

# **The prevalence of hope, subjective well-being, and psychopathology among trauma survivors at community-based clinics in Gauteng**

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## **Abstract**

This study examined the prevalence of hope and subjective well-being as well as symptoms of depression and post-traumatic stress disorder among trauma survivors at community-based clinics in Gauteng. We further explored traumatic events and help-seeking behaviour in this context. Using a cross-sectional survey design, we collected demographic information and administered questionnaires measuring hope, well-being, depression, and post-traumatic stress. The sample comprised of 120 adults, of whom the majority were black females. Results showed that participants experienced low levels of hope, positive affect, and life satisfaction as well as high levels of negative affect, depression, and post-traumatic stress. In addition, the majority of participants experienced multiple traumatic events in the past five years, which had a negative impact on their well-being. However, receiving professional help and being able to cope in the aftermath of trauma may contribute towards higher levels of well-being and fewer psychopathological symptoms. Our findings thus highlighted the need for effective therapeutic interventions among trauma survivors.

**Keywords:** Community mental health, depression, hope, post-traumatic stress, subjective well-being, trauma

The experience of trauma seems to have become endemic in the South African context. 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 et al., 2013; Williams et al., 2007). South Africans are commonly exposed to physical violence, accidents, witnessing of community violence, and the unexpected death of a loved one. Emotional, physical, and sexual abuse in the context of intimate relationships are also relatively common (Atwoli et al., 2013; 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 et al., 2013). Furthermore, despite the establishment of a non-racial democracy in 1994, the country 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 prevail. For example, 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; Williams et al., 2007). South African communities are therefore predisposed to multiple and continuous trauma which tend to have a cumulative negative effect on citizens' psychological health (Eagle, 2015; Kaminer & Eagle, 2010).

Trauma survivors may develop psychiatric disorders, including post-traumatic stress disorder (PTSD), depression, anxiety, and substance abuse. Individuals with PTSD are also 80% more likely than those without PTSD to have a comorbid mental disorder, such as depression (American Psychiatric Association [APA], 2013; Brady et al., 2000). Trauma is further associated with increased suicidal risk, emotional and interpersonal problems, and poor self-image (Brady et al., 2000). Exposure to continuous trauma, in particular, may lead to somatic symptoms, concentration problems, irritability, feelings of guilt and despair, and self-

destructive behaviour (Crawford-Browne & Benjamin, 2012; Eagle, 2015). Trauma therefore places a burden on mental health services in South Africa, especially community-based services, as the majority of the population are dependent on the public health system (Council for Medical Schemes, 2014). However, this sector is often characterised by an insufficient number of community psychiatric clinics, poor accessibility of clinics, and limited mental health practitioners (De Kock & Pillay, 2017). This highlights the need for effective trauma interventions in this context.

Trauma may also have an impact on people's experience of hope and subjective well-being (SWB). 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). Research suggests that hope is negatively related to various traumatic events, including interpersonal and community violence, war, and sexual assault (Chang et al., 2015; Levi et al., 2012; Machado et al., 2010; Scher & Resick, 2005). In South Africa, Isaacs and Savahl (2014) found that violent perpetration is associated with a loss of hope for the future among adolescents residing in a high-violence community. Since hope is a multidimensional experience, influenced by an interplay of individual, relational, communal, and spiritual factors, it is important to explore hope in an Afrocentric context (Isaacs & Savahl, 2014). Yet, studies concerning the prevalence of hope among adult trauma survivors in South Africa are lacking.

Traumatic experiences may further impact on individuals' well-being, in particular SWB, which is a multidimensional concept, comprised of cognitive and affective dimensions. Life satisfaction refers to the cognitive component, while a preponderance of positive affect in relation to negative affect reflects the affective component (Diener, 1984). Traumatic life

events seem to have a significant, but relatively short-term, negative effect on SWB as people tend to adapt to the consequences of these events (Frederick & Loewenstein, 1999; Suh et al., 1996). For example, local and international studies have shown that happiness is negatively impacted by the loss of a close relative, being diagnosed with a life-threatening illness, exposure to accidents, violence and crime (Buccioli & Zarri, 2017; Mahuteau & Zhu, 2016; Powdthavee, 2005). 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 (Buccioli & Zarri, 2017; Calvo et al., 2015; Lucas, 2007). Moreover, cross-national studies have highlighted the influence of cultural, economic, and political factors concerning SWB. Research on SWB in a socio-culturally diverse country such as South Africa is therefore warranted (Tov & Diener, 2013).

