CONCEPTUALIZATION OF POST TRAUMATIC GROWTH

IN THE WORK OF EXPERT TRAUMA THERAPISTS

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A thesis

submitted in partial fulfillment of the

requirements for the degree of

Master of Social Work

University of Washington

2013

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Program Authorized to Offer Degree:

Social Work

University of Washington

University of Washington

ABSTRACT

Conceptualization of Post Traumatic Growth

in trauma experts-therapists' work

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The concept of Post-Traumatic Growth (PTG), focusing on positive outcomes and transformations occurring in the aftermath of trauma, opens a new line of thinking about trauma's effects. This turn to the potential for growth in the wake of trauma has emerged only after decades of research and experience with the negative effects of exposure to trauma. While the concept of PTG has been investigated in recent years, it is still relatively new in clinical practice. The purpose of this study is to shed light on the concept of PTG and how it is viewed and manifested in clinical practice. The study examines the conceptualization of trauma expert therapists of PTG, regarding different kinds of trauma, and related concepts such as resilience, well-being and symptoms reduction. These terms, although depicted in the literature, appear under different definitions and therapists' views of these concepts and the relationship between them have not been deeply explored.

Eight trauma expert therapists active in the Seattle area were recruited and interviewed. The interviews, using sensitization by an interview guide, were coded using grounded theory and the finding summarized in nine themes. Interviewees were not familiar with PTG as a term, but recognized it as an important concept in their work, a phenomenon that enables survivors to thrive in spite of their trauma. The main themes that emerged in this study include: PTG is viewed as more subjective rather than objective, manifested in clients' reported perception changes and not limited to external behaviors; Resilience and PTG were recognized as different concepts, whereas resilience was addressed as a mental state or ability

to recover and PTG was addressed as progressing and thriving. The implications for social work practice and research based on the study's findings include the need for recognition of concepts of PTG by clinicians that work in the trauma field, social workers as well as decision makers.

Keywords: Posttraumatic Growth, PTG, Resilience, Well-Being, meaning making, qualitative research, Grounded Theory

ACKNOWLEDGEMENT

DEDICATION

This work is dedicated to my beautiful parents for their many sacrifices and unconditional love, for teaching me to be a strong, independent and opinionated woman and for their constant compassion and love.

This project is also dedicated to the memory of Henia, my maternal grandmother who survived the Holocaust and transmitted her talent and passion for art to the next generations.

AIM

This study is intended to investigate trauma experts' understanding and conceptualizations of Post Trauma Growth (PTG), and the effect of these concepts on their practice. The notions of Resilience and Well Being related to PTG are explored in the literature and in therapists' perceptions and practice in order to assess the value and impact of the construct of PTG in current therapy practice. The study aims to offer useful knowledge to psychologists, social workers, counselors and other scholars interested in the field of trauma, and to provide new insights on the concept of PTG.

LITERATURE REVIEW

The term "Trauma" covers a broad spectrum of injuries, physical and mental. For this research the term is used to refer to mental or psychological injuries. Trauma of one kind or another affects a significant percentage of the population and results in mental health problems and difficulties in many areas of life for trauma survivors (Herman, 1997). At the moment of the trauma, the victim is rendered helpless by an overwhelming force. The force can be a natural disaster or can arise from the atrocities caused by human beings. Traumatic events include, but are not limited to, hurricanes, earthquakes, rape, battering, and other forms of sexual, domestic violence and military trauma, accidents, diagnoses of life threatening illnesses and losses of family, friends and community associated with refugee status (Basham, 2007).

Implications of Trauma

Traumatic events overwhelm the ordinary psychological systems of care that give people a sense of control, connection and meaning. Trauma survivors are frequently burdened by major impairments in self-care, by changes in their capacities to form stable relationships, and by disturbances in memory, identity and cognition (Herman, 1997). This can particularly be the case when the trauma is interpersonal in nature. The trauma response involves a set of neurobiological reactions along with an affective experience of terror and powerlessness, as well as altered cognitions about the self, the world and others. Trauma commonly leads to self-blame, stigma, high incidence of concurrent depression, increased risk of suicide and high risk of Post-Traumatic Stress Disorder (PTSD) as well as other complex mental health

issues and injuries resulting from trauma (Ickovics, Meade, Kershaw, Milan, Lewis & Ethier, 2006; Herman, 1997).

The concept of PTG, focusing on positive outcomes and transformations occurring in the aftermath of trauma, opens a new line of thinking about trauma's effects. This turn to the potential for growth in the wake of trauma has emerged only after decades of research and experience with the negative effects of exposure to trauma.

Co-occurrence of Positive and Negative Outcomes

The field of Positive Psychology explores co-occurrence of positive and negative outcomes of traumatic events. Positive psychology theorists argue that potential positive and transformative effects should be taken in consideration when thinking about the impact of trauma (Waterman, 2013; Seligman &Csikszentmihalyi, 2000; Seligman, 2008; Folkman, 1997). People who deal with difficulties engendered by trauma often struggle in many aspects of their lives, including basic relationships, love and community, and shuttered belief systems that give meaning to human experience. Yet trauma survivors also frequently find new meaning in life as they heal from trauma.

Victor E. Frankel, a psychiatrist and concentration camp survivor, wrote, in his book *Man's Search for Meaning* (1970) that without experiencing suffering and death, a person cannot be whole. He drew upon his experiences in camp to argue that in all forms of existence, even the most sordid, absurd, painful and dehumanized situation, life has potential meaning. Mazliach-Chanoch (2009) discusses trauma as a healing force and offers the idea of the need to touch death in order to be reborn in life. When experiencing psychological traumas, one can reevaluate the meaning and purpose of one's life, and may develop a sense of gratitude for one's family, achievements and one's very existence. These reappraisals may lead to new/renewed active participation in the person's family and community life.

Attribution of Core Beliefs

Some scholarly literature suggests that following the negative effects of trauma cognitive schemata transformation can occur. For some time such changes to schemata have been regarded as negative only. However, more recent research sheds new light on positive potentials of what was once

seen as only problematic. For example, self-blame is a cognition now thought to increase not only negative effects of trauma exposure, but also sometimes lead to positive outcomes. Hickling, Blanchard, Buckly & Taylor, (1999) studied a sample of 158 of Motor Vehicle Accidents (MVA) survivors recruited from outpatient care one to four months post MVA. They found that those with PTSD who blames themselves for the MVA demonstrated fewer symptoms initially and recovered more rapidly in the first six months than those with PTSD who blame another party for the accident. There is also research looking at attributions for sexual assault, which found that rape victims who blame themselves have less PTSD. It's a coping strategy that allows the reinstatement of the positive belief (core belief) of control in life (Starzynski, Ullman, Filipas& Townsend, 2005)

Extensive literature addresses self-blame as a problematic post-trauma symptom. For example, Shapiro (1995) examined attribution of self-blame among individuals who were sexually abused in childhood and found that either guilt or feelings of powerlessness would be inevitable because the sexual trauma survivors would seem to view the trauma as either within or outside their control. The dilemma faced by childhood abuse survivors and therapists is that if self-blame is lowered, helplessness will be increased. However, if helplessness is reduced, self-blame will intensify. This dilemma raises the question whether self-blame is adaptive or maladaptive. According to Shapiro, holding oneself responsible for trauma may preserve a sense of personal control, while absolving oneself of blame may carry the distressing implication of helplessness to prevent similar experiences in the future.

Self-blame and helplessness can both be positive or negative .Timko & Janoff-Bulman (1985) conducted a study using intensive interviews of 42 breast cancer survivors and found that the relationship between specific attributions and responses to the trauma were mediated by core beliefs.

Self-blame and helplessness are due to beliefs about oneself. Beliefs about oneself, others and the world play a major role in determining one's feelings, core beliefs and behaviors. It has been suggested, that in the aftermath of trauma a person's core beliefs may become more complex than prior to the trauma. This increased complexity can be perceived as a positive outcome, allowing the individual to gain a broader and more profound understanding of life and the world (Harms & Talbot, 2007; Stasko

&Ickovics, 2007; Sheikh, 2008;Zoellner, Rabe, Karl, &Maercker, 2008; Dekel, Mandi, & Solomon, 2010; Triplett, Tedeschi, Cann, Calhoun & Reeve, 2012). The implications of these findings are that trauma may subsequently lead to the individual's life becoming more meaningful and rich than prior to the trauma. These and similar findings have led to the development of the construct of PTG. PTG also has roots in research on the topics of *resilience* and *well-being.*

Post Traumatic Growth (PTG)

PTG is defined as the positive psychological changes experienced as a result of a struggle with traumatic life events or circumstances. The trauma is associated with significant challenges to the existing internal and external resources of the individual and to the individual's way of understanding the world and his or her place in it. In a sense trauma allows some suffers to take a new look at life. This new view becomes an experience of improvement or change that for some is profound (Calhoun & Tedeschi, 2006).

Emergence of the concept PTG. Tedeschi & Calhoun (2004) noted that the idea that human beings can be changed by their encounters with life challenges is not new. The theme is present in ancient spiritual and religious traditions, literature, and philosophy. For example, Christian literature describes stories of a "change of heart" or a "conversion" following a traumatic event or an ongoing traumatic experience that enhanced spirituality among religious Christians in 1617 (Kleinman, 1992; Bar-On, 2010). The term PTG was coined in 1995 by Tedeschi & Calhoun, who indicated that although the concept is ancient, it has only recently become a focus of investigation by clinicians and researchers in the field of trauma studies. PTG occurs in the context of attempts to adapt to traumatic circumstances that often create high levels of psychological distress and unpleasant psychological reactions, but over time give way to positive changes (Tedeschi & Calhoun, 1995). Personal distress and growth often co-exist. High levels of PTG provide meaning and leading to positive changes, thus allowing for unpleasant outcomes not to be the entire focus of attention in the aftermath of trauma (Holgersen, Boe & Holen, 2010; Laufer, Solomon, 2006 ; Lev-Wiesel, Amir &Besser, 2005; Lindstrom, Cann, Calhoun, Tedeschi,2013; Shakespeare-Finch & Dassel, 2009).

