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Master's Research Report

**Demographic Profiling of South African Young Adults in Relation to Post-Traumatic
Stress Symptomatology.**

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Declaration

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Abstract

Post-Traumatic Stress Symptomatology (PTSS) among young adults in South Africa remains an understudied area despite the country's high exposure to trauma. This study examines the prevalence of PTSS and its associations with key demographic factors, including gender, home language, socioeconomic status, and religious beliefs. Utilising secondary data from the Africa Long Life Study (ALLS), a quantitative, non-experimental, and cross-sectional design was employed. A total of 819 participants were recruited through convenience and snowball sampling. The International Mental Health Assessment (IMHA) was used to assess PTSS, while socioeconomic status and religiosity were measured using the Family Affluence Scale (FAS) and the Duke Religion Index (DUREL), respectively. Descriptive statistics and inferential analyses were conducted. Correlation analyses, t-tests, and ANOVA tests were employed to determine the relationships between demographic variables and PTSS. Results indicated that PTSS prevalence was low within the sample, with significant variations observed across gender and socioeconomic groups. Females reported higher levels of PTSS compared to males, and individuals with lower socioeconomic status exhibited heightened PTSS. Religious involvement, particularly organisational religious activity, demonstrated a protective effect against PTSS. However, home language did not show a statistically significant association with PTSS. These findings underscore the importance of targeted mental health interventions, particularly for socioeconomically disadvantaged groups and young women. The study contributes to the broader discourse on trauma and mental health in emerging adulthood within the South African context.

Keywords: Post-Traumatic Stress Symptomatology, Emerging Adulthood, South Africa, Demographic Profiling, Mental Health.

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Chapter 1: Introduction

1.1 Problem Statement

Mental health concerns for the youth are increasingly being highlighted as a serious risk area considering the challenge that mental health disorders present to health systems, especially in the 21st century (Whiteford et al., 2013). In fact, 14% of 10–19-year-olds experience some form of mental health disorder which contributes to the overall global burden of disease (WHO, 2021). The youth are more vulnerable to developing mental health disorders as they are exposed to more risk factors that tend to carry over into adulthood if not addressed, which then further cripples mental and physical wellness (Bor et al., 2014).

Across mental health, trauma and in particular, Post-Traumatic Stress Disorder (PTSD) is often featured as an important area of concern among adolescents and young adults. It is shown that posttraumatic stress disorder symptoms that are present in adulthood usually have an early onset from childhood, indicating the need to focus on preventative measures addressing the youth (Koenen et al., 2017). The prevalence of PTSD in adolescents, aged 13 to 18 years, is reported to be 8 % whereas only 3.5% of adults are affected by PTSD (APA, 2022). In a study conducted looking at the prevalence of PTSD in world health mental surveys, results indicated that there is a 2.5 % prevalence in ages 18-29, which is higher than in other age groups (Koenen et al., 2017). According to the U.S. National Centre for PTSD (Hamblen & Barnett, 2018), children and adolescents who experience at least one form of trauma are at high risk for developing a trauma-related disorder.

However, many of the studies focusing on posttraumatic stress in adolescents and young adults disproportionately focus on the Global North with very few studies looking at low and middle-income countries (LMICs), the majority world, the Global South, or African countries (Robson et al., 2019; Thalmayer et al., 2020). It has been shown that world mental health

surveys tend to include more studies conducted in high-income countries which affect prevalence rates and leave out important nuances specific to those countries (Koenen et al., 2017). One study highlighted that the overall prevalence of people prone to developing PTSD in sub-Saharan African countries is 22% (Ng et al., 2020). This study also showed that countries that are exposed to conflict have a higher overall prevalence of 30%, whereas those countries that do not have a lower overall prevalence of 8%. Hence there is a need for exploring the prevalence of post-traumatic stress symptoms in adolescents and young adults, especially in conflict regions like South Africa.

Furthermore, it can be argued that socio-cultural and political factors influence the prevalence of trauma and PTSD (Atwoli et al., 2013). According to the World Health Organisation (WHO) report in 2022, PTSD is shown to be higher in countries that experience high rates of conflict. Moreover, variables like gender, race, ethnicity, nationality, religion, and age, may influence the risk of developing PTSD in response to a traumatic event (Yuntri et al., 2021). In South Africa, we see that there are high rates of poverty, prejudice, and violence, which may also contribute to high risks of traumatic experiences across the population as well as for certain social groups more than others, for example, Black females (Ndungu et al., 2020). This increases the need for a better understanding of post-traumatic stress in young adults while focusing on its demographic determinants.

1.2 Research Aims of the Study

This research aims to explore the prevalence of Post-traumatic Stress Symptoms (PTSS) in a sample of emerging adults in South Africa. Further, this study aims to explore the demographic factors of young individuals who display symptoms of post-traumatic stress, especially in South Africa, which can further inform intervention and therapeutic methods.

1.3 Research Questions

1. What are the prevalence levels of Post-Traumatic Stress symptomatology in emerging adults in South Africa?
2. What are the relationships between demographic characteristics (gender, home language, socioeconomic status, and religious beliefs) and a tendency to experience symptoms of post-traumatic stress among South African emerging adults?

1.4 Methods

This study employs a quantitative, non-experimental, and cross-sectional research design to analyse post-traumatic stress symptomatology (PTSS) in South African young adults. Data is sourced from the Africa Long Life Study (ALLS), a longitudinal project examining emerging adulthood in Sub-Saharan Africa, specifically focusing on young adults in South Africa. Participants were recruited using convenience and snowball sampling, ensuring a diverse representation across different regions in South Africa. The final sample size was 819 participants, with demographic variables including age, gender, geographic location, language, socioeconomic status, and religious beliefs. Several validated instruments were used to measure key variables: International Mental Health Assessment (IMHA) – which assesses PTSS using six items aligned with DSM-5 TR criteria; Family Affluence Scale (FAS) – which measures socioeconomic status based on household resources; Duke Religion Index (DUREL) – which evaluates organisational and non-organisational religious activities and intrinsic religiosity. The study adhered to ethical research principles, ensuring informed consent, participant confidentiality, and data protection measures. Statistical methods, including descriptive statistics, correlation analysis, and hypothesis testing, were employed to determine the relationships between demographic factors and PTSS.

1.5 Outline of Chapters

Chapter one provides an understanding of the topic by outlining the prevalence of PTSS and other important issues related to mental health in emerging adults. It introduces the research problem, rationale, aims, and questions that guide the study, highlighting the significance of investigating PTSS in young adults within the South African context. The theoretical framework supporting the study is also introduced, setting the stage for the research.

Chapter two presents a comprehensive review of the literature on trauma, PTSD, and emerging adulthood. It contextualises the study within global and South African research, exploring factors influencing PTSS such as gender, socioeconomic status, and religiosity. Theoretical models, including Arnett's Emerging Adulthood Theory and the Biopsychosocial-Spiritual Model, are discussed to provide a conceptual foundation for understanding the study's key themes.

Chapter three details the research methodology, outlining the study's design, data sources, sampling methods, and instruments. It explains the approaches used to assess PTSS among young adults, including the IMHA, DUREL, and FAS scales. Additionally, it discusses the ethical considerations and data analysis techniques employed to ensure the validity and reliability of the study.

Chapter four presents the study's findings, focusing on the prevalence of PTSS and its relationships with demographic factors. The chapter includes statistical analyses, descriptive data summaries, and hypothesis testing outcomes. Visual representations such as tables and figures illustrate key trends and associations within the dataset.

Chapter five discusses the study's findings in relation to the research questions and existing literature. It interprets the results, explores their implications, and highlights the study's limitations. Recommendations for future research and potential mental health

interventions are provided. The chapter concludes with a summary of the study's contributions to understanding PTSS in young South African adults.

Chapter 2: Literature Review

2.1 Introduction

Across the world, traumatic events are a feature of everyday life. In fact, most people experience some form of trauma at some point in their lives. According to the National Centre for PTSD, 6 in every 10 men and 5 in every 10 women experience at least one form of trauma in their lives. Approximately 1 in 11 people are then diagnosed with Post Traumatic Stress Disorder (PTSD). PTSD is a condition that develops after a person has experienced or witnessed a traumatic event (Sue et al., 2017). This may result from factors such as death, accidents, abuse, and the effects of natural disasters (APA, 2022). In a study conducted by Lewis and colleagues (2019), it showed that of 31% of participants who reported exposure to trauma, 7.8% experienced PTSD by the age of 18 years old. More than that, with the emergence of the COVID-19 pandemic, the prevalence of PTSD increased, spreading to many people who were directly and indirectly affected (WHO, 2022; Yunitri et al., 2021).

The prevalence of post-traumatic stress symptoms (PTSS) varies across different populations. In South Africa, lifetime PTSD prevalence is relatively low to medium (1.8%–2.3%), while emerging adults in South Africa, Uganda, and Zimbabwe experience medium to high PTSS levels (Swain et al., 2017; Webb et al., 2022). Internationally, PTSD rates range from moderate in the general population to high in trauma-exposed groups, such as military veterans (Sareen, 2014). Additionally, emerging adults living with HIV in Zimbabwe have a high prevalence of probable PTSD, highlighting their increased vulnerability (Silveira et al., 2025).

Given the heightened risk of PTSD among emerging adults in South Africa, there is a critical need for further research to better understand the prevalence and severity of PTSS in this demographic. Identifying the extent of PTSS and examining its distribution across different

demographic groups are essential to developing targeted interventions and treatment strategies. This study, therefore, aims to explore the prevalence of PTSS in a sample of emerging adults in South Africa, with a particular focus on understanding the demographic factors associated with post-traumatic stress symptomatology. By identifying key risk factors and vulnerable populations, this research seeks to contribute to the development of more effective therapeutic and intervention methods tailored to the specific needs of young South Africans.

In the literature review to follow, the concepts of adolescence and young adulthood will be clarified. Jeff Arnett's (2000) theory of emerging adulthood will be presented to best describe the developmental phase of the population on which this study is being conducted. Following this, posttraumatic stress will be discussed in relation to the pathology. The literature review will discuss the factors that are antecedent to the development of PTSS in this sample of emerging adults using the findings from both international and local literature. This will be done in line with the biopsychosocial-spiritual model, extending from the biopsychosocial model (Engel, 1977; Sulmasy, 2002).

2.2 Emerging Adults and the Youth

There are various definitions of the concept of young adulthood which differ according to theorists and institutions. According to the National Institute of Health, young adulthood can be seen as a period in life generally occurring between the ages of 18 and 26 (Breiner et al., 2015). In South Africa, the National Youth Act of 1996 considers the youth to be individuals between the ages of 14 and 35 years. It is also understood more clearly as a transitional stage from childhood and adolescence to adulthood (Breiner et al., 2015).

Developmentally, young adulthood is a stage during which there are many physiological, mental, psychological and social changes, which indicate exploration of the self

as well as identity formation (Higley, 2019). This is grounded in Erik Erikson's psychosocial theory of development as he describes the development as based on an individual and their relationship to the environment in having to resolve social crises in order to move onto the next stage (Austrian, 2008). Breiner and colleagues (2015) argue that this period in one's life is the most critical and vulnerable as it paves the way not only for an individual's future but also for the state of the nation at large. They explain that young adults are required to overcome certain milestones to progress to adulthood and independence which then places a large burden on young adults. It is also important to note that young adults are more prone to experiencing physical and mental health ailments as a result of risk-taking behaviour which feeds into their vulnerability as a group (Higley, 2019).

Studies on the prevalence of PTSD are mostly centred around children and childhood traumas (Briggs-Gowan et al., 2011; Dhungana et al., 2022; Dye, 2018; Guterman et al., 2016). A study that focused on older adults noted that middle and younger adults are more at risk for developing PTSD as compared to older adults (Cook et al., 2017). This indicates that while it is useful to consider the occurrence of PTSD in other age groups, more emphasis should be placed on those who are more prone to developing the disorder. However, not all young adults who are exposed to trauma develop PTSD. Despite these definitions and conceptualisations, the term, young adults, in itself is riddled with disparities that suggest the presence of contextual-dependent elements (Makiwane & Kwizera, 2009). This can be further explored using a theoretical framework looking into the concept of emerging adulthood (Arnett, 2000).

2.3 Theory of Emerging Adulthood

Jeffery Arnett (2000) formulated the concept of emerging adulthood as a new period in development situated between adolescence and young adulthood. He argues that the term 'young adulthood' cannot fully encapsulate the experience of individuals going from late

teenagehood into adulthood. This is especially relevant in industrialised societies where socially constructed milestones, such as marriage and employment, are experienced very differently from previous generations. Arnett explains that this period is constituted by change and exploration that is shaped by societal norms and factors that manifest within communities that all affect the experiences of these individuals. Emerging adulthood underpins the interrelated exchange of socio-demographic factors within one's subjective experience as there is an increase in demographic diversity and instability which highlights this transitional period of change and exploration. Consequently, this period is not only applicable to Western societies but rather is able to encapsulate diverse experiences cross-culturally, taking into consideration variations in terms of ethnicity and socioeconomic status (Arnett, 2007). The way that young adults experience their 'adulthood' is very tightly linked to their demographics which thus influences their overall experience which differs across contexts.

This period, typically occurring between the late teens and late twenties, is marked by significant transitions in relationships, education, career paths, and personal responsibilities. However, it is also a time of heightened vulnerability, where exposure to trauma and the onset of mental health difficulties, including PTSS, become more prevalent. The freedom and independence associated with emerging adulthood, while providing opportunities for growth, may also contribute to an increased susceptibility to psychological distress (Arnett, 2007), particularly in those who have experienced trauma. Research suggests that trauma exposure can significantly impact identity formation, further complicating this developmental stage (Truskauskaite-Kuneviciene et al., 2020). The process of constructing a stable sense of self may be disrupted by past traumatic experiences, affecting both personal and social identity development. This theory identifies the period from the late teens through the twenties as a distinct developmental phase characterised by exploration and transition. This phase encompasses several key aspects which can be depicted in Figure 2.1.

One of the defining aspects of emerging adulthood is identity exploration, particularly in love and work. During this phase, individuals actively seek to understand their personal values, career aspirations, and relationship preferences. However, for those who have experienced trauma, this search for identity may be complicated by psychological distress, intrusive memories, and difficulties in emotional regulation (Truskauskaite-Kuneviciene et al., 2020). Emerging adults who have been exposed to adverse childhood experiences, violence, or significant life disruptions may struggle to form a stable sense of self, leading to increased vulnerability to mental health challenges (Arnett et al., 2014). The instability that often characterises emerging adulthood can exacerbate these difficulties, making it harder for individuals to establish a secure and coherent identity.

Another key feature of emerging adulthood is instability, which arises due to frequent changes in education, employment, relationships, and living arrangements. As emerging adults transition from structured adolescent environments to self-directed life choices, they often experience shifts in career paths, romantic relationships, and financial independence. This instability, while a natural consequence of exploration, can be particularly distressing for individuals with a history of trauma. Arnett (2004) notes that the unpredictability of this period may heighten feelings of anxiety and uncertainty, which could then potentially trigger or worsen symptoms of PTSD. Furthermore, gender differences in coping mechanisms and perceived social support play a significant role in psychological distress during this stage (Matud et al., 2020). Research indicates that women may experience higher levels of distress due to differences in coping strategies and social expectations, further complicating identity development and emotional regulation.

A third characteristic of emerging adulthood is that it is a self-focused stage, where individuals prioritise personal development and independence. While this focus can be beneficial for fostering autonomy, it may also result in emotional isolation, particularly for

those experiencing mental health difficulties. Arnett (2014) argues that this self-focus is necessary for developing independence, but for those with trauma histories, it may lead to disengagement from supportive relationships and difficulty seeking help. The lack of external structures, such as parental guidance or institutional support, means that emerging adults must navigate their mental health largely on their own. This independence, while empowering for some, may lead others to cope through maladaptive behaviours such as substance use, risky sexual behaviour, or avoidance (Arnett et al., 2014), all of which have been linked to increased risk of PTSS. Gender differences also influence stress responses, as women often report greater reliance on social support, while men may engage in more avoidant coping strategies, further impacting mental health outcomes (Matud et al., 2020).

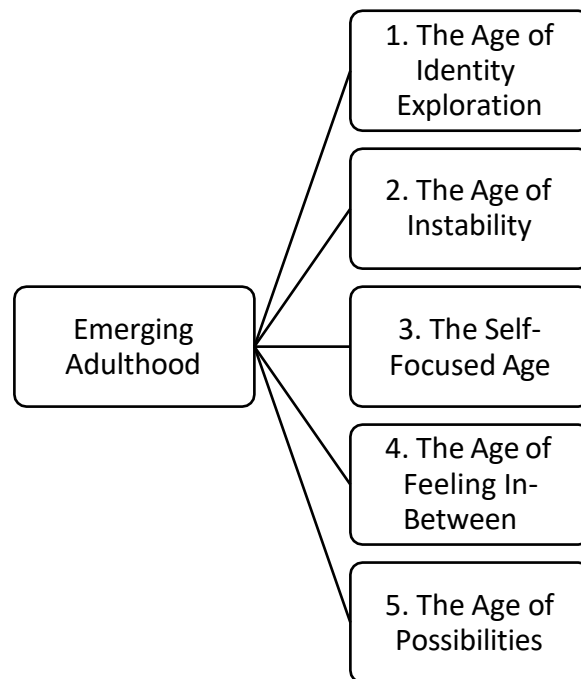
Despite increasing autonomy, many emerging adults feel in-between, not fully identifying as either adolescents or adults. Arnett (2000) found that individuals in this stage often report feeling like they are in transition, acknowledging greater independence but also recognizing their reliance on parental or societal support. This uncertainty may contribute to heightened emotional distress, particularly for those who have experienced trauma. Many emerging adults who struggle with PTSS may feel disconnected from both their adolescent past and their adult future, creating a sense of alienation and emotional instability. The difficulty in defining one's role in society, combined with unresolved trauma, can lead to increased vulnerability to anxiety, depression, and other mental health disorders (Arnett et al., 2014).

Finally, emerging adulthood is an age of possibilities, where individuals see their futures as open-ended and full of potential. Arnett (2004) emphasises that this stage offers young people the chance to redefine their life trajectories, particularly for those who have faced adversity in childhood or adolescence. While this optimism can be a source of resilience, it can also create pressure to overcome past trauma without adequate support. Those who have experienced significant psychological distress may struggle with the expectation that they

should be thriving and making progress, leading to feelings of inadequacy or hopelessness. However, emerging adulthood also presents an opportunity for recovery and healing, as individuals have the flexibility to seek professional help, build new support networks, and develop coping strategies that contribute to long-term well-being (Truskauskaite-Kuneviciene et al., 2020).

Emerging adulthood is a dynamic and transformative period, shaped by identity exploration, instability, self-focus, feeling in-between, and an awareness of possibilities. While this stage presents challenges, it also provides unique opportunities for personal growth and development. However, for those with a history of trauma or mental health difficulties, the vulnerabilities of this stage may increase the risk of PTSS and related disorders. As societal and economic conditions continue to evolve, it is crucial to consider the mental health implications of emerging adulthood and provide adequate support for those navigating this critical life stage. Emerging adulthood is also able to account for traumatic experiences as it factors in risky behaviour that occurs as a result of novel experiences and changes. It suggests that emerging adults are more prone to developing mental health disorders due to the lessening of societal structures around them but at the same time the rise of responsibilities; this freedom and independence then may be a cause for an increase in vulnerability (Arnett, 2007). Furthermore, due to this uncertainty and vulnerability, emerging adults tend to have a higher prevalence of developing mental health disorders (Arnett et al., 2014). Whilst this study makes use of the terms young adults and youth to describe the population, it is helpful to use this theoretical standpoint in this context.

Figure 2.1: *Defining Characteristics of Emerging Adulthood*



Note. Own figure illustrating the core features of emerging adulthood, adapted from Arnett, J. J. (2000). *Emerging adulthood: A theory of development from the late teens through the twenties*. *American Psychologist*, 55(5), 469–480, and Arnett, J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties*. Oxford University Press.

2.4 Post-Traumatic Stress

Traumatic stress events encompass a range of experiences that are primarily defined by their distressing nature and their potential to cause significant psychological and physiological effects (Pai et al., 2017). These events may vary in intensity and impact, leading to different outcomes for individuals who experience them. In some cases, exposure to trauma can contribute to the development of pathological conditions, including trauma-related disorders (Iribarren et al., 2005). However, not all individuals who experience trauma develop a diagnosable disorder, as responses to trauma are highly individualised and influenced by various biological, psychological, and social factors (Smith et al., 2019).

One of the most widely studied trauma-related conditions is post-traumatic stress disorder (PTSD), which is recognized as the most prevalent disorder following traumatic experiences. PTSD is a mental health condition that arises after an individual has either directly experienced or witnessed a traumatic event (Sue et al., 2017). Such events may include life-threatening situations, severe accidents, experiences of abuse, or exposure to natural disasters. According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.; American Psychiatric Association [APA], 2022), PTSD is characterised by symptoms that persist for at least one month following the traumatic event. These symptoms are categorised into four clusters: intrusive symptoms, avoidance symptoms, negative alterations in cognition and mood, and alterations in arousal and reactivity. Intrusive symptoms include recurrent, involuntary, and distressing memories of the traumatic event, flashbacks, and nightmares that cause significant emotional distress. Avoidance symptoms manifest in behaviours that help individuals evade distressing thoughts, emotions, or external reminders associated with the trauma. Negative alterations in cognition and mood include difficulties in recalling aspects of the traumatic event, persistent negative beliefs about oneself or the world, and distorted blame directed at oneself or others. Additionally, individuals may experience persistent negative emotional states, feelings of detachment, and diminished interest in activities. Alterations in arousal and reactivity are marked by heightened irritability, aggressive behaviour, sleep disturbances, difficulties concentrating, and an exaggerated startle response.

The severity and presence of these symptoms can be measured using standardised assessment tools based on DSM-5-TR criteria (APA, 2022). However, it is essential to recognise that a formal clinical diagnosis is required for PTSD to be considered a disorder (APA, 2022). While many individuals who encounter traumatic events may exhibit post-traumatic stress symptoms (PTSS), only a subset will meet the full criteria for PTSD. Various factors, such as genetic predisposition, environmental support systems, coping mechanisms,

and resilience levels contribute to an individual's ability to recover from trauma without formal intervention (Eagle & Kaminer, 2015). Given these complexities, this study will focus on PTSS while also drawing on existing literature regarding the prevalence and aetiology of PTSD to develop a more comprehensive understanding of trauma exposure and its effects.

A crucial aspect of understanding PTSD is recognizing its sociocultural and political dimensions. Some scholars argue that PTSD is, in part, a socially constructed disorder that requires interpretation within a broader sociopolitical context. Eagle (2002) suggests that the diagnosis of PTSD is influenced by political factors and historical narratives of trauma, particularly in regions with a history of systemic violence and oppression, such as South Africa. In such contexts, marginalised and disadvantaged communities are often disproportionately affected by trauma due to ongoing socio-economic hardships, political instability, and a lack of access to mental health resources. Silver (2020) further highlights that the availability of resources and the surrounding social environment significantly shape our understanding and response to psychological trauma. Thus, investigating populations that are particularly vulnerable to trauma—along with the risk and protective factors that influence their psychological outcomes—is crucial for developing effective interventions. By exploring PTSD through both a clinical and sociocultural lens, this study aims to contribute to a more nuanced understanding of trauma and its broader implications for mental health.

