

Caring Does Not Always Cost: The Role of Fortitude in the Association Between Personal Trauma Exposure and Professional Quality of Life Among Lay Trauma Counselors

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Despite evidence that lay trauma counselors can be adversely affected as a result of their work, there is also increasing recognition that a significant proportion of them do not develop psychological problems. This differential vulnerability points to specific protective factors that promote coping. The current study investigated the role of fortitude as a potential protective factor among lay trauma counselors in South Africa. Fortitude is derived from positive cognitive appraisals of the self, the family, and external sources of support. Participants ($N = 143$) completed the Professional Quality of Life Scale (PROQOL), the Life Events Checklist, and the Fortitude Questionnaire. Moderated regression analysis was used to examine the relationship between fortitude, personal trauma, compassion satisfaction (CS), secondary traumatic stress (STS), and burnout. There were a range of direct effects for fortitude on the PROQOL subscales. Unexpected findings included that higher levels of personal trauma ($\beta = .27, p < .05, R^2 = .13$) and lower support-appraisals ($\beta = -.28, p < .01, R^2 = .16$) predicted higher levels of CS. More positive support-appraisals and family appraisals significantly predicted STS (support: $\beta = .81, p < .01, R^2 = .66$; family: $\beta = .48, p < .1, R^2 = .27$) and burnout (support: $\beta = .73, p < .01, R^2 = .54$; family: $\beta = .25, p < .05, R^2 = .09$), respectively. These findings suggest that lay trauma counselors may not be susceptible to the same risk and protective factors as professional mental health care providers.

Keywords: burnout, fortitude, lay trauma counselors, secondary traumatic stress, South Africa

In South Africa, exposure to traumatic events is a significant public health problem. Nationally representative surveys indicate that 73% of the population has experienced at least one traumatic event in their lifetime (Atwoli, Stein, Koenen, & McLaughlin, 2015). Furthermore, exposure to multiple traumas is also common, with the average person having experienced at least 4.3 incidences of trauma exposure (Atwoli et al., 2015; Closson et al., 2016). The most common types of traumatic events include sexual assault, armed robbery, unexpected death of a loved one, physical violence, and motor vehicle accidents (Atwoli et al., 2015).

Living in a context where trauma is prevalent can lead to the development of chronic psychological problems. The prevalence of mental health disorders in the country is higher compared with other African countries (Benjet et al., 2016; Padmanabhanunni, 2018). This burden of mental illness is further aggravated by a low ratio of professional mental health care providers to the population (e.g., 2.5 psychologists per 100 000 of the population) and limited access to psychological services particularly in low-income communities (Padmanabhanunni, 2019). To address the demand for counseling services and fill an essential gap in the provision of psychological care to vulnerable populations, the services provided

by nonprofessional or lay counselors have been utilized for several decades in South Africa. Lay trauma counselors are often the first point of contact for those in need of psychological services after a traumatic event (Howlett & Collins, 2014). In contrast to professional mental health care providers (e.g., social workers, psychologists, counselors, etc.), these counselors typically receive some form of short-term training in basic counseling skills and do not have formal professional qualifications (Howlett & Collins, 2014; MacRitchie & Leibowitz, 2010).

Comparative studies of professional and nonprofessional trauma workers (Avieli, Ben-David, & Levy, 2016) have found a higher prevalence of adverse psychological outcomes, specifically secondary traumatic stress (STS) and burnout among nonprofessionals. STS is characterized by symptoms that mirror posttraumatic stress disorder (PTSD) and include intrusive trauma-related images, avoidance of trauma-related stimuli, physiological hyperarousal, and changes in basic beliefs about the self and others (Figley, 2013). However, unlike PTSD, STS is a psychological reaction to a specific type of stressor in the work environment, namely the graphic verbal recounting of a traumatic event by a survivor (Figley, 2013). STS can occur rapidly after minimal exposure to trauma narratives or gradually from the persistent accumulation of such exposure. It can lead to burnout, which is typified by symptoms of emotional exhaustion, feelings of cynicism, a sense of detachment from work, and reduction in feelings of personal accomplishment (Figley, 2013).