Evidence and Controversies. Evidence for the existence of PTG and attempts to quantify it have required the development of formal measures. The Post-traumatic Growth Inventory (PTGI) is the inventory most often used in the literature reviewed for this study in order to measure growth that can follow a traumatic life event. The PTGI is a 21-item self-report inventory that uses a six-point Likert scale to measure positive outcomes that result from traumatic experiences. In addition to an overall scale score, the PTGI comprises five factors (Tedeschi & Calhoun, 1996):

1) Relating to others - knowing that I can count on people in times of trouble; a sense of closeness with others; a willingness to express my emotions; having compassion for others; putting effort into my relationships; I learned a great deal about how wonderful people are, I accept needing others.

2) New possibilities - I developed new interests; I established a new path for my life; I'm able to do better things with my life; new opportunities are available which wouldn't be otherwise; I'm more likely to try to change things which need changing.

3) Personal strength - A feeling of self-reliance; knowing I can handle difficulties; being able to accept the way things work out; I discovered that I'm stronger than I thought I was.

4) Spiritual change - A better understanding of spiritual matters; I have stronger religious faith.

5) Appreciation for life - My priorities about what is important in life; an Appreciation for the value of my own life; appreciating each day.

The psychometric properties of the PTGI measure factors have been reported: Internal consistency was found to be high,(α=0.90), and test-retest reliability was acceptable with r=0.71. Among persons reporting a variety of life difficulties, scores on the scale were found to be approximately normally distributed.

Examination of PTGI. A growing body of literature has examined the use of the PTGI in adult populations from various cultures. A few studies have also examined youth. A recent study by Taku, Kilmer Cann, Tedeschi & Calhoun (2012) provided support for the five-factor PTGI. The study examined PTG and perceived growth in traumatized and non-traumatized samples of Japanese youth. Results as measured by Short Form of Post Traumatic Growth (SF-PTG) showed that greater growth was reported

by those who experienced trauma, and the objective severity of the trauma was reliably related to perceived growth.

Cann, Calhoun, Tedeschi, Taku, Vishnevsky, Triplett & Danhauer (2010) conducted a study on a Short Form of PTGI (SF-PTGI). A sample of 1351 adults who had completed the PTGI questionnaires in previous studies provided a basis for a Short Form of PTGI (SF-PTGI). The resulting 10 item form included two items from each of the five subscales of the original PTGI, selected on the basis of loading on the original factors and breadth of item content. The original PTGI has 5 factors and 21 item scale. SF-PTGI has the same five factors (e.g.: Relating to others; New possibilities; Personal strength & Appreciation for life) and out of the 21 items that were indicated in PTGI, it has the following 10 items: 1) I changed my priorities about what is important in life. 2) I have a greater appreciation for the value of my own life. 3) I am able to do better things with my life 4) I have a better understanding of spiritual matters. 5) I have a greater sense of closeness with others 6) I established a new path for my life. 7) I know better that I can handle difficulties. 8) I have a stronger religious faith. 9) I discovered that I'm stronger than I thought I was and 10) I learned a great deal about how wonderful people are. Over all 5 items from PTGI are exactly the same as in SF-PTGI, whereas others are removed or changed. Appendix A demonstrates the items that are included in PTGI and SF-PTGI.

A separate sample of 186 completed SF-PTGI. Three studies of homogenous clinical samples (including bereaved parents, intimate partner violence victims and acute leukemia patients) demonstrated that SF-PTGI yields relationships with other variables of interest that are equivalent to those found in PTGI. A final study demonstrated that administrating the 10 short term items in random order did not impact the content of the original scale and did not impact the performance of the SF-PTGI. Overall, these results indicated that the SF-PTGI- could substitute for the PTGI with little loss of information.

Gallaway, Millikan & Bell (2011) conducted a study on PTG with U.S. Army soldiers using PTGI. A sample of soldiers with prior combat deployment experience (n = 1,834) completed an anonymous survey including demographics, the PTGI, and negative Behavioral Health (BH) conditions. Soldiers were instructed to indicate the degree to which the change occurred in their life ''as a result of

their deployment,'' using the following Likert rating scale: 0) not at all 1) very small degree, 2) small degree, 3) moderate degree, 4) great degree, or 5) very great degree of change. The results indicated that among previously deployed soldiers, those reporting the highest number of combat traumatic experiences also reported significantly higher overall PTG. It was reported that most of the personal growth appeared in the decades after their discharge from the military. This may indicate that PTG is an ongoing process. It may in turn, affect whether and how psychotherapists working with trauma survivors perceive PTG, as it may or may not emerge during the course of treatment.

Controversies. There is an on-going controversy about the validity and significance of the concept of PTG. Frazier, Gavian, Tomich, &Tashiro, (2009) cast doubt on the existence or the validation of reported PTG. These researchers found first in an experimental study that the connections between perceived growth, i.e. self report- and PTG measures were insignificant. They also found that the distress from the traumatic event was even greater when positive changes were reported. These researchers argued that it is possible that a reported positive change is a phase, or part of the process of change interpretation of reality undergoes. They posit that deeper personality changes do not necessarily result from the trauma or distress. Frazier, Gavian, Tomich, &Tashiro (2009) also argue that there should be a distinction between two types of trauma effects: one in which stressful events may lead to empowerment and growth, and another one, in which traumatic events or circumstances inflict a deep shock to the existence and the personality of the survivor. It seems that their stance is that there is a threshold level of traumatic stress that precludes the likelihood of positive changes. It is not clear whether when these critics refer to personality changes, they are describing the five factors of PTGI, since none of them explicitly indicates personality change, but rather changes in one's relationship to life and others. Ironically, the research supportive of PTG tends to agree with these critics' argument that higher levels of PTG are found in the context of more severe traumatic events or circumstances (e.g. Laufer & Solomon, 2006).

Does PTG Reflect a "True" Change or a Positive Belief? One of the remaining questions in the literature on PTG is whether PTG is based on objective or subjective data. Some studies address this issue. For example, a comparative study found that members of one sample of Vietnam prisoners of war reported

that captivity had also positive benefits for them, in contradiction to another sample whose members did not report any positive benefits. This was true despite the findings that the two groups did not differ in their responses to objective measures of psychological functioning (Ursano, Wheatley, William, &Alton, 1986).

PTG may result in internal changes to sense of self or world-view that are reported as such by the survivor, even with little external indication of such changes, such as improved relationships, or external positive changes that are observable by other people. Positive internal change can reduce threats to a survivor's sense of self by increasing that sense of self, strengthening hope and optimism and creating a perception of control. However, some researchers believe that growth is limited only to subjective changes, and is not an indication for measurable behavioral, cognitive, or affective change that may lead to better life for the survivor. Some researchers have argued that the only way to examine improvement in the individual's state of mind is by a decrease in objectively measurable symptoms (Zoellner, Rabe, Karl & Maercker, 2008). In other words, simply feeling better about oneself may not count if one continues to have nightmares and flashbacks.

Some researchers view PTG as a middle path between positive belief (self report) and objectively measurable change, including components of both. The significant component of growth, in their view, is a positive change in the individual's perception, replacing unhelpful cognitive schemata with more helpful effective ones. Actual growth is characterized as an active process leading to cognitive action that improves the way the individual deals with the trauma in both the short and long term. PTG, they maintain, is a reflection of the internal process of changing cognitive schemata. Therefore, growth may occur even when there are few external expressions but also when the individual reports improvement in some subjective factors such as enhancement in spirituality or appreciation of life (Tedeschi, Calhoun & Cann, 2007). Other researchers disagree and suggest that reported PTG indeed reflects genuine positive changes that are lasting (Cohen, 2010; Laufer, 2009; Smith & Cook, 2004).

Studies Exploring the Objective Nature of PTG

Laufer & Solomon (2006) examined the influence of exposure to traumatic events on post trauma symptoms and PTG among 2999 Israeli adolescents between the seventh and the ninth grades from areas with varying levels of exposure to trauma in the form of terror attacks. All of the research participants completed surveys constructed by Lavi (2005) which allowed them to endorse having experience 17 different types of traumatic events and to rate the level of fear experienced on a scale of 1-4. PTSD was assessed using Child Post Traumatic Stress Reaction Index, (CPTS-RI), a 20-statement self report questionnaire, based on DSM-IV aimed at evaluating PTSD level (Frederick & Pynoos, 1988). They also administered a PTG survey that was based on Post Traumatic Growth Inventory-PTGI (Tedeschi & Calhoun, 1996).

Exposure to trauma was defined as "objective exposure," based on the number of events endorsed and the level of exposure to them, according to Lavi's questionnaire (including statements such as: "A close person was shot", "I got injured in a terror act", etc.), and by "subjective exposure" reflected in the level of fear reported for each endorsed event. Two thirds of the research participants were exposed to one event and a quarter were exposed to more than 3 different events. 41% of the subjects reported post traumatic symptoms and 74.4% reported some level of PTG. It was also found that the degree of subjective fear experience was the variable leading both to PTSD and PTG.

These studies show that trauma can be a catalyst not only for difficulties, but also for growth (Cadell, 2007; Morrill, Brewer, O'Neill, Lillie, Dees, Carey & Rimer, 2008; Linley & Joseph, 2006; Laufer, 2009; Schroevers, Helgeson, Sanderman &Ranchor, 2010; Shakespeare-Finch & Enders, 2008). However, trauma also presents the danger of collapse of the person's coping strategies at the highest levels of distress.