2.5 Demographic Characteristics

Demographic characteristics refer to the distinct features of a population that are shaped by socio-political constructs, including but not limited to gender, home language, living arrangements, number of children, relationship status, level of education, financial income, and employment status (Lee & Schuele, 2010). These characteristics provide a framework for understanding variations within and between populations, allowing for meaningful contextual

generalisations (Hammer, 2011). This is particularly relevant in diverse and multi-faceted societies such as South Africa, where the standardisation of interventions and policies is inherently challenging due to the heterogeneity of the population (Maphumulo & Bhengu, 2019). Analysing demographic factors within population groups enables researchers to replicate studies more effectively and facilitates the formulation of evidence-based policies that are rigorous and contextually appropriate (Kerlinger et al., 2000).

In addition to their role in research and policy development, demographic characteristics significantly influence individuals' lived experiences, particularly in relation to mental health. These factors shape individuals' perceptions of their sociocultural context and influence their worldview (Sue et al., 2016). Furthermore, they determine how individuals experience mental disorders, interpret their symptoms, and their willingness to seek therapeutic interventions (Cauce et al., 2002; Picco et al., 2016). Understanding these dynamics is essential for mental health practitioners and policymakers aiming to address disparities in mental health outcomes across different demographic groups.

There is substantial evidence supporting the examination of socio-demographic variables in mental health research to identify populations at increased risk of developing mental health disorders (Cao et al., 2022). Concurrently, these demographic factors can also provide insight into resilience mechanisms that protect individuals from developing such disorders. In this regard, socio-demographic variables serve as indicators of both risk and protective factors (Claudius et al., 2022; Turner et al., 2012). Factors such as physical, financial, and emotional stability—often derived from familial and social structures—can act as protective buffers against the development of trauma-related pathology (Turner et al., 2012). Recent research conducted during and after the COVID-19 pandemic highlights the influence of demographic characteristics on the prevalence of psychological disorders, particularly post-traumatic stress symptoms (Cao et al., 2022).

Given the substantial impact of demographic variables on mental health outcomes, it is crucial to identify these variables to determine individuals who may be at higher risk of developing PTSS. Moreover, demographic analysis can offer valuable insights into protective and risk factors, which can, in turn, inform targeted preventative and promotive mental health interventions. To enhance the understanding of these associations, demographic determinants of PTSS should be examined within a theoretical framework that contextualizes their impact on mental health outcomes.

2.6 The Biopsychosocial-Spiritual Model

This study will employ the biopsychosocial-spiritual model as a theoretical framework to explore the impact of demographic characteristics on mental health disorders. Originally developed as the biopsychosocial model by George Engel (1977), this approach considers the dynamic interactions among biological, psychological, and social factors in shaping an individual's mental health outcomes. Biological factors encompass genetic predispositions and physical health conditions, while psychological factors involve emotional and cognitive processes, such as subjective experiences, coping mechanisms, and interpersonal skills. Social factors refer to external influences such as environmental conditions, socioeconomic status, crime, violence, poverty, and unemployment (Swartz et al., 2016). By integrating these elements, the biopsychosocial model provides a holistic perspective on mental health, accounting for the interplay of internal and external influences on well-being (Swartz et al., 2016). Furthermore, this model posits that illness arises from interactions at these three levels, shaping an individual's experience of pathology, access to healthcare, and response to treatment (Alvarez et al., 2012). This perspective is particularly useful in understanding how demographic variables influence vulnerability to mental health disorders and the protective factors that may mitigate such risks.

Despite its comprehensive nature, the biopsychosocial model has been critiqued for its

limitations, particularly in failing to adequately address cultural factors that shape mental health experiences. It has been argued that factors such as discrimination, cultural identity, and historical oppression play a critical role in the manifestation of mental disorders (Sue et al., 2016). Additionally, the model has been found to be less effective in guiding clinical interventions due to its broad and multifaceted nature (Alvarez et al., 2012). Given that conceptualizations of psychopathology are deeply embedded in cultural contexts, Trujillo (2008) advocates for a more culturally informed approach, particularly in research. Western diagnostic frameworks may misinterpret or overlook culturally specific expressions of distress, potentially leading to misdiagnosis (Hassim & Wagner, 2013). Nonetheless, research indicates that the biopsychosocial model remains a valuable tool in identifying and predicting mental health risk factors (Imsiragic et al., 2017; Sexton et al., 2019).

To address these limitations and better contextualise mental health in South Africa, this study incorporates the biopsychosocial-spiritual model (Sulmasy, 2002). This model extends the biopsychosocial framework by recognising spirituality as a fundamental component of human experience, particularly in cultures where spiritual and religious beliefs play a central role in daily life. Sulmasy (2002) initially proposed this model in the context of end-of-life care, emphasising the need for a holistic approach that considers physical, mental, environmental, and metaphysical dimensions of well-being. Spirituality, within this framework, is not limited to religious beliefs but encompasses an individual's broader connection with the transcendent, providing a source of meaning, coping, and resilience in the face of adversity (Sulmasy, 2002).

Hatala (2013) further expands on the biopsychosocial-spiritual model by advocating for a more integrative health psychology framework that explicitly incorporates spirituality as a critical factor in health and illness. He argues that spirituality intersects with psychological and

social dimensions in meaningful ways, influencing coping strategies, emotional regulation, and overall well-being. This perspective supports the notion that health psychology must move beyond reductionist frameworks to incorporate the full spectrum of human experience, including spiritual beliefs and practices (Hatala, 2013). This theory underscores the necessity of considering spirituality not as an isolated variable but as an essential component interwoven with other determinants of health.

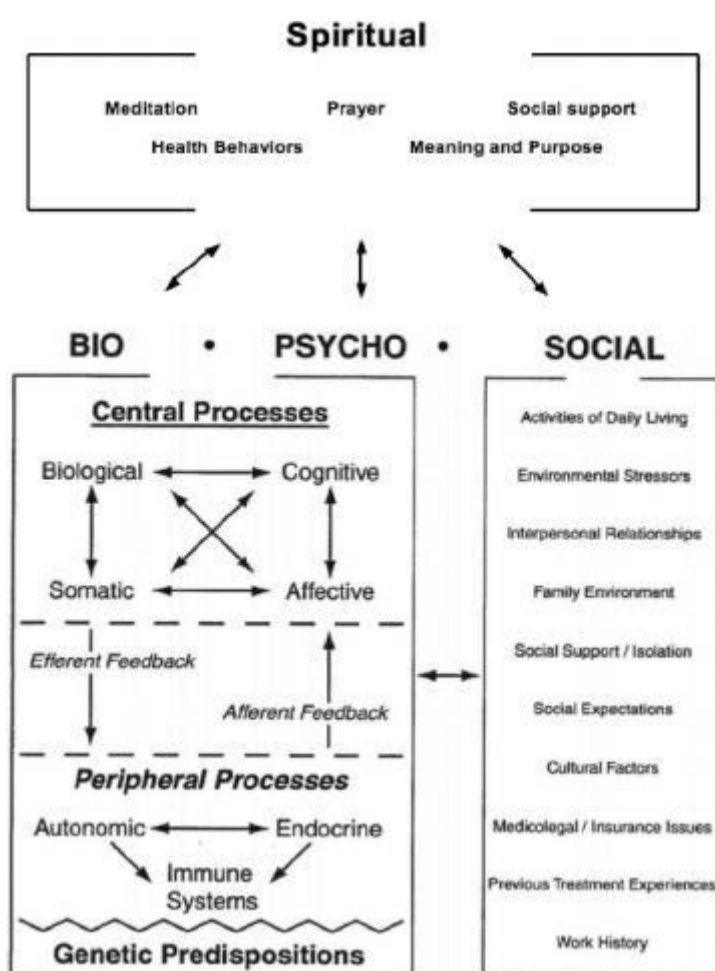
This perspective aligns with findings from Naude and Fick (2022), who explored the role of spirituality in emerging adult women's experiences of identity development during postgraduate psychology studies in South Africa. Their study highlights how spiritual identity contributes to personal growth, emotional well-being, and coping mechanisms, reinforcing the need to integrate spirituality into psychological models. Similarly, Saad et al. (2017) argue that the concept of spirituality has multiple interpretations across cultures and disciplines, making it essential to consider its diverse meanings when applying the biopsychosocial-spiritual model. Their work emphasises the necessity of moving beyond purely medicalised understandings of spirituality to incorporate its broader psychosocial and existential dimensions.

In the South African context, where diverse spiritual traditions—including religious, traditional, and ancestral belief systems—remain prominent, the biopsychosocial-spiritual model provides a more culturally responsive approach to understanding mental health (Edward & Thwala, 2010). Given the role of spirituality in shaping individuals' experiences of illness and healing, incorporating spiritual well-being and spiritual distress as socio-demographic variables may offer deeper insights into the prevalence and impact of PTSS. As part of decolonising psychology, this model challenges the dominance of secular Western frameworks and promotes a more inclusive understanding of mental health that reflects the lived realities of South African populations.

Thus, the biopsychosocial-spiritual model (Sulmasy, 2002; Hatala, 2013) will be

employed to underpin this study, offering a comprehensive framework for examining the complex interactions between socio-demographic factors and PTSS, particularly among young South Africans. By acknowledging the interconnectedness of biological, psychological, social, and spiritual dimensions, this model facilitates a more holistic understanding of mental health and informs culturally attuned interventions aimed at promoting well-being.

Figure 2.2: *The Biopsychosocial-Spiritual Model Highlighting the Various Aspects Impacting Mental Health*



Note. Image “A Biopsychosocial–Spiritual Interactive Processes Involved in Health and Illness” from Hatala, A. R. (2013). Towards a biopsychosocial–spiritual approach in health psychology: Exploring theoretical orientations and future directions. *Journal of Spirituality in*

2.7 Research Findings on PTSS and Demographics Factors From International Studies

Studies have indicated conflicting results in determining the relationship between demographic characteristics and post-traumatic stress symptoms (PTSS). Most studies show that age and gender greatly contribute to the risk of developing symptoms of post-traumatic stress (Alisic et al., 2014; Koenen et al., 2017; Lewis et al., 2019; Lotzin et al., 2022; Pekonigg et al., 2001; Trickey et al., 2012; Wang et al., 2020). While others show no significant relationship in gender (Cao et al., 2022; Idoiaga et al., 2022; Ng et al., 2020). It has been shown that the age range of those most susceptible to developing some form of mental disorder in particular PTSD, fluctuates between childhood and young adulthood which points to emerging adulthood and vulnerability present within this age group (Arnett, 2004; Koenen et al., 2017).

Results on gender are varied and this can be accounted for by social disparities regarding mental health (Trickey et al., 2012). Even though females are seen to be more at risk of developing symptoms of post-traumatic stress, males could be less likely to report that they are experiencing any difficulties with life which could contribute to the disparity. It has also been reported that the significance of other factors such as marital status (Strohschein et al., 2005), socioeconomic conditions, level of education, employment, and income status may contribute to exposure to traumatic events (Cao et al., 2020; Digongi et al., 2013; Koenen et al., 2017; Lewis et al., 2019; Sedlack et al., 2010; Trickey et al., 2012). Demographic features seem to contribute to these discrepancies. Factors such as gender, age, and prior trauma exposure significantly influence PTSS rates. For example, females and individuals with a

history of multiple traumatic events are generally at higher risk for developing PTSS (Brewin et al., 2000).

A European study conducted by Lotzin and colleagues (2022) indicated that being younger and female were risk factors for PTSD, while high income as compared to low income reduced the risk for PTSD. In terms of emerging adulthood, it has been noted that high education level, marriage and parenthood contribute to mental health (Arnett et al., 2014). These studies have pointed out the relationship that certain social and environmental factors have an impact on PTSS. It can be argued that interpersonal factors such as being in a relationship and having children may be seen as a protective factor contributing to resilience against developing a trauma-related disorder.

Similarly, factors such as high socioeconomic status and education may highlight a social protective frame. Whereas those who have lower education and socioeconomic status may be more at risk of developing PTSS. Beyond socioeconomic status, education, and social support, other demographic factors also serve as protective elements against PTSS. For example, being married or in a stable relationship has been associated with lower PTSS prevalence, possibly due to the emotional support provided by partners. Additionally, employment offers structure, purpose, and financial resources, which can reduce the impact of traumatic events. A comprehensive review identified that individuals with these characteristics exhibit greater resilience to PTSS (Brewin et al., 2000). It can be acknowledged that many different demographic factors contribute to some aspect of PTSS and to an extent, PTSD whether it is in relation to experiencing the symptoms, the onset of the disorder or even in helping prevent or mitigate it.

Theoretical and empirical studies on traumatic stress have been mainly centred in the global north and high-income countries which then assumes universality and applicability to

all populations in terms of conceptualisations of pathologies such as PTSD. There is a need for geographically representative knowledge on traumatic stress that takes into account socio-economic constraints, and socio-political and experiential differences of traumatic events relevant to that setting (Robson et al, 2019). It is argued that in non-western countries and LMICs, traumatic experiences such as adverse social conditions, poverty, poor parenting, and family and neighbourhood violence place one at risk of developing trauma-related symptoms (Briggs-Gowan et al., 2011; Dhungana et al., 2022).

2.8 South African Research on PTSS and Demographic Factors

The conceptualisation of wellness and illness in South Africa is dependent on socio-cultural, socio-political and socio-historical elements. It is important to note these contextual factors when establishing an understanding of mental health disorders, especially in a country that is filled with political and social conflict (Eagle and Kaminer, 2014). It has been argued that population demographics are expected to differ especially due to the exposure to trauma and institutionalised violence directed toward specific groups during the Apartheid regime (Atwoli et al., 2013). As a result, there have been many studies conducted on the prevalence of PTSD, especially traumatic events experienced but at the same time results on demographic factors and PTSS are inconsistent (Edwards, 2005).

In a survey conducted by Seedat and colleagues (2004), on trauma exposure and PTSS in urban African schools, results from Cape Town showed that both boys and girls were likely to meet the criteria for PTSS, indicating that there are no gender differences. These findings are reflected in other South African studies looking at PTSS (Atwoli et al., 2013; McGowan & Kagee, 2013). On the other hand, gender differences are less prevalent in other studies that indicate that females as compared to males have a higher risk of developing PTSS (Calitz et al., 2014; Stein et al., 2008). Other socio-demographic characteristics such as racial and ethnic

differences are shown to intersect with gender, thus contributing to a layered risk of developing PTSS (Idemudia 2017; Mgoqi-Mbalo & Zhang, 2017).

In the South African context, community cohesion and extended family support play significant roles in protecting against PTSS. The collectivist culture, which emphasises mutual aid and strong family ties, can serve as a buffer against PTSD symptoms, particularly in collectivist cultures where close-knit relationships foster resilience (Nduna & Jewkes, 2011). Additionally, family structures in South Africa are deeply rooted in traditional values, which promote a sense of belonging and emotional security, reducing vulnerability to PTSS (Cluver et al., 2013). Community-based interventions have also been shown to be effective in providing psychosocial support in regions where mental health services are limited, reinforcing the protective role of community networks (Kaminer & Eagle, 2010). These cultural and social factors collectively contribute to resilience against PTSS in South African communities. Atwoli et al. (2013) noted that such social structures can mitigate the development of PTSD, even in environments with high trauma exposure.

Home language was not explored in the literature or was shown not to have a significant relationship with PTSS (McGowan & Kagee, 2013), but it is important to take into consideration the differences that might present themselves in different home languages. Furthermore, there is hardly any research on the presence of religion or even any spiritual element. This should be taken into account as aforementioned, religious belief systems may prove to be an important factor in considering PTSS in young South Africans.

2.9 Conclusion

Based on the literature reviewed in this chapter, it can be argued that trauma is a pervasive part of human experience, and post-traumatic stress disorder (PTSD) affects a significant portion of those exposed to traumatic events. Emerging adulthood, a critical life

stage presents unique vulnerabilities to PTSD, influenced by factors like social, economic, and developmental challenges. The biopsychosocial-spiritual model provides a holistic framework for understanding PTSS, integrating biological, psychological, social, and spiritual elements that impact susceptibility and resilience to trauma. While demographic factors such as age, gender, and socioeconomic status play essential roles in PTSS risk, contextual factors—such as the socio-historical trauma specific to South Africa—add layers of complexity. Therefore, understanding PTSS, especially among young adults in diverse socio-cultural settings, requires more nuanced research that acknowledges both universal and locally specific factors shaping mental health. This study aims to explore these dimensions, focusing on young South Africans to inform tailored approaches to PTSD prevention and intervention. Thus, this study aims to further understand and determine whether there are any relationships between physical, interpersonal, social and spiritual demographics and post-traumatic stress symptomatology experienced in South African young adults.

Chapter 3: Research Methods

3.1 Introduction

This chapter outlines the research methodology employed in this study, detailing the design, data sources, sampling techniques, instruments used, and data analysis methods. The study adopts a quantitative, non-experimental, and cross-sectional research design to explore the prevalence of post-traumatic stress symptomatology (PTS) among South African young adults and its relationship with demographic factors. It utilises secondary data from the Africa Long Life Study (ALLS), a longitudinal research project investigating key psychological and social factors affecting young adults in South Africa. The sampling process involved a combination of convenience and snowball sampling to recruit participants, ensuring a diverse and representative sample. The research instruments include the International Mental Health Assessment (IMHA) for measuring PTSS, the Duke Religion Index (DUREL) for assessing religiosity, and the Family Affluence Scale (FAS) for socioeconomic status measurement. Ethical considerations, such as informed consent and participant confidentiality, are also discussed. Finally, this chapter provides an overview of the data analysis techniques used to examine the relationships between demographic variables and PTSS.

3.2 Data Source

This study utilises secondary data from the *Africa Long Life Study* (ALLS) (Thalmayer et al., 2024), a longitudinal research project exploring the development of young adults aged 18 and above in three Sub-Saharan African countries: South Africa, Namibia, and Kenya. The ALLS investigates key psychological domains, including personality development, mental health, emerging adulthood, and cultural mindset, aiming to test the cross-cultural relevance of psychological theories and develop context-specific insights. Data for the ALLS is collected biannually over a five-year period, which began in 2022, with participants completing two surveys per year. This study specifically focuses on the first wave of data collected from

the South African cohort, providing an initial exploration of personality traits, mental health conditions, and cultural influences in shaping the experiences of young adults within this context.

3.3 Research Design

This study adopted a quantitative research design, which is well-suited for systematically examining relationships between variables and identifying patterns within a large population (Babbie, 2020). By relying on numerical data and statistical analysis, a quantitative approach allows for objective measurement of post-traumatic stress symptomatology (PTSS) in relation to the demographic characteristics of South African young adults. This method enhances the study's reliability and enables broader generalisability of the findings (Creswell & Creswell, 2017).

Additionally, this study employed a non-experimental research design, meaning that no independent variables were manipulated, no control group was established, and no participants were randomly assigned to different conditions (Fallon, 2016). Instead, the study sought to analyse naturally occurring data, making it particularly suitable for demographic profiling. A non-experimental design is beneficial in this context because it allows for the assessment of associations between demographic factors and PTSS in a real-world setting without ethical or practical concerns related to experimental manipulation (Schutt, 2018).

Furthermore, this study was cross-sectional in nature, as it utilised data collected from a single point in time, specifically from Wave 1 of the study. A cross-sectional design is advantageous because it provides a snapshot of the prevalence and distribution of post-traumatic stress symptoms among young adults within the given demographic profile (Setia, 2016). This approach is particularly useful for identifying correlations between variables and

detecting potential risk factors associated with PTSS, offering valuable insights that could inform future longitudinal research or targeted interventions (Sedgwick, 2015).

By employing a quantitative, non-experimental, and cross-sectional research design, this study ensures a rigorous and systematic exploration of the relationship between demographic characteristics and post-traumatic stress symptomatology, contributing to a deeper understanding of mental health challenges among South African young adults.

3.4 Research Questions

1. What are the prevalence levels of Post-Traumatic Stress symptomatology in emerging adults in South Africa?
2. What are the relationships between demographic characteristics (gender, home language, socioeconomic status, and religious beliefs) and a tendency to experience symptoms of post-traumatic stress amongst South African young adults?

3.5 Hypotheses

- H1. There is a significant relationship between gender and a tendency to experience post-traumatic stress symptoms among SA young adults.
- H2. There is no significant relationship between home language and a tendency to experience post-traumatic stress symptoms among SA young adults.
- H3. There is a significant relationship between socioeconomic status and a tendency to experience post-traumatic stress symptoms among SA young adults.
- H4. There is a significant relationship between religious beliefs and a tendency to experience post-traumatic stress symptoms among SA young adults.

3.6 Sample

The ALLS project recruited participants from provinces in South Africa, namely, Gauteng, Western Cape, and Free State. Researchers employed a convenience sampling technique, sourcing data from universities and local communities across these regions. Additionally, elements of snowball sampling were incorporated, where recruited participants referred their peers or acquaintances, further expanding the sample. These methods were particularly useful in ensuring diverse regional representation.

The use of convenience and snowball sampling provided several advantages for the ALLS study. Convenience sampling allowed researchers to efficiently recruit a large sample of young adults within a short period of time (Etikan et al., 2016). This approach also proved to be cost-effective, as it reduced the need for extensive travel and large-scale advertising, making it financially viable for a longitudinal study (Acharya et al., 2013). However, one of the key drawbacks of convenience sampling is limited generalisability—findings may not accurately represent the broader population (Bornstein et al., 2013). There is also a risk of selection bias, as certain groups may be overrepresented while others are underrepresented.

Additionally, snowball sampling was beneficial in reaching hard-to-access populations, such as individuals without stable phone numbers or internet access (Naderifar et al., 2017). By leveraging social networks, researchers were able to ensure cultural and regional diversity in the study, particularly in South Africa, where different linguistic and ethnic groups were represented. However, one major disadvantage of snowball sampling is the risk of homogeneity, as referrals often come from within the same social circles, leading to limited diversity in responses (Sadler et al., 2010). Additionally, the success of recruitment depends heavily on the initial participants, meaning that if the first group of recruits lacks diversity, the entire sample may be skewed.

To be included in the ALLS study, participants had to meet specific inclusion criteria. They had to be 18 years old at the time of recruitment, as this aligns with the theoretical framework of emerging adulthood, which identifies 18 as a key transitional phase (Arnett, 2000). Participants also had to be from South Africa, Namibia, or Kenya to ensure the study's focus remained on Sub-Saharan African populations. For the purpose of this study, data was sourced from the South African cohort. Furthermore, all participants were required to provide informed consent to participate in the study. The exclusion criteria included individuals below the age of 18, as the study specifically targeted young adults. Those unwilling to complete biannual surveys or provide follow-up contact information were also excluded. Additionally, individuals who could not understand or complete the survey in English were not included, as English was the primary language of data collection.

3.6.1 *Sample Demographics*

For this study, the initial South African sample from the ALLS project consisted of N=874 participants. However, after applying various exclusion criteria, the final sample was reduced to N=819 participants. Individuals who were younger than 18 years old or did not report their age were excluded. Additionally, participants aged 20 to 22 years were removed to maintain the study's focus on 18-year-olds. To ensure an accurate description of the data, individuals with more than 50% missing data were also excluded.