Several researchers (Caringo et al., 2017) have suggested that trauma work may attract individuals with a personal history of

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trauma, and this may increase their vulnerability to STS and burnout, particularly if their personal trauma history is unresolved. However, there remains a significant gap in the literature on the role of personal trauma in psychological outcome for lay trauma counselors working in countries with a history of violence. In these contexts, it is more likely that trauma counselors may have experienced traumatic events in their own lives (Sui & Padmanabhanunni, 2016). Furthermore, the majority of research on the impact of working with traumatized populations has focused on professionals including nurses (Mashego, Nesengani, Ntuli, & Wyatt, 2016), rescue workers (Avieli et al., 2016), social workers (MacRitchie & Leibowitz, 2010), and psychologists (Sui & Padmanabhanunni, 2016).

Several studies in developing countries have confirmed the prevalence of STS and burnout among nonprofessional counselors. Peltzer, Matseke, and Louw (2014), for instance, reported that STS and burnout were common among lay HIV counselors working in health care facilities in South Africa. Ager et al. (2012) found significant rates of depression, PTSD, and emotional exhaustion among volunteer aid workers in Uganda. In a qualitative study, Howlett and Collins (2014) described experiences of secondary trauma among lay counselors at an NGO working with victims of intimate-partner violence in South Africa. Shah, Garland, and Katz (2007) reported a high rate of STS among volunteer aid workers providing counseling services to traumatized communities in India. Despite the evidence that nonprofessional trauma counselors can be adversely affected as a result of their work, there is also increasing recognition that a significant proportion do not develop chronic psychological problems (Burnett & Wahl, 2015; Figley & Figley, 2017; Ortlepp & Friedman, 2002). Many trauma workers derive a sense of personal fulfillment and satisfaction from their work and believe they are contributing to social good (Figley & Figley, 2017). This experience has been referred to as compassion satisfaction (CS; Figley, 2013). The variability in response to indirect exposure to traumatic material points to the role of specific protective factors that influence the development of adverse psychological outcomes. Several of these factors have been identified including self-efficacy, peer support, self-care strategies, and social support from family and friends (Miller & Sprang, 2017; Molnar et al., 2017). The current study focuses on fortitude as a potential protective factor.

Fortitude as a Protective Factor in Psychological Outcome

Fortitude is defined “as the strength to manage stress and stay well” (Pretorius, Padmanabhanunni, & Campbell, 2016, p.154). Although fortitude has often been used interchangeably with resilience, there are key distinctions between these constructs. Resilience is grounded in the salutogenic paradigm and refers to the ability to “bounce back” from adversity and maintain relatively stable levels of psychological and physical functioning following exposure to stressors (Bonanno & Mancini, 2012). It comprises a range of protective factors that serve to moderate the effect of adversity and that are necessary for resilience to occur. These protective factors include individual characteristics (e.g., self-esteem, cognitive flexibility, and humor) as well as features of the environment (e.g., social support; Schetter & Dolbier, 2011). Unlike resilience, the construct of fortitude is grounded in the para-

digim of fortigenesis (i.e., the origins of psychological strength) and derives from Lazarus’s (1966) seminal work on stress and coping. In terms of this perspective, it is an individual’s *cognitive appraisal* of the coping strategies or resources (both internal and external) at their disposal that influences psychological outcome rather than the objective presence of these resources (Pretorius et al., 2016). Fortitude (or psychological strength) is argued to derive from positive cognitive appraisals of the self (e.g., as capable and competent), the family (e.g., as reliable, accessible and supportive), and external sources of support such as friends and peers (e.g., as being accessible for advice, care and support).