Resilience versus PTG

Resilience is a concept related to PTG that has a longer tradition in research and practice. According to Luthar (1991) who completed a synthesis of research on resilience across five decades, the concept was introduced into the scientific literature during the second half of the twentieth century. The roots of resilience research can be tracked to "Kauai longitudinal study," which followed children born in

1955 on Hawaiian Islands from perinatal period to adulthood. Over time, researchers have found that resilience is common and can be found in the everyday lives of most people, using ordinary interpersonal and internal resources (Rutter, 1985; Werner, 1993; Masten, 2001; Bonanno, 2004).

Resilience Is Defined As Recovery. The understanding that suffering and trauma may potentially yield positive changes is ancient. It has also been seen to be present in some of the large public traumas of modern life, such as the Holocaust (Kellerman, 2001; Lifton, 1980). There is, however, no standard definition for resilience, and some researchers use the word "resiliency" for the same purpose. For the sake of clarity, "resilience" is used in this study to denote the ability to recover or to return to ordinary life following an event such as a trauma. Resilience reflects not having traumatic symptoms (e.g. PTSD) following trauma or having traumatic symptoms reduced. One measure of resilience is the Child Post Traumatic Stress Reaction Index (CPTS-RI PTSD). CPTS-RI PTSD is a 20-statement self-report questionnaire, based on DSM-IV aimed at evaluating PTSD level (Frederick &Pynoos, 1988), other measures of resilience include Brauth Protective Factors Inventory (BPFI), Connor-Davidson Resilience Scale (CD-RISC), the Resilience Scale for Adults (RSA) and the Resilience Scale (RS). A more complete review of these and similar scales may be found in Ahern, Kiehl, Sole & Byers, (2006).

Resilience can be defined as the process of adapting well in the face of trauma and returning to the psychological strength and functioning abilities available to the person prior to the trauma (Calhoun &Tesdeschi, 2006; Malchiodi, Steel & Kuban, 2008). In this research, resilience will be defined as recovery from and an absence of symptoms of PTSD.

Resilience Factors. Studies show that the primary factor supporting resilience in children is having caring and supportive relationships within and outside the family. Resilience is bolstered by relationships that create love and trust, provide role models, and offer encouragement and reassurance. Additional factors found empirically to be associated with resilience include the capability to make realistic plans and take steps to carry them out, a positive view of oneself and confidence in one's strengths and abilities, communication and problem solving skills, and the capability to manage strong feelings and impulses (Lepore & Revenson, 2006). Contextual and referential influences affecting resilience include race,

ethnicities, income, gender, access to treatment services and other variables of people's multiple and intersecting identities (Luthar, 2006; Luthar & Brown, 2007 & Ungar, 2003, 2004).

PTG is not Isomorphic with Resilience. In contrast to resilience, PTG refers to a change in people that goes beyond an ability to mitigate damage by highly stressful circumstances. It is, rather, an improvement or enhancement. PTG involves movement beyond pre-trauma levels of functioning. It is possible that those who are highest on dimensions of pre-trauma resilience will report relatively little growth, primarily because they may be less affected or challenged by trauma. It is possible that the struggle with trauma may be crucial for post-traumatic growth (Tedeschi & Calhoun, 2004; Lev-Wiesel &Amir, 2003)

Expressions of PTG. Research on PTG in children has found that it develops as a result of lessons learned from exposure to trauma or crisis (Tedeschi & Calhoun, 2004). Post-traumatic growth is manifested in several clearly defined behaviors and thought patterns not necessarily present prior to exposure (Turner & Cox, 2004). Experiences associated with post-traumatic growth that children and adolescents may have include: feeling more compassion and empathy for others after personal trauma or loss; increased psychological and emotional maturity when compared to age-related peers ; a more complex appreciation of life as compared with age related peers; a deeper understanding of one's personal values, purpose, and meaning in life; and a greater value attributed to interpersonal relations (Tedeschi & Calhoun, 2004; Lev-Wiesel & Amir, 2003). None of these imply being symptom-free. Thus, the relation between resilience and PTG is complex.

In spite of the difference between the two concepts, PTG and resilience are often confused in the literature, and there is a debate whether PTG is a form of resilience (Hobfoll, Hall, Canetti-Nisim, Galea, Johnson, and Palmieri, 2007; Westphal &Bonanno, 2007). This debate may be driven by the lack of a common definition for these terms, as well as by a dearth of commonly accepted tools for assessing them. Both PTG and resilience are defined, however, as salutogenic processes (Bonanno, 2004; Tedeschi& Calhoun, 2004).

Relationship between PTG and Resilience. Levine, Laufer, Stein, Hamama-Raz & Solomon (2009) examined the relationship between resilience and PTG in another Israeli study. The definition used by

these researchers for PTG was the development of a positive outlook following trauma; resilience was

defined as the ability to sustain trauma without reporting PTSD. They found an inverse relationship

between the two concepts. They conducted two studies of Israeli adolescents exposed to trauma (N=588)

and of Israeli citizens and army personnel following the second Lebanon War (N=588). Data was drawn

from the two samples. The first sample included adolescents in grades 7-9 from 11 Israeli schools, with

varied levels of trauma exposure (Laufer & Solomon, 2006). The second sample consisted of adolescents

aged 16 diversely distributed in Israel (Hamama-Raz, Solomon, Cohen & Laufer, 2008). Both samples

used the same methods, but the first study was conducted during a period of higher level of trauma (i.e.:

more objective traumatic events).

Resilience was measured by low scores of symptoms by the CPTS-RI questionnaire. Exposure to

trauma was examined with Lavi's questionnaire (which assessed levels of exposure to trauma that include

3 levels of exposure:1) personal exposure (e.g someone close was injured or killed in terror attack),

2)indirect exposure (e.g. being near the site of terror attack, 3) no exposure to terror attack either directly

or indirectly except for media coverage.

The results of these studies showed that higher levels of resilience, defined as an absence of

PTSD symptoms, were associated with the lowest post-traumatic growth scores. According to the

researchers, the results imply that although growth and resilience are both salutogenic constructs they are

inversely related. The findings support the contention that resilience as conceptualized and measured by

an absence of symptoms of PTSD following adversity is inversely associated with PTG. Laufer &

Solomon (2006) indicated that unlike resilience, which reflects absence of PTSD, PTG represents a

change for the better in the context of having experienced PTSD. The dimensions of PTG include positive

factors such as new possibilities for life and appreciation of life. They conclude that high levels of

resilience may make a person less likely to perceive threat to the self or their world views. They also

suggest that a possible explanation for the inverse relation between resilience and PTG is that PTG only

occurs if trauma has been upsetting enough to drive the survivor to positive meaning making of the event.

They suggest that PTG involves finding meaning in a traumatic event and that individuals who

demonstrate resilience are less likely to engage with meaning making behaviors. They argue that the presence of resilience may create little need or opportunity for PTG. They also discussed the possibility that PTG is a positive belief requiring "wishful thinking," a kind of willful optimism unwarranted by circumstances. According to this explanation, those with resilience do not need to resort to such optimistic attitudes as they are less affected by the trauma, whereas those who have less or no resilience strive to rectify their distress by developing optimistic beliefs.

Researchers from Stanford University followed up the mental health of individuals who were present near by the Twin Towers terror attack in 9/11/2001. The sample included 1505 individuals participating in a longitudinal internet-based study. Using the PTGI, results indicated that initial mean PTG levels at nine weeks post-attacks were generally associated with higher trauma symptoms as measured by the PTSD Checklist – Specific (PCS), and positive changes in worldview, measured with the Changes in Outlook Questionnaire (Butler et al, 2005). Those reporting symptoms at intermediate levels reported the highest levels of growth. Levels of PTG declined somewhat over time with the exception of the Spiritual Change factor. As expected, mean PTG levels at follow-up 6.5 months post-attacks were primarily predicted by initial PTG level, decrease in PTSD from baseline and increase in PTG (e.g. positive worldview). Findings from a study conducted 9 weeks after the attacks demonstrated the existence of a positive connection between the level of PTG and the level of PTSD symptoms. (Butler, Blasey, Garlan, McCaslin, Azarow, Chen, Desjardins, DiMiceli, Seagraves, Hastings, Kraemer & Spiegel, 2005).

PTG involves Schemata Change. PTG is a process that takes place in the aftermath of trauma. Trauma alters fundamental schema about the world and self. Trauma schemata are in some ways distorted (e.g. self-blame, sense of powerlessness) when they are generalized from the trauma to non-trauma related aspects of life. In the process of PTG, the schemata alter again and the individual understands that the world is good, although not always, that people are good, although not always and that reality can be partially controlled (Calhoun &Tedeschi, 2006; Tedeschi & Calhoun, 1996, 2004).

Positive changes in the individual's perception of the world and the individual's life are essentially health-promoting as they enable the individual to create changes in priorities and in how life is lived. In the most fundamental way, such changes enable survivors to believe that one has a choice and can thus make a greater commitment to her or his priorities. With these changes, the individual develops the sense of a more meaningful life than prior to the trauma (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996, 2004). This reevaluation produces a sense of wisdom, life satisfaction and purpose in life (Tedeschi, Calhoun & Cann, 2007).

Studies involving bereaved individuals facing violent loss in the US, and Bosnian civilians in the immediate aftermath of the Balkan civil war were conducted by Bonnano, Field, Kovacevic & Kaltman (2002). In a challenge to traditional views of mental health, it was argued that an overly positive perception of the self was adaptive, particularly in conditions of extreme adversity. Researchers have tempered this view with evidence linking self-enhancing biases to negative social consequences. This research reports studies examining the effects of positive perception of the self in the context of civil war in Bosnia (Study 1) and premature conjugal traumatic loss (Study 2). Study 1 included 78 Bosnia-Herzegovina citizens (18-69 yrs. old) and Study 2 included 74 bereaved adults in the US, aged 34-56 yrs. old who had lost their spouses. In both studies, mental health experts rated individuals (watching them on videos). It was found, that among bereaved participants, those who demonstrated growth, were people who had suffered the most severe and violent losses, suggesting that PTG is activated by more severe trauma. The researchers measured PTSD (e.g. resilience equals no PTSD). It was found that those with positive self-perceptions experienced PTG and were strongly associated with PTSD (Bonanno, Field, Kovacevic, & Kaltman, 2002). In both studies, mental health experts rated individuals with positive self-perceptions as better adjusted than other participants. Positive self-perceptions proved particularly salutary for bereaved participants who suffered more adverse losses. These effects were evidenced regardless of whether global judgments or structured clinical interviews were used, whether ratings were collected cross- or longitudinally, and when negative affect was statistically controlled for. However consistent with previous studies, positive self-perceptions also evoked negative impressions among

untrained observers. This research may suggest that positive self-perception, a subjective belief, may

contribute to PTG that is observable by others and thus reflects a true change.