Against this backdrop, this study examined the prevalence of hope, SWB, and psychopathology (symptoms of depression and PTSD) among trauma survivors at community-based clinics in Gauteng. We conceptualised psychopathology as the absence of well-being (Keyes, 2002). We also explored traumatic events and help-seeking behaviour in this context.

## **Method**

### *Participants*

Using non-probability purposive sampling, 136 adult patients at community-based clinics in Gauteng, exposed to one or more traumatic event during the past 5 years and willing to participate in the study, were identified. However, only 120 completed the questionnaires and were included in this study. The majority of participants were females (83%) and most were between the ages of 26 and 45 years (64%). Most of the participants were black (79%). The sample's home language was primarily isiZulu (35%), Sesotho (27%), English (13%) or Afrikaans (13%). More than half were single (54%) and most had completed, at least, Grade

12 (67%). Just under half of the participants were unemployed (48%), although slightly more than half of them lived in a free-standing brick house (53%).

### *Instruments*

A biographical questionnaire provided socio-demographic information as well as trauma-related information (e.g. traumatic event/s exposed to, participants' responses to the trauma, and help-seeking behaviour).

The *Adult State Hope Scale (AHS)* (Snyder et al., 1996) measured participants' momentary hopeful thinking as conceptualised by Snyder's (2000) hope theory. This 6-item instrument consists of three agency and three pathways items scored on an eight-point Likert scale, ranging from 1 (*definitely false*) to 8 (*definitely true*). The scores for each of these subscales are added, with higher scores representing higher levels of hope. Snyder et al. (1996) reported Cronbach alpha coefficients ranging from 0.90 to 0.95 for the scale. Furthermore, Nel and Boshoff (2014) found the psychometric properties of this scale to be acceptable in the South African context. The current study yielded a Cronbach alpha coefficient of 0.82 for the total scale.

The *Scale of Positive and Negative Experience (SPANE)* (Diener et al., 2009) measured the affective components of SWB. This 12-item questionnaire comprises of two sub-scales to assess positive feelings (SPANE-P) and negative feelings (SPANE-N) on a 5-point Likert scale, ranging from 1 (*rarely never or never*) to 5 (*very often or always*). The scores for each of these sub-scales are added to obtain a total score, with higher scores indicating higher levels of positive or negative feelings. The SPANE showed good psychometric properties with a Cronbach alpha coefficient ranging from 0.81 to 0.90 (Diener et al., 2009). Du Plessis and Guse (2017) also found the SPANE to be a valid instrument for measuring positive and negative affect 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 et al., 1985) assessed the cognitive component of SWB. This 5-item scale measures global cognitive judgements of life satisfaction on a 7-point Likert scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The scores for each item are added, with higher scores suggesting higher levels of life satisfaction. Reliability studies of the SWLS indicated a mean Cronbach alpha coefficient of 0.78 (Corrigan et al., 2013). In South Africa, researchers reported satisfactory psychometric properties for the English version among a multi-cultural sample (Wissing et al., 2008). The current study yielded a Cronbach alpha coefficient of 0.83.

The *Patient Health Questionnaire (PHQ-9)* (Kroenke et al., 2001) and the *Post-Traumatic Stress Disorder Checklist for DSM-V (PCL-5)* (Weathers et al., 2013) were used to measure the presence of psychopathology. The PHQ-9 is a 9-item, self-administered scale that measures depression severity in the past two weeks. Each item is scored on a 4-point Likert scale, ranging from 0 (*not at all*) to 3 (*nearly every day*). The scores for each item are added, with a score  $\geq 10$  suggesting a possible diagnosis of major depression. Kroenke et al. (2001) reported a Cronbach alpha coefficient of 0.86. The PHQ-9 also appears to be a valid screening tool to use in South Africa's public health facilities (Bhana et al., 2015). In the current study, a Cronbach alpha coefficient of 0.86 was obtained,

The PCL-5 (Weathers et al., 2013) was used to assess the presence and severity of PTSD symptoms in the past month. This 20-item self-report measure is scored on a 5-point Likert scale, ranging from 0 (*not at all*) to 4 (*extremely*). The scores for each item are added, with a score  $\geq 33$  indicating a provisional PTSD diagnosis. Previous psychometric studies have confirmed satisfactory reliability and validity for this measure in various contexts (Ashbaugh

et al., 2016; Wortmann et al., 2016). Makhubela (2018) also provided evidence for the factorial validity and reliability of PCL-5 scores in the South African context. The current study yielded a Cronbach alpha coefficient of 0.91.