As evident from Table 3.1, the dataset provides a detailed overview of the demographic characteristics, educational background, relationship status, employment, and financial circumstances of the sample group. The total sample consisted of 819 participants, with 74.2% aged 18 years old and 25.8% aged 19 years old. The sample was predominantly female (67.6%), while 31.9% were male. A small percentage (.5%) identified as “other” – which were gender categories outside of male or female.

The geographic distribution indicated that participants resided in a variety of settings, with the largest proportion living in suburban areas (44.4%). Townships (21.1%) and the city (21.6%) also make up a notable portion of the sample. A smaller percentage of participants lived in informal settlements (5.0%), towns (1.2%), rural areas (.4%) or villages (.1%). The interpretation of these geographic terms may overlap, potentially resulting in inaccurate self-reporting of geographic locations.

The sample reflects South Africa's linguistic diversity, with Xhosa speakers making up the largest proportion (25.9%), followed by English (19.3%) and Southern Sotho (18.4%). Other languages represented include Zulu (11.1%), Afrikaans (6.8%), and Tswana (6.2%). An additional 10.6% of participants reported speaking various South African languages, including Pedi, Swati, Tsonga, Venda, Portuguese, Swahili, Shona, and Ndebele. To ensure clarity and simplify data analysis, these languages were grouped under the category of "Other South African Languages." This consolidation helped streamline the interpretation of linguistic diversity while maintaining the representation of less commonly reported languages.

Regarding education level, the majority of participants have completed high school (70.8%), while 24.4% have less than a high school qualification. A small proportion have pursued some after-school training (2.1%), are currently studying at an undergraduate level (1.1%), or were still in school (.4%). Only .2% are currently studying. The high percentage of participants with a high school qualification aligns with the study's focus on emerging adulthood, a stage where individuals transition into further education or employment. The educational background of participants' caregivers varied, with 32.3% having completed high school. A significant portion (25.0%) did not complete high school, while 13.1% reported some level of after-school training. Additionally, 20.6% of caregivers hold a degree, and 7.6% have obtained a postgraduate qualification.

A large proportion of participants were not currently in a romantic relationship (76.7%). Among those in relationships, 22.0% were dating but did not live with their partner, while only 1.2% lived with their partner. A small fraction (.1%) reported an alternative relationship status. In terms of parental status, the vast majority of participants did not have children (95.7%). A small percentage reported having one child (3.6%), while .1% had two children and .2% had three or more children. These statistics suggest that most participants are still in the early stages of emerging adulthood, with limited parental responsibilities.

A significant majority of participants (82.8%) were full-time learners or students, reflecting the study's focus on young adults who are still pursuing education. 8.1% reported having no paid work, while 3.8% were both studying and working. A smaller proportion engaged in occasional paid work (1.7%), regular part-time work (1.8%), or full-time employment (1.6%).

Perceived financial status varied among participants, with 64.6% reported occasional financial difficulties. A smaller percentage (15.0%) experienced significant financial strain, while 19.7% reported having no financial problems. These findings suggest that financial instability is a common concern among young adults, reinforcing the challenges faced during the transition into independent adulthood.

Table 3.1

Demographic Characteristics of the South African Sample

Variable		Frequency	%
Age	18 years	608	74.2
	19 years	211	25.8
	Total	819	
Gender	Female	552	67.6
	Male	260	31.9

	Other	4	.5
	Total	816	
Geographical Location	City	177	21.6
	Informal Settlement	41	5.0
	Rural Area	3	.4
	Suburb	364	44.4
	Town	10	1.2
	Township	173	21.1
	Village	1	.1
	Total	769	
Language	Afrikaans	56	6.8
	English	158	19.3
	Southern Sotho	151	18.4
	Tswana	51	6.2
	Xhosa	212	25.9
	Zulu	91	11.1
	Other South African Languages	87	10.6
	Total	806	
Education	Still in School	4	.4
	Less than High School Qualification	200	24.4
	High School Qualification	581	70.8
	Some After-School Training	17	2.1
	Currently Studying	2	.2
	Undergraduate Degree	9	1.1
	Total	813	
Education of the Caregiver	Less than High School Qualification	204	25.0
	High School Qualification	265	32.3
	Some After-School Training	107	13.1
	Degree	169	20.6

	Post-Graduate Qualification	62	7.6
	Total	807	
Relationship Status	I do not have a boyfriend/girlfriend	628	76.7
	I am in a relationship but do not live with my partner	180	22.0
	I am in a relationship and live with my partner	10	1.2
	Other	1	.1
	Total	819	
Parental Status	No	784	95.7
	Yes, 1 Child	29	3.6
	Yes, 2 Children	1	.1
	Yes, 3 or More Children	2	.2
	Total	816	
Employment	No Paid Work Currently	66	8.1
	Full-time Learner/Student	678	82.8
	Studying and Working	31	3.8
	Occasional Paid Work	14	1.7
	Regular Part-time Paid Work	15	1.8
	Regular Full-time Paid Work	13	1.6
	Total	817	
Finance	We do not have any financial problems	161	19.7
	Sometimes we have slight financial difficulties	529	64.6
	We have great financial difficulties	123	15.0
	Total	813	

Self-reported perceived financial status in conjunction with the Family Affluence Scale (FAS II) and additional items, provides insights into the socioeconomic status of the

participants. As evident from Table 3.2, the total FAS score ($M = 9.94$, $SD = 3.01433$), suggests a moderate level of affluence across the sample. The lack of skewness in the total FAS score (0.000) indicates an even distribution of affluence levels within the sample, reflecting that respondents' access to family resources is spread relatively equally across the measured range.

Table 3.2

Descriptive Statistics for Family Affluence Scale

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	<i>Skewness</i>
FAS Total	795	9.94	3.01	1	24	.000

Table 3.3 presents the distribution of participants' family affluence levels, highlighting differences in access to transportation, living conditions, technology, and essential utilities. This includes FAS Items 1 to 9; however, Item 6 was excluded as it was an open-ended question that looked at how many people live in your household. Due to varying living arrangements, responses may have been inconsistent, making it a less reliable indicator of affluence.

Car ownership serves as an indicator of household wealth. The results show that 41.0% of participants reported that their families do not own a car, while 30.2% have access to one vehicle, and 28.9% reported that their family owns two or more cars. Having a personal bedroom can reflect household space and affluence. The data indicates that 57.4% of participants have their own bedroom, while 42.6% share their sleeping space. Family holidays can serve as an indirect measure of disposable income. Nearly half of the participants, 48.1%, reported that they had not travelled on holiday in the past 12 months. Additionally, 22.5% travelled once, 14.4% went on holiday twice, and 15.0% reported travelling more than twice. Access to computers is an important resource for education and digital connectivity. The findings reveal that 34.7% of participants do not have a functional computer in their household,

while 29.4% reported having one computer. Additionally, 17.5% have two computers, and 18.3% have access to more than two computers. Running water is a fundamental necessity for daily living. The vast majority of participants, 87.8%, reported having access to running water, while 12.2% indicated that they did not. The majority of participants, 71.3%, reported living in a house or apartment owned by themselves or their family, while 15.3% reside in rented accommodations. A smaller percentage, 9.4%, live in informal or non-permanent structures, and 4.1% are staying in someone else's home. Electricity access is nearly universal among participants, with 97.8% reporting that they have electricity, while only 2.2% lack access. Personal phone ownership is an indicator of technological access and communication ability. The vast majority of participants, 90.0%, reported owning a personal phone, while 10.0% did not have their own phone.

Table 3.3

Frequency Distribution of Family Affluence Indicators

Variable: Family Affluence Items	Responses	<i>n</i>	%
FAS1: Does your family own a car?	No	335	41.0
	Yes, one	247	30.2
	Yes, two or more	236	28.9
	Total	818	
FAS 2: Do you have your own bedroom for yourself?	No	348	42.6
	Yes	469	57.4
	Total	817	
FAS3: During the past 12 months, how many times did you travel away on holiday with your family?	Not at all	394	48.1
	Once	184	22.5
	Twice	118	14.4
	More than twice	123	15.0

	Total	819	
FAS4: How many functional computers do you have in your household?	None	283	34.7
	One	240	29.4
	Two	143	17.5
	More than Two	149	18.3
	Total	815	
FAS5: Do you have running water where you stay?	No	99	12.2
	Yes	714	87.8
	Total	813	
FAS7: What kind of structure do you stay in?	In an informal/non-permanent structure	76	9.4
	Staying in someone else's home	33	4.1
	In a house or apartment that is rented by me and my family	124	15.3
	In a house or apartment owned by me or my family	578	71.3
	Total	811	
FAS8: Do you have electricity where you stay in?	No	18	2.2
	Yes	799	97.8
	Total	817	
FAS9: Do you have your own phone?	No	82	10
	Yes	734	90
	Total	816	

Table 3.4 provides a descriptive overview of the Duke Religion Index Scale (DUREL), capturing participants' engagement in religious activities and the significance of religious

beliefs in their lives. The descriptive statistics for DUREL in the South African sample reveal key insights into religious engagement and beliefs. Organisational Religious Activity (ORA), which measures the frequency of attending religious meetings such as church, mosque, or temple, has a mean score of 3.64 with a standard deviation of 1.52, indicating moderate variability in responses. The minimum reported frequency is 1 (never), and the maximum is 6 (a few times a week). The skewness value of -0.047 suggests that the distribution is nearly symmetrical.

Non-Organisational Religious Activity (NORA), which assesses private religious practices such as prayer, meditation, or scripture study, has a mean score of 3.63 and a standard deviation of 1.68, showing slightly greater variability compared to ORA. Responses range from 1 (never) to 6 (more than once a day), with a skewness of -0.126, indicating a very slight left skew.

Intrinsic Religiosity (IR), a composite measure derived from three DUREL items (DUREL3, DUREL4, and DUREL5), has a mean score of 11.25 with a standard deviation of 3.26, suggesting moderate dispersion in responses. The minimum score is 3, while the maximum is 15, and the skewness of -0.819 indicates a left-skewed distribution, meaning that more individuals scored on the higher end of intrinsic religiosity.

The DUREL Total Score, which sums across all five items of the scale, has a mean of 18.53 with a standard deviation of 4.99, showing considerable variability among respondents. The lowest reported total score is 5, while the highest is 27. The skewness of -0.510 suggests a moderate left skew, meaning that a larger proportion of participants scored on the higher end of the religiosity spectrum. This group reduces some variation seen in individual items, reflecting that most participants report moderate to high religiosity.

The descriptive data for DUREL1 (ORA) – Organisational Religious Activity shows that among the 819 valid responses, 9.5% reported never participating, while 14.4% attended once a year or less. A larger portion, 24.8%, engaged in religious activities a few times a year, and 18.8% participated a few times a month. Regular participation was observed among 18.6% who attended once a week and 13.9% who engaged in religious activities a few times a week.

For DUREL2 (NORA) – Non-Organisational Religious Activity, which includes private religious practices such as prayer and scripture reading, 14.5% reported never or rarely engaging in these activities. 15.6% participated a few times a year, while 15.0% engaged a few times a month. More frequent participation was observed among 18.4% who practiced a few times a week, and 19.4% who did so once a day. The highest level of engagement was seen in 16.6%, who participated more than once a day.

Table 3.4*Descriptive Statistics for Religiosity Scale (Duke Religion Index for the South African Sample)*

Variable: Duke Religion Index Scale (DUREL)	<i>n</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>Min</i>	<i>Max</i>	<i>Skewness</i>
DUREL1: How often do you attend church, mosque, temples, or other religious meetings? *	819	3.64	1.516	1	6	-.047
DUREL 2: How often do you spend time in private religious activities, such as prayer, meditation, or study of religious of study scriptures? **	817	3.63	1.681	1	6	-.126
DUREL 3: In my life, I experience the presence of the divine.	812	3.76	1.290	1	5	-.850
DUREL 4: My religious beliefs are what really lie behind my whole approach to life.	814	3.73	1.393	1	5	-.850
DUREL 5: I try hard to carry my religious dealings over into all other dealings in life.	815	3.74	1.404	1	5	-.903
Intrinsic Religiosity (IR)***	808	11.25	3.26	3	15	-.819
DUREL Total	806	18.53	4.994	5	27	-.510

Note. * Organisational Religious Activity (ORA) ** Non-Organisational Activity (NORA) *** IR includes DUREL3, DUREL4, and DUREL5

3.7 Instruments

The ALLS study utilised a questionnaire (see Appendix A) that included a demographic section and several scales assessing personality, mental health, and aspects of emerging adulthood. The questionnaire comprised a total of 179 items, incorporating both closed-ended and open-ended questions. The first section focused on demographic information and contained 24 items. This was followed by various standardised instruments, including the General Self-Reported Health (GSRH) scale (DeSalvo et al., 2006) with 1 item, the Cross-Cultural Big Two (Thalmayer et al., 2024) with 55 items, the International Mental Health Assessment (IMHA) scale (Thalmayer et al., 2023) with 64 items, the Duke University Religion Index (DUREL) scale (Koenig & Büssing, 2010) with 5 items, and the Family Affluence Scale (FAS II) with additional items (Boyce et al., 2006), totalling nine items. Additionally, the survey concluded with 8 open-ended questions, allowing participants to provide further insights beyond the structured response options.

The surveys used in this study were self-reported, with participants providing responses based on their own perceptions and experiences. One limitation of using self-reported data is the potential for response bias, as participants may misreport or inaccurately recall information due to social desirability or memory limitations (Podsakoff et al., 2003). This can affect the reliability of the data, particularly when assessing sensitive topics such as mental health or financial status. Despite this, self-report methods remain a practical and widely used approach in psychological and social research, which can provide insight into subjective experiences and perceptions.

For this study, demographic variables such as gender, home language, geographic location, living arrangements, number of children, relationship status, level of schooling, employment status, socio-economic status (SES) and religious beliefs were examined. Certain demographic variables, including geographic location, living arrangements, employment

status, number of children, relationship status, and level of schooling, were used for descriptive purposes only, as they have not shown significant relevance in previous studies. In contrast, key variables used to address the research questions included the presence of post-traumatic stress symptoms (PTSS), assessed using the Post-Traumatic Stress (PTS) subscale from the IMHA (Thalmayer et al., 2023), as well variables from the demographic section such as gender, home language, SES which was measured through the self-reported financial status variable and the Family Affluence Scale (FAS)(Boyce et al., 2006), and religiosity was assessed using the Duke Religion Index scale (DUREL) (Koenig & Büssing, 2010).

3.7.1 Demographic Section

Participants provided demographic information through a combination of open-ended and closed-ended questions. Most close-ended questions were quantifiable using rating scales to describe the participant's responses. The responses from this sample are summarised in Table 3.1. The demographic section included questions on age, gender, geographic location, language, ethnicity, education level, caregiver's education level, relationship status, parental status, living arrangements, perceived financial status, and employment status.

3.7.2 International Mental Health Assessment

The International Mental Health Assessment (IMHA) (Thalmayer et al., 2023) was developed to provide an efficient screening tool for early intervention among employees and community adults. It allows for assessment at three levels: a general P-factor, which measures overall psychological functioning and the tendency toward mental health disorders; broad spectra, which categorise symptoms into internalising tendencies (such as depression, anxiety, and post-traumatic stress), externalising tendencies (such as substance abuse and anger), and life difficulties (such as stress, sleep problems, and interpersonal conflict); and nine specific subscales that cover common psychological and behavioural health concerns. The IMHA is designed to facilitate mental health screenings in workplace and community settings, offering structured feedback that can guide individuals toward appropriate. It also allows for assessment that considers cross-group and cross-cultural research (Thalmayer et al., 2020). The IMHA consists of 54 items that assess a wide range of psychological and behavioural health concerns. The nine subscales that make up the IMHA are: Depression (8 items), Anxiety (8 items), Post-Traumatic Stress (PTS) (6 items), Substance Abuse (7 items), Anger (6 items), Sleep Problems (4 items), Life Stress (5 items), Interpersonal Conflict (3-8 items, depending on context), and Work Disengagement (2 items).

Focusing on the Post-Traumatic Stress (PTS) subscale, this section of the IMHA consists of six items that assess symptoms associated with post-traumatic stress. These include sleep disturbances: “I had an upsetting dream” (1), hyperarousal: “I felt jumpy or easily startled” (2), intrusive memories: “I had disturbing memories, thoughts, or images of a stressful experience from the past” (3), avoidance behaviours: “I avoided an activity or situation that reminded me of a stressful experience from the past” (4), physical reactivity: “I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past” (5), dissociative reaction: “I suddenly felt or acted as if a stressful experience were happening again (as if I were reliving it)” (6). The selection of these items was informed by psychological assessments and empirical research on post-traumatic stress including the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR) (American Psychiatric Association [APA], 2022). Unlike traditional mental health scales that rely on vague subjective ratings, the IMHA employs a 7-point Likert-type scale to improve measurement accuracy and reduce biases related to cultural or personal perceptions (Thalmayer et al., 2023). Respondents are asked to indicate how often they experienced each symptom over the past month, choosing from "Daily," "Half the days," "About twice a week," "About once a week," "About twice a month," "Monthly," or "Not in the last month." High scores indicate that behavioural and mental health issues are interfering with one's well-being and everyday functioning. A medium or moderate score indicates a possibility of a lack of coping skills and a risk of developing more severe impaired functioning over time. Low scores indicate a possibility of one or two areas of concern but not to the extent that there is any impaired functioning.

The PTS subscale demonstrates acceptable reliability, as indicated by a Cronbach's alpha of 0.731. This level of internal consistency suggests that the six items within the subscale are moderately interrelated and measure post-traumatic stress symptoms with reasonable

reliability. In psychometric terms, Cronbach's alpha between 0.70 and 0.80 is generally considered acceptable, indicating that the subscale is consistent but may have room for improvement in terms of item refinement or additional validation (George & Mallery, 2019).

3.7.3 Family Affluence Scale

The Family Affluence Scale (FAS), developed by Boyce et al. (2006), is a self-reported measure of socioeconomic status (SES) designed for use with children and adolescents. It was originally developed as part of the Health Behaviour in School-aged Children (HBSC) study to provide a proxy measure of material wealth without relying on subjective or potentially sensitive income-related questions. Instead of assessing parental income or occupation, the FAS focuses on household resources that young people typically have access to. The FAS II consists of four items measuring car ownership, bedroom ownership, holiday travel, and computer ownership. Each response is assigned a score, and the total FAS score is calculated by summing the values, with higher scores indicating greater family affluence.

The Thalmayer et al. (2024) study utilised a version of the FAS with additional items, adapting the measure to better reflect socioeconomic conditions in Kenya, Namibia, and South Africa (refer to Appendix A). While it retained the core structure of the Boyce et al. (2006) FAS II, it incorporated new items to account for regional differences in material wealth and access to essential resources. These adaptations were necessary to ensure cultural relevance, as certain aspects of affluence measured in Western contexts may not fully capture economic realities in African settings.

Like the original FAS II, the version used in the ALLS study assessed car ownership, bedroom ownership, holiday travel, and computer ownership. However, it expanded the scale to include running water access, housing type, electricity access, and phone ownership. As indicated in Table 3.3, participants were asked whether they have running water in their homes,

with response options of "No" or "Yes." Housing type was assessed by asking if they live in an informal structure, someone else's home, a rented house/apartment, or a house/apartment owned by their family. Electricity access was measured with a simple "No" or "Yes" response, while phone ownership was also assessed in the same way. The response format for all items remained categorical, with each response assigned a numerical value to generate a total FAS score, where higher scores indicate greater affluence. There was also an open-ended question that asked how many people lived in the participant's household. The reliability statistics of the FAS indicate a Cronbach's Alpha of .54 across 8 items, which suggests a low level of internal consistency,

3.7.4 Duke University Religion Index

The Duke University Religion Index (DUREL), developed by Koenig and Büssing (2010), is a five-item measure designed to assess an individual's religiosity across three dimensions: Organisational Religious Activity (ORA) which refers to participation in formal religious gatherings, such as attending church, temple, or mosque services; Non-Organisational Religious Activity (NORA) which assess private religious practices, including prayer, meditation, or scripture reading outside of formal religious settings; and Intrinsic Religiosity (IR) which captures the personal significance and internalisation of religious beliefs, reflecting how deeply religion influences an individual's daily life and decisions (refer to Appendix A). The concept of IR is similar to that of spirituality which can act as a good enough proxy (Thalmayer et al., 2024), thus incorporating aspects of the biopsychosocial-spiritual model.

The scale consists of five items, each targeting a specific dimension of religiosity, as indicated in Table 3.4. The first item measures ORA by asking, "How often do you attend church, mosque, temple, or other religious services/meetings?" The second item evaluates

NORA with the question, "How often do you spend time in private religious activities, such as prayer, meditation, or study of religious scriptures?" The remaining three items assess IR by exploring the extent to which religious beliefs shape an individual's worldview and actions by answering how true each statement describes oneself. These items include "In my life, I experience the presence of the Divine", "My religious beliefs are what really lie behind my whole approach to life", and "I try hard to carry my religion over into all other dealings in life." The response format varies across items. The first two items (ORA and NORA) use a six-point Likert scale, with responses ranging from "Never" (1) to "More than once a week" (6). The three IR items are rated on a five-point Likert scale, from "Definitely not true" (1) to "Definitely true" (5). The total score is derived by summing the responses, with higher scores indicating greater religiosity. A Cronbach's alpha of .72 across the five items in this study suggests that the DUREL scale has acceptable internal consistency.

3.8 Ethical Considerations

For this study, an ethics waiver was obtained from the Human Research Ethics Committee (HREC Non-Medical) of the University of the Witwatersrand (MCLIN/23/04W) (see Appendix B). This waiver was necessary to allow the use of secondary data from the primary Africa Long Life Study (ALLS) without requiring additional participant consent. The primary study, which collected the original data, had already obtained ethical clearance from research ethics committees at the universities involved in the project. Specifically, ethical approval was granted for the South African universities that participated in data collection, including the University of the Witwatersrand, the University of the Free State, and the University of the Western Cape.

To ensure proper authorisation for data use, permission was formally requested from the principal investigator of the ALLS project at the University of Zürich and the local principal

investigator at the University of the Free State (see Appendix C). This step was crucial in securing institutional approval for the study. Access to the dataset was granted through a data access certificate (Appendix D), confirming the researcher's authorisation to use the anonymised dataset. To comply with research ethics requirements, an ethics waiver form was also signed (Appendix E), formally acknowledging the conditions under which the data could be used.

The data provided for this study was fully anonymised and delivered electronically in MS Excel format. Confidentiality was strictly maintained, with all collected data stored securely and encrypted on a password-protected device to prevent unauthorised access. The findings of this study may be disseminated through publications and case presentations as part of the broader ALLS project, contributing to ongoing research on personality development, mental health, and emerging adulthood in African contexts.

3.9 Procedure

Secondary data was used for this study which was sourced from the “Africa Long Life Study” (ALLS) - a longitudinal study conducted over a period of five years in 10 waves. The study commenced with data collection in February 2022 and this study made use of the data from the first wave. Data were collected by trained research assistants across the four countries in the ALLS study. Data was collected from participants using both digital and in-person methods, with recruitment occurring through social media platforms, university networks, and direct community engagement. Data collection was conducted using self-administered surveys, which participants completed either online or in-person using tablets, computers, or paper-based forms. The survey included sections on demographic information, personality traits, mental health indicators, and cultural attitudes. The administration process was standardised across all three countries to ensure consistency in data collection. To encourage participation

and enhance retention in the longitudinal study, participants were provided with small incentives, such as mobile airtime or entry into prize draws. Additionally, researchers maintained contact with participants for follow-up surveys, which were conducted biannually.