Well-being and PTG

Subjective Well Being (SWB). Well-being can be viewed through two different lenses: subjective or

psychological. Subjective Well-Being (SWB) is defined as the state that underlines happiness. This

concept is derived from the Hedonic Approach, which is a broad phenomenon that is based on the notion

that increased pleasure and decreased pain lead to happiness, and includes individuals' emotional

response (e.g.life satisfaction). SWB is thought to influence individuals' goals, coping efforts and

dispositional influences, adaptation and coping strategies (Diener, Suh, Lucas, & Smith, 1999). In

addition to optimal psychological functioning and experience (Ryan, &Deci, 2001), a person's

temperament and cultural influences (e.g. collectivistic versus individualistic values) are also factors in

people's well-being and happiness (Diener, 2000). According to McDowell (2010) SWB refers to a

person's contentment, satisfaction, or happiness. SWB can be assessed in physical, emotional, social and

spiritual domains.

The field of SWB has deep roots in survey research, and the most common assessment technique

in this field is the single-occasion, self-report happiness scale. (Diener, Suh, Lucas, & Smith, 1999).

Positive Psychology connects SWB with the term "quality of life", which encompasses loving others,

pleasure, self-insight and the desire of people to think they have good lives (Diener, 2000). SWB focuses

on judgment of life as a whole, viewed as comprising global life satisfaction, satisfaction with important

domains (e.g.: work), positive affect (experiencing many pleasant emotions and mood) and low levels of

negative affect (few unpleasant emotions and moods) (Diener, 2000). Happiness is a concept connected to

SWB and is defined by the frequency and intensity of pleasant emotions, feeling pleasant emotions most

of the time and infrequently experiencing unpleasant emotions (Diener, 2000).

Components of SWB. Components identified in the literature reviewed are: pleasant affect, which includes

joy, elation, contentment, pride, affection, happiness and ecstasy; unpleasant affect, which includes guilt

and shame, sadness, anxiety and worry, anger, stress, depression and envy. Life satisfaction, which

includes desire to change life, satisfaction with current life, satisfaction with past, satisfaction with future prospects, significant others' views of one's life; and domain satisfaction, which includes work, family, leisure, health, finances, self and one's group.

Culture has been found to be an important determinant for SWB. For example, the constructs of individualism vs. collectivism have significance in determining SWB. In individualist cultures such as North America and Western Europe, individuals attempt to distinguish themselves from others and therefore those who achieve autonomy in having and voicing their unique feelings and emotions tend to achieve higher levels of SWB. In contradiction, in collectivist cultures a central goal is to maintain harmony with others. Therefore, opportunities for expression of individual emotions and needs are less valued and less central to SWB (Diener, Suh, Lucas, & Smith, 1999).

Psychological well-being (PWB). The construct of Psychological Well-Being (PWB) is derived from a slightly different philosophical perspective, the eudemonic (producing well-being and growth) one. More recent research supports the broader eudemonistic approach that reflects a drive for personal growth versus the striving for pure pleasure that is reflected by the hedonic approach (Diener, 2000; McDowell, 2010). Joseph, Maltby, Wood, Stockton, Hunt & Regel (2011) conducted research using the Psychological Well-Being Post-Traumatic Changes Questionnaire (PWB-PTQC), an 18 item self-report measure, to assess perceived changes in PWB following traumatic events and using the PTGI to assess PTG. Three groups were studied: two regionally different general population groups (N=214 and N=85 respectively), and a trauma sample (N=254). These researchers found that PTG was associated with PWB. They found that actual change and perceived change were not synonymous and that there was a distinction between perception of growth (subjective) and actual growth (objective). Higher scores on the PWB-PTCQ were correlated with actual PTG (r=.41, p<.001), and higher scores on PWB-PTCQ were associated with lower scores on PTSD (R=-. 44, P< .001).

Findings of this research suggest that PWB is more closely related to PTG than is SWB. SWB implies the absence of suffering; PTG appears to require the experience of suffering, and may, in fact, only occur when suffering persists in some manner in the aftermath of trauma. PWB, on the other hand,

relates to aspects of PTG such as transforming the meaning of a traumatic experience. PTSD and PTG can co-exist; a person experiencing PTG may thus have PWB, even though still in some degree of post-traumatic distress. The model of PTG is early in its development as a theory and as a scholarly body of research. It nonetheless constitutes a unique, challenging and innovate lens through which to understand the human capacity to deal with trauma. The notion that well-being can be examined, not merely as reduction in distress and an absence of symptoms, but rather as a change in life philosophy. For example, it is potentially important in a treatment environment that often emphasizes the former and totally neglects the latter in assessing outcome of interventions. This is a view that includes subjective dimensions upon which the individual judges her or his life and tells her or his story. This means that well-being can be enhanced not only by reducing distress, but rather through the cultivation of a deeper, broader view of oneself as a complex being having both pathological and salutogenic aspects. In the framework of PTG, the existence of pain does not preclude the presence of growth.

In summary, the concepts of PTG, resilience and well-being as currently represented in the scholarly literature were defined and reviewed. Each of these concepts was found to be associated with corresponding assessment tools. Evidence for the presence of PTG, resilience and well-being was presented. The relationships between them, obtained by using the respective tools, were examined and discussed.

- Co-occurrence of positive and negative outcomes: Traumatic effects result in both negative and positive outcomes

- Trauma affects core beliefs (e.g. self-blame)

- PTG is defined as positive psychological changes resulting of a struggle with traumatic events or circumstances

- These positive changes reflect appearance of factors/dimension that did not exist before the trauma.

- There is evidence for PTG:

- o   PTGI and SF-PTGI: Tools have been developed and used for measuring PTG

- o   The tools satisfy common criteria of psychometry

- o   PTG was found as an on-going process, taking place years, even decades after the traumatic event

- Controversies regarding PTG. PTG can be viewed subjectively (self-report) - Changes occur in the survivor's thoughts and feelings, not in externally observable behavior. Some researchers claim that PTG reflects positive belief (subjective), rather than true change (objective).

- PTG vs. Resilience:

- o   Whereas successful resilience leads to returning to pre-trauma state, PTG may lead beyond it- e.g. to positive changes that did not exist prior to the trauma.

- o   Resilience is absence of traumatic symptoms or reduced symptoms

- o   PTG may only occur when the trauma is 'strong enough'

- Well-being reflects not only welfare and happiness, but also growth

METHODOLOGY

The measurement

A key choice that the researcher following Grounded Theory has to make is whether to start "tabula rasa" (blank slate) or use sensitizing concepts (ideas, concepts, theories) from the literature. These sensitizing concepts anchor the research allowing it to grow in various directions according to the information obtained in the process (Patton, 2002). I chose to form an interview guide based on concepts taken from the literature review.

The study utilized grounded theory in order to explore the following questions as they appear in the interview guide:

1. In your work as a therapist, do you take into account positive changes that result from trauma? If so, how?

2. In what aspects of functioning or living have you seen PTG or positive changes?

3. What would you see as PTG in each of the following areas of functioning?

      a. Emotions

      b. Behavior

      c. Cognitions

Please provide an example of each without disclosing confidential client information

4. Is there a difference between the concepts of resilience and PTG/positive changes? If yes, what is the difference? If no, what does the concept of PTG/positive changes add to your understanding of resilience?

5. What is the relationship between symptom reduction and PTG/positive changes? How does this relationship affect your work with clients?

6. Do you view changes as subjective in the perception of the self and/ or in your own view? Please describe.

7.   Which of the following factors/ elements/dimensions are included in your understanding of PTG or positive changes? How are they included?

      a. Culture

      b. Social class

      c. Spirituality and spiritual change

      d. Pre-existing vulnerabilities

      e. Perceived changes in self

      f. A changed sense of relationships with others

      g. A changed philosophy of life

      h. New possibilities (e.g. new interests, opportunities)

      i. Personal strength

      j. Appreciation of life

      k. Other

8. Please rank each of these factors in terms of how important each is to understanding PTG. Rank 1 as most important, 2 as second most important, 3 as third most important, etc.

9. Do you define well-being in relation to factors external to the individual internal to the individual?

10. What is your primary theoretical orientation for trauma therapy?

11. How many years have you worked as a trauma therapist? Which kinds of trauma have you treated?

12. In your practice, what is the importance of the concept of post traumatic growth? Please describe.

Interviewees were eight practicing psychotherapists, nominated by peers as experts in trauma treatment, from the Seattle area. They were interviewed in their own office and responses were audio recorded, transcribed, and then analyzed. The analysis was aimed at extracting and coding categories, themes and sub-themes using Grounded Theory. One specific category was quantitatively analyzed by requesting interviewees to rank PTGI factors in order of importance to the understanding of PTG. In order to meet the time and ethical requirements of this study and to ensure minimum emotional risk to participants the interview guide for the student was developed relying on literature on PTG and related concepts: resilience and well-being, controversial aspects of PTG (e.g. its objective nature) as well as relying on Post Traumatic Growth Inventory (PTGI), developed by Tedeschi and Calhoun (1996) and included factors of PTG. I developed the guide with the collaboration and consultation of the committee chair. Each interview was analyzed and separately coded into themes by the investigator. The themes were grouped into six categories generated by the interviewees' responses. Data was then analyzed collectively and themes were merged to produce fewer overall themes and sub-themes under each category, as well as to produce the seventh, eighth and ninth categories, which are overreaching themes. I chose this exploratory procedure so as to focus on the perception of therapists regarding the construct of PTG. A goal was to understand how they understood some of the issues that have emerged in the scholarly literature regarding PTG and to see how or if they differentiated it from the related constructs of resilience and well-being. The various themes that emerged from my analysis of these data reflected the trends apparent in the interviewees' comments. Additionally, my request to interviewees to quantify the relative contributions of several factors to PTG may have led to the emergence of certain themes and

subthemes, as potentially these participants began to unconsciously organize their responses to the more open-ended questions around the content of the quantitative section of the interview.