There are two possible pathways through which fortitude is hypothesized to influence psychological outcome: namely, a direct or health-sustaining pathway and a buffering or stress-reducing pathway (Pretorius et al., 2016). The direct effect hypothesis would postulate that high levels of fortitude will result in higher levels of professional quality of life (i.e., higher CS and lower levels of STS and burnout) irrespective of the level of stress (i.e., personal exposure to trauma). The buffering hypothesis would suggest that at low levels of fortitude, the relationship between personal exposure to trauma and professional quality of life should be strong and direct (increased exposure to personal trauma should be associated with low levels of professional quality of life), and as fortitude increases the relationship should weaken.

The existing trauma literature has extensively investigated CS, STS, and burnout particularly among professional mental health care providers. The current study is distinctive in that it investigates the role of fortitude in the association of these variables among lay trauma counselors in a developing context. Given that the health care system and many support organizations in South Africa rely heavily on lay counselors, it is important to understand the risk and protective factors associated with this type of work.

Method

Site of Study

The study used a cross sectional research design. Participants ($N = 146$) in the study worked for NGO’s that provided services to historically disadvantaged communities in the Western Cape Province of South Africa. These communities were created as part of the apartheid policy of racial segregation which involved the physical separation of race groups in terms of residential area. The areas designated to Black South Africans were very poorly resourced, and this historical legacy contributes to ongoing socio-economic inequalities. Many of these communities continue to be plagued by poverty, high crime rates, gang activity, and substance abuse (Pretorius et al., 2016).

Participant Population

The majority of participants were female (76.9%) and had a mean age of 44 years. Most participants were Colored (72.3%), a term used in South Africa to describe those of mixed ancestry. With reference to educational attainment, close to half of the participants (41.5%) had a diploma, which is typically obtained after completing Grade 12 and requires a minimum of 2 years of postsecondary school study. Approximately a quarter of participants had an undergraduate degree (21.4%). None of the partici-

pants had a professional qualification in the mental health care field. In terms of income, a lay counselor earns approximately \$158 a month (Department of Health, 2020).

Procedure

Ethical approval for the study was granted by the Humanities and Research Ethics Committee of the University of the Western Cape. The directors of community-based NGOs working specifically with trauma survivors were contacted and informed of the nature and aims of the study. Following consent from these directors, lay trauma counselors at these sites were contacted with a request to participate in the study. Counselors interested in participating were provided with the questionnaires and informed-consent forms electronically or in person. All questionnaires were completed in English. Participants were able to submit their completed survey electronically or a research assistant collected the completed surveys and consent forms. Surveys were distributed over a six-month period. The response rate was 58%.

Measures

Participants completed three self-report questionnaires: namely, the Life Events Checklist (LEC-5; Weathers et al., 2013), the Professional Quality of Life Scale (PROQOL; Stamm, 2005), and the Fortitude Questionnaire (FORQ; Pretorius, 1998). The LEC-5 comprises 16-items inquiring about the respondent's experience of 16 different types of potentially traumatic events (PTEs) that are associated with PTSD. For each PTE, the respondent rates their experience of the event on a 6-point nominal scale. A unique feature of the LEC is that it inquires about both direct and indirect exposure to trauma (1 = *happened to me*, 2 = *witnessed it*, 3 = *learned about it*, 4 = *part of my job*, 5 = *not sure if it applies*, and 6 = *does not apply*). It also includes an item (17) which asks about the respondent's experience of any other traumatic event not captured by the 16 items. The LEC is also distinctive because it inquires about exposure to multiple types of traumas. The LEC has demonstrated adequate temporal stability and good convergence with established measures of trauma history (Gray, Litz, Hsu, & Lombardo, 2004). Given that the focus of the study is on personal exposure to trauma, the LEC was coded to reflect personal exposure (which included happened to me and witnessed) and absence of personal exposure (which included learned about it, part of my job, not sure if it applies and does not apply). The Cronbach's alpha value was .76, which indicates good internal consistency reliability.