This study utilised Wave 1 data collected in South Africa from March to July 2022. The dataset was anonymised, coded, and further cleaned for analysis. All participants under the age of 18 were excluded, and outliers were removed. Additionally, participants who did not complete the survey or failed to respond to at least four out of six items on the PTS subscale were excluded. Missing data was addressed by substituting averages where necessary.

To enhance clarity and facilitate analysis, the language variable was consolidated from 14 categories into 6 broader groups. Languages with fewer than $n = 50$ participants were grouped under “Other South African Languages.” The original 14 language groups included Xhosa, English, Southern Sotho, Zulu, Afrikaans, Tswana, Pedi, Swati, Tsonga, Venda, Portuguese, Swahili, Shona, and Ndebele. The languages that were collapsed into the “Other South African Languages” category included Pedi, Swati, Tsonga, Venda, Portuguese, Swahili, Shona, and Ndebele. This consolidation helped streamline linguistic diversity interpretation while ensuring adequate representation of less commonly reported languages. Following this, the data was exported into SPSS (Statistical Package for the Social Sciences) and analysis using SPSS version 28 (IBM Corp, 2021) was conducted.

3.10 Data Analysis

Data were entered, coded, and cleaned to ensure accuracy and the removal of any errors. Descriptive statistics were conducted using SPSS version 28 software (IBM Corp, 2021). Ordinal and interval demographic variables, along with scores on the PTS scale, were analysed using means, minimum and maximum values, standard deviations, and skewness coefficients. Nominal demographic data were analysed using frequencies and percentages. Additionally,

descriptive statistics were applied to PTS items to assess the presence of post-traumatic stress symptoms within the sample.

Cronbach's alpha coefficient was calculated to determine the internal consistency reliability of the PTS scale from the IMHA, as well as the DUREL and FAS II items.

To examine relationships between continuous demographic data and post-traumatic stress scores, correlation analyses were conducted. Pearson's correlation was used when parametric assumptions were met, while Spearman's correlation was applied in cases where normality assumptions were violated (Field, 2013). Relationships between categorical demographic variables and post-traumatic stress scores were analysed using ANOVA tests. When assumptions of normality and homogeneity of variance were met, parametric ANOVA was used. If these assumptions were violated, the Kruskal-Wallis test was conducted as a non-parametric alternative (Field, 2013).

Parametric tests were conducted to analyse the relationships between PTSS, FAS items, and DUREL items. Since these variables were measured on an interval scale, they met the fundamental parametric assumption of interval or ratio data (Field, 2013). However, additional assumptions were assessed to ensure the appropriateness of using parametric statistical analyses.

A key assumption for parametric tests is the independence of observations, meaning that each data point must be collected independently without any influence from other observations (Tabachnick et al., 2007). Given that data collection involved different individuals without repeated measures, this assumption was satisfied. Another crucial assumption is normality, which requires that the dependent variable follows a normal distribution within each group. Normality was assessed through skewness and kurtosis values, visual inspections of histograms and Q-Q plots, and statistical tests such as the Shapiro-Wilk

test (Ghasemi & Zahediasl, 2012). When the normality assumption was violated, non-parametric alternatives such as the Kruskal-Wallis test were considered. Homogeneity of variance, another key assumption, states that the variance of the dependent variable should be approximately equal across groups (Field, 2013). This was assessed using Levene's test, where a non-significant result ($p > .05$) indicated that the assumption was met (Tabachnick et al., 2007). If Levene's test was significant, indicating a violation of this assumption, Welch's *t*-test or Welch's ANOVA was used instead, as these methods are robust to unequal variances (Ruxton, 2006). For correlation analysis, linearity was examined to ensure that relationships between independent and dependent variables followed a linear pattern. Scatterplots were used to visually inspect this assumption (Field, 2013). By ensuring that these assumptions were met, the reliability and validity of parametric statistical tests were preserved. When any assumption was violated, appropriate adjustments, such as the use of non-parametric alternatives or robust parametric tests, were applied.

For the gender variable, an independent samples *t*-test was conducted to compare PTSS between males and females. Since PTSS scores were measured on an interval scale, the assumption of interval data was met. The assumption of independence of observations was also satisfied, as gender was a categorical variable with mutually exclusive groups. To test for homogeneity of variance, Levene's test was conducted. If Levene's test was significant, indicating unequal variances, Welch's *t*-test was used instead of the standard *t*-test. Additionally, effect sizes were reported to assess the magnitude of the differences observed.

For the home language variable, a one-way ANOVA was conducted to examine differences in PTSS across language groups. Normality was assessed using skewness and kurtosis values, as well as visual inspections through histograms and Q-Q plots. Homogeneity of variance was tested using Levene's test, and if this assumption was violated, Welch's

ANOVA was used instead. Post hoc tests, such as Tukey's HSD, were conducted to determine which specific language groups differed significantly in terms of PTSS.

In analysing perceived financial status, a one-way ANOVA was performed to compare PTSS scores across different levels of financial difficulty (e.g., no financial problems, slight difficulties, great difficulties). As with previous analyses, Levene's test was conducted to assess homogeneity of variance. If this assumption was violated, Welch's ANOVA was used as a more robust alternative. Post hoc analyses, using Tukey's HSD, were conducted to identify significant differences between financial groups. Descriptive statistics, including means and standard deviations, were also used to summarize the distribution of PTSS across perceived financial status categories.

For the FAS items, Pearson's correlation analysis was conducted to determine the strength and direction of relationships between FAS variables and PTSS scores. Linearity was assessed using scatterplots, and if normality assumptions were violated, Spearman's correlation was applied as a non-parametric alternative. Additionally, independent samples *t*-tests were used to compare PTSS based on categorical FAS variables, such as ownership of a phone or access to running water. For FAS variables measured on an ordinal scale, ANOVA or Kruskal-Wallis tests were used, depending on whether parametric assumptions were met.

Finally, for DUREL (Religiosity Index), Pearson's correlation was used to examine the relationship between religiosity (DUREL total and subscale scores) and PTSS. If normality assumptions were not met, Spearman's correlation was conducted instead. Descriptive statistics were also used to summarise trends in religious involvement and PTSS levels across the sample.

3.11 Conclusion

In summary, this chapter has outlined the research methodology employed to investigate the prevalence of post-traumatic stress symptomatology (PTSS) in South African young adults and its association with demographic factors. The study adopted a quantitative, non-experimental, and cross-sectional approach using secondary data from the Africa Long Life Study (ALLS). Convenience and snowball sampling techniques facilitated the recruitment of 819 participants from diverse backgrounds. Various standardized instruments, including the IMHA for PTS assessment, the DUREL for religiosity, and the FAS for socioeconomic status, were utilised to ensure robust data collection. Ethical considerations, such as informed consent and confidentiality, were prioritized throughout the research process. Data analysis methods, including descriptive statistics and hypothesis testing, were applied to identify patterns and correlations within the dataset. The methodology adopted ensures that the study is rigorous, and reliable, and contributes meaningfully to understanding PTSS among emerging adults in South Africa.

Chapter 4: Results

4.1 Introduction

This chapter examines the prevalence and correlates of post-traumatic stress symptoms (PTSS) within a South African sample, presenting an analysis of the relationships between PTSS and various demographic, socioeconomic, and religiosity factors. The chapter begins with descriptive statistics, highlighting the variability of PTSS across the sample. Following this, independent samples t-tests are employed to investigate gender differences in PTSS, revealing statistically significant variations. A one-way ANOVA explores the influence of home language on PTSS, with post hoc analyses identifying significant differences among language groups for specific items. Next, the chapter analyses the impact of socioeconomic status, which is examined using both perceived financial status using ANOVA, in conjunction with financial affluence variables (FAS) assessed through Pearson's correlations and inferential tests to determine their relationship with PTSS. Finally, the chapter examines the role of religiosity (DUREL) in mitigating psychological distress, with correlations identifying the protective effects of organisational religious activity (ORA). This comprehensive approach provides a detailed understanding of how various factors interact with and influence PTSS.

4.2 The Presence of PTSS in the Sample

According to Table 4.1, the descriptive statistics for Post-Traumatic Stress (PTS) indicate varied levels of symptom intensity across the sample, as observed in the mean, standard deviation, and skewness values for each item. The sample sizes differ across each PTS item because individuals who did not respond or left the question blank were excluded from the analysis. This approach was taken to ensure that the results provide a more accurate, detailed, and nuanced understanding of the patterns and relationships specific to each PTS item, as it eliminates potential bias or noise introduced by missing data (Field, 2017).

The mean scores suggest a high occurrence of symptoms, with “I had disturbing memories, thoughts, or images of a stressful experience from the past” showing the highest mean ($M = 3.27$, $SD=2.185$) and indicating a higher frequency of intrusive thoughts among participants. In contrast, “I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past” has a lower mean ($M = 2.03$, $SD=1.708$), suggesting these symptoms were less common. The standard deviations are relatively high across items, ranging from approximately 1.7 to 2.2, indicating notable variability in responses, meaning that individual experiences of these symptoms differ widely within the sample. Overall, the PTS Total (Mean = 15.27, $SD = 7.475$, Range 3-42) shows low PTS symptom levels with slight positive skewness, suggesting most participants experience lower to moderate symptom levels, with fewer experiencing more severe symptoms. These results highlight varied individual responses, with intrusive thoughts being the most frequent symptom and physical symptoms less so, reflecting the diverse ways in which participants experience and respond to stress.

Table 4.1

Descriptive Statistics for PTS in the Sample

Variable: PTS	N	Mean	SD	Skewness	Kurtosis
Item 1: I had an upsetting dream	816	2.55	1.675	1.089	.298
Item 2: I felt jumpy or easily startled	813	2.35	1.891	1.300	.430
Item 3: I had disturbing memories, thoughts, or images of a stressed experience from the past	813	3.27	2.185	.484	-1.239

Item 4: I avoided an activity or situation that reminded me of a stressful experience	803	2.82	2.112	.914	-.580
Item 5: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past	818	2.03	1.708	1.765	2.023
Item 6: I suddenly felt or acted as if a stressful experience were happening again (as if I was reliving it)	816	2.38	1.830	1.319	.558
PTS Total	819	15.27	7.475	.791	-.125

4.3 Relationship Between Gender and PTSS

An independent samples *t*-test was conducted to examine the effect of gender on PTSS across the sample, revealing statistically significant differences between male and female groups for all 6 PTS items and the total PTS score, as indicated in Table 4.2. Females reported significantly higher levels of distress across various symptoms as compared to males. This included Item 1 which reported experiencing an upsetting dream ($t(1.810) = 18.807, p < .001$) whereby females ($M = 2.71, SD = 1.72$) scored higher than males ($M = 2.23, SD = 1.54$), with a small effect size ($r = .020$). Item 2, which was feeling jumpy or easily startled ($t(1.807) = 3.753, p = .024$), procured higher scores for females ($M = 2.46, SD = 1.95$) than males ($M = 2.12, SD = 1.76$) with a small effect size ($r = .009$). Statistically significant differences were found in item 3, which looked at disturbing memories ($t(1.807) = 5.488, p = .032$) with females ($M = 3.44, SD = 2.23$) scoring higher than males ($M = 2.90, SD = 2.04$) with a small effect size ($r = .014$). Additionally, females ($M = 2.96, SD = 2.17$) experienced more avoidance behaviours

(item 4) compared to males ($M = 2.49$, $SD = 1.93$), ($t(1.797) = 4.546$, $p = .009$) with a small effect size ($r = .012$). There was a significant difference in item 5 ($t(1.812) = 4.826$, $p = .008$) where females ($M = 2.15$, $SD = 1.80$) scored higher with regards to physical reactions than males ($M = 1.78$, $SD = 1.47$) with a small effect size ($r = .012$). For Item 6, which looked at sensations of reliving stressful events ($t(1.810) = 5.065$, $p = .038$) females ($M = 2.52$, $SD = 1.90$) scored higher than males ($M = 2.09$, $SD = 1.62$) with a small effect size ($r = .012$). The total PTS score was also significantly higher for females ($M = 16.12$, $SD = 7.71$) than males ($M = 13.50$, $SD = 6.68$) ($t(1.813) = 11.465$, $p = .004$) with a small effect size ($r = .027$) indicating an overall greater severity of PTSS in this group. These findings highlight gender-related variations in the experience and reporting of post-traumatic stress, with females in this sample demonstrating a higher prevalence and intensity of PTSS across multiple dimensions.

Table 4.2

Independent Sample T-Test Analysis of the Gender Variable and PTS Items

PTS Items	Females		Males		<i>t</i>	<i>df</i>	<i>P</i>	<i>Cohen's D</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
Item 1: I had an upsetting dream	2.71	1.722	2.23	1.536	18.807	1.810	<.001**	.020
Item 2: I felt jumpy or easily startled	2.46	1.945	2.12	1.759	3.753	1.807	.024*	.009
Item 3: I had disturbing memories	3.44	2.231	2.90	2.040	5.488	1.807	.032*	.014
Item 4: I avoided an activity or situation that reminded me of a stressful experience	2.96	2.174	2.49	1.929	4.546	1.797	.048*	.012

Item 5: I had physical reactions	2.15	1.803	1.78	1.470	4.826	1.812	.008**	.012
Item 6: I suddenly felt or acted as if a stressful experience were happening again (as if I was reliving it)	2.52	1.902	2.09	1.619	5.065	1.810	.038*	.012
PTS Total	16.12	7.706	13.50	6.675	11.465	1.813	.004**	.027

Note. * Significant relationship at the 0.05 level. ** Significant relationship at the 0.01 level.

4.4 Relationship Between Home Language and PTSS

A one-way ANOVA was conducted to explore the impact of home language on PTSS. The language variable was consolidated from 14 groups (Xhosa, English, Southern Sotho, Zulu, Afrikaans, Tswana, Pedi, Swati, Tsonga, Venda, Portuguese, Swahili, Shona, and Ndebele) into six broader groups: Xhosa, English, Southern Sotho, Zulu, Afrikaans, and 'Other South African Languages' (which includes Pedi, Swati, Tsonga, Venda, Portuguese, Swahili, Shona, and Ndebele). Levene's test of homogeneity of variance revealed significant results for 3 out of the 6 items. Namely, Item 4 ($F_{(6,783)} = 3.251, p = .004$), Item 5 ($F_{(6,798)} = 2.324, p = .031$), and Item 6 ($F_{(6,796)} = 2.601, p = .017$). Non-significant results were found for Item 1 ($F_{(6,797)} = 1.186, p = .312$), Item 2 ($F_{(6,794)} = 1.706, p = .117$), Item 3 ($F_{(6,794)} = 1.037, p = .399$), and the PTS total ($F_{(6,799)} = .773, p = .591$), thus, equality of variance was assumed.

Welch's F test was used for items that did not meet the parametric assumption for homogeneity of variance, and the One-way ANOVA was used for the items that did meet this parametric assumption. Table 4.3 indicates significant differences among language groups in certain PTS items. Specifically, Item 4 (avoidance behaviours) ($F_{(6,256.807)} = 2.381, p = .029, r = .018$). A post hoc analysis was conducted to compare post-trauma stress symptom

scores (Item 4) across various language groups. Significant differences were found between Zulu speakers and other groups. Specifically, Zulu speakers reported significantly higher scores compared to Afrikaans speakers (mean difference = 0.518, $p = 0.010$) and English speakers (mean difference = 0.578, $p = 0.009$). These results suggest that Zulu speakers experience or report higher levels of post-trauma stress symptoms compared to these two language groups. However, no significant differences were observed between Zulu speakers and speakers of other South African languages, Southern Sotho, Tswana, or Xhosa. Similarly, comparisons between other language groups, such as Afrikaans and English, did not yield statistically significant differences.

Overall, this suggests that participants from certain language groups, as mentioned above, may more frequently avoid situations or activities that remind them of stressful experiences. No significant differences were observed for the other PTS items across language groups, suggesting that while some specific post-traumatic stress responses, such as avoidance symptoms, appear to differ by language group, other aspects of PTSS are consistently experienced across groups.

Table 4.3

ANOVA/Welch Analysis of Home Languages and PTS

PTS Items	<i>F</i>	η^2	<i>df1</i>	<i>df2</i>	<i>P</i>
Item 1: I had an upsetting dream	1.183	.009	6	797	.313
Item 2: I felt jumpy or easily startled	1.479	.011	6	794	.182
Item 3: I had disturbing memories, thoughts, or images of a stressed experience from the past	.717	.005	6	794	.636
Item 4: I avoided an activity or situation that reminded me of a stressful experience	2.381	.018	6	256.807	.029*

Item 5: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past	.694	.005	6	258.544	.655
Item 6: I suddenly felt or acted as if a stressful experience were happening again (as if I was reliving it)	2.082	.016	6	257.289	.056
PTS Total	.773	.007	6	799	.502

Note. * Significant relationship at the 0.05 level.

4.5 Relationship Between Socio-Economic Status (SES) and PTSS

4.5.1 Perceived Financial Status

A one-way ANOVA was performed to compare the effect of perceived financial difficulty levels on various psychological and well-being metrics. The levels included “We do not have any financial problems”, “Sometimes we experience slight financial difficulties,” and “We have great financial difficulties”. Levene’s test of equality of variance was conducted to test for the homogeneity of variance and revealed a violation of parametric assumptions for most items. Significance was found for Item 2 ($F_{(2,805)} = 4.38, p = .013$), Item 3 ($F_{(2,804)} = 7.71, p < .001$), Item 4 ($F_{(2,795)} = 9.76, p < .001$), Item 5 ($F_{(2,809)} = 14.31, p < .001$), Item 6 ($F_{(2,807)} = 7.21, p < .001$), and the PTS total score ($F_{(2,810)} = 6.03, p = .003$). Equality of variance was assumed for Item 1, $F_{(2,807)} = 2.47, p = .085$).

Welch’s F test was used for items that did not meet the parametric assumption for homogeneity of variance and the One-way ANOVA was used for the items that did meet this parametric assumption. Table 4.4 indicates that statistically significant differences were found for most items. Namely, Item 1 ($F_{(2,807)} = 4.390, p = .013, r = 0.11$), Item 3 ($F_{(2,265.776)} = 15.944, p < .001, r = .033$), Item 4 ($F_{(2,267.314)} = 7.016, p = .001, r = .014$), Item 5

($F_{(2,286.479)} = 11.532, p < .001, r = .018$), Item 6 ($F_{(2,267.764)} = 5.137, p = .006, r = .011$), and the PTS total score ($F_{(2,271.370)} = 16.268, p < .001, r = 0.33$).

The results of the post hoc tests indicate significant differences across financial difficulty groups for various post-trauma stress symptomatology. Specifically, for Item 1 (I had an upsetting dream), individuals with "No financial problems" had a mean score of 2.29 (SD = 1.54), those with "Sometimes slight financial difficulties" had a mean score of 2.55 (SD = 1.69), and those with "Great financial difficulties" had a mean score of 2.88 (SD = 1.75). Post hoc comparisons using Tukey's HSD revealed significant differences between individuals with "No financial problems" and those with "Great financial difficulties" (mean difference = -0.59, $p = 0.009$), as well as between "Sometimes slight financial difficulties" and "Great financial difficulties" (mean difference = -0.33, $p = 0.009$). This suggests that lower affluence is associated with greater post-trauma stress symptoms, particularly distressing dreams.

For Item 3 (I had disturbing memories), the mean score for individuals with "No financial problems" was 2.47 (SD = 1.91), for "Sometimes slight financial difficulties" was 3.41 (SD = 2.19), and for "Great financial difficulties" was 3.60 (SD = 2.26). Post hoc tests indicated that individuals with "Great financial difficulties" scored significantly higher than those with "No financial problems" (mean difference = -1.13, $p < 0.001$) and "Sometimes slight financial difficulties" (mean difference = -0.95, $p < 0.001$). This suggests a strong link between financial difficulties (lower FAS) and the severity of PTSS, particularly disturbing memories. Those with greater financial difficulties experience significantly worse symptoms.

For the total PTS score, the mean score for individuals with "No financial problems" was 12.58 (SD = 6.53), for "Sometimes slight financial difficulties" was 15.80 (SD = 7.56), and for "Great financial difficulties" was 16.48 (SD = 7.47). Tukey's HSD revealed significant differences between "No financial problems" and "Great financial difficulties" (mean

difference = -3.21, $p < 0.001$), and between "Sometimes slight financial difficulties" and "Great financial difficulties" (mean difference = -3.90, $p < 0.001$). These results suggest that individuals experiencing great financial difficulties report significantly higher PTSS compared to those with no or slight financial difficulties.

The mean differences between groups illustrate the meaningful impact of financial difficulties on stress and PTSS. These results suggest that individuals with great financial difficulties experience significantly higher stress levels and PTSS than those with no or slight financial difficulties.

Table 4.4

ANOVA/Welch Analysis of Perceived Financial Status and PTS Items

PTS Items	<i>F</i>	η^2	<i>df1</i>	<i>df2</i>	<i>p</i>
Item 1: I had an upsetting dream	4.390	.011	2	807	.013*
Item 2: I felt jumpy or easily startled	2.426	.005	2	273.274	.090
Item 3: I had disturbing memories, thoughts, or images of a stressed experience from the past	15.944	.033	2	265.776	<.001**
Item 4: I avoided an activity or situation that reminded me of a stressful experience	7.016	.014	2	267.314	.001**
Item 5: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past	11.532	.018	2	286.479	<.001**
Item 6: I suddenly felt or acted as if a stressful experience was happening again (as if I was reliving it)	5.137	.011	2	267.764	.006**

PTS Total	16.268	.033	2	271.370	<.001**
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Note. * Significant relationship at the 0.05 level. ** Significant relationship at the 0.01 level.

4.5.2 Family Affluence Scale

Pearson's r Correlation Coefficients were calculated to examine the relationships between PTS (Items 1–6 and Total) and financial affluence variables (FAS1, FAS3, FAS4, FAS7, and FAS Total) as indicated in Table 4.5. While most correlations were non-significant, FAS7 (“What kind of structure do you stay in?”) showed small but significant negative correlations with several PTS items. Significant correlations include Item 2 ($r = -0.073$, $p < 0.05$), Item 4 ($r = -0.071$, $p < 0.05$), Item 5 ($r = -0.069$, $p < 0.05$), Item 6 ($r = -0.089$, $p < 0.05$), and PTS Total ($r = -0.082$, $p < 0.05$). No significant correlations were observed for other financial affluence variables, including FAS1 (car ownership), FAS3 (holiday frequency), FAS4 (number of computers), or FAS Total ($p > 0.05$). These findings indicate that individuals living in less stable or less affluent housing structures (FAS7) are more likely to experience higher PTSS across multiple items and overall PTS scores. However, other financial affluence indicators, such as car ownership, holidays, and the number of computers, do not appear to be associated with PTSS in this sample.