The study was to generate themes for further study grounded in data emerging from general question of how trauma experts- clinicians view the concept of PTG. Other information that emerged from their responses included their view of PTG in light of the related concepts of resilience and well-being, their sense of whether PTG is 'objective' or 'subjective', and how they perceived the factors of PTGI.

Design

Grounded Theory methodology informed this study. According to Patton (2002) Grounded Theory is a qualitative methodology allowing for the discovery of quantifiably theory from data systematically obtained through social research. The interview guide was developed based on the literature review and data was collected from the responses of the interviewees. From the data collected, the key points are marked by me with a series of codes in the form of possibly hierarchal set of categories that include themes and sub themes. Data collection is considered sufficient when theoretical saturation is achieved. This is defined as "the point in category development at which no new properties, dimensions, or relationships emerge during analysis" (Strauss & Corbin, 1998, p.43, in Patton, 2002). It is suggested that categories and properties are concepts that are identified by the researcher and evolve from the constant comparing of the data and the researcher's immersion in and relationship with those data.

Patton (2002) describes that a category emerges from the data and may stand by itself as a conceptual element. Coding consist of assigning data to hierarchy: categories- themes and sub-themes, then reworking on the themes and sub-themes by identifying relationships and leading to grouping and merging and ensuring all available data has been coded. A property is an attribute of a category. For example, in this study, the category 'conceptualization and use of the concept Post Traumatic Growth (PTG)' has properties: the theme- "clients heal and progress" and three sub-themes- "positive behavioral changes", "positive internal changes", "clients learn from the trauma". The constant comparison process may support existing categories or generate new ones.

Grounded Theory was chosen as it focuses on the process of generating theory in well-developed categories (e.g. themes, concepts) that are systematically interrelated through statements of relationships from a theoretical framework that explains some relevant phenomenon (Patton, 2002). Because the main aim was to explore perceptions and conceptualization of trauma experts, Grounded Theory provided a useful methodology for organizing this kind of qualitatively obtained data.

Sample and Recruitment

This study was completed using a snow-ball purposive sample. The sample included trauma experts who are therapists in the Seattle area. They were chosen because they are considered as what Patton (2002) describes as "information-rich key informants" on the subject of trauma. It seems that interviewing experienced and knowledgeable experts on trauma will enable a researcher to get rich and important information. "By asking a number of people who else to talk with, the snowball gets bigger as you accumulate new rich information" (Patton, 2002).

The thesis chair nominated the first trauma therapist, and each therapist was asked to identify two other trauma therapists. Four people were contacted who did not respond to phone messages and or emails. I contacted the participants via email or phone and all received a consent form and the interview questions prior to the interview. Some of the therapists proposed the same colleagues as additional interviewees, indicating some consensual collegial validation of their being perceived as "expert." Additionally, among those interviewed were people who had been in the elected leadership of national and international trauma organizations; individuals who had published or presented professionally in the field of trauma; individuals who conducted training and/or supervision of students and colleagues in working with trauma survivors; and individuals who had won awards for their work in the field of trauma.

The inclusion criteria for the sample were: 1) being a therapist working in the Seattle area with 2) clients experiencing trauma. There were no exclusion criteria apart from being unable to provide consent. Eight trauma clinicians participated in the study.

The sample (n=8) consisted of female therapists working in the following theoretical orientation (some therapists combine several theories): inter-relational- neurobiological, psychodynamic,

interpersonal -cognitive behavioral, strategic, positive psychology, feminist therapy, existential therapy, family system, somatic theories and Accelerated Experiential, Dynamic Therapy (AEDP).Table 1 in Appendix B summarizes the participants' theoretical orientation. Most of the therapists recommended other female therapists. The two male therapists who were recommended did not respond to email or phone communication.

Participants' years of clinical practice experience in the field of trauma ranged from 13 to 40 years at the time of their interview. The kinds of trauma that these therapists work with included: domestic violence and witnessing domestic violence, physical abuse, sexual abuse and sex trade trauma, emotional abuse and neglect, natural disasters, car accidents, workplace violence, massive shooting, torture, combat trauma, prisoners of war, hate crime trauma and health related trauma . See Table 2 in Appendix C for a complete listing. All therapists in this sample work mostly with adults, although many of their clients were traumatized as children or adolescents.

Data Collection

Data was collected between late January and late March of 2013 in the Seattle area. Interviews lasted between 30 to 60 minutes, depending on the length of the participant's responses. Interviews began with the review and signing of consent documents. Separate signatures were obtained for participation in the interview and audio recording of the interview. Each interview followed a prepared questions guide, which can be found in the Appendix. I sent the interview guide and consent form by email to each participant in advance of the interview. I offered participants a hard copy of the guide to look at while they were answering the questions. The participants were asked if they would like to receive the study results when the study and the thesis were completed.

Ethical Consideration

The study materials and procedures were reviewed and approved as exempted by the Human Subjects Division, exempt category 2, at the University of Washington, as the study inquired into therapists' views of the concept of PTG and other related concepts, and did not include specific questions

regarding clients. See exemption approval in appendix. Materials included consent form and a structured interview questionnaire.

Data Analysis

The data analysis process involves three types of coding. According to Patton (2002) there are three stages of coding. First, 'open' coding involved assigning the data to analysis entities: categories, themes and sub-themes that are identified from the data by the researcher. This was done by using the question guide. Second, 'axial' or 'theoretical' coding involves identifying relationships between the analysis entities. Repeated or similar analysis entities from different questions were grouped. These relationships support the identification of an overall theoretical framework. Third, 'selective' coding involves ensuring that all available data are associated with emerging analysis entities (e.g. themes and subthemes), and that core analysis entities are identified to support the conceptualization of the theoretical framework.

Eventually, a situation of theoretical saturation is attained where no new categories or properties emerge from the gathering of further data. The analysis entities change as new information was received until there was no longer new information. Some degree of saturation was reached. Due to the small sample size, and the fact that all interviewees were from the same area there may be limitations to the degree of saturation. However, both sample size and geographic parameters were within norms for a qualitative study using Grounded Theory methodology, given that results are not expected to generalize, but rather to develop questions that can be quantitatively studied for purposes of later generalization (Strauss & Corbin, 1990).

Expanded notes were written before moving to another interview. Therefore, I considered emerging theory when conducting the next interview, so that I could search for additional and or disconfirming evidence as the interview proceeded. This process of analysis included reflection and repeatedly listening to the interview. Recalling additional data about the interviewees' responses with generating literature review ideas about the interview questions. Grounded Theory's coding system (Strauss & Corbin, 1990) was used to analyze transcripts, field notes and self-reflective notes

RESULTS

The eight participants in this study were female trauma experts with varying experience in the trauma field. The therapists all practiced in the Seattle area and work mostly with adults. Many of the therapists who participated in this study knew one another. Therapists are referred to via numbers (e.g. therapist 1, therapist 2, etc.) for the purpose of confidentiality. A very brief description of each trauma expert will follow as appears in appendix.

Therapist 1: has 23 years of experience in the trauma field using inter-relational neurological theories working with trauma The types of trauma she has treated include physical abuse; sexual abuse (including Childhood Sexual Abuse –CSA, sex trade victims, military sexual trauma); natural disasters; hate crimes and workplace violence; combat trauma; torture/prisoners of war; accidents; health related trauma (e.g. life threating illness such as cancer, HIV, musculoskeletal injuries, brain injury, spinal cord injury, cancer, mutation and amputation) and emotional abuse/neglect.

Therapist 2: has 20 years of experience in the trauma field using psychodynamic theory. The types of trauma she has treated include: physical abuse; sexual abuse; natural disasters; hate crimes/workplace violence; combat trauma; accidents and emotional abuse/neglect.

Therapist 3: has 14 years of experience in the trauma field using interpersonal cognitive behavioral therapy. The types of trauma she has treated include health related trauma.

Therapist 4: has 33 years of experience in the trauma field using inter-relational-neurobiological theories, strategic therapy, family system therapy and somatic theories. The types of trauma she has treated include physical abuse; sexual abuse; combat trauma; torture/prisoners of war; accidents; health related trauma; emotional abuse/neglect; and international persecution trauma (e.g. refugees).

Therapist 5: has 40 years of experience in the trauma field using feminist therapy. The types of trauma she has treated include physical abuse; sexual abuse; combat trauma; accidents; emotional abuse/neglect.

Therapist 6: has 31 years of experience in the trauma field using inter-relational-neurobiological theories, Accelerated Experiential Dynamic Therapy (AEDP) and somatic theories, The types of trauma she has

treated include physical abuse; sexual abuse; natural disasters; hate crimes/workplace violence; combat trauma; accidents; health related trauma and emotional abuse/neglect.

Therapist 7: has 13 years of experience in the trauma field using interpersonal-cognitive behavioral, positive psychology and existential therapy. The types of trauma she has treated include health related trauma.

Therapist 8: has 16 years of experience in the trauma field using interpersonal-cognitive-behavioral therapy. The types of trauma she has treated include physical abuse; sexual abuse; hate crimes/workplace violence; and emotional abuse/neglect.