The PROQOL is a 30 item self-report measure on a 5-point scale (1 = never to 5 = very often). It consists of three 10-item subscales namely (a) CS, which refers to the pleasure derived from working with trauma survivors, (b) STS which entails symptoms characteristic of PTSD, and (c) burnout. The PROQOL has good internal consistency with Stamm (2010) reporting Cronbach's alpha values of .82 for CS, .78 for STS, and .71 for burnout. High scores on all the subscales indicate higher CS, STS, and burnout. In the current study, the Cronbach's alpha values were .79 for CS, .76 for STS, and .71 for burnout.

The FORQ is a 20-item questionnaire and uses a four-point scale ranging from *does not apply* to *applies very strongly*. The scale measures three domains, namely self-appraisals, family ap-

praisals, and support-appraisals, and the sum of the three domains is seen as representing the individual's level of fortitude. Pretorius (1998) in a validation study reported coefficient alpha values of between .74 and .82 for the subscales and a coefficient of .85 for the full scale. Other South African studies have reported reliability coefficients between .77 and .88 (Heyns, Venter, Esterhuysen, Bam, & Odendaal, 2003; Wissing, Wissing, Du Toit, & Temane, 2006). In addition, the FORQ also correlated with measures of psychological distress as well as with measures of self-appraisal (i.e., self-esteem), social support, and family environment (Pretorius, 1998). In the current study, the Cronbach's alpha for the FORQ was .89 and subscale alphas were .71 for self-appraisals, .81 for support-appraisals, and .89 for family appraisals.

Data Analysis

Data were captured and analyzed using the Statistical Package for the Social Sciences (SPSS-25). Descriptive statistics were used to analyze demographic information. Moderated regression analyses (Cohen & Cohen, 1975) was performed to examine the direct and moderating effects of fortitude. In this form of analyses the psychological outcome (i.e., CS, STS, and burnout) is used as the dependent variable in a two-step regression analyses. The scores of the adverse condition (e.g., personal trauma) and the presumed moderating variable (fortitude) are entered together in the regression equation in Step 1, whereas an interaction term (the product of fortitude and various subscales of the PROQOL) is entered in Step 2. To avoid the problem of multicollinearity, the deviation scores (score minus mean) of the adverse condition and the presumed moderating variable are used in the calculation of the product term (Good & Hardin, 2012). A significant effect for fortitude in Step 1 indicates a direct effect for fortitude (i.e., a health-sustaining effect). A significant effect for the product term in Step 2 indicates that fortitude has a moderating effect (i.e., stress-reducing effect).

Results

The means, standard deviations, and reliability coefficients (coefficient α) for the scales are reported in Table 1. The reliability of all the scales is satisfactory (Personal trauma: $\alpha = .76$; CS: $\alpha = .79$; STS: $\alpha = .76$; Burnout: $\alpha = .71$; Fortitude: $\alpha = .89$; Self-Appraisals: $\alpha = .71$; Support-Appraisals: $\alpha = .81$; Family Appraisals: $\alpha = .89$).

Table 1
Descriptive Statistics and Reliabilities of PROQOL, Personal Trauma and Fortitude

Scale	N of items	M	SD	α
Compassion satisfaction	10	42.46	4.52	0.79
Secondary traumatic stress	10	21.75	5.76	0.76
Burnout	10	19.28	4.83	0.71
Personal trauma	17	2.70	2.69	0.76
Fortitude	20	62.94	9.16	0.89
Fortitude self-appraisals	7	22.79	2.99	0.71
Fortitude support-appraisals	6	19.43	3.44	0.81
Family appraisals	7	20.82	4.91	0.89

Note. PROQOL = Professional Quality of Life Scale.

Table 2
Intercorrelations: Professional Quality of Life, Personal Exposure to Trauma, and Fortitude

	CS	Burnout	STS	Personal trauma	Self-appraisals	Support appraisals	Family appraisals	Fortitude
CS	1	-.62**	-.15	.13	.37**	-.22*	.32**	.27**
Burnout		1	.56**	-.13	-.32**	.69**	.23**	-.23*
STS			1	-.11	-.04	.80**	.52**	-.01
Personal trauma				1	.14	-.13	-.04	-.09
Self-appraisals					1	-.14	.00	.67**
Support appraisals						1	.37**	-.11
Family appraisals							1	.06
Fortitude								1

Note. CS = compassion satisfaction; STS = secondary traumatic stress.
* $p < .05$. ** $p < .01$.