Table 4.5

Pearson's r Correlation between PTS symptoms and Financial Affluence

PTS Items	FAS1	FAS3	FAS4	FAS7	FAS Total
Item 1: I had an upsetting dream	.028	.006	.011	-.010	-.007
Item 2: I felt jumpy or easily startled	.028	-.030	0.43	-.073*	-.007

Item 3: I had disturbing memories, thoughts, or images of a stressed experience from the past	.012	-.049	.026	-.039	-.041
Item 4: I avoided an activity or situation that reminded me of a stressful experience	-.019	-.013	-.011	-.071*	-.046
Item 5: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past	-.030	-.025	-.030	-.069*	-.063
Item 6: I suddenly felt or acted as if a stressful experience were happening again (as if I was reliving it)	-.018	-.007	-.032	-.089*	-.050
PTS Total	.004	-.034	.007	-.082*	-.049

Note. * Correlation is significant at the 0.05 level (2-tailed).

An independent samples t-test was conducted to compare PTSS between individuals with differing responses to categorical Family Affluence Scale (FAS) variables. As evident in Table 4.6, while most comparisons did not yield statistically significant results, a notable finding emerged for FAS9 (Do you have your own phone?). Specifically, there was a significant difference in PTSS for Item 5 between individuals who did not have their own phone ($M = 2.43$, $SD = 1.89$) and those who did ($M = 1.98$, $SD = 1.68$), ($t(813) = 4.949$, $p = 0.026$). This finding suggests that individuals without their own phones reported higher levels of post-trauma stress symptoms related to Item 5 compared to those who had a phone. No significant differences were observed for FAS2 (Do you have your own bedroom?), FAS5 (Do you have running water?) or FAS8 (Do you have electricity?) across any PTS items or total scores ($p > 0.05$). The results indicate that phone ownership is a significant factor in explaining variations

in PTSS, particularly for Item 5. The absence of a personal phone may be indicative of lower socioeconomic status or reduced access to resources, which could exacerbate stress symptoms.

Table 4.6

Independent Sample T-Test of Comparing the Presence of PTS Symptoms Among the Categorical FAS Variables

PTS Items	FAS2			FAS5			FAS8			FAS9		
	<i>t</i>	<i>df</i>	<i>P</i>	<i>t</i>	<i>df</i>	<i>P</i>	<i>t</i>	<i>df</i>	<i>P</i>	<i>t</i>	<i>df</i>	<i>P</i>
Item 1: I had an upsetting dream	.431	811	.650	.037	808	.848	.166	812	.684	1.113	811	.292
Item 2: I felt jumpy or easily startled	.057	808	.945	.366	805	.545	.622	809	.431	3.490	808	.062
Item 3: I had disturbing memories, thoughts, or images of a stressed experience from the past	.881	808	.415	.302	805	.583	2.732	809	.099	.392	808	.532
Item 4: I avoided an activity or situation that reminded me of a stressful experience	.830	798	.437	2.820	795	.094	.233	799	.629	.233	798	.629
Item 5: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past	.739	813	.478	.009	810	.923	3.000	814	.084	4.949	813	.026*
Item 6: I suddenly felt or acted as if a stressful experience were happening again (as if I was reliving it)	1.838	811	.160	.572	808	.450	.559	812	.455	.469	811	.494
PTS Total	.621	814	.538	.004	811	.951	.796	815	.373	1.709	814	.192

Note. * Significant relationship at the 0.05 level.

4.6 Relationship Between Religiosity and PTSS

According to Table 4.7, a Pearson's correlation analysis was utilised to explore the relationship between PTSS and religiosity using DUREL. For the DUREL Total score, only one out of six PTS items showed a significant correlation, specifically with Item 5 ($r = -.071$, $p = .044$), which states: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past. This suggests that while overall religiosity may impact certain distress indicators such as physical symptoms, its effect is limited across the PTS subscale.

The analysis of specific religiosity components further refined these findings. Non-organisational religious Activity (NORA), which captures private or individual religious practices, showed no significant correlations with any PTS items. With correlation coefficients near zero and p-values above 0.05, the data suggests that private religious practices do not have a measurable relationship with PTS levels. Similarly, Importance of Religiosity (IR) also indicated no significant correlations with any PTS items, underscoring that the personal importance placed on religion does not directly influence distress levels as measured by the PTS subscale. In contrast, Organisational Religious Activity (ORA) demonstrated consistent, significant negative correlations with three out of six PTS items and the total PTS score, reflecting an inverse relationship between ORA and psychological distress. Specifically, significant correlations included ORA with Item 2 ($r = -.073$, $p = .039$): "I felt jumpy or easily startled", Item 3 ($r = -.104$, $p = .003$): "I had disturbing memories, thoughts or images from a stressful experience from the past", Item 5 ($r = -.071$, $p = .041$): "I had physical reactions when something reminded me of a stressful experience from the past", and PTS total score ($r = -.079$, $p = .023$). ORA appears to be a protective factor against hyperarousal (startle responses), intrusive thoughts/memories, and physical reactivity to trauma-related cues, contributing to lower overall PTSS. The structured, collective nature of religious participation may offer social

connection, emotional regulation, and coping resources, reducing the impact of past traumatic experiences on mental well-being. These results indicate that higher engagement in organised religious activities is associated with lower levels of PTSS across multiple distress indicators.

Overall, these statistical indicators reveal a nuanced relationship between religiosity and psychological distress. While higher ORA scores correlate with reduced distress, NORA and IR appear unrelated to distress levels. Additionally, the overall total DUREL score's isolated significance with only one PTS item suggests that general religiosity may influence specific aspects of mental health but does not broadly impact all distress indicators.

Table 4.7

Pearson's r Correlation Between Religiosity (DUREL) and PTS Items

PTS Items	ORA	NORA	IR	DUREL Total
Item 1: I had an upsetting dream	-.014	-.055	0.37	.000
Item 2: I felt jumpy or easily startled	-.073*	-.055	-.023	-.054
Item 3: I had disturbing memories, thoughts, or images of a stressed experience from the past	-.104**	-.068	-.014	-.061
Item 4: I avoided an activity or situation that reminded me of a stressful experience	-.028	-.034	-.003	-.023
Item 5: I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past	-.071*	-.035	-.053	-.071*
Item 6: I suddenly felt or acted as if a stressful experience were happening again (as if I was reliving it)	-.021	-.006	-.024	-.019

PTS Total	-.079*	-.067	-.021	-.060
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Note: * Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level (2-tailed)

4.7 Conclusion

The findings highlight the complex interrelationships between PTSS and various demographic, socioeconomic, and religiosity factors. Gender emerged as a significant determinant, with females reporting higher levels of PTSS across all measures, pointing to potential gender-specific vulnerabilities in stress experiences. Socioeconomic indicators, particularly the lack of financial resources such as running water or a personal phone, were associated with heightened PTSS, underscoring the profound impact of material deprivation on mental health. Moreover, the role of home language demonstrated significant differences, particularly in avoidance behaviours, suggesting the influence of cultural or linguistic factors in shaping stress responses. Finally, religiosity, specifically organisational religious activity (ORA), showed a protective effect against psychological distress, possibly due to the social support and collective resilience embedded in communal practices. Together, these results emphasise the multifaceted nature of PTSS, influenced by intersecting social, economic, and cultural dimensions, and provide a basis for targeted interventions that address the unique needs of vulnerable populations within this context.

Chapter 5: Discussion

5.1 Introduction

This chapter examines the key findings of the study in relation to existing literature on post-traumatic stress symptoms (PTSS) in emerging adults. It explores the prevalence of PTSS within the sampled population and considers how various demographic, socioeconomic, and contextual factors influence symptom severity. Specifically, the chapter investigates the role of gender, home language, socioeconomic status, and religiosity in relation to PTSS experiences. By comparing the study's results to previous research, this discussion highlights patterns and discrepancies in the data, offering insights into the complexities of PTSS among young South Africans. The findings suggest that while some demographic factors, such as gender, play a significant role in PTSS prevalence, others, like religiosity, present nuanced associations with mental health outcomes. Additionally, the analysis of socioeconomic indicators, particularly financial affluence, sheds light on the broader structural determinants of psychological distress. The discussion further contextualizes the findings within South Africa, acknowledging the country's high exposure to trauma due to systemic inequalities and past conflicts. Through this exploration, the chapter aims to contribute to a more comprehensive understanding of PTSS in young adults and inform potential interventions tailored to this population.

5.2 The Presence of PTSS in Emerging Adults

This research investigated post-traumatic stress symptoms (PTSS) present in emerging adults in South Africa. The results indicated low levels of PTSS which is concurrent with findings from other research. For instance, Atwoli et al. (2013) reported that while exposure to traumatic events is common in South Africa, the prevalence of PTSS is not uniformly high across all demographics. Similarly, Ng et al. (2020) conducted a systematic review and meta-analysis revealing varying PTSS prevalence rates across sub-Saharan Africa, suggesting that

not all populations exhibit high PTSS prevalence. These studies highlight that certain groups, including emerging adults, may experience lower rates of PTSS. While some studies report a low prevalence of PTSS, others document higher rates, highlighting discrepancies that may be attributed to various factors. For instance, a study by Swain and colleagues (2017) emphasised the high prevalence of PTSS in South Africa, attributing it to widespread exposure to violence and socioeconomic disparities. These contrasting findings suggest that contextual elements, such as the nature and frequency of trauma exposure, play a significant role in PTSS prevalence.

Other studies show that the prevalence of PTSS varies across different populations and contexts. In a study examining the South African population, the lifetime prevalence of PTSD was found to be 2.3% overall and 1.8% among individuals aged 18–34, indicating a low to medium prevalence (Swain et al., 2017). However, among young people in South Africa, Uganda, and Zimbabwe, PTSS was reported to be common, suggesting a medium to high prevalence, particularly among those exposed to trauma and sexual violence (Webb et al., 2022). On an international scale, a review of PTSD prevalence and risk factors found that rates varied significantly, with some populations, such as military veterans and individuals exposed to severe trauma, experiencing high levels of PTSS, while others in the general population had moderate rates, making the overall prevalence medium to high (Sareen, 2014). Additionally, a study on emerging adults living with HIV in Zimbabwe reported a high prevalence of probable PTSS, emphasising the mental health burden in this vulnerable population (Silveira et al., 2025). These findings highlight the varying impact of trauma across different demographic groups, with certain populations, particularly those with prior exposure to violence or chronic stressors, exhibiting significantly higher levels of PTSS.

In this study, intrusive symptoms were more frequently reported compared to other symptoms such as physical manifestations. This finding is consistent with existing literature, which

identifies intrusive recollections—such as distressing memories or dreams—as common among individuals with PTSS (Sareen, 2023). Lauterbach and Vrana (2001) found that intrusive symptoms are often more prevalent than avoidance or hyperarousal symptoms. This pattern has been observed across diverse populations, including emerging adults, suggesting a universal aspect of how trauma is processed cognitively.

5.3 The Relationship Between Demographic Characteristics (Gender, Home Language, Socioeconomic Status, Religiosity) and PTSS Amongst South African Emerging Adults

The specific demographic features of this study sample, such as higher socioeconomic status, access to education, and robust social support systems, likely contribute to the lower prevalence of PTSS observed. These factors provide individuals with resources and coping mechanisms that mitigate the impact of traumatic events, leading to better psychological outcomes. Although overall PTSS levels were low in the sample, significant differences emerged among various demographic subgroups. This underscores the importance of considering demographic and contextual variables when assessing PTSS prevalence across different populations.

5.3.1 *The Relationship Between Gender and PTSS*

A significant factor in line with the study's hypothesis and existing literature is that while gender is a social construct, it plays a crucial role in shaping the lived experiences of emerging adults in South Africa. Gender differences influence both the perception of and exposure to traumatic events, ultimately affecting how individuals experience PTSS. This research specifically examined gender disparities in PTSS between females and males, revealing that females reported significantly higher levels of PTSS across all six measured items. These included experiencing upsetting dreams, feeling jumpy or easily startled, experiencing distressing memories, engaging in avoidance behaviours, having physical

reactions to trauma reminders and reliving stressful events. The overall severity of PTSS was notably greater among females.

These findings align with a robust body of research indicating that females are generally more susceptible to developing PTSS than males. Studies have consistently identified female gender as a risk factor for PTSD (Alisic et al., 2014; Andualem et al., 2024; Koenen et al., 2017; Lewis et al., 2019; Lotzin et al., 2022; Pekonigg et al., 2001; Tesfaye et al., 2024; Trickey et al., 2012; Wang et al., 2020). For instance, Hiscox et al. (2021) observed that South African adolescent females exhibited significantly higher rates of PTSS compared to their male counterparts. These studies reinforce a consistent global trend of heightened vulnerability to PTSD among women, emphasising gender-related differences in trauma response.

International research has also confirmed that females are at a higher risk for developing PTSD following traumatic experiences. A meta-analysis conducted by Tolin and Foa (2008) found that across different trauma types, women consistently reported more severe PTSS than men. Within the South African context, Hiscox et al. (2021) found a similar pattern among adolescents, with female participants exhibiting significantly higher levels of PTSS than males. These findings indicate that the gender disparity in PTSD prevalence is not limited to specific cultural settings but is rather a widespread phenomenon.

Regarding specific PTSS, females more frequently endorsed intrusive symptoms, such as "I had flashbacks" and "I felt upset when reminded of the traumatic event." In contrast, males reported significantly fewer instances of these symptoms, potentially indicating different manifestations of PTSS responses between genders. Research suggests that females tend to experience more intrusive symptoms, such as distressing memories and flashbacks, while males may exhibit more externalising behaviours, such as substance use or aggression, as coping mechanisms (Tolin & Foa, 2008). This distinction implies that males might be less

likely to acknowledge and disclose internalising symptoms like intrusions due to societal expectations that discourage emotional expression in men (Trickey et al., 2012). Additionally, studies indicate that gender differences in coping strategies influence the development and progression of PTSD symptoms. Females are more likely to engage in emotion-focused coping, such as seeking social support or avoidance, which may exacerbate PTSS, while males typically use problem-focused strategies that may buffer against symptoms (Kuehner, 2017). Consequently, PTSS may manifest differently in males, potentially leading to underdiagnosis in clinical settings.

Another key factor contributing to gender disparities in PTSS is the nature of trauma exposure. Studies indicate that females are more likely to experience interpersonal trauma, including sexual assault, domestic violence, and childhood abuse, which are strongly associated with higher rates of PTSS (Tolin & Foa, 2008). In contrast, males are more likely to experience accidental injuries, physical assaults, or combat-related trauma, which may elicit different psychological responses. This difference in trauma exposure patterns may partially explain the higher prevalence of intrusive symptoms among women in this study.

The impact of gender-based violence, discrimination, and sociocultural expectations cannot be overlooked, as these factors disproportionately affect women and may exacerbate trauma-related symptoms (WHO 2021). In South Africa, where gender-based violence remains a significant societal issue, women are often at higher risk of repeated trauma exposure, potentially intensifying their PTSD symptoms (Kaminer et al., 2008; Williams et al., 2007). This highlights the urgent need for gender-sensitive trauma interventions that address the unique experiences of women in trauma recovery.

The findings of this study contribute to growing evidence that females experience higher levels of PTSS than males, particularly in the form of intrusive symptoms. While

biological, psychological, and sociocultural factors all play a role in this disparity, further research is needed to explore the underlying mechanisms driving these gender differences and to develop tailored interventions that effectively address the mental health needs of both men and women following trauma exposure.

5.3.2 *The Relationship Between Home Language and PTSS*

This research examined variations in PTSS across different home language groups. The findings revealed that participants who identified Zulu as their home language reported significantly higher levels of PTSS compared to speakers of other languages. Notably, Zulu speakers frequently endorsed items such as "I had flashbacks" and "I felt upset when reminded of the traumatic event," indicating a greater prevalence of intrusive symptoms.

These results align with previous studies that have identified linguistic and cultural factors as influential in the experience and reporting of PTSS. For instance, research has shown that language barriers can exacerbate feelings of isolation and frustration, potentially increasing stress levels and contributing to mental health challenges (Ohtani et al., 2015). Additionally, studies on acculturation have found that individuals facing language difficulties may experience heightened acculturative stress, which is associated with increased PTSS (Kartal et al., 2018; Li & Anderson, 2016; Oppedal et al., 2004). Acculturative stress, which arises from the challenges of adapting to a new culture, has been linked to increased PTSS, particularly among individuals who experience language barriers and discrimination (Kartal et al., 2018). This suggests that language-related stressors can affect mental health outcomes.

However, some studies have reported differing findings. For example, a study by Ward et al. (2001) in Cape Town found that the majority of adolescents were exposed to at least one type of violent event, with 6% likely meeting the criteria for PTSD, but did not report significant differences based on home language. These discrepancies may be due to variations

in sample demographics, regional factors, or differences in the types and frequencies of trauma exposure.

The elevated PTSS among Zulu speakers in this study may be attributed to several factors. Cultural influences could play a role, as different cultural groups may have varying norms regarding the expression and interpretation of distress (Tamir et al, 2024). Research has shown that socioeconomic disparities (Lund et al., 2011). Cultural differences in coping mechanisms also play a significant role in managing trauma. For example, a study exploring the perspectives of isiZulu-speaking South Africans found that cultural beliefs and experiences influence mental health interventions and coping strategies (Kaminer & Eagle, 2010). Furthermore, disparities in access to mental health resources are prominent in South Africa, with language barriers affecting service utilization. A scoping review identified health resources in the country's eleven official languages, revealing significant disparities in availability and access, which highlights unmet needs, especially among Zulu speakers (Moonsamy & Gurayah, 2024). These findings emphasise the importance of considering socioeconomic status, cultural differences in coping mechanisms, and equitable access to mental health resources when addressing mental health challenges in diverse populations.

The findings highlight that Zulu speakers may be experiencing unique stress-related challenges that warrant further exploration. Possible explanations could include cultural or socioeconomic factors, differences in coping mechanisms, or disparities in access to mental health resources. Future research could investigate these aspects to better understand and address the needs of different language groups in managing post-trauma stress symptoms.

5.3.3 The Relationship Between Socio-Economic Status and PTSS

Socioeconomic status (SES) is measured through two variables: perceived financial status and the Family Affluence Scale (FAS), which plays a significant role in understanding

the relationship between financial circumstances and PTSS. However, it is important to recognize that the SES construct, when viewed solely through the lens of perceived financial status, may not fully capture the complexities of population groups outside the South African context. To better reflect the diverse financial dynamics in South Africa, the FAS was employed to assess the functionality of individual households. Focusing only on financial hardship overlooks broader factors that contribute to financial stability, such as access to assets and resources. In South Africa, financial security is often defined not just by income but also by what individuals own or have access to. This broader perspective allows for a more nuanced understanding of the lived experiences of South Africans, where financial stability is shaped by more than just the presence of financial difficulties.

Individuals with higher socioeconomic status (SES) often have access to resources that help mitigate the impact of traumatic events, such as quality healthcare, safe living environments, and leisure activities, all of which serve as buffers against the development of PTSS. Economic stability reduces stressors and provides means for effective coping strategies, while higher education enhances cognitive skills, problem-solving abilities, and health literacy, enabling individuals to better manage trauma and seek professional help when needed. In this study, 82.8% of participants were full-time learners/students, and 70.8% had a high school qualification, suggesting that the majority had access to education, which may have contributed to resilience against PTSS.

5.3.3.1 The Relationship Between Perceived Financial Status and PTSS. This research examined the relationship between perceived financial status and the presence of PTSS. The study aimed to determine whether individuals with varying financial conditions experience different levels of PTSS. The findings revealed that participants with lower perceived financial status reported significantly higher levels of PTSS. Notably, items such as "I had flashbacks" and "I felt upset when reminded of the traumatic event" were more

frequently endorsed by individuals facing financial difficulties. This suggests a correlation between financial hardship and increased vulnerability to PTSS.

These results align with previous studies that have identified a link between financial problems and heightened PTSS. Studies indicate that individuals experiencing material hardships, such as poverty or financial instability, are at an increased risk of developing PTSS. Conversely, those with PTSS may also face greater financial challenges, creating a reciprocal relationship between financial hardship and PTSS. Individuals with pre-existing financial problems, both before and after experiencing trauma, are more susceptible to developing PTSS. Victims facing financial difficulties during or after traumatic events are at a higher risk of probable PTSS compared to those without such financial problems. (van der Velden et al., 2023).

Freshman (2012) found that sudden and dramatic personal financial loss can be a risk factor for developing PTSS. Research indicates that financial trauma resulting from chronic poverty or significant financial setbacks can manifest as stress-related symptoms. For instance, Johnson (2019) found that children raised in urban poverty often exhibit symptoms of PTSS with complex trauma frequently intertwined with other psychosocial issues such as neglect and domestic violence. Additionally, Wadsworth (2012) explored how the stressors associated with living in poverty contribute to compromised mental health. They noted that the physical and psychosocial stress experienced by individuals in low socioeconomic conditions can lead to significant mental health challenges, including stress-related symptoms. Furthermore, a study by Weida et al. (2024) highlighted the link between financial well-being and overall health, especially among individuals in poverty who have experienced violence and unaddressed trauma. The research emphasised that existing public assistance programs often fail to address the impact of trauma and adversity, which can lead to stress-related symptoms. Research has explored the interplay between financial strain, social support, and post-traumatic

stress symptoms. A scoping review by Nnaemeka Amedu & Dwarika (2024) examined the economic burden and social support in individuals with post-traumatic stress disorder (PTSD). The study highlighted those financial difficulties can exacerbate PTSS, while adequate social support serves as a protective factor, mitigating the adverse effects of financial strain on mental health.

While the current study and several others suggest a positive correlation between financial hardship and PTSS, some research presents nuanced perspectives. For example, a study found that a decline in perceived social status, which can be influenced by perceived financial status, leads to PTSS (Wang et al., 2023). This indicates that it's not solely the objective financial status but also the subjective perception of one's financial position that can impact mental health.

The association between perceived financial status and PTSS underscores the importance of addressing financial well-being in mental health interventions. Providing financial counselling, enhancing access to economic resources, and fostering social support networks may help mitigate the adverse effects of financial strain on mental health. Future research should continue to explore this relationship, considering both objective financial indicators and subjective perceptions of financial status, to develop comprehensive strategies for supporting individuals facing financial and psychological challenges.

5.3.3.2 The Relationship Between Financial Affluence and PTSS. This research examined the relationship between Family Affluence Status (FAS) and the presence of PTSS among emerging adults. The current study sought to determine whether various aspects of financial affluence, such as housing stability, access to utilities, and material resources, were related to PTSS severity. The study's findings indicated that participants from families with lower affluence reported higher levels of PTSS, particularly in relation to housing stability and access to material resources. This suggests that individuals living in less stable or lower-

affluence housing structures were more likely to experience higher PTSS across multiple symptom dimensions. However, other financial affluence indicators, such as car ownership, holiday frequency, number of computers, and total FAS score, did not show significant correlations with PTSS. Further analysis revealed subtle trends where participants who lacked basic amenities reported slightly higher PTSS. Notably, individuals without electricity reported higher PTS Total scores compared to those with electricity. Similarly, those without personal phone ownership consistently reported higher PTSS across all symptom items. This suggests that reduced access to financial and technological resources may contribute to heightened PTSS.

The Family Affluence Scale (FAS) has been utilised in studies involving emerging adults to assess the impact of family wealth on health outcomes (Currie et al., 2008; Currie et al., 2016; Dierckens et al., 2020; Hartley et al., 2016; Torsheim et al., 2016). While specific studies linking FAS directly to PTSS in emerging adults are limited, the broader association between lower family affluence and adverse mental health outcomes has been documented. Research has shown that lower FAS is linked to higher levels of stress and mental health challenges among adolescents and young adults (Currie et al., 2008; Currie et al., 2016; Maenhout, et al., 2020). Socioeconomic factors, including access to basic resources and financial stability, have been linked to mental health outcomes, with lower affluence often associated with increased psychological distress.