Themes and sub-themes

During the interviews, themes emerged from each of the responses for the interview guide. Categories were divided to themes and further to sub-themes. Citations are marked by the use of italics. Citations are associated with the themes or sub themes that precede them. Results are reported in the following format: category based on the interview guide, the main theme that emerged from this category, and sub-themes within the category. The findings are organized in the form of a level of categories- themes (numbered 1, 2, etc.), sub-themes (numbered 1.1, 1.2, etc.)

Nine categories emerged from the data that derived directly from the responses:

(1) Clients heal and progress

(2) Factors/dimensions of PTG

(3) Resilience versus PTG

(4) Objective and subjective views of PTG

(5) Views of well-being

(6) PTG enables thriving, in spite of trauma

After the completion of the interview, in second look at the above categories, overarching themes were identified by grouping and merging themes that appeared in multiple responses. These overarching themes were differentiated from and not included in any of the above six categories. Overarching themes added three additional categories:
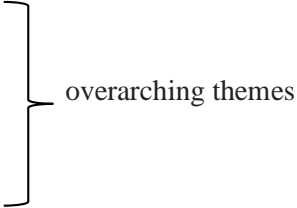
(7) Meaning making (e.g. becoming an advocate of the trauma (s)he survived)

(8) Trauma-informed treatment may contribute to PTG

(9) PTG can continue and progress over time

Moreover, subthemes that emerged in this study are detailed below:

1. Clients heal and progress

    1.1. Positive behavioral changes

    1.2. Positive internal changes

    1.3. Clients learn from the trauma

2. Factors/dimensions of PTG

    2.1. Spirituality can be important for growth

    2.2. Pre-existing vulnerabilities to trauma have mixed effects

    2.3. New possibilities, a changed philosophy of life and new appreciation of life appear in the small and big ways

3. Resilience versus PTG

    3.1. Resilience factors

    3.2. Resilience and PTG are different concepts ad may be interconnected

    3.3. Symptom reduction and PTG are different

4. Objective and subjective views of PTG

    4.1. I conceptualize changes related to PTG as subjective, in client's perception

    4.2. I conceptualize changes related to PTG through my own clinical judgment

    4.3. I conceptualize changes both as subjective, through the client's perception and as objective, through my own clinical judgment.

5. Views of Well-being

    5.1. Well-being is about happiness

    5.2. Well-being is about growth

6. PTG enables thriving, in spite of trauma

7. Meaning making

8. Trauma-informed treatment may contribute to PTG   overarching themes

9. PTG can increase and progress over time

(1) Clients heal and progress. Five out of eight therapists indicated that they were not familiar with the concept of Post Traumatic Growth and referred to the concept as positive changes. According to Tesdeschi & Calhoun (1996) Posttraumatic Growth has also been defined as positive changes. All eight therapists indicated that they have witnessed PTG/positive changes in their work with clients around issues of trauma. Therapists used the concepts of positive changes and PTG interchangeably. For the sake of clarity and succinctness, the term PTG will be used in this section. All eight therapists indicated that the importance of PTG is in the idea that clients in the aftermath of trauma heal and progress. Sub-themes of this category include (1.1) Positive behavioral changes; (1.2) Positive internal changes and (1.3) Clients learn from trauma.

(1.1) Positive behavioral changes were described as positive changes in relationships, as well as becoming advocates for trauma related causes. Five therapists indicated that clients became advocates, and six therapists indicated observing positive changes in clients' relationships. In the sub-theme of positive behavioral changes via advocacy, Therapist 8 described clients' healing and therapeutic progress:

> *"I've seen people (clients) go through trauma help others who experience the same trauma and feel good about their ability to help others…they become advocates or activists like sexual abuse survivors. They start to feel gratitude or appreciation for things that they have and didn't before, and start for example a forum for sexual abuse survivors."*

Therapist 5 described the positive relationship changes that clients experienced through PTG. Specifically, she noted that clients strengthened positive relationships and eliminated unwanted relationships.

> *"[Trauma] changes how they look at themselves and other people, they see who the people they*
>
> *want to be close to are and who they no longer want in their lives."*

(1.2) Positive internal changes were also described by all eight therapists. These included the development of affect tolerance, positive views and experiences of self and others, development of priorities/perspectives, meaning making, and the enhancement of sexuality. Four therapists indicated witnessing clients develop affect tolerance and experience a change in priorities. Seven therapists indicated witnessing clients experience feelings of appreciation and gratitude, as well as a sense of meaning, and three therapists indicated that clients experienced emotional closeness with family and friends and enhanced sexuality.

Therapist 2 described that though following the trauma, clients' observable behaviors may be the same, their feelings may include more joy, gratitude and compassion.

> *"Still doing the same activities, but feeling different- feeling more love, joy and gratitude and*
>
> *appreciate the significance for life and their role in it. For example, a parent that appreciate that*
>
> *their child came back home and had a good experience at school, for example- being grateful for*
>
> *all the days when that (trauma) does not happen… also feeling compassion to others…'I don't*
>
> *know how much time I have in life so I don't want to take it for granted and might as well take*
>
> *advantage of all the good while I can'"*

Therapist 1 described observing clients decreasing avoidance behaviors, and developing affect tolerance and perspective, as well as the enhancement of love, connection, meaning and sexuality.

> *"People are not sweating on the small stuff…having tolerance to distress… in touch with what*
>
> *meaningful in life, showing consistency over time, engaged in life around them…they process the*
>
> *connection and meaning of life, sexual self was damaged by the trauma in the healing process*
>
> *they connect, have, meaningful connection and sexual life…they are not scared of emotions, less*
>
> *avoidance, feel love where there was absence of love before… feel and show love."*

(1.3) Clients learn from trauma- although this theme addresses behavioral and internal changes, because it was emphasized by therapists separately from their description of internal and behavioral changes, learning from trauma was placed in its own sub-theme.

Four therapists indicated that learning and awareness occurred following the trauma that provide clients a sense of control.

Therapist 6 described clients' learning as being more careful following the trauma, or as the opposite, taking more calculated risks. She also incorporates meaning making as part of the learning from the trauma.

> *"People are taking more risks, or being more careful when need to, understand cause and effect and feel more in control, like behavior in driving after an accident…'I really can't date assholes anymore'...meaning is made out of the trauma in the form of awareness –'I survived', especially after long trauma, a whole different human being, a sense of present, feeling worthy, work for what they want and being a person with other people".*

(2) factors/dimensions of PTG. The following factors or dimensions were taken from PTGI : (c) Spirituality and spiritual change; (e) Perceived changes in self; f) A changed sense of relationships with others; (g) A changed philosophy of life; (h) New possibilities (e.g. new interests, opportunities); (i) Personal strength and (j) Appreciation of life. (a) Culture; (b) Social class and (d) Pre-existing vulnerabilities were taken from sources of literature (Timko, & Janoff-Bulman, 1985; Taku, Kilmer Cann, Tedeschi & Calhoun 2012).

Question 8 asked that therapists to rank aspects of their understanding of concept-PTG in order of importance, and to suggest any additional factors. All eight therapists responded that it was difficult and felt somewhat artificial for them to rank the factors of PTG, as they viewed all of the factors as important and applicable to the process of PTG to occur.

Therapist 5 discussed how all the dimensions of PTG can be important:

> *"We have multiple intersecting identities and all is relevant- aspects of how we define who we are, options of what you do impacted by vision and by resources, gender, culture social class*

> *etc… overlapping things, the core sense of me in the world and the world is with me- human*
>
> *relationship."*

Although the therapists expressed difficulty in ranking items in order of importance in understanding PTG, they did in fact do so. The average importance ranking for each item was calculated. One of the participants, therapist 8, was removed from this calculation as she did not rank some of the factors. Ranking a factor first means that the factor is the highest in importance, which means that the lowest mean reflects the most important factor. Changed sense of relationship with others was ranked as most important in the understanding of PTG). The mean rankings of the eight factors are as follows:

1) A changed sense of relationship with others – (2.25)

2) Perceived changes in self (2.57)

3) A changed philosophy of life (2.75)

4) New possibilities (2.875)

5) Personal Strength (3)

6) Spirituality; Appreciation of life (3.375)

7) Pre-existing vulnerabilities (4.57)

8) Culture; Social class (5.8)

The additional PTG factors suggested by therapists were:

1) Access to a model of healing (e.g. therapy)

2) Pro-social change

3) Attention to therapeutic relationship

4) Compassion

5) self awareness

6) Attention to physical well-being

7) Ability to feel appropriate anger

8) Creativity

Compassion, awareness, attention to well-being, and ability to feel appropriate anger can be included in previously indicated factors of PTGI (new possibilities, a changed sense of self).

Five sub-themes emerged from the above themes: (2.1) Spirituality is important for growth; (2.2) Pre-existing vulnerabilities have mixed effects (2.3) New possibilities, a changed philosophy of life and new appreciation of life appear in small and big ways.

(2.1) Spirituality can be important for growth- Five therapists indicated that spirituality is an important aspect of PTG.

Therapist 8 indicated that spirituality may cause PTG and PTG may cause increased spirituality.

> *"Spirituality helps people get PTG. Their beliefs help them relate, to connect to self and to the*

community... PTG may increase spirituality or spirituality may increase PTG, its chicken and egg..."

Three out of the five therapist indicated that clients returned to their original spirituality, and two out of five therapists indicated that their clients found a new spirituality following the trauma.