The intercorrelations between the various scales are reported in Table 2. All of the subscales of the FORQ as well as the total fortitude scale were related to CS (self-appraisals: $r[124] = .37, p < .01$; support-appraisals: $r[130] = -.22, p < .05$; family appraisals: $r[124] = .32, p < .01$; fortitude: $r[122] = .27, p < .01$) and burnout (self-appraisals: $r[128] = -.32, p < .01$; support-appraisals: $r[129] = .69, p < .01$; family appraisals: $r[131] = .23, p < .01$; fortitude: $r[126] = -.23, p < .05$). However, fortitude and self-appraisals were negatively related to burnout while support appraisals were negatively related to CS. STS was positively related to the support, $r(127) = .80, p < .01$, and family appraisals, $r(126) = .52, p < .01$ subscales of the FORQ.

The results of the moderated regression analysis with CS as the dependent variable are indicated in Table 3. Self-appraisals ($\beta = .34, p < .01$), support appraisals ($\beta = -.28, p < .01$), family appraisals ($\beta = .27, p < .05$), fortitude ($\beta = .25, p < .05$), and personal exposure to trauma ($\beta = .27, p < .05$) were significant predictors of CS. In the case of support appraisals, the association is negative in that lower appraisals of support were associated with higher CS. With regard to appraisals of the self and the family environment, more positive appraisals were associated with higher levels of CS. Similarly, higher levels of fortitude were signifi-

cantly associated with higher levels of CS. In the case of personal exposure to trauma, the higher the number of traumatic events experienced, the higher the level of CS. None of the interaction terms was significant, indicating no moderating effects for fortitude in terms of the association between personal exposure to trauma and CS.

The results of the moderated regression analysis with STS as the dependent variable are indicated in Table 4. Support appraisals ($\beta = .81, p < .01$) and family appraisals ($\beta = .48, p < .01$) were significant predictors of STS. More positive appraisals were associated with higher levels of STS. None of the interaction terms was significant, indicating no moderating effects for fortitude in terms of the association between personal exposure to trauma and STS.

The results of the moderated regression analysis with burnout as the dependent variable are indicated in Table 5. Support appraisals ($\beta = .73, p < .01$), family appraisals ($\beta = .25, p < .05$), self-appraisals ($\beta = -.41, p < .01$), and fortitude ($\beta = -.28, p < .05$) were significant predictors of burnout. In the case of support and family appraisals, more positive appraisals were associated with higher levels of burnout. Higher self-appraisals and higher levels of fortitude were associated with lower levels of burnout.

Table 3
Moderated Regression Analyses With CS as Dependent Variable

Predictor	df	t	Cum R ²	β
Personal trauma	2,85	1.73	.16	.17
Self-appraisals ^a		3.36**		.34
Exposure \times Self	3,84	.52	.16	.05
Personal trauma	2,90	0.90	.09	.09
Support-appraisals ^a		-2.77**		-.28
Exposure \times Support	3,89	1.66	.12	.18
Personal trauma	2,87	1.31	.09	.13
Family appraisals ^a		2.61*		.27
Exposure \times Family	3,86	0.35	.09	.04
Personal trauma	2,83	2.60*	.12	.27
Fortitude ^a		2.43*		.25
Exposure \times Fortitude	3,82	0.79	.13	.08

^a Different steps in regression analyses.
* $p < .05$. ** $p < .01$.