### *Procedure*

Participants were obtained from four district health government clinics in Gauteng (Ekurhuleni), situated in both urban and semi-rural areas. The first author is a clinical psychologist at these clinics and had access to prospective participants. Those who met the inclusion criteria volunteered or were referred by nurses at the clinics. The first author administered the questionnaires, either individually or in groups, depending on convenience and resources available. Individual and group administration occurred under the same conditions of confidentiality, were facilitated by the same person, and provided the same amount of support or guidance to participants in terms of translation. All questionnaires were administered in English. Where necessary, a trained field worker (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 of questionnaires.

### *Ethical considerations*

Approval to conduct the study was obtained from the University of Pretoria's Research Ethics Committee (GW20180913HS) as well as the Ekurhuleni Health District Research Committee (EHDRC) (GP\_201810\_082). The participants provided written informed consent and although debriefing was available for participants who experienced distress as a result of participation, this was never requested.

### *Data analysis*

Data were analysed using the IBM SPSS (Version 26, 2019) computer software program. Biographical information was categorised into discrete categories. Descriptive statistics,

reliability of measuring instruments, and frequency distributions of biographical and trauma-related information were determined. We conducted independent group t-tests, assuming equal variances, to determine whether there was a difference in the mean scores of hope, SWB, depression, and PTSD (at a significance level of .05) for different trauma-related variables (number of traumatic events, professional help, and coping). A two-tailed independent group t-test was also performed to compare the mean scores of hope, SWB, depression, and PTSD with other samples from existing studies. For these tests, the appropriate t-values and degrees of freedom were chosen based on Levene's test for equality of variance.

## Results

### *Trauma-related experiences*

Table 1 indicates that the most common traumatic events participants experienced were: the death of a loved one (49%), physical assault/abuse (32%), and a life-threatening illness/injury (24%). 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. The negative impact of these events was mirrored by the fact that half (51%) of the participants indicated that they were not coping with the consequences of the trauma.

**Table 1.** Trauma experiences of participants.

Trauma variable	<i>n</i>	%
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		
1	52	43
2	27	23
3	21	18
4	5	4
≥5	15	13
Currently coping with trauma		
No	53	51
Partially	27	26
Yes	25	24

### *Help-seeking behaviour*

Table 2 shows that most participants (84%) disclosed their trauma to someone, particularly a family member (57%) or a friend (38%). However, the majority (62%) of participants did not receive any professional help following their traumatic experience. Only 17% received assistance from a medical doctor or psychiatrist and even less (13%) consulted a psychologist. Those who did seek professional help, mostly (55%) did so less than 6 months after the traumatic event. The majority (71%) of these participants highlighted the value of professional help and indicated that it was helpful; or at least partially helpful.

**Table 2.** Help-seeking reported by participants.

Help-seeking variable	<i>n</i>	%
Disclosure of traumatic event		
Family member	68	57
Friend	45	38
Spouse	26	22
Spiritual/religious leader	20	17
Nobody	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

### *Prevalence of hope, subjective well-being, and psychopathology*

Table 3 reflects the mean scores obtained from the questionnaires to indicate the prevalence of hope, SWB, and psychopathology among the current sample.

