged her to talk about problem in following session.
Participant 4	Collaborative nature of conversation.	-	Visualising and describing ideal future self in detail.	• Focusing on small steps already taken; and • Identifying strengths and skills used to cope.	• Painful to talk about trauma; and • Not useful to analyse or dwell on problem as it will not necessarily yield solutions.

Participant	Therapeutic conversation	Empathy and acceptance in therapy	Visualising a better future	Focusing on strengths	Talking about trauma
Participant 5	• Open and trustful conversation; and • Therapist listening.	• Not being judged; and • Therapist not trying to change her.	-	• Talking about the good things in life (e.g. strengths, resources and interests); and • Remembering past success.	• Painful to talk about bad things; and • Trauma should be buried.
Participant 6	-	• Therapist accepting her; and • Therapist being kind, friendly, and attentive.	Imagining and describing happy version of herself.	Talking about happiness.	• Good to talk about trauma; but then • Make peace with it and build future.
Participant 7	• Talking to an objective professional; and • Collaborative nature of conversation.	• Not being judged; and • Therapist being relaxed and welcoming.	-	• Talking about strengths (e.g. passions, skills, interests); • Remembering past coping and past success; and • Talking about important people in her life (e.g. children).	• Painful to talk about trauma; and • Not useful to talk about details of trauma as it cannot be changed.

Appendix H: Ethical Approval from the University of Pretoria's Research Ethics Committee

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

6 November 2018

Dear Ms Joubert

Project:	**A Solution Focused Brief Therapy (SFBT) intervention model to facilitate hope and subjective wellbeing among trauma survivors at community clinics in Gauteng: A mixed-method study**
Researcher:	**J Joubert**
Supervisor:	**Prof T Guse**
Department:	**Psychology**
Reference number:	**27119255 (GW20180913HS)**

Thank you for your response to the Committee's correspondence.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 6 November 2018. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

cc: Prof T Guse (Supervisor and HoD)

Appendix I: Ethical Approval from the Ekurhuleni Health District Research Committee

City of Ekurhuleni

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

EKURHULENI HEALTH DISTRICT RESEARCH PERMISSION

Research Project Title: A Solution Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Wellbeing among Trauma Survivors at Community Clinics in Gauteng: A Mixed-Method Study

NHRD No: GP_201810_032

Research Project Number: 13/09/2018-05

Name of Researcher(s): Ms Jolize Joubert

Division/Institution/Company: University of Pretoria

Date of review by the EHDRC: 13 September 2018

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
- Facilities approved for the research: Goba Clinic, Alberton Clinic, Brackenhurts and Dresser Clinics. The researcher will report to the relevant manager/facility manager before initiating the study.
- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.

- The EHDRC must be informed in writing before publication or presentation of research findings and a copy of the report/publications/presentation must be submitted to the EHDRC

- The district must be acknowledged in all the reports/publications generated from the research.

- The researcher will be expected to provide the EHDRC with

  - Six monthly progress updates including any adverse events
  - The final study report in electronic format
  - Present the final research findings at the annual Ekurhuleni research conference if possible.

- The EDHRC reserves the right to withdraw the approval, if any of the conditions mentioned above have being breached

- The research committee wishes the researcher(s) the best of success.

DR JOSEPH SEPUYA

DEPUTY CHAIRPERSON: CITY OF EKURHULENI

Dated: 11/10/2018

Dr R. Kellerman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI HEALTH DISTRICT)

Dated: 11/10/2018