Table 4
Moderated Regression Analyses With STS as Dependent Variable

Predictor	df	t	Cum R ²	β
Personal trauma	2,85	-0.92	.05	-.10
Self-appraisals ^a		-1.77		-.19
Exposure \times Self	3,84		.06	-.10
Personal trauma	2,88	0.12	.66	.01
Support-appraisals ^a		12.85**		.81
Exposure \times Support	3,87	0.24	.66	.02
Personal trauma	2,87	-1.12	.25	-.10
Family appraisals ^a		5.20**		.48
Exposure \times Family	3,86	-1.42	.27	-.13
Personal trauma	2,83	-1.13	.02	-.12
Fortitude ^a		-0.91		-.10
Exposure \times Fortitude	3,82	-1.34	.43	-.15

^a Different steps in regression analyses.
** $p < .01$.

Table 5
Moderated Regression Analyses With Burnout as
Dependent Variable

Predictor	df	t	Cum R ²	β
Personal trauma	2,85	-1.11	.20	-.11
Self-appraisals		-4.21**		-.41
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Exposure × Self	3,84	0.38	.20	.04
Personal trauma	2,87	-0.13	.54	-.01
Support-appraisals		9.91**		.73
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Exposure × Support	3,86	-.61	.54	-.05
Personal trauma	2,89	-1.20	.08	-.12
Family appraisals		2.48*		.25
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Exposure × Family	3,88	-1.15	.09	-.12
Personal trauma	2,83	-1.45	.09	-.15
Fortitude		-2.61*		-.28
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Exposure × Fortitude	3,82	0.70	.10	.08

^a Different steps in regression analyses.

* $p < .05$. ** $p < .01$.

None of the interaction terms was significant, indicating no moderating effects for fortitude in terms of in terms of the association between personal exposure to trauma and burnout.

Discussion

The current study aimed to investigate the role of fortitude in the association between personal exposure to trauma on the one hand, and professional quality of life on the other hand, among a sample of community-based lay trauma counselors in South Africa. No stress-buffering effects were found for fortitude or any of its subscales. A number of health-sustaining or direct effects were noted, but several of these were not in the directions indicated in the existing literature.

Consistent with existing studies that have investigated similar constructs, such as resilience in relation to professional quality of life (Burnett & Wahl, 2015), higher levels of fortitude were associated with greater CS and lower levels of burnout. More positive self-appraisals and family related appraisals predicted higher levels of CS. Furthermore, lower self-appraisals were found to be a direct predictor of burnout. Self-appraisals refer to appraisals of the self as competent and capable and bears similarity with the construct of self-efficacy. Existing literature has shown that lower perceptions of one's ability to cope effectively have been associated with negative outcomes. Higher self-efficacy has been associated with lower levels of STS among trauma counselors (Ortlepp & Friedman, 2002), rescue workers (Shakespeare-Finch, Rees, & Armstrong, 2015), and psychology counselors (Ames, Salmond, Holly, & Kamienski, 2017). The study had several unexpected findings and these are discussed below.

First, lower appraisals of support from the broader social environment (e.g., friends and colleagues) predicted higher CS. This is contrary to the existing literature (MacRitchie & Leibowitz, 2010) wherein a lack of perceived support from the broader social network, particularly the peer group, has been found to lower CS and aggravate STS and burnout and lead to feelings of hopelessness, a sense of disconnection from others, and general work-

related dissatisfaction (Setti, Lourel, & Argentero, 2016). Peer groups can provide opportunities to debrief and reduce perceptions of isolation and normalize challenging work-related experiences (Duffy, Avalos, & Dowling, 2015). As such, appraising the peer group as a resource can lead to a greater sense of fulfilment and job satisfaction (Barr, 2017; Berlanda, Pedrazza, Trifiletti, & Fraizzoli, 2017). In explaining the current finding, it is possible that lower appraisals of support from the broader social environment may be partly related to a lack of actual support. Many lay counselors in South Africa work in resource-poor settings where they have few peers or supervisors who they can access for support (MacRitchie & Leibowitz, 2010). An awareness of resource constraints in community contexts may also lead to lay trauma counselors appraising their work as more important and contribute to greater investment in providing care and support to those in need and this may lead to higher CS.