**Table 3.** Comparison of means and standard deviations between different samples.

Scale	Comparison sample	Comparison study M (SD)	Current study M (SD)	t-value	df	p-value
AHS	American students (mass testing) (Snyder et al., 1996)	37.15 (6.33)	29.53 (10.93)	7.15	133.05	<.001
	American students (follow-up) (Snyder et al., 1996)	33.99 (7.02)	29.53 (10.93)	3.85	175.79	<.001
SPANE-P	South African (SA) students (Du Plessis & Guse, 2017)	21.96 (3.81)	18.78 (4.78)	6.86	130.05	<.001
	American students (Diener et al., 2010)	22.05 (3.73)	18.78 (4.78)	6.97	136.73	<.001
SPANE-N	SA students (Du Plessis & Guse, 2017)	15.96 (3.94)	19.38 (4.88)	-7.07	123.98	<.001
	American students (Diener et al., 2010)	15.36 (3.95)	19.38 (4.88)	-8.18	131.37	<.001
SWLS	White SA students and adults (Wissing et al., 2008)	24.8 (5.8)	16.92 (7.76)	10.19	159.18	<.001
	Black SA students and adults (Wissing et al., 2008)	24.2 (5.1)	16.92 (7.76)	8.63	198.98	<.001
PHQ-9	US clinical clients (Pavot & Diener, 1993)	14.4 (6.7)	16.92 (7.76)	-1.56	143	.121
	SA primary health patients (Bhana et al., 2015)	9.4 (5.3)	12.52 (7.01)	-4.45	128.64	<.001
PCL-5	American veterans (Hassija et al., 2012)	13.08 (6.73)	12.52 (7.01)	0.69	316	.490
	Canadian students (Ashbaugh et al., 2016)	20.9 (17.7)	41.69 (17.60)	-11.59	946	<.001
	UK military members and retired veterans (Wortmann et al., 2016).	42.41 (15.06)	41.69 (17.60)	0.41	128.98	.682

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 Checklist for DSM-V.

### *Prevalence of provisional clinical diagnosis*

Table 4 shows that more than two thirds of participants had a provisional diagnosis of either depression (68%) or PTSD (69%), as determined by the cut off scores on the PHQ-9 and PCL-5, respectively. A larger number of the participants also met the criteria for both these clinical diagnoses (62%).

**Table 4.** Prevalence of participants with a provisional clinical diagnosis.

Provisional clinical diagnosis	Scale	Possible range	Observed range	Clinical score	n	%
Depressive disorder	PHQ-9	0-27	0-27	≥ 10	71	68
PTSD (post-traumatic stress disorder)	PCL-5	0-80	3-75	≥ 33	72	69
Both depression and PTSD					64	62

PHQ-9: Patient Health Questionnaire; PCL-5: Post-Traumatic Stress Disorder Checklist for DSM-V.

### *Hope, SWB, and psychopathology compared for different samples*

To shed more light on the variables examined among the current sample, the mean scores and standard deviations (SD) obtained from the questionnaires were compared to that reported in earlier local and international samples (see Table 3). For this sample, the mean scores of hope, positive affect, and life-satisfaction were significantly lower than that of South African and

American student samples. The mean scores of negative affect, depression, and PTSD were also significantly higher compared to groups not exposed to trauma. However, in this study, the mean scores of life-satisfaction did not differ significantly from a US clinical sample ( $t(143) = 1.56, p = .121$ ). Considering depression, no significant differences were also observed between the current sample and a group of American veterans ( $t(316) = 0.69, p = .490$ ). Similarly, the mean score of PTSD did not differ significantly compared to that of military service members and retired UK veterans ( $t(128.98) = 0.41, p = .682$ ). Thus, the mean scores from this sample did not differ significantly from that of other clinical samples, however, when compared to community samples there was a large difference.

#### *Hope, SWB, and psychopathology compared for different trauma-related variables*

We compared the mean scores of hope, SWB, and psychopathology between various groupings (traumatic event exposure, help seeking behaviour, and coping). Most pairwise comparisons, after a Bonferonni adjustment for the number of comparisons, were not significant.

However, participants exposed to two or more traumatic events experienced significantly higher levels of PTSD ( $M = 45.42, SD = 16.18$ ), compared to participants exposed to only one trauma ( $M = 37.22, SD = 18.35$ ) ( $p = .014$ ). Similarly, the group who experienced multiple traumas reported significantly lower levels of life satisfaction ( $M = 15.61, SD = 7.01$ ) than the group exposed to only one traumatic event ( $M = 18.65, SD = 8.41$ ) ( $p = .035$ ).