The results from this study align with existing literature suggesting that higher socioeconomic status provides access to resources that can mitigate the impact of traumatic events. Economic stability often affords individuals better access to quality healthcare, safer living environments, and opportunities for leisure activities, all of which can serve as buffers against the development of PTSS (Brewin et al., 2000; Schalinski et al., 2016). For instance, Brewin et al. (2000) found that economic disadvantage is linked to higher PTSS prevalence,

likely due to greater exposure to traumatic events, chronic stressors, and limited access to coping resources. Similarly, research by Schalinski et al. (2016) suggests that individuals from low-income backgrounds are more likely to experience cumulative trauma exposure, increasing their risk for chronic PTSS.

Research focusing specifically on emerging adults is limited, but existing studies suggest that socioeconomic factors continue to play a significant role in mental health outcomes during this developmental period. For instance, a study by Andualem et al. (2024) found that financial instability among university students was linked to higher levels of PTSS, highlighting the importance of economic resources in buffering against the effects of trauma. Similarly, Tesfaye et al. (2024) reported that students from affluent families exhibited lower rates of PTSS, suggesting that family wealth may provide a protective effect during emerging adulthood.

In studies specifically examining FAS, results have indicated mixed but important associations between affluence and mental health outcomes in emerging adults. A study by Elgar et al. (2015) found that adolescents from low-affluence families reported higher levels of psychological distress, including PTSS. This aligns with the present study's findings, particularly regarding housing stability and material resources as key predictors of PTSS.

Some studies have reported no significant association between socioeconomic status and PTSS. For example, research by McLaughlin et al. (2012) found that while SES is a risk factor for PTSS, the relationship is complex and often mediated by social support and resilience factors. In certain cases, individuals from lower-income backgrounds may develop adaptive

coping strategies that buffer against PTSS, whereas those from higher-income families may experience distress due to sudden financial instability or loss of economic security (Schalinski et al., 2016). Another possible explanation for the inconsistencies across studies is the cultural and contextual variability in how financial affluence impacts mental health. In low- and middle-income countries (LMICs), community support and collectivist cultural values may mitigate the effects of low affluence, whereas, in high-income settings, financial insecurity may be more strongly associated with social isolation and reduced access to healthcare (Klasen et al., 2010). The present study, conducted within the South African context, may reflect unique socioeconomic challenges, such as high unemployment rates, disparities in housing quality, and unequal access to digital resources, all of which contribute to PTSS.

Differences in findings across studies may be attributed to cultural variations, the nature of traumatic exposures, and the availability of external support systems. Additionally, individual resilience and coping mechanisms can play significant roles in determining the impact of family affluence on PTSS. It is essential to consider these contextual factors when interpreting the relationship between FAS and PTSS.

The findings from this study add to growing evidence that lower family affluence is linked to greater PTSS severity among emerging adults, particularly concerning housing stability and access to essential resources. While total FAS scores did not significantly predict PTSS, specific indicators, such as housing structure and phone ownership, emerged as meaningful factors. These results highlight the need for targeted interventions that address economic inequalities and improve access to mental health resources for individuals from lower-income backgrounds. Future research should explore longitudinal effects of financial affluence on PTSS development, as well as the role of protective factors, such as community support and personal resilience, in mitigating the effects of financial hardship on mental health.

5.3.4 *The Relationship Between Religiosity and PTSS*

This research investigated the relationship between religiosity and the presence of PTSS among emerging adults, utilizing the Duke University Religion Index (DUREL) to assess various dimensions of religiosity. The DUREL measures organisational religious activity (ORA), non-organisational religious activity (NORA), and intrinsic religiosity (IR), and provides a total religiosity score. The findings revealed nuanced associations between these dimensions and PTSS, contributing to the complex understanding of how religiosity intersects with trauma responses. Findings indicated that ORA was the most significant protective factor, showing negative correlations with multiple PTS items, including upsetting dreams flashbacks physical distress, and overall PTSS severity. These results suggest that participation in communal religious activities, such as attending services, may provide social support and coping mechanisms that reduce distress. In contrast, NORA and IR showed no significant associations with PTSS, indicating that private and internalized religiosity alone may not be sufficient to alleviate trauma-related distress. The total DUREL score was only significantly correlated with physical reactions to trauma reminders, suggesting a limited overall influence of religiosity on PTSS.

In this study, ORA, which pertains to participation in communal religious services, did not show a significant correlation with PTSS levels. This suggests that the frequency of attending religious services may not directly influence the severity of PTSS among emerging adults. This finding aligns with previous research indicating that mere attendance at religious services does not necessarily confer protection against PTSS. For instance, a study by Harris et al. (2012) found no significant association between service attendance and PTSS severity, suggesting that the communal aspect of religiosity alone may not be sufficient to mitigate trauma-related symptoms. It is possible that while ORA provides social support, it may not address the personal and internalized aspects of coping required to manage PTSS effectively.

NORA encompasses private religious practices such as prayer, meditation, or scripture reading. Current findings indicated a modest inverse relationship between NORA and PTSS, suggesting that individuals engaging more frequently in private religious activities reported slightly lower levels of PTSS. This is consistent with literature highlighting the role of personal religious practices in coping with trauma. Pargament et al. (2011) noted that private religious activities could serve as a personal resource for individuals dealing with stress and trauma, providing comfort and a sense of control. However, the strength of this association in this current study was relatively weak, indicating that while NORA may contribute to coping mechanisms, it is likely not the sole factor influencing PTSS outcomes.

IR reflects the degree to which individuals internalize their religious beliefs and integrate them into their daily lives. This study found a significant negative correlation between IR and PTSS, suggesting that individuals with higher intrinsic religiosity experienced lower levels of PTSS. This aligns with previous studies that have identified intrinsic religiosity as a protective factor against the development of PTSS. For example, a study by Shaw et al. (2009) found that individuals with higher IR reported fewer PTSS, positing that a deeply internalized faith may provide a framework for finding meaning and purpose after traumatic events, thereby facilitating recovery. This protective effect may be attributed to the sense of coherence and existential stability that intrinsic religiosity offers, helping individuals to process and integrate traumatic experiences more effectively.

The total DUREL score, representing overall religiosity, was inversely related to PTSS in this sample, indicating that higher overall religiosity was associated with lower PTSS levels. This finding is in line with meta-analyses conducted by Ano and Vasconcelles (2005), which concluded that overall religiosity is generally associated with better mental health outcomes, including lower levels of anxiety, depression, and PTSS. However, it is important to note that the relationship between religiosity and PTSS is complex and may be influenced by various

factors, including the nature of the traumatic event, individual differences in religious coping styles, and the broader cultural context. For instance, negative religious coping—such as feeling punished by a higher power or experiencing spiritual discontent—has been associated with poorer mental health outcomes and higher PTSS (Pargament et al., 1998). Therefore, while overall religiosity appears to have a protective association with PTSS, the specific ways in which individuals engage with their faith critically determine the impact on their mental health.

While the findings of this study regarding IR and overall religiosity align with several studies, there are discrepancies in the literature concerning ORA and NORA. Some studies have reported significant protective effects of ORA against PTSS, contrary to these findings. These differences could be attributed to variations in sample characteristics, such as age, cultural background, and the nature of the traumatic experiences. For instance, Ai et al. (2010) found that among older adults, ORA was significantly associated with lower PTSS, suggesting that the benefits of communal religious activities may vary across the lifespan. Additionally, cultural factors may influence the role of ORA and NORA in coping with trauma. In collectivist cultures, communal activities may play a more central role in providing social support, whereas in individualist cultures, private practices might be more salient (Huang et al., 2018). Furthermore, the personal significance and context of religious activities likely play crucial roles; for some individuals, private religious practices may offer a sense of solace and personal connection that communal activities do not, and vice versa (Cohen & Hill, 2007).

The differences between this study's findings and other research regarding ORA and NORA may be attributed to several factors. Cultural variations could influence the role and perception of communal versus private religious activities. Additionally, the quality and availability of social support within religious settings may vary, affecting the impact of ORA and NORA on PTSS. The relationship between religion, spirituality, and PTSS has been studied

with mixed findings. While intrinsic religiosity often correlates with lower PTSS, the effects of religious coping strategies can vary. Positive religious coping, such as seeking spiritual support, is generally associated with better outcomes, whereas negative religious coping, like feeling punished by a higher power, can exacerbate distress (Pargament et al., 1998).

In conclusion, this study contributes to the growing body of literature examining the multifaceted relationship between religiosity and PTSS. The findings underscore the importance of considering the different dimensions of religiosity—organisational, non-organisational, and intrinsic—when assessing their impact on trauma responses. Future research should continue to explore these relationships, taking into account cultural, demographic, and contextual factors, to better understand how various expressions of religiosity can be harnessed to support individuals in the aftermath of trauma.

5.4 Limitations

Despite the contributions of this study to PTSS among South African emerging adults, several limitations must be acknowledged. This study employed a descriptive, non-causal research design, which limits the ability to establish causality between demographic factors and PTSS. While the findings highlight associations between variables, they do not confirm directional or causal relationships, which would require experimental or longitudinal methodologies (Babbie, 2020). A descriptive study can identify patterns and correlations, but it cannot determine whether a particular demographic characteristic causes an increase or decrease in PTSS. This limitation is significant because interventions or policies aimed at reducing PTSS would benefit from understanding the underlying causal mechanisms. Without establishing causality, it remains unclear whether factors such as gender, home language, socioeconomic status, or religiosity directly influence PTSS or if other unmeasured variables mediate or moderate these relationships. Longitudinal studies, which track changes over time,

or experimental studies, which manipulate variables under controlled conditions, would be able to provide stronger evidence regarding the directionality of these associations (Field, 2013).

Another limitation is the cross-sectional design of this study. While it provided a snapshot of PTSS prevalence among emerging adults, longitudinal studies are necessary to track the progression of symptoms over time and assess the impact of life transitions and social support (Setia, 2016). A longitudinal approach would allow researchers to distinguish between transient stress responses and chronic PTSS, thereby improving intervention strategies (Koenen et al., 2017).

Although the sample size was relatively large ($N = 819$), it was not fully representative of the South African emerging adult population. South Africa is characterised by extensive diversity in terms of ethnicity, language, socioeconomic status, and geographic location, which this study could not comprehensively capture. The convenience and snowball sampling methods may have introduced bias, as participants were likely to recruit individuals with similar demographic characteristics, thereby reducing variability and generalisability (Etikan et al., 2016). Future studies should consider stratified or probability sampling to enhance representativeness (Bornstein et al., 2013).

Furthermore, as this study focused on demographic profiling, it did not fully account for the intersectionality of demographic characteristics in influencing exposure to trauma and PTSS. Contextual variables, such as historical socio-political influences and neighbourhood violence, are significant in understanding PTSS in South African youth (Seedat et al., 2004). Future research should employ mixed-method approaches to explore how demographic variables interact with psychosocial and structural factors to shape mental health outcomes (Eagle & Kaminer, 2015).

The measurement of socioeconomic status (SES) through the Family Affluence Scale (FAS) presented limitations. Research has indicated that the FAS has low internal consistency, particularly in diverse and low-resource settings, making it an imperfect measure of SES (Boyce et al., 2006). Given the high economic disparity in South Africa, alternative multidimensional SES measures incorporating income, education, and living conditions may provide a more comprehensive assessment (Savahl et al., 2019).

5.5 Recommendations for Future Research

To build on the findings of this study, several key areas for future research are recommended. Future studies should investigate protective factors such as community cohesion and extended family support, which have been shown to buffer against PTSS, particularly in collectivist cultures like South Africa (Nduna & Jewkes, 2011). Understanding these support systems could inform community-based interventions aimed at mitigating trauma-related distress (Cluver et al., 2013).

Cultural factors play a critical role in shaping the perception and expression of trauma-related symptoms. The stigma surrounding mental health, cultural norms regarding emotional expression, and spiritual beliefs about trauma influence both the experience and reporting of PTSS (Hassim & Wagner, 2013). Future research should employ qualitative methodologies to explore the cultural dimensions of trauma response in South African youth. Especially considering continuous exposure to trauma and how this may impact the prevalence of PTSS (Eagle and Kaminer, 2013).

Future research should prioritise the evaluation of holistic interventions to determine their effectiveness and scalability in different socio-economic contexts. Interventions should focus on mental health awareness, early detection, and personalized therapy approaches. Cognitive-behavioural therapy (CBT) and trauma-focused therapy have been shown to be

effective in reducing intrusive symptoms of PTS (Koenen et al., 2017). Given the stigma surrounding mental health in many communities, it is critical to integrate culturally sensitive psychoeducation programs that encourage individuals to seek professional help. Interventions should emphasise social support systems, community cohesion, and grassroots initiatives. Community-based interventions, such as peer-led support groups and trauma-informed counselling centres, should be established in underserved areas. Moreover, addressing the broader socioeconomic factors, such as crime and poverty, is essential in reducing exposure to trauma. Community safety initiatives, educational programs, and economic empowerment projects can mitigate the risks associated with chronic exposure to violence and instability (Cluver et al., 2013). Furthermore, policy reforms should focus on improving access to mental health services, integrating trauma-informed care into public health systems, and addressing systemic inequalities. South Africa's high crime rates and economic disparities contribute significantly to the prevalence of trauma-related disorders. Policies that promote equitable access to healthcare, mental health education in schools, and job creation initiatives for at-risk youth could reduce the long-term impact of trauma exposure (Seedat et al., 2004).

5.6 Conclusion

This study contributes to the growing body of research on PTSS in young South Africans by examining the role of demographic and socioeconomic factors in shaping mental health outcomes. The findings highlight significant relationships between PTSS and variables such as gender, perceived financial status, and home language, reinforcing existing literature that suggests socioeconomic and cultural contexts influence psychological distress. While gender differences were particularly notable, with females reporting higher levels of PTSS, the role of financial hardship emerged as a critical determinant of symptom severity. Additionally, religiosity showed limited but nuanced associations with PTSS, suggesting that spiritual or religious engagement may have varying effects on mental health resilience. These results

underscore the need for targeted mental health interventions that consider both individual and structural factors. Addressing socioeconomic disparities and improving access to mental health resources are essential steps toward mitigating the impact of trauma-related distress. Furthermore, given South Africa's socio-historical context of inequality and violence, future research should continue to explore the interplay between social determinants and mental health outcomes. By doing so, interventions can be better tailored to the lived experiences of young South Africans, ensuring a more comprehensive and effective approach to psychological well-being.

References

- Acharya, A. S., Prakash, A., Saxena, P., & Nigam, A. (2013). Sampling: Why and how of it? *Indian Journal of Medical Specialties*, 4(2), 330–333.
<https://doi.org/10.7713/ijms.2013.0032>
- Ai, A. L., Pargament, K. I., Appel, H. B., & Kronfol, Z. (2010). Depression following open-heart surgery: A path model involving interleukin-6, spiritual struggle, and hope under preoperative distress. *Journal of Clinical Psychology*, 66(10), 1057-1075.
- Alisic, E., Zalta, A. K., Wesel, F. van, Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *The British Journal of Psychiatry*, 204(5), 335–340.
<https://doi.org/10.1192/bjp.bp.113.131227>
- Álvarez, A. S., Pagani, M., & Meucci, P. (2012). The Clinical Application of the Biopsychosocial Model in Mental Health: A Research Critique. *American Journal of Physical Medicine & Rehabilitation*, 91(13), S173–S180.
- American Psychiatric Association. (2013). Diagnostic and Statistical Manual for Mental Disorders: DSM-5 (5th Ed). APA.
- American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
- American Psychiatric Association (2022). Trauma- and Stressor-related Disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed.)
- Andualem F, Melkam M, Takelle GM, Nakie G, Tinsae T, Fentahun S, Rtbey G, Begashaw TD, Seid J, Tegegn LF, Gedef GM, Bitew DA and Godana TN (2024). Prevalence of posttraumatic stress disorder and associated factors among displaced people in Africa: a systematic review and meta-analysis. *Front. Psychiatry* 15:1336665.
<https://doi.10.3389/fpsy.2024.1336665>

- Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology*, 61(4), 461–480.
<https://doi.org/10.1002/jclp.20049>
- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55(5), 469–480.
<https://doi.org/10.1037/0003-066X.55.5.469>
- Arnett, J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties*. Oxford University Press.
- Arnett, J. J. (2007). Emerging adulthood: What is it, and what is it good for? *Child development perspectives*, 1(2), 68-73.
- Arnett, J. J., Žukauskienė, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18–29 years: Implications for mental health. *The Lancet Psychiatry*, 1(7), 569-576.
- Atwoli, L., Stein, D. J., Williams, D. R., McLaughlin, K. A., Petukhova, M., Kessler, R. C., & Koenen, K. C. (2013). Trauma and posttraumatic stress disorder in South Africa: Analysis from the South African Stress and Health Study. *BMC Psychiatry*, 13(18). <https://doi.10.1186/1471-244X-13-182>
- Austrian, S. G. (2008). *Developmental theories through the life cycle* (2nd ed.). Chichester, NY: Columbia University Press.
- Babbie, E. R. (2020). *The practice of social research*. Cengage Au.
- Bor, W., Dean, A. J., Najman, J., & Hayatbakhsh, R. (2014). Are child and adolescent mental health problems increasing in the 21st century? A systematic review. *Australian & New Zealand Journal of Psychiatry*, 48(7), 606-616.
- Bornstein, M. H., Jager, J., & Putnick, D. L. (2013). Sampling in developmental science: Situations, shortcomings, solutions, and standards. *Developmental Review*, 33(4), 357–

370. <https://doi.org/10.1016/j.dr.2013.08.003>

- Boyce, W., Torsheim, T., Currie, C., & Zambon, A. (2006). The family affluence scale as a measure of national wealth: validation of an adolescent self-report measure. *Social indicators research*, 78, 473-487. <http://dx.doi.org/10.1007/s11205-005-1607-6>
- Breiner, H., Stroud, C., & Bonnie, R. J. (Eds.). (2015). *Investing in the health and well-being of young adults*. National Academies Press. <https://doi.org/10.17226/18869>
- Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68(5), 748-766. <https://doi.org/10.1037/0022-006X.68.5.748>
- Briggs-Gowan, M. J., Carter, A. S., & Ford, J. D. (2012). Parsing the Effects Violence Exposure in Early Childhood: Modeling Developmental Pathways. *Journal of Pediatric Psychology*, 37(1), 11-22. <https://doi.org/10.1093/jpepsy/jsr063>
- Calitz, F. J. W., De Jongh, N. J., Horn, A., Nel, M. L., & Joubert, G. (2014). Children and adolescents treated for post-traumatic stress disorder at the Free State Psychiatric Complex. *South African Journal of Psychiatry*, 20(1), 6. <https://doi.org/10.4102/sajpsychiatry.v20i1.441>
- Cao, Y., Siu, J. Y., Shek, D. T. L., & Shum, D. H. K. (2022). COVID-19 one year on: Identification of at-risk groups for psychological trauma and poor health-protective behaviour using a telephone survey. *BMC Psychiatry*, 22, 1-16. <https://doi.org/10.1186/s12888-022-03904-4>
- Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, 70(1), 44.
- Claudius, M., Shino, E. N., Job, S., Hofmann, D., & Thalmayer, A. G. (2022). Still Standing Inside: A Local Idiom Related to Trauma among Namibian Speakers of

- Khoekhoegowab. *International Journal of Environmental Research and Public Health*, 19(21), 14323. <https://doi.org/10.3390/ijerph192114323>
- Cohen, A. B., & Hill, P. C. (2007). Religion as culture: Religious individualism and collectivism among American Catholics, Jews, and Protestants. *Journal of personality*, 75(4), 709-742.
- Cook, J. M., McCarthy, E., & Thorp, S. R. (2017). Older Adults with PTSD: Brief State of Research and Evidence-Based Psychotherapy Case Illustration. *The American Journal of Geriatric Psychiatry*, 25(5), 522–530. <https://doi.org/10.1016/j.jagp.2016.12.016>
- Cluver, L., Boyes, M., Orkin, M., Pantelic, M., Molwena, T., & Sherr, L. (2013). Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity-score-matched case-control study. *The lancet global health*, 1(6), e362-e370.
- Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.
- Currie, C., Molcho, M., Boyce, W., Holstein, B., Torsheim, T., & Richter, M. (2008). Researching health inequalities in adolescents: The development of the Health Behaviour in School-Aged Children (HBSC) Family Affluence Scale. *Social Science & Medicine*, 66(6), 1429–1436.
- Currie, D., Samdal, O., Torsheim, T., & Augustson, L. (2016). *Growing up unequal: gender and socioeconomic differences in young people's health and well-being. Health Behaviour in School-aged Children (HBSC) study: international report from the 2013/2014 survey* (No. 7). World Health Organization.
- DeSalvo, K. B., Fisher, W. P., Tran, K., Bloser, N., Merrill, W., & Peabody, J. (2006). Assessing measurement properties of two single-item general health measures. *Quality of Life Research*, 15, 191-201. <https://doi.org/10.1007/s11136-005-0887-2>
- Dierckens, M., Weinberg, D., Huang, Y., Elgar, F., Moor, I., Augustine, L., ... & Currie, C. (2020). National-level wealth inequality and socioeconomic inequality in adolescent

- mental well-being: A time series analysis of 17 countries. *Journal of Adolescent Health*, 66(6), S21-S28.
- DiGangi, J. A., Gomez, D., Mendoza, L., Jason, L. A., Keys, C. B., & Koenen, K. C. (2013). Pretrauma risk factors for posttraumatic stress disorder: A systematic review of the literature. *Clinical Psychology Review*, 33(6), 728–744.
<https://doi.org/10.1016/j.cpr.2013.05.002>
- Dhungana, S., Thapa, S. B., Koirala, R., & Ojha, S. P. (2022). Association of childhood trauma, and resilience, with quality of life in patients seeking treatment at a psychiatry outpatient: A cross-sectional study from Nepal. *PLoS One*, 17(10), e0275637.
<https://doi.org/10.1371/journal.pone.0275637>
- Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment*, 28(3), 381–392.
<https://doi.org/10.1080/10911359.2018.1435328>
- Eagle, G. T. (2002). Posttraumatic Stress Disorder (PTSD): The Malleable Diagnosis? *South African Journal of Psychology*, 32(2), 37–42.
<https://doi.org/10.1177/008124630203200205>
- Eagle, G., & Kaminer, D. (2013). Continuous traumatic stress: Expanding the lexicon of traumatic stress. *Peace and Conflict: Journal of Peace Psychology*, 19(2), 85.
- Eagle, G. T., & Kaminer, D. (2015). Traumatic stress: Established knowledge, current debates and new horizons. *South African Journal of Psychology*, 45(1), 22–35.
<https://doi.org/10.1177/0081246314547124>
- Edwards, D. (2005). Post-traumatic stress disorder as a public health concern in South Africa. *Journal of psychology in Africa*, 15(2), 125-134.
- Edward, S., & Thwala, J. (2010). South African spiritual healing: Some empirical research investigations and interventions. *Journal of psychology in Africa*, 21(1), 242-263.