Therapist 3 discussed clients returning to their original spirituality:

> *"Religious or spiritual beliefs are important to them, or (they) use it as something that helps them*
>
> *to cope after the trauma. It plays a role. I haven't witnessed developing spirituality following the*
>
> *trauma only if they were already engaged with it"*

Whereas therapist 2 discussed finding new spirituality:

> *"Connection to a new spirituality, a sense of peace that is different from the spirituality they grew*
>
> *up with that helps them cope with unknown"*

(2.2) Pre-existing vulnerabilities have mixed effects -Two therapists indicated that it was hard for clients with pre-existing vulnerabilities to the trauma to experience PTG, however when they did experience PTG, they experienced it to a greater degree in comparison with those who did not have preexisting vulnerabilities. Therapist 5 described that it may be harder to experience PTG with pre-existing vulnerabilities, which may imply that on the one hand, additional adversities may inhibit PTG, and on the other hand, that these preexisting vulnerabilities may facilitate greater PTG

"With preexisting vulnerabilities- then it's a lot harder, even with small trauma can bring up all the past trauma ...positive changes are much bigger because there is rebuild to the person, - 'I exist, it's ok to be present, I'm lovable, I can be safe in the world for the first time in my life.' They (clients) get more out of it because they needed more- positive (change/s) is more likely (to occur) than the person that had a onetime accident after a terrific life."

Therapist 7 describes a similar view, where past trauma may hinder growth in some cases, and may promote PTG in other cases.

"Multiple trauma early on sometimes people get so beaten down that there is no room for growth, (they are) so strained by coping mechanisms that clients are not able to see benefit, they are emptied out. But sometimes it goes the other way: with high vulnerability they (clients) see it(trauma) as another challenge they can overcome. It depends if they see it (the trauma) as a challenge or as a threat..."

(2.3) New possibilities, a changed philosophy of life and new appreciation of life appear in the small and big ways. Five therapists indicated that new possibilities and a changed philosophy and appreciation of life manifest in clients' changed values, affect tolerance, appreciation of life, and gratitude (e.g. developing positive cognitions and emotions). Therapist 8 described changes in clients' values and development of positive cognitions and emotions.

"People want to live fully and shift in values (they go through changes) like change in the values of consumerism and the rat race- (they) want to travel more or to be with their family. People have to grapple with it (the trauma), they come up with a new accurate philosophy as opposed to a globally negative one... people have gratitude"

Therapist 4 described observing positive cognitions and emotions:

"People feel they are capable human beings and ...they tolerate, have yearning and ask the world to meet their yearnings...People commit to life...they have experiences of pleasure in talents and interests, appreciation of all they have accomplished"

Therapists indicated that class and culture do not usually change in PTG and therefore, it is a preexisting variable that does not change as other PTG factors change (e.g. clients do not change their culture or class as part of PTG). Therefore, there is no emerging theme regarding culture, class, and PTG. Four therapists indicated that culture and class were significant in understanding trauma and growth. One therapist indicated that those who come from lower socio-economic status usually show more growth as they are from a more difficult situation that enables more growth. One therapist indicated that as she works with clients from similar cultural and class background (middle SES or upper, meaning that within her clientele there is no struggle in these domains).

Two quotes exemplify therapists' perspectives on culture and class as PTG factors. These quotes are analyzed in the discussion section.

> *"We are multiple intersecting identities- aspects of how we define who we are ...our gender, culture and social class ...very much a part of construct of how your PTG looks like."* (Therapist 5)

> *"More connection to healthy aspects of culture-family culture, the country they live in and lived in, cultural identities. With PTG the person will have more understanding how the culture in their lives impacted what happened, broader understanding of the culture helps with self-blame, helps them have more compassion to themselves, helps them have connection to the healthy aspects of their culture...say the family wasn't the best culture for them, some of the growth will be: `I'm not going to spend that much time in that aspect of culture, but I can develop a family with a broader sense of culture- my town, my country, my people`."* (Therapist 1)

(3) Resilience versus PTG- Three Sub-themes emerged. These include: (3.1) Resilience factors; (3. 2) Resilience and PTG are different concepts and may be interconnected; (3. 3) Symptom reduction and PTG are separate.

(3.1) Resilience factors- All eight therapists conceptualized resilience factors as biological and historical factors that interact with trauma. Therapist 5 discussed historical factors such as family, the presence of role models, talent, and intelligence.

"Resilience has to do with specific aspects of history like a calm temperament – physiological baseline that can provide more resilience …extraordinary trauma survivors connect with sense of meaning, good family, being a formed person like Elie Wiesel, (Victor) Frankel, and (Nelson) Mandela …If a child has a role model, talent and intelligence… the child has resilience…

Therapist 7 also described the presence of a role model as a resilience factor.

"Personality characteristics that can be molded or shaped by experiences of trauma, but they (survivors of trauma) came like that genetically, even if they grew up traumatically they had a role model, had a relative or a teacher what was needed."

(3.2) Resilience and PTG are different concepts and may be interconnected. Resilience was defined by six therapists as the ability to recover and by two therapists as a state of (e.g. flexibility, strength). Six therapists described resilience and PTG as different concepts, however there were widely varying views of the connection between the two concepts.

For example, therapist 1 viewed resilience as a specific state, PTG as any positive change, and suggested that resilience is necessary for PTG to occur.

"The concepts rely on each other. Resilience is specific- a state, strength and flexibility and PTG is general, any positive change after the trauma"

Therapist 7, also views resilience as a pre-disposition for PTG:

"Some (are) more resilient by nature. They will probably be more prompted to develop PTG because they have the base for it, the recognition, that difficult things can make more strength… resilience was there before and can open the door for PTG".

In comparison, however, therapist 5 viewed resilience as the ability to recover, suggested that resilience may result from PTG, and that both concepts can exist separately:

"Once the person experienced PTG it offers them a pathway to resilience…You have the ability to know that about you, 2 different things you can get one without the other, people that don't have resilience, for example if they grew up very poor, they can have PTG, which is the ability

to transform. It can take more time, but they have more room to grow" (in comparison to those with resilience).

(3.3) Symptom reduction and PTG are separate. According to the literature reviewed in this study, the absence of PTSD reflects resilience, and PTG does not occur when symptoms are completely reduced. The therapists in this research concurred with these findings. Thus, PTG and resilience are separate and different, and somewhat reflect opposite effects. None of the therapists indicated that symptom reduction can lead to PTG. Four therapists (half of the sample) indicated that PTG may lead to symptom reduction and the other four therapists indicated that there is no connection between the two concepts. Therapist 2, for example describes that PTG can facilitate symptom reduction.

"(Symptoms reduction and PTG) are not the same. One can have symptom reduction without having PTG. when working on symptom reduction I will also work through the trauma and on the growth at the same time. Often I look at the long term recovery from trauma as evolving through the PTG, which can facilitate the symptom reduction, you can reduce symptoms with no trauma growth, you can work on PTG and get little or lots of symptom reduction".

Therapist 5 states that PTG can occur without symptom reduction.

"(Symptoms reduction and PTG are) two parallel phenomena. Depending on the person you can have growth at the same time you have symptoms, they are not two pieces of the same thing, and they are two really separate tracks. (Clients) can have joy at the same time that they suffer from symptoms"

Therapist 7 indicated that one must have traumatic symptoms in order for the growth to occur and that both phenomena can change over time:

"Sometimes (clients) can score high on symptoms and PTG at the same time... many times you have both, ... you have to be shaken out, you have to be traumatized for the growth to occur. Over time symptoms may be reduced, depending on where they are at. It varies- people can have a couple of good days, they can distract themselves and then have traumatic symptoms again. They can have the ability to move back and forth with PTG. They have both, even (at one point) have

more symptoms and less growth… over time (symptoms) will reduce and (are) not the focus…It

doesn't have to be one or another".

(4) Objective and subjective views of PTG- Therapists were divided in their responses on this theme. In this section, PTG is viewed as subjective, objective, or both. It is important to indicate that both clients and therapists have objective and subjective views of PTG. However for the sake of clarity of this theme, client's view is addressed as subjective in terms of self reporting changes even if the changes are not observable, whereas, therapist's view is addressed as objective in terms of viewing external, observable changes. Sub- themes included: (4.1). I conceptualize changes related to PTG as subjective, in client's perception; (4.2) I conceptualize changes related to PTG through my own clinical judgment and (4.3) I conceptualize changes both as subjective, through the client's perception and as objective, through my own clinical judgment.

(4.1) I conceptualize changes related to PTG as subjective, in client's perception -Three therapists indicated that they conceptualize PTG as subjective, in the eyes of the clients. For example, therapist 7 described her view of clients' perception, suggesting that PTG is internal.

> *"I am looking in the lens of clients … I would follow the client perception whether or not I see*
>
> *it… a lot in PTG is hard to observe. It's internal"*

(4.2) I conceptualize changes related to PTG through my own clinical judgment - One therapist, therapist 3, indicated that she viewed PTG through her own clinical judgment. This may indicate a view of a PTG as it can be observe in external changes:

> *"I am more aware of positive changes than clients. Some of the clients I work with, I might share*
>
> *something that I see and they don't…"*

(4.3) I conceptualize changes both as subjective, through the client's perception and as objective, through my own clinical judgment.

This sub-theme addresses the concept of PTG as a positive belief versus 'a true change.' It also reflects therapists' views regarding whether PTG is an internal phenomenon (reported by clients, and experienced internally -e.g. emotions and positive beliefs that are not necessarily viewed by others) or an external one

(viewed externally by visible change –'true change'-e.g. behaviors, actions). Four therapists reported understanding PTG as both subjective, or in the client eyes, and objective in their own eyes. This may demonstrate views of both internal and external changes, or "true changes" and "positive beliefs".

Therapist 6 described these twofold views of PTG:

> *"We both acknowledge (PTG) If the clients are not noticing it…and I see it… I will bring it up, but often they do, and they will tell me, they notice the change like I had sex and it was fun".*

(5) View of well-being

Growth is seen as an important component in well-being. Sub-themes included (5.1) Well-being is about happiness and growth and (5.2) well-being is about growth.

Therapists' responses may reflect here similarly to the last theme, the notion that the concept is subjective and internal or external and objective.

All eight therapists identified different aspects of well- being. External factors included clients' awareness of their surroundings and relationships, and attending to needs hierarchically (like the Maslow scale). Internal well-being factors included positive emotions towards self, distress tolerance and self-awareness.