Participants who received some form of professional help also experienced marginally higher levels of hope ( $M = 32.07, SD = 9.82$ ), compared to those who did not receive professional help ( $M = 27.93, SD = 11.35$ ) ( $p = .049$ ).

Furthermore, participants who were coping with their trauma experienced significantly higher levels of hope (Coping:  $M = 36.32, SD = 9.28$ ; Not coping:  $M = 27.30, SD = 10.34$ ) ( $p = .002$ ), positive affect (Coping:  $M = 21.28, SD = 4.96$ ; Not coping:  $M = 17.45, SD = 4.40$ ) ( $p = .003$ ),

and life satisfaction (Coping:  $M = 22.48$ ,  $SD = 6.92$ ; Not coping:  $M = 15.06$ ,  $SD = 7.75$ ) ( $p = .000$ ), compared to those who felt they were not coping. The latter group also scored significantly higher on negative affect (Not coping:  $M = 20.75$ ,  $SD = 4.29$ ; Coping:  $M = 15.87$ ,  $SD = 5.20$ ) ( $p = .000$ ), PTSD (Not coping:  $M = 43.72$ ,  $SD = 16.62$ ; Coping:  $M = 32.54$ ,  $SD = 15.43$ ) ( $p = .025$ ), and depression (Not coping:  $M = 13.73$ ,  $SD = 6.99$ ; Coping:  $M = 8.83$ ,  $SD = 6.77$ ) ( $p = .011$ ) than the group that felt they were coping. Lastly, those who said they coped partially ( $M = 19.22$ ,  $SD = 4.75$ ) experienced significantly more negative affect than those who coped ( $M = 15.87$ ,  $SD = 5.20$ ) ( $p = .038$ ).

## **Discussion**

This study focused on trauma and the prevalence of hope, SWB, and psychopathology among trauma survivors at community-based clinics in Gauteng. Similar to previous studies, results indicated that the unexpected death of a loved one, physical violence, and accidents are some of the most common traumatic events South Africans experience (Atwoli et al., 2013). However, compared to the South African Stress and Health (SASH) study, this sample reported a higher prevalence of physical assault/abuse (Williams et al., 2007). This may reflect the criminal activities, gender-based violence, and high-risk behaviour facing communities in South Africa (Jewkes & Abrahams, 2002; Schneider et al., 2016). The relatively high prevalence of life-threatening illness/injury among participants in this study may furthermore be due to the clinical setting and the high incidence of HIV/AIDS in the community (Schneider et al., 2016). Concerning the number of traumatic events, results from this study were supported by previous studies identifying a high prevalence of multiple and continuous trauma among South Africans (Atwoli et al., 2013; Williams et al., 2007). The fact that most participants reported that they are not coping furthermore highlighted the negative impact of trauma (APA, 2013; Kaminer & Eagle, 2010).

In terms of help seeking behaviour, this sample shared their traumatic experience with someone they trusted, such as a family member or a friend, similar to an earlier study among South African women exposed to childhood sexual abuse (Walker-Williams, 2012). However, few participants received professional help following the traumatic event. This may be ascribed to the various challenges community mental health services face in South Africa (De Kock & Pillay, 2017). A lack of awareness and negative attitudes towards government-based mental health services may also have prevented participants from seeking professional help (Kaminer & Eagle, 2010; Schneider et al., 2016). Traditional cultural and spiritual beliefs, held by a large portion of the South African population, furthermore influence individuals to consult traditional or faith healers, before approaching formal psychiatric services (Burns, 2011). Nevertheless, more than half of participants who sought professional help, did so less than 6 months after exposure to the traumatic event; suggesting that they may have held a more accepting perspective regarding mainstream mental health services. This notion was echoed by the fact that participants generally regarded professional help as useful, or at least partially helpful.

In agreement with existing literature, results indicated that traumatic events may erode trauma survivors' experience of hope, as the mean hope score was lower than those reported in other community samples. This concurs with local and international research suggesting that hope is negatively associated with various traumatic events (Chang et al., 2015; Isaacs & Savahl, 2014; Levi et al., 2012; Machado et al., 2010; Scher & Resick, 2005). Violence, victimisation, loss, and non-supportive environments, in particular, contribute towards diminished hope in the context of trauma (Snyder, 2002). This was supported by our findings which indicated that participants who did not receive some form of professional help showed lower levels of hope, compared to those who did receive help. Similarly, those who indicated that they were not coping with their trauma experienced significantly lower levels of hope than those who were

coping. These findings highlighted the impact professional help may have on trauma survivors' experience of hope.