- Elgar, F. J., Pfortner, T. K., Moor, I., De Clercq, B., Stevens, G. W., & Currie, C. (2015). Socioeconomic inequalities in adolescent health 2002–2010: a time-series analysis of 34 countries participating in the Health Behaviour in School-aged Children study. *The Lancet*, 385(9982), 2088–2095.
- Engel, G.L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129–136.
- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1-4. <https://doi.org/10.11648/j.ajtas.20160501.11>
- Fallon, M. (2016). *Writing up Quantitative Research in the Social and Behavioral Sciences*. Brill.
- Fares-Otero, N. E., Sharp, T. H., Balle, S. R., Quaatz, S. M., Vieta, E., Åhs, F., ... Halligan, S. L. (2024). Social support and (complex) posttraumatic stress symptom severity: does gender matter? *European Journal of Psychotraumatology*, 15(1). <https://doi.org/10.1080/20008066.2024.2398921>
- Field, A. (2013). *Discovering Statistics Using IBM SPSS Statistics (4th ed.)*. Sage Publications.
- Field, A. (2017). *Discovering statistics using IBM SPSS statistics (5th ed.)*. Sage Publications.
- Freshman, A. (2012). Financial disaster as a risk factor for post-traumatic stress disorder: Internet survey of trauma in victims of the Madoff Ponzi scheme. *Health & Social Work*, 37(1), 39-48.
- George, D., & Mallery, P. (2019). *IBM SPSS statistics 26 step by step: A simple guide and reference*. Routledge.
- Ghasemi, A., & Zahediasl, S. (2012). Normality tests for statistical analysis: A guide for

- non-statisticians. *International Journal of Endocrinology and Metabolism*, 10(2), 486–489.
- Gutermann, J., Schreiber, F., Matulis, S., Schwartzkopff, L., Deppe, J., & Steil, R. (2016). Psychological Treatments for Symptoms of Posttraumatic Stress Disorder in Children, Adolescents, and Young Adults: A Meta-Analysis. *Clinical Child and Family Psychology Review*, 19(2), 77–93. <https://doi.org/10.1007/s10567-016-0202-5>
- Hamblen, J., & Barnett, E. (2018). PTSD: National center for PTSD. *Behavioral Medicine*, 366-367.
- Hammer, C. S. (2011). The importance of participant demographics. *American Journal of Speech-Language Pathology*, 20(4), 261.
- Harris, J. I., Erbes, C. R., Engdahl, B. E., Ogden, H., Olson, R. H., Winskowski, A. M. M., ... & Mataas, S. (2012). Religious distress and coping with stressful life events: A longitudinal study. *Journal of clinical psychology*, 68(12), 1276-1286.
- Hartley, J. E. K., Levin, K., & Currie, C. (2016). A new version of the HBSC Family Affluence Scale—FAS III: Scottish qualitative findings from the international FAS development study. *Child Indicators Research*, 9(1), 233–245.
- Hassim, J., & Wagner, C. (2013). Considering the cultural context in psychopathology formulations. *South African Journal of Psychiatry*, 19(1), 4-10.
- Hatala, A. R. (2013). Towards a biopsychosocial–spiritual approach in health psychology: Exploring theoretical orientations and future directions. *Journal of Spirituality in Mental Health*, 15(4), 256–276. <https://doi.org/10.1080/19349637.2013.776442>
- Higley, E. (2019). *Defining Young Adulthood*. DNP Qualifying Manuscripts. 17. https://repository.usfca.edu/dnp_qualifying/17
- Hiscox, L. V., Hiller, R., Fraser, A., Rabie, S., Stewart, J., Seedat, S., ... & Halligan, S. L.

- (2021). Sex differences in post-traumatic stress disorder in a high adversity cohort of South African adolescents: An examination of depressive symptoms, age, and trauma type as explanatory factors. *European Journal of Psychotraumatology*, 12(1), 1978669.
- Huang, Z., Jing, Y., Yu, F., Gu, R., Zhou, X., Zhang, J., & Cai, H. (2018). Increasing individualism and decreasing collectivism? Cultural and psychological change around the globe. *Advances in Psychological Science*, 26(11), 2068.
- IBM Corp. Released 2021. IBM SPSS Statistics for Windows, Version 28.0. Armonk, NY: IBM Corp.
- Idemudia, E. S. (2017). Trauma and PTSS of Zimbabwean refugees in South Africa: summary of published studies. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(3), 252–257. <https://doi.org/10.1037/tra0000214>
- Idoiaga, N., Legorburu, I., Ozamiz-Etxebarria, N., Lipnicki, D. M., Villagrasa, B., & Santabárbara, J. (2022). Prevalence of Post-Traumatic Stress Disorder (PTSD) in University Students during the COVID-19 Pandemic: A Meta-Analysis Attending SDG 3 and 4 of the 2030 Agenda. *Sustainability*, 14(13), 7914. <https://doi.org/10.3390/su14137914>
- Imširagić, A. S., Begić, D., Šimičević, L., & Bajić, Ž. (2017). Prediction of posttraumatic stress disorder symptomatology after childbirth—A Croatian longitudinal study. *Women and Birth*, 30(1), 17–23.
- Iribarren, J., Prolo, P., Neagos, N., & Chiappelli, F. (2005). Post-Traumatic Stress Disorder: Evidence-Based Research for the Third Millennium. *Evidence-Based Complementary and Alternative Medicine*, 2(4), 503–512. <https://doi.org/10.1093/ecam/neh127>
- Johnson, K. (2019). Chronic poverty: The implications of bullying, trauma, and the education of the poverty-stricken population. *European Journal of Educational Sciences*,

(Special), 76-101.

Kaminer, D., Grimsrud, A., Myer, L., Stein, D. J., & Williams, D. R. (2008). Risk for post-traumatic stress disorder associated with different forms of interpersonal violence in South Africa. *Social science & medicine*, 67(10), 1589-1595.

Kaminer, D., & Eagle, G. (2010). Trauma and posttraumatic stress disorder in South Africa. *Journal of Traumatic Stress*, 23(1), 85–90. <https://doi.org/10.1002/jts.20485>

Kartal, D., Alkemade, N., Eisenbruch, M., & Kissane, D. (2018). Traumatic exposure, acculturative stress and cultural orientation: The influence on PTSD, depressive and anxiety symptoms among refugees. *Social Psychiatry and Psychiatric Epidemiology*, 53(9), 931–941. <https://doi.org/10.1007/s00127-018-1532-z>

Kerlinger, F. N., Lee, H. B., & Bhanthumnavin, D. (2000). Foundations of behavioral research: The most sustainable popular textbook by Kerlinger & Lee (2000). *Journal of Social Development Volume*, 13(2), 131-144.

King, M. W., Street, A. E., Gradus, J. L., Vogt, D. S., & Resick, P. A. (2013). Gender differences in posttraumatic stress symptoms among OEF/OIF veterans: An item response theory analysis. *Journal of Traumatic Stress*, 26(2), 175–183. <https://doi.org/10.1002/jts.21799>

Klasen, F., Oettingen, G., Daniels, J., Post, M., Hoyer, C., & Adam, H. (2010). Posttraumatic resilience in former Ugandan child soldiers. *Child development*, 81(4), 1096-1113.

Koenen, K. C., Ratanatharathorn, A., Ng, L., et al. (2017). Posttraumatic stress disorder in world mental health surveys. *Psych Med* 47 (13), 2260-2274.

Koenig, H. G., & Büssing, A. (2010). The Duke University Religion Index (DUREL): a five-item measure for use in epidemiological studies. *Religions*, 1(1), 78-85. <https://doi.org/10.3390/rel1010078>

- Kuehner, C. (2017). Why is depression more common among women than among men? *The Lancet Psychiatry*, 4(2), 146-158. [https://doi.org/10.1016/S2215-0366\(16\)30263-2](https://doi.org/10.1016/S2215-0366(16)30263-2)
- Lauterbach, D., & Vrana, S. (2001). The relationship among personality variables, exposure to traumatic events, and severity of posttraumatic stress symptoms. *Journal of Traumatic Stress*, 14, 29-45.
- Lee, M., & Schuele, C. M. (2010). Demographics. *Encyclopedia of research design*, 3, 2-4.
- Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J. K., ... & Patel, V. (2011). Poverty and mental disorders: Breaking the cycle in low-income and middle-income countries. *The Lancet*, 378(9801), 1502-1514. [https://doi.org/10.1016/S01406736\(11\)60754-X](https://doi.org/10.1016/S01406736(11)60754-X)
- Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Mathews, T., Moffitt, T. E., ... & Danese, A. (2019). The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *The Lancet Psychiatry*, 6 (3), 247-256.
- Li, M., & Anderson, J. G. (2016). Pre-migration trauma exposure and psychological distress for Asian American immigrants: Linking the pre-and post-migration contexts. *Journal of immigrant and minority health*, 18, 728-739.
- Lotzin, A., Krause, L., Acquarini, E., Ajdukovic, D., Anastassiou-Hadjicharalambous, X., Ardino, V., Bondjers, K., Böttche, M., Dragan, M., Figueiredo-Braga, M., Gelezelyte, O., Grajewski, P., Javakhishvili, J. D., Kazlauskas, E., Lenferink, L., Lioupi, C., Lueger-Schuster, B., Mooren, T., Sales, L., ... Schäfer, I. (2022). Risk and protective factors for posttraumatic stress disorder in trauma-exposed individuals during the COVID-19 pandemic – findings from a pan-European study. *European Journal of Psychotraumatology*, 13(2). <https://doi.org/10.1080/20008066.2022.2138099>

- Maenhout, L., Peuters, C., Cardon, G., Compennolle, S., Crombez, G., & DeSmet, A. (2020). The association of healthy lifestyle behaviors with mental health indicators among adolescents of different family affluence in Belgium. *BMC Public Health*, 20, 1-13.
- Makiwane, M., & Kwizera, S. (2009). Youth and Well-Being: A South African Case Study. *Social Indicators Research*, 91(2), 223–242. <https://doi.org/10.1007/s11205-008-9279>
- Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1), 1-9.
- Matud, M. P., Díaz, A., Bethencourt, J. M., & Ibáñez, I. (2020). Stress and psychological distress in emerging adulthood: A gender analysis. *Journal of Clinical Medicine*, 9(9), 2859.
- McGowan, T. C., & Kagee, A. (2013). Exposure to traumatic events and symptoms of post-traumatic stress among South African university students. *South African Journal of Psychology*, 43(3), 327–339. <https://doi.org/10.1177/0081246313493375>
- McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2012). Childhood adversities and first onset of psychiatric disorders in a national sample of US adolescents. *Archives of general psychiatry*, 69(11), 1151-1160.
- Mgoqi-Mbalo, N., Zhang, M., & Ntuli, S. (20170123). Risk factors for PTSD and depression in female survivors of rape. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(3), 301. <https://doi.org/10.1037/tra0000228>
- Moonsamy, A., & Gurayah, T. (2024). Cultural perspectives and experiences of mental healthcare in Kwa-Zulu Natal, South Africa. *South African Journal of Occupational Therapy*, 54(1), 34-44.

- Naderifar, M., Goli, H., & Ghaljaie, F. (2017). Snowball sampling: A purposeful method of sampling in qualitative research. *Strides in Development of Medical Education*, 14(3), e67670. <https://doi.org/10.5812/sdme.67670>
- National Youth Act 54 of 1996. (1996). Republic of South Africa.
- Naude, L., & Fick, S. (2022). It's a journey... Emerging adult women's experiences of spiritual identity development during postgraduate psychology studies in South Africa. *Journal of Psychology in Africa*, 32(1), 45–55. <https://doi.org/10.1080/14330237.2022.2037914>
- Ndungu, J., Ramsoomar, L., Willan, S., Washington, L., Ngcobo-Sithole, M., & Gibbs, A. (2020). Depression, posttraumatic stress disorder (PTSD) and their comorbidity: Implications of adversity amongst young women living in informal settlements in Durban, South Africa. *Journal of Affective Disorders Reports*, 1, 100022. <https://doi.org/10.1016/j.jadr.2020.100022>
- Nduna, M., & Jewkes, R. K. (2011). Silence: a strategy used to deal with psychological distress by young people in the Eastern Cape, South Africa. *Vulnerable Children and Youth Studies*, 6(4), 360-372.
- Nnaemeka Amedu, A., & Dwarika, V. V. (2024). Economic Burden and Social Support in Individuals with Post-traumatic Stress Disorder: A Scoping Review. *Journal of Research and Health*, 14(4), 6-6.
- Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H. (2015). Language barriers and access to psychiatric care: A systematic review. *Psychiatric Services*, 66(8), 798–805. <https://doi.org/10.1176/appi.ps.201400351>
- Oppedal, B., Røysamb, E., & Sam, D. L. (2004). The effect of acculturation and social support on change in mental health among young immigrants. *International Journal*

of *Behavioral Development*, 28(6), 481-494.

- Pai, A., Suris, A., & North, C. (2017). Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations. *Behavioral Sciences*, 7(4), 7. <https://doi.org/10.3390/bs7010007>
- Pargament, K. I., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, 2(1), 51–76. <https://doi.org/10.3390/rel2010051>
- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37(4), 710–724. <https://doi.org/10.2307/1388152>
- Perkonig, A., Kessler, R. C., Storz, S., & Wittchen, H.-U. (2000). Traumatic events and post-traumatic stress disorder in the community: Prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica*, 101(1), 46–59. <https://doi.org/10.1034/j.1600-0447.2000.101001046.x>
- Picco, L., Abidin, E., Chong, S. A., Pang, S., Shafie, S., Chua, B. Y., Vaingankar, J. A., Ong, L. P., Tay, J., & Subramaniam, M. (2016). Attitudes toward seeking professional psychological help: Factor structure and socio-demographic predictors. *Frontiers in Psychology*, 7, 547.
- Podsakoff, P. M., MacKenzie, S. B., Lee, J. Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: a critical review of the literature and recommended remedies. *Journal of applied psychology*, 88(5), 879.
- Robson, B., Chang, L., & Kaminer, D. (2019). Representation of low- and middle-income countries in traumatic stress journals from 2006 to 2015. *South African Journal of Psychology*, 49(4), 562–574. <https://doi.org/10.1177/0081246319831605>
- Ruxton, G. D. (2006). The unequal variance *t*-test is an underused alternative to Student's *t*-

- test and the Mann–Whitney *U* test. *Behavioral Ecology*, 17(4), 688–690.
- Saad, M., de Medeiros, R., & Mosini, A. C. (2017). Are we ready for a true biopsychosocial-spiritual model? The many meanings of "spiritual". *Medicines (Basel)*, 4(4), 79. <https://doi.org/10.3390/medicines4040079>
- Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & Health Sciences*, 12(3), 369–374. <https://doi.org/10.1111/j.1442-2018.2010.00541.x>
- Sareen, J. (2014). Posttraumatic stress disorder in adults: impact, comorbidity, risk factors, and treatment. *The Canadian Journal of Psychiatry*, 59(9), 460-467.
- Sareen, J. (2023). Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis. *UpToDate, Post TW, Wolters Kluwer*. <https://medil ib. ir/uptod ate/show/500>.
- Savahl, S., Adams, S., Benninger, E., Florence, M., Jackson, K., Manuel, D., ... & Isobell, D. (2019). Researching Children’s Subjective Well-Being in South Africa: Considerations for Method, Theory, and Social Policy. *Handbook of quality of life in African societies*, 407-430.
- Schalinski, I., Teicher, M. H., Nischk, D., Hinderer, E., Müller, O., & Rockstroh, B. (2016). Type and timing of adverse childhood experiences differentially affect severity of PTSD, dissociative and depressive symptoms in adult inpatients. *BMC psychiatry*, 16, 1-15.
- Schutt, R. K. (2018). *Investigating the social world: The process and practice of research*. Sage publications.
- Sedlak, A. J., Mettenburg, J., Basena, M., Peta, I., McPherson, K., Greene, A., & Li, S. (2010). Fourth national incidence study of child abuse and neglect (NIS-4). *Washington, DC: US Department of Health and Human Services*, 9.
- Sedgwick, P. (2015). Bias in observational study designs: cross sectional studies. *Bmj*, 350.

- Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B., & Stein, D. J. (2004). Trauma exposure and post-traumatic stress symptoms in urban African schools: Survey in Cape Town and Nairobi. *British Journal of Psychiatry*, 184(2), 169–175. <https://doi.org/10.1192/bjp.184.2.169>
- Setia, M. S. (2016). Methodology series module 3: Cross-sectional studies. *Indian Journal of Dermatology*, 61(3), 261-264.
- Sexton, M. B., Davis, A. K., Buchholz, K. R., Winters, J. J., Rauch, S. A. M., Yzquibell, M., Bonar, E. E., Friday, S., & Chermack, S. T. (2019). Veterans with recent substance use and aggression: PTSD, substance use, and social network behaviors.
- Shaw, R. J., Bernard, R. S., DeBlois, T., Ikuta, L. M., Ginzburg, K., & Koopman, C. (2009). The relationship between acute stress disorder and posttraumatic stress disorder in the neonatal intensive care unit. *Psychosomatics*, 50(2), 131-137.
- Silveira, R., Eleti, S., Saruchera, E., Mwamuka, R., Whitwell, S., Abas, M. A., & Jack, H. E. (2025). Prevalence of probable post-traumatic stress disorder and experiences of trauma in emerging adults living with HIV in Zimbabwe. *BJPsych Open*, 11(1), e7.
- Silver, R. C. (2020). Surviving the trauma of COVID-19. *Science*, 369(6499), 11. <https://doi.org/10.1126/science.abd5396>
- Smith, P., Dalgleish, T., & Meiser-Stedman, R. (2019). Practitioner Review: Posttraumatic stress disorder and its treatment in children and adolescents. *Journal of Child Psychology and Psychiatry*, 60(5), 500–515. <https://doi.org/10.1111/jcpp.12983>
- Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *British Journal of Psychiatry*, 192(2), 112–117. <https://doi.org/10.1192/bjp.bp.106.029280>
- Strohschein L, McDonough P, Monette G, Shao Q (2005). Marital transitions and mental

- health: Are there gender differences in the short-term effects of marital status change? Soc Sci Med, 61(11):2293–303. <https://doi.org/10.1016/j.socscimed.2005.07.020>.
- Sue, D., Sue, D.W., Sue. D., & Sue, S. (2017). *Essentials of understanding abnormal behavior*. Cengage Learning.
- Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The gerontologist*, 42(suppl_3), 24-33.
- Swain, K. D., Pillay, B. J., & Kliewer, W. (2017). Traumatic stress and psychological functioning in a South African adolescent community sample. *South African Journal of Psychiatry*, 23.
- Swartz L. De la Rey C. Duncan N. Townsend L. & O'Neill V. (2016). *Psychology: an introduction (Fourth)*. Oxford University Press Southern Africa (Pty).
- Tabachnick, B. G., Fidell, L. S., & Ullman, J. B. (2007). *Using multivariate statistics* (Vol. 5, No. 7). Boston, MA: pearson.
- Tamir, M., Ito, A., Miyamoto, Y., Chentsova-Dutton, Y., Choi, J. H., Cieciuch, J., ... & García Ibarra, V. J. (2024). Emotion regulation strategies and psychological health across cultures. *American Psychologist*, 79(5), 748.
- Tesfaye AH, Sendekie AK, Kabito GG, Engdaw GT, Argaw GS, Desye B, et al. (2024) Post traumatic stress disorder and associated factors among internally displaced persons in Africa: A systematic review and meta-analysis. *PLoS ONE* 19(4): e0300894. <https://doi.org/10.1371/journal.pone.0300894>
- Thalmayer, A.G., Marshall, J. & Scalise, K. (2020). The Cascades Mental Health Assessment: A broad, efficient behavioral health risk assessment.
- Thalmayer, A. G., Marshall, J., & Scalise, K. (2023). The International Mental Health Assessment: Validation of an Efficient Screening Inventory. Collabra: Psychology,

- 9(1). 74546. <https://doi.org/10.1525/collabra.74546>
- Thalmayer, A. G., Asatsa, S., Shino, E. N., Naudé, L., Laher, S., Hassem, T., Florence, M., Adonis, T.-A., Uugwanga, S. N., Rotzinger, J. S., Hofmann, D., Makunda, J., Botha, C., Murangi, A., & Shirima, C. M. (2024). Lifespan research in Kenya, Namibia, and South Africa: Cohort profile of the Africa Long Life Study. *Personality Science*, 5, 1–15. <https://doi.org/10.1177/27000710241264492>
- Thalmayer, A. G., Mather, K. A., Saucier, G., Naudé, L., Florence, M., Adonis, T. A., ... & Condon, D. M. (2024). The cross-cultural big two: A culturally decentred theoretical and measurement model for personality traits. *Journal of Personality and Social Psychology*.
- Tolin, D. F., & Foa, E. B. (2008). Sex differences in trauma and posttraumatic stress disorder: a quantitative review of 25 years of research. *Psychological Bulletin*, 132(6), 959–992. <https://doi.org/10.1037/0033-2909.132.6.959>
- Torsheim, T., Cavallo, F., Levin, K. A., Schnohr, C., Mazur, J., Niclasen, B. V., & Currie, C. (2016). Psychometric validation of the revised Family Affluence Scale: A latent variable approach. *Child Indicators Research*, 9(3), 771–784.
- Trickey, D., Siddaway, A. P., Meiser-Stedman, R., Serpell, L., & Field, A. P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review*, 32(2), 122–138. <https://doi.org/10.1016/j.cpr.2011.12.001>
- Trujillo, M. (2008). Multicultural Aspects of Mental Health. *Primary Psychiatry*.
- Truskauskaite-Kuneviciene, I., Brailovskaia, J., Kamite, Y., Petrauskaite, G., Margraf, J., & Kazlauskas, E. (2020). Does trauma shape identity? Exploring the links between lifetime trauma exposure and identity status in emerging adulthood. *Frontiers in psychology*, 11, 570644.
- Turner, H. A., Finkelhor, D., Ormrod, R., Hamby, S., Leeb, R. T., Mercy, J. A., & Holt, M. (2012). Family context, victimization, and child trauma symptoms: Variations in safe,

stable, and nurturing relationships during early and middle childhood. *American Journal of Orthopsychiatry*, 82, 209–219. <https://doi.10.1111/j.1939-0025.2012.01147x>

United Nations World Youth Report. (2005). “Young people today and in 2015”. New York, United Nations.

van der Velden, P. G., Contino, C., Muffels, R., Verheijen, M. S., & Das, M. (2023). The impact of pre-and post-trauma financial problems on posttraumatic stress symptoms, anxiety and depression symptoms, and emotional support: A prospective population based comparative study. *Journal of Anxiety Disorders*, 96, 102714.

Vujanovic, A. A., & Tran, J. K. (2021). Trauma and posttraumatic stress disorder among first responders. In A. A. Vujanovic & J. K. Tran (Eds.), *Integrative clinical psychology, psychiatry and behavioral medicine: Perspectives, practices, and research* (pp. 1–15). Springer. https://doi.org/10.1007/978-3-030-56934-1_21-1

Wadsworth, M. E. (2012). Working with low-income families: Lessons learned from basic and applied research on coping with poverty-related stress. *Journal of Contemporary Psychotherapy*, 42, 17-25.