(5.1) Well-being is about happiness and growth- Five therapists included both aspects of happiness/fun/joy and growth in their definition. Their definition fits more the hedonic approach to Subjective Well-Being (SWB) and emphasizes striving for pleasure (Diener, Suh, Lucas, & Smith, 1999).

Therapist 5 describes well-being as having more positive aspects than negative:

> *"Well-being- a sense that life has meaning and that relationships are nourishing more often than not, I know what I feel and want and think and be able to communicate about those, I have capacity to have joy and play more often than not"*

Therapist 4 describes satisfaction, trust, humor and play as aspects of well-being:

> *"Well-being springs from a good relationship with the self in which one gets good and meaningful messages interoperates with them, acts on them and expresses satisfaction and trust in self… there is stability …also play and humor… (Well-being is) a capacity to yearn, and accept nurturance and being able to provide it."*

Five out of eight therapists also included meaning making in their description of well-being.

(5. 2) Well-being is about growth- Three therapists indicated that well-being is different from happiness, which provides support for the definition of the eudemonic approach to Psychological Well- being. For example, therapist 8 distinguishes between happiness and growth in her description of well-being:

> *"Well- being- (is) distinguished from happiness- (it is) defined as a sense of peacefulness, contentment, health mental, physical and emotional, satisfying relationships, impacted by external factors, but it's not solely determined by external factors. Even with difficult external factors (one) can have a sense of peacefulness".*

All eight therapists indicated importance of meaning or purpose in factors such as jobs, relationships, and reasons for living. For example, therapist 7 describes well-being as achieving beyond the basic needs for stability, to growth that is described by meaning, and purpose. She uses the example of Maslow's hierarchy needs: Maslow used hierarchy scale that included the terms Physiological, Safety, Belongingness and Love, Esteem, Self-Actualization and Self-Transcendence needs to describe the pattern that human motivations generally move through (Maslow, 1958).

> *"Externally for well- being (people need) some sort of work, volunteer, hobby, something that gives purpose or meaning, your calling, a huge piece of Maslow's hierarchy. People need good nutrition, roof, good health care, safe environment and neighborhood, having community family, social support, others you can go to, Internal - huge one is the ability to tolerate distress, sit with it, be ok with it, have emotional strength or flexibility, realization that emotions can come and go and they don't define who you are…good personal boundaries, ego strength where you end and the other person begins. … capacity to feel positive emotions like love, gratitude…feeling that life is worth living, to be enjoyed in life. I can contribute, I can give back- that's the core…I have a purpose".*

(6) PTG enables thriving, in spite of trauma- All eight therapists discussed the importance of PTG as important not only for healing, but also for progressing and growing beyond who they were prior to the trauma. All therapists emphasized the importance of listening not only to the trauma, but also the growth.

Therapists discussed witnessing clients experiencing enhancement of positive cognitions and a wholeness of body and mind via more helpful thoughts, feelings and actions. Therapists also described the impact of PTG on themselves as therapists.

Therapist 2 stated that the reason she works in the field of trauma is to thrive, in spite of the pain and traumatic symptoms:

> *"That's (PTG) the reason why I'm a therapist specializing in trauma. When we deal with so much difficulty and pain we can still thrive. Trauma is not rare; it is not exception to the rule. PTG - that's the question- what can we do in life so we can live life, not just to not have symptoms ... but also to create, love our family and do something in community."*

Therapist 3 describes that the hope that characterizes PTG enables moving forward in the aftermath of trauma*:*

> *"The importance of PTG is hope. I see importance in room for improvement, ability to move forward in one's life even though there is a sense of loss or fear... I view it as acceptance, letting go, hope, moving forward, new perspective, new appreciation, new ability and personal growth."*

Throughout the interviews, some overarching themes emerged that did not fall under a specific category and recurred throughout the established categories. These themes are: (7) Meaning making; (8) Trauma-informed treatment may contribute to PTG; (9) PTG can continue and progress over time

(7) Meaning making- All eight therapists discussed PTG as enabling transformation of the trauma into meaning. They described the meaning in different ways, including "becoming an advocate or a role model for other trauma survivors", "pursuing dreams – travelling, writing a book", "finding God".

Therapists 1 and 5 discussed meaning making in general, as well as ways to create meaning after the trauma.

Therapist 1 described meaning making via bodily well-being" or "somatic well-being:

> *"Trauma makes people look at the meaning of life and how to actualize it...I'm a huge fan of Victor Frankel and view growth and change in his models of trauma in connection to meaning, meaning in the smallest things that can help with healing from trauma and growth ...people feel*

more free… they pay more attention to physical well-being. Before they didn't exercise and eat

well, when they are in growth, they are very attuned with their body".

Therapist 5 describes meaning making via engagement with life and developing new roles and purpose:

"The existential piece… you need a capacity to engage in life…It's the person's capacity to

change the trauma into something else, a hobby, a new role, a different view of life and self,

finding a purpose".

Therapist 6 addressed spirituality as an example that reflects finding meaning:

"(Clients') hearts could break open, they can go through unbelievable grief and pain and then they get

God back or a different spirituality which they lost, they begin to feel worthy".

Therapist 8 described her use of the concept of PTG for self and in therapy:

"I have worked and am working with lots of trauma survivors… I also had trauma that connected

with homophobia, and this informed my view for self and in therapy as well. Very important…

highlighting when it's happening, the realization that one can help someone across the

country…a sexual abuse survivor that can help many others that have been through the same

thing, by becoming an advocate. This shift sense of self…

(8) Trauma-informed treatment may contribute to PTG- Five out of the eight participants described the

use of trauma-informed treatment as being helpful in the promotion of PTG. Therapist 1 described the use

of Eye Movement Desensitization Reprocessing (EMDR) as contributing to PTG:

"In EMDR, clearing negative cognitions and connecting with positive cognitions… the body

wants balance, the body will find a way to grow and change. They may find by themselves that the

mind won't allow them to do things that are unhealthy. I say to people, I may tell them "this

sounds rough, but with the process you may see the gifts that trauma gave you, like seeing things

more clearly, being in touch with others, feeling yourself as a strong person even though right

now it's hard for you to imagine that. I weave it into what someone might expect from a good

trauma therapy".

Therapist 2 described the use of psychodynamic theory for an understanding that facilitates choice and growth.

> *"The way things that have occurred (in the past) affects what happens now, affects cognitions, emotions and behavior. A person can have understanding that generates illumination of a choice. Instead of feeling this is the way this has got to be, it's about making things conscious, with understanding, there is a choice….the choice was not there before… when it's there, growth can occur".*

Seven out of eight therapists indicated that they do not "push" the idea of PTG on clients; rather, they notice and reflect it when clients exhibit it. Therapist 7 discussed the use of PTG in therapy:

> *"It is very important; they come in the end of the rope, mad at the system, may not want to be here, and not always open to it (PTG). Despite it, people still say PTG is happening and it's a blessing, when they are faced with mortality, they are more open to PTG. I never push this idea or put it on them, I'm listening for it when it comes"*

Therapist 8 described that she looks for opportunities to highlight PTG, but does not force the issue:

> *"I'm looking for opportunities when it might happen. I do not push it, but I offer it when I see it as an opportunity, I highlight changes that I observe in terms of their own trauma or selves."*

(9) PTG can continue and progress over time-Six therapists addressed the importance of time in PTG. They indicated that for many trauma survivors, in order to get to growth, where the trauma is severe and lasting (e.g. lasting sexual abuse), passing time is a factor. Therapists working with EMDR, for instance described that working with clients who experienced chronic traumas, often with combination of other adversities (e.g. attachment issues, poverty, racism) may need more time in therapy to heal and grow. Therapist 6 describes that it may be a long time before PTG appears:

> *"With EMDR, it takes several years for growth to occur if it's a major trauma, it's hard to see the growth, but many times you see the growth, for example you see it in gratitude…"*

DISCUSSION

In recent years there has been an increasing interest by scholars and researchers in the concept Post Traumatic Growth. Researchers are attempting to trace the phenomenon of positive changes that result from traumatic experiences. PTG is expressed internally as changes in emotions and cognitions and externally as changes in behaviors or ways of functioning. It is a challenge to understand and try to decipher the complexity of this concept. This research aims to examine the definition, the characteristics and expressions of PTG in the eyes of clinicians who are experienced in the field of trauma.

The research focused on the general conceptualization of trauma experts-therapists in addressing PTG factors, relying on the PTGI, considering resilience and well-being and examining whether PTG reflects positive belief or a 'true' change. This study is qualitative, using Grounded Theory with sensitizing concepts from the literature and the assumption that trauma experts are able to identify the presence of PTG or positive changes in their work.

Main findings

View of Resilience versus PTG. Although the literature review used in this study addressed resilience as recovery and absence of traumatic symptoms, the therapists were not given that definition. They were rather asked about their own definition of resilience. Therapists gave different definitions for resilience; however all reported viewing resilience as different from PTG signifying either the ability to recover or a state. These facts are consistent with Almedom's (2005) review of the concept of resilience by addressing different researchers, indicating that according to some definitions it is addressed as recovery-"rebound from crisis" and according to other, resilience is a state (e.g. a sense of coherence or self-efficacy), and with Westphal & Bonanno's (2007) view of PTG as different from resilience. PTG in this study was defined by the participants as achieving something new, progressing and thriving and not merely recovering. Some therapists suggested that resilience can be the platform for achieving PTG. Resilience enables return to functioning. It includes developmental pathways and predisposing behaviors and attitudes that buffer the effects of the trauma (Masten, 2001). The distinction between PTG and resilience

is consistent with viewing of absence of PTSD as different from PTG and the finding of co-occurrence of PTG and traumatic symptoms (Laufer & Solomon, 2006).

Meaning Making. This overarching theme was connected to PTG in fulfilling, becoming advocates for other survivors of the trauma that clients have survived and helping others. PTG was seen as not only by overcoming the trauma, but also as thriving in spite of the trauma. Hooyman & Kramer (2006) discuss their personal reflections