We further found that participants in this study experienced low levels of both affective and cognitive SWB, compared to non-clinical local and international samples. The findings concur with literature suggesting that various traumatic events may negatively affect people's experience of SWB (Buccioli & Zarri, 2017; Lucas, 2007; Lucas et al., 2003; Mahuteau & Zhu, 2016; Powdthavee, 2005). The type of traumatic event, the degree of exposure, and post-event resources and support, in particular, appear to influence individuals' well-being after trauma (Calvo et al., 2015; Janoff-Bulman & Frieze, 1983). Similarly, we found that participants exposed to multiple traumatic events (compared to only one trauma) reported significantly lower levels of SWB, in particular life-satisfaction. Furthermore, participants who coped with their trauma experienced significantly higher levels of SWB, than the group who was not coping. Although trauma may have a significant impact on survivors' well-being, interventions that facilitate coping may thus be beneficial in this context.

Socio-demographic factors may also have influenced participants' experience of well-being. 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 (Zuckerman et al., 2017). Local studies (Möller, 2001; Wissing et al., 2008) furthermore reported that individuals (especially women) from previously disadvantaged communities are less satisfied with their lives. This may be attributed to a history of racial segregation and oppression, as well as prevailing psychosocial challenges. Despite the possible influence of socio-demographic factors, the impact trauma had on participants' well-being was emphasised by the high prevalence of trauma-related psychopathology they reported.

For example, findings suggested that two thirds of the participants possibly met the criteria for major depression (Kroenke et al., 2001) and/or PTSD (Weathers et al., 2013). The literature concurs that PTSD and depression commonly co-occur in the aftermath of trauma (APA, 2013; Brady et al., 2000). Although previous South African studies reported lower than anticipated levels of PTSD among trauma survivors, other psychiatric disorders, especially major depressive disorder, were common (Atwoli et al., 2013; Kaminer & Eagle, 2010). This might explain the high incidence of depression among participants in this study. Hence, our results indicated that trauma survivors may experience prominent symptoms of psychopathology, when compared to the general population, which reflect an absence of well-being (Keyes, 2002). In our study, participants exposed to multiple traumatic events reported significantly higher levels of PTSD, compared to participants exposed to only one trauma. This illustrates the cumulative negative effect of multiple and continuous trauma on survivor's well-being (Eagle, 2015; Kaminer & Eagle, 2010). Nevertheless, in our study, the group that were coping with their trauma reported significantly lower levels of PTSD and depression, compared to the group that were not coping. These findings emphasised the value of appropriate trauma interventions to facilitate coping.

This study contributed towards the limited literature regarding the prevalence of well-being and psychopathology among trauma survivors in the South African context, specifically at community-based clinics. It also highlighted the negative impact of multiple traumatic events and emphasised the need for therapeutic interventions that may facilitate effective coping in this context. Despite the potentially valuable findings of this study, some limitations exist. First, this study was based on a relatively small, homogenous sample, and can therefore not be generalised to the broader population. Second, data were collected via self-report questionnaires which may yield subjective results. Third, questionnaires were not administered in participants' vernacular and constructs were measured according to a western

conceptualisation. Hence, being cognisant of socio-cultural factors, further studies regarding the prevalence and experience of well-being among trauma survivors in South Africa are recommended.

## **Conclusion**

Trauma survivors at community-based clinics in Gauteng experienced low levels of hope, positive affect, and life satisfaction. High levels of negative affect and psychopathology (symptoms of depression and PTSD) were also present. These findings concurred with existing international research. The majority of participants experienced multiple traumatic events in the past five years, which had a significant negative impact on their well-being. However, receiving professional help and being able to cope in the aftermath of trauma may contribute towards higher levels of well-being and fewer psychopathological symptoms. It is therefore essential to implement effective and contextually relevant trauma interventions at community-based clinics.

## **Declaration of conflicting interests**

The author(s) declare(s) that there is no conflict of interest.

## **Funding**

The first author received a bursary from the University of Pretoria.

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