Second, more positive appraisals of support and more positive family appraisals were found to predict higher levels of STS and burnout. This is also contrary to existing research findings showing that perceived social support is inversely related to psychological distress. For example, in their study of lay trauma counselors, Ortlepp and Friedman (2002) found that social support was associated with reduced STS and burnout. Similar findings have been reported in studies focusing on professional mental health care providers including emergency personnel (Setti et al., 2016), child welfare workers (Salloum, Kondrat, Johnco, & Olson, 2015), and social workers (Setti et al., 2016). One possible explanation for this finding is that although existing social networks may be positively appraised, they may not be actually utilized for coping because of concerns about vicariously traumatizing significant others by sharing work-related material (Hyman, 2004; Setti et al., 2016). It is possible that lay trauma counselors may want to protect their family and broader social networks from traumatic material and therefore avoid accessing and utilizing available supports for coping. A second explanation is that awareness of the availability of social support may lead to lay counselors over extending themselves within the work environment. Overextending themselves may also be a result of perceptions that those they provide services to may not have similar types of support networks to draw on. This may enhance their vulnerability to STS and burnout.

Third, personal exposure to trauma was associated with higher levels of CS among the sample. A range of studies (Dworkin, Sorell, & Allen, 2016; Ivicic & Motta, 2017) have provided evidence that a personal history of trauma exposure increases risk of adverse psychological outcomes and negatively impacts satisfaction in the work environment. However, several of these studies (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2011; Hargrave, Scott, & McDowall, 2006) have reported that the extent of psychological resolution of the trauma impacts on the development of STS. Unresolved traumatic material is more likely to be reactivated when working with survivors of traumatic events and produce symptoms of PTSD for the service provider. In a comparative study of professional and volunteer mental health care providers, Hargrave et al. (2006) found that trauma resolution was the only variable that distinguished the two groups in terms of vulnerability to STS and burnout. Resolution of past trauma can also enhance coping skills in assisting others to work through a traumatic event. In the current study, the experience of trauma and its resolution may have motivated the decision to become a lay trauma counselor

and subsequently providing support to those with similar experiences may have led to a greater sense of personal fulfillment and satisfaction with trauma work. However, this assertion is purely speculative because the current study did not directly assess for trauma resolution. Another possible explanation is that previous experiences of trauma may contribute to lay trauma counselors experiencing increased empathy with survivors. Providing care and support may then enhance feelings of fulfillment and satisfaction with their work. Existing studies among health care professionals (Beauvais, Andreychik, & Henkel, 2017; Hunt, Denieffe, & Gooney, 2019) have demonstrated that empathic responses can lead to increased motivation to help others in distress and promote a sense of personal satisfaction with work. Compassion for others has also been demonstrated to buffer the effects of stress on psychological wellbeing (Hansen et al., 2018).

Limitations

This is a preliminary study, and few generalizations can be made beyond the current sample. It is therefore recommended that a similar study be conducted on a larger scale. In the present study, it was also difficult to separate the influence of factors such as resource limitations, lack of supervisory support, and ongoing community trauma on professional quality of life. It is possible that STS and burnout may be aggravated by these factors, and future research would need to be conducted to investigate the role of these types of variables.

Conclusion

A review of the existing literature indicates that this is the first study to investigate the role of fortitude in professional quality of life of lay trauma counselors working in a developing country. The study therefore makes an important contribution to the knowledge base in this area. A salient finding was that the nature of the association between appraisals of support and vulnerability to psychological distress appears more complex for lay trauma counselors in developing contexts and does not necessarily reflect the findings that dominate the literature in this area. It is recommended that further research, particularly qualitative studies, be undertaken to further understand the association between support appraisals and STS and burnout. Another potential avenue for further study is the role of culture in fortitude. In collectivist societies where there is stronger focus on extended family, the sharing of resources, and a sense of community, cognitive appraisals related to family and other sources of support may be more salient in determining psychological outcome. As such, further research comparing individualist and collectivist societies could provide important theoretical insights and have implications for interventions to reduce STS and burnout.

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