Wang C, Pan R, Wan X, Tan Y, Xu L, McIntyre RS, Choo FN, Tran B, Ho R, Sharma VK, Ho C. (2020). A longitudinal study on the mental health of general population during the COVID-19 epidemic in China. *Brain Behav Immun*, 87:40–8. <https://doi.org/10.1016/j.bbi.2020.04.028>.

Wang, Y., Xu, S., Chen, Y., & Liu, H. (2023). A decline in perceived social status leads to post-traumatic stress disorder symptoms in adults half a year after the outbreak of the COVID-19 pandemic: consideration of the mediation effect of perceived vulnerability to disease. *Frontiers in Psychiatry*, 14, 1217264.

- Ward, C. L., Flisher, A. J., Zissis, C., Muller, M., & Lombard, C. (2001). Exposure to violence and its relationship to psychopathology in adolescents. *Injury prevention*, 7(4), 297-301.
- Webb, H., Dietrich, J. J., Jaggernath, M., Louw, C. E., & Naidoo, S. (2022). Symptoms of post-traumatic stress and associations with sexual behaviour and PrEP preferences among young people in South Africa, Uganda, and Zimbabwe. *BMC Infectious Diseases*, 22(1), 430.
- Weida, E. B., Carroll-Scott, A., Le-Scherban, F., Bloom, S., & Chilton, M. (2024). Trauma-informed Financial Empowerment Programming Associated with Improved Financial Well-being. *Journal of child and family studies*, 33(11), 3541-3550.
- Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., ... & Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The lancet*, 382(9904), 1575-1586.
- Williams, S. L., Williams, D. R., Stein, D. J., Seedat, S., Jackson, P. B., & Moomal, H. (2007). Multiple traumatic events and psychological distress: the South Africa stress and health study. *Journal of traumatic stress*, 20(5), 845-855.
- World Health Organisation (WHO) (2021). *Mental Health of Adolescents*. <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>
- World Health Organisation (WHO) (2022). *World health mental report: Transforming mental health for all*. <https://www.who.int/publications/i/item/9789240049338>
- Yunitri, N., Chu, H., Kang, X. L., Jen, H., Pien, L., Tsai, H., Kamil, A. R., Chou, K. (2022). Global prevalence and associated risk factors of posttraumatic stress disorder during COVID-19 pandemic: A meta-analysis. *International Journal of Nursing Studies*,

126. <https://doi.org/10.1016/j.ijnurstu.2021.104136>.



A1. Please enter your participant ID.

A2. What is your age?

A3. What is your gender?

Female

☐

Male

☐

Other

☐

A4. Please answer the questions below.

What is your home / first language?

What other languages do you speak?

A5. To what racial group do you belong?

A6. What is the highest level of education that you have completed?

Less than a high school qualification

☐

High school qualification

☐

Some after school training

☐

Degree

☐

Postgraduate qualification

☐

A7. What is your mother's or female caregiver's level of schooling?

Less than a high school qualification

☐

High school qualification

☐

Some after school training

☐

Degree

☐

Postgraduate qualification

☐

A8. What is your relationship status?

I am single.

☐

I am in a relationship and live with my partner.

☐

I am in a relationship but do not live with my partner.

☐

A9. Do you have children?

Yes, one child

☐

Yes, two children

☐

Yes, three or more children

☐

No

☐

A10. What is your living arrangement? Who do you stay with?

A11. Who bears the financial responsibility for providing your home and for food?


A12. Which best describes your current work situation?

- Full time learner/student ☐
- Studying and working ☐
- No paid work currently ☐
- Occasional paid work ☐
- Regular part-time paid work ☐
- Regular full-time paid work ☐

A13. About how much money in South African Rands do you receive each month from work, family, and other sources?

A14. How would you describe the financial situation of your household?

- We do not have any financial problems, our financial situation is good. ☐
- Sometimes we have slight financial difficulties, but our financial situation is average. ☐
- We have great financial difficulties, our financial situation is bad. ☐

A15. Are you currently seeking (additional) paid work?

- Yes ☐
- No ☐

A16. In general, would you say your health is...

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

B1. How accurate is each statement in describing your typical behavior or attitudes?
Do you tend to be...

	Very inaccurate	Moderately inaccurate	Slightly inaccurate	Slightly accurate	Moderately accurate	Very accurate	I do not know this word
I tend to be silent.	☐	☐	☐	☐	☐	☐	☐
I tend to be energetic.	☐	☐	☐	☐	☐	☐	☐
I tend to be kindhearted.	☐	☐	☐	☐	☐	☐	☐
I tend to be gentle.	☐	☐	☐	☐	☐	☐	☐
I tend to be diligent.	☐	☐	☐	☐	☐	☐	☐
I tend to be disobedient.	☐	☐	☐	☐	☐	☐	☐
For this item, please tick the box for "slightly inaccurate".	☐	☐	☐	☐	☐	☐	☐
I tend to be courteous.	☐	☐	☐	☐	☐	☐	☐
I tend to be weak.	☐	☐	☐	☐	☐	☐	☐
I tend to be daring.	☐	☐	☐	☐	☐	☐	☐
I tend to be hardworking.	☐	☐	☐	☐	☐	☐	☐



	Very inaccurate	Moderately inaccurate	Slightly inaccurate	Slightly accurate	Moderately accurate	Very accurate	I do not know this word
I tend to be benevolent.	☐	☐	☐	☐	☐	☐	☐
I tend to be honest.	☐	☐	☐	☐	☐	☐	☐
I tend to be clever.	☐	☐	☐	☐	☐	☐	☐
I tend to be compassionate.	☐	☐	☐	☐	☐	☐	☐
I tend to be naive.	☐	☐	☐	☐	☐	☐	☐
I tend to be aggressive.	☐	☐	☐	☐	☐	☐	☐
I tend to be sad.	☐	☐	☐	☐	☐	☐	☐
I tend to be hot-tempered.	☐	☐	☐	☐	☐	☐	☐
I tend to be determined.	☐	☐	☐	☐	☐	☐	☐
I tend to be arrogant.	☐	☐	☐	☐	☐	☐	☐
I tend to be shy.	☐	☐	☐	☐	☐	☐	☐
I tend to be respectful.	☐	☐	☐	☐	☐	☐	☐
I tend to be inhumane.	☐	☐	☐	☐	☐	☐	☐
I tend to be humane.	☐	☐	☐	☐	☐	☐	☐
For this item, please tick the box for "moderately accurate".	☐	☐	☐	☐	☐	☐	☐
I tend to be modest.	☐	☐	☐	☐	☐	☐	☐
I tend to be kind.	☐	☐	☐	☐	☐	☐	☐
I tend to be happy.	☐	☐	☐	☐	☐	☐	☐
I tend to be timid.	☐	☐	☐	☐	☐	☐	☐
I tend to be bold.	☐	☐	☐	☐	☐	☐	☐
I tend to be gossipy.	☐	☐	☐	☐	☐	☐	☐
I tend to be unhappy.	☐	☐	☐	☐	☐	☐	☐
I tend to be industrious.	☐	☐	☐	☐	☐	☐	☐
I tend to be courageous.	☐	☐	☐	☐	☐	☐	☐
I tend to be lively.	☐	☐	☐	☐	☐	☐	☐
I tend to be cowardly.	☐	☐	☐	☐	☐	☐	☐
I tend to be generous.	☐	☐	☐	☐	☐	☐	☐
I tend to be a loner.	☐	☐	☐	☐	☐	☐	☐



	Very inaccurate	Moderately inaccurate	Slightly inaccurate	Slightly accurate	Moderately accurate	Very accurate	I do not know this word
I tend to be cheerful.	☐	☐	☐	☐	☐	☐	☐
I tend to be brave.	☐	☐	☐	☐	☐	☐	☐
I tend to be quiet.	☐	☐	☐	☐	☐	☐	☐
I tend to be hotheaded.	☐	☐	☐	☐	☐	☐	☐
I tend to be peaceful.	☐	☐	☐	☐	☐	☐	☐
I tend to be active.	☐	☐	☐	☐	☐	☐	☐
I tend to be confident.	☐	☐	☐	☐	☐	☐	☐
I tend to be self-confident.	☐	☐	☐	☐	☐	☐	☐
I tend to be bad.	☐	☐	☐	☐	☐	☐	☐
I tend to be faithful.	☐	☐	☐	☐	☐	☐	☐
I tend to be polite.	☐	☐	☐	☐	☐	☐	☐
I tend to be dynamic.	☐	☐	☐	☐	☐	☐	☐
I tend to be pessimistic.	☐	☐	☐	☐	☐	☐	☐
I tend to be good-natured.	☐	☐	☐	☐	☐	☐	☐
I tend to be bashful.	☐	☐	☐	☐	☐	☐	☐
I tend to be friendly.	☐	☐	☐	☐	☐	☐	☐
I tend to be obedient.	☐	☐	☐	☐	☐	☐	☐
I tend to be calm.	☐	☐	☐	☐	☐	☐	☐

C1. Think back over the last month. How often was the following true for you?

	Not in the last month (or NEVER)	Once a month	About twice a month	Once a week	About twice a week	More than twice a week / Half the days	Daily or almost daily
I had difficulty falling asleep.	☐	☐	☐	☐	☐	☐	☐
I used weed.	☐	☐	☐	☐	☐	☐	☐
I had an upsetting dream.	☐	☐	☐	☐	☐	☐	☐
I felt afraid.	☐	☐	☐	☐	☐	☐	☐
I had 3 or more alcoholic beverages in a day.	☐	☐	☐	☐	☐	☐	☐
I got dizzy or lightheaded.	☐	☐	☐	☐	☐	☐	☐
I argued with friends or family.	☐	☐	☐	☐	☐	☐	☐
Stressful things (family illness, financial setbacks, accidents) occurred in my life.	☐	☐	☐	☐	☐	☐	☐



	Not in the last month (or NEVER)	Once a month	About twice a month	Once a week	About twice a week	More than twice a week / Half the days	Daily or almost daily
I had difficulty making decisions.	☐	☐	☐	☐	☐	☐	☐
A friend, partner, or family member treated me poorly.	☐	☐	☐	☐	☐	☐	☐
I woke up too early or had trouble staying asleep.	☐	☐	☐	☐	☐	☐	☐
I felt angry with someone at work, at school, or at church.	☐	☐	☐	☐	☐	☐	☐
Not getting enough sleep interfered with my daily activities.	☐	☐	☐	☐	☐	☐	☐
There was more I needed to do than could fit into the day.	☐	☐	☐	☐	☐	☐	☐
I got bad news about something important in my life.	☐	☐	☐	☐	☐	☐	☐
It was hard to control my worrying.	☐	☐	☐	☐	☐	☐	☐
When I got up in the morning, I did not feel well-rested.	☐	☐	☐	☐	☐	☐	☐
I avoided a situation that made me nervous or anxious.	☐	☐	☐	☐	☐	☐	☐
I had so many responsibilities that there was no time to relax.	☐	☐	☐	☐	☐	☐	☐
Medical issues (my own or those of someone close) caused stress in my life.	☐	☐	☐	☐	☐	☐	☐
I used a stimulant, like cocaine.	☐	☐	☐	☐	☐	☐	☐
I felt jumpy or easily startled.	☐	☐	☐	☐	☐	☐	☐
I lost interest or pleasure in doing things I used to like.	☐	☐	☐	☐	☐	☐	☐
For this item, please tick box for "about twice a week".	☐	☐	☐	☐	☐	☐	☐
I felt distant or cut off from other people.	☐	☐	☐	☐	☐	☐	☐
My heart beat fast (not due to exercise/sports).	☐	☐	☐	☐	☐	☐	☐
I had disturbing memories, thoughts, or images of a stressful experience from the past.	☐	☐	☐	☐	☐	☐	☐
My worrying got in the way of doing something I intended to do.	☐	☐	☐	☐	☐	☐	☐
I felt shaky or trembly.	☐	☐	☐	☐	☐	☐	☐
I argued with someone at work, at school, or at church.	☐	☐	☐	☐	☐	☐	☐
For this item, please tick box for "once a month".	☐	☐	☐	☐	☐	☐	☐
I avoided an activity or situation that reminded me of a stressful experience from the past.	☐	☐	☐	☐	☐	☐	☐
Someone I'm close to made me feel badly about myself.	☐	☐	☐	☐	☐	☐	☐
I felt sad and unhappy.	☐	☐	☐	☐	☐	☐	☐
I yelled at someone at work, at school, or at church.	☐	☐	☐	☐	☐	☐	☐
I had difficulty breathing (not due to a medical condition).	☐	☐	☐	☐	☐	☐	☐



	Not in the last month (or NEVER)	Once a month	About twice a month	Once a week	About twice a week	More than twice a week / Half the days	Daily or almost daily
I expressed anger at someone I encountered in public/stranger.	☐	☐	☐	☐	☐	☐	☐
I got so angry I threatened someone.	☐	☐	☐	☐	☐	☐	☐
I had physical reactions (heart pounding, trouble breathing, sweating) when something reminded me of a stressful experience from the past.	☐	☐	☐	☐	☐	☐	☐
I felt hopeless about the future.	☐	☐	☐	☐	☐	☐	☐
I suddenly felt or acted as if a stressful experience were happening again (as if I were reliving it).	☐	☐	☐	☐	☐	☐	☐
I lacked confidence in myself.	☐	☐	☐	☐	☐	☐	☐
I missed two hours or more of work, school, or other commitments due to personal problems.	☐	☐	☐	☐	☐	☐	☐
I got so angry I broke something.	☐	☐	☐	☐	☐	☐	☐
I felt that someone could hear my thoughts, or that I could hear what another person was thinking.	☐	☐	☐	☐	☐	☐	☐
I felt guilty or had a bad conscience.	☐	☐	☐	☐	☐	☐	☐
It was difficult to do my job or meet my responsibilities due to personal problems.	☐	☐	☐	☐	☐	☐	☐
When I had a task that required a lot of thought, I avoided or delayed getting started.	☐	☐	☐	☐	☐	☐	☐
I drank alcohol to the degree that I felt intoxicated.	☐	☐	☐	☐	☐	☐	☐
I fidgeted or squirmed with my hands or my feet when I had to sit down for a long time.	☐	☐	☐	☐	☐	☐	☐
I had difficulty getting things in order when I had to do a task that required organisation.	☐	☐	☐	☐	☐	☐	☐
I had problems remembering appointments or obligations.	☐	☐	☐	☐	☐	☐	☐
I felt overly active and compelled to do things, like I was driven by a motor.	☐	☐	☐	☐	☐	☐	☐
I wanted to die or thought about killing myself.	☐	☐	☐	☐	☐	☐	☐
I heard things other people can't hear, such as voices even when no one was around.	☐	☐	☐	☐	☐	☐	☐
I thought I should cut down on my drinking or drug use.	☐	☐	☐	☐	☐	☐	☐
I drank enough to pass out.	☐	☐	☐	☐	☐	☐	☐
I forgot things I did while using alcohol or drugs.	☐	☐	☐	☐	☐	☐	☐
I felt guilt or remorse after drinking or using drugs.	☐	☐	☐	☐	☐	☐	☐
Family or friends suggested I should cut down on my drinking or drug use.	☐	☐	☐	☐	☐	☐	☐
I failed to do what was normally expected from me because of drinking or drug use.	☐	☐	☐	☐	☐	☐	☐



C2.

	Not in the last month (or never)	Once a month	About twice a month	Once a week	About twice a week	More than twice a week / Half the days	Daily or almost daily
Arguments with my romantic partner went unresolved.	☐	☐	☐	☐	☐	☐	☐
My romantic partner insulted me or made me feel bad about myself.	☐	☐	☐	☐	☐	☐	☐
I felt afraid of my romantic partner.	☐	☐	☐	☐	☐	☐	☐
My romantic partner threatened me.	☐	☐	☐	☐	☐	☐	☐
My romantic partner physically hurt me.	☐	☐	☐	☐	☐	☐	☐

D1. How often do you attend church, mosque, temple, or other religious services/meetings?

Never	☐
Once a year or less	☐
A few times a year	☐
A few times a month	☐
Once a week	☐
More than once a week	☐

D2. How often do you spend time in private religious activities, such as prayer, meditation, or study of religious scriptures?

Never or rarely	☐
A few times a year	☐
A few times a month	☐
A few times a week	☐
Once a day	☐
More than once a day	☐

D3. How true is each of the following three statements, in describing you?

	Definitely untrue	Somewhat untrue	Neither true nor untrue	Somewhat true	Definitely true
In my life, I experience the presence of the Divine.	☐	☐	☐	☐	☐
My religious beliefs are what really lie behind my whole approach to life.	☐	☐	☐	☐	☐
I try hard to carry my religion over into all other dealings in life.	☐	☐	☐	☐	☐

E1. Does your family own a car?

No	☐
Yes, one	☐
Yes, two or more	☐

E2. Do you have your own bedroom for yourself?

No	☐
Yes	☐

E3. Do you have running water where you stay?

Yes	☐
No	☐



E4. During the past 12 months, how many times did you travel away on holiday with your family?

Not at all ☐
Once ☐
Twice ☐
More than twice ☐

E5. How many functional computers do you have in your household?

None ☐
One ☐
Two ☐
More than two ☐

E6. How many people live in your household?

E7. What kind of structure do you stay in?

In an informal/non-permanent structure. ☐
Staying in someone else's home. ☐
In a house or apartment that is rented by me or my family. ☐
In a house or apartment owned by me or my family. ☐

E8. Do you have electricity where you stay?

Yes ☐
No ☐

E9. Do you have your own phone?

Yes ☐
No ☐

E10. We have asked you many things about yourself today. Do you have any questions for us?

E11. Is there anything that you would like to know about other 18-year-olds in South Africa? What questions would you add to our study?

Appendix B: Ethics Clearance Certificate

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG



SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE **CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)**

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: MClin/23/04W

PROJECT TITLE:

Demographic profiling of South African young adults in relation to post-traumatic stress symptomatology.

INVESTIGATOR

Mayet Safiyyah (1669260)

SCHOOL/DEPARTMENT OF INVESTIGATOR

SHCD/Psychology

DATE CONSIDERED

16 May 2023

DECISION OF THE COMMITTEE

Approved unconditionally

RISK LEVEL

No Risk

EXPIRY DATE

31 December 2025

ISSUE DATE OF CERTIFICATE

23 May 2023

CHAIRPERSON


(Dr Aline Ferreira Corrêa)

cc: Prof. Sumaya Laher (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure as approved, I/we undertake to submit an amendment of the protocol to the Committee.



Signature

Date

02 / 06 / 2023

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix C: Approach Letter to Principal Investigator



SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT
PSYCHOLOGY

6 April 2023

Professor Amber Gayle Thalmayer
Department of Psychology
University of Zürich

Professor Luzelle Naudé
Department of Psychology
University of the Free State

Dear Professor Thalmayer and Professor Naudé

My name is Safiyyah Mayet (1669260), and I am a master's student in Clinical Psychology at the University of the Witwatersrand under the supervision of Prof Sumaya Laher. As part of the requirements for my degree, I will be conducting a cross-sectional study looking at the relationships between demographic characteristics and a tendency to experience symptoms of post-traumatic stress among South African young adults.

I am writing to request permission to use pre-collected data for a research study titled "Demographic Profiling of South African young adults in Relation to post-traumatic stress Symptomatology." The data I am interested in using is from Wave 1 of the Africa Long Life Study. Specifically, I will need access to the demographic variables as well as data collected from the Cascades Mental Health Assessment.

The purpose of my research is to investigate the demographic factors associated with post-traumatic stress disorder among young adults in South Africa. The study aims to explore the prevalence of relationships between demographic determinants of post-traumatic stress disorder in South Africa.

As an academic researcher, I will comply with all ethical standards and regulations pertaining to data use and confidentiality. I will ensure that the data is used solely for the purpose stated above and will not be shared with anyone without your prior consent. Furthermore, I will take appropriate measures to protect the confidentiality of the data provided by the individuals who are a part of the Africa Long Life Study.

If you require any further information or have any questions, please do not hesitate to contact me.

Thank you for your time and consideration.

Sincerely,
Safiyyah Mayet
MA Clinical Psychology Student
1669260



Appendix D: Letter Granting Permission to Use Data



**University of
Zurich^{UZH}**

Department of Psychology
Personality, Mental Health, and Culture

University of Zurich
Department of Psychology
Personality, Mental Health, and Culture
Binzmuehlestrasse 14, Box 19
CH-8050 Zurich

www.psychology.uzh.ch/psyges

UZH, Department of Psychology, Personality, Mental Health,
and Culture, Binzmuehlestrasse 14, Box 19, CH-8050 Zurich

Prof. Amber Gayle Thalmayer
Phone +41 44 635 72 49
amber-gayle.thalmayer@psychologie.uzh.ch

Zurich, May 5, 2023

RE: Africa Long Life Study Data Access

This letter serves to confirm that Safiyyah Mayet has been granted permission to conduct research with the Africa Long Life Study (ALLS) participants over the age of 18 using already collected data from South Africa, Kenya, and Namibia. The title of her research project is "Demographic Profiling of South African Young Adults in Relation to Post-Traumatic Stress Symptomatology". The researchers have undertaken to ensure the safety of data collected.

Sincerely

A handwritten signature in black ink, reading 'Amber Gayle Thalmayer'.

Prof. Amber Gayle Thalmayer
Department of Psychology
University of Zurich

Appendix E: Data Confidentiality Agreement



University of
Zurich^{UZH}

Data confidentiality agreement

This confidentiality declaration must be signed by all persons who, in the capacity of their professional role or studies have access to data from the Africa Long Life Study (ALLS), which is subject to the duty of confidentiality. It prohibits the disclosure of facts that are neither public knowledge nor generally accessible, but that are confided in the context of the person's position, or that have become known to the person while carrying out this role.

Person subject to the duty of confidentiality

Last name	Mayet
First name	Safiyyah
Affiliation	MA Student
Student number	1669260
Date of birth	1999/02/17
E-mail	1669260@students.wits.ac.za

Supervisor

Name	Prof. Sumaya Laher
Affiliation	Co-investigator of the Gauteng Research Team at the University of Witwatersrand

By signing this form, I **SAFIYYAH MAYET** agree that:

- I have been provided with an ALLS dataset in electronic format for the sole purpose of conducting an analysis of the data.
- The dataset remains the property of the ALLS leadership team, which includes my supervisor.
- I may not present or publish or claim rights to authorship of research pertaining to or based on the dataset without a separate explicit signed agreement established with my supervisor and the ALLS leadership team.
- I will not share the whereabouts or content of the data set with anybody other than my supervisor.
- I will not distribute or pass the data set on to other individuals for any reason whatsoever, without the written permission of my supervisor.
- No information or personal data is to be made accessible to third parties, either in full or in part, in any shape or form, regardless of the storage medium (e.g., hard copy, CD, memory chip), either as an original or a copy, without the express permission of my supervisor.
- I am aware of the ethical requirement of maintaining data confidentiality. I undertake to do so at all times, and I will take all necessary measures for data protection.

- The only course-related output based on this data set that I will produce will be a research report or thesis to be submitted for examination at my university as defined above.
- The production of any further research outputs (such as conference presentations or publications) based on access to this data will require a separate and explicit authorship agreement between myself and my supervisor.
- I will credit my supervisor (as well as any other researchers specified by my supervisor) for data access in the research report.

Johannesburg, South Africa

Place

25/04/2023

Date

Safiyyah Mayet

Student Name



Signature

Sumaya Laher

Supervisor Name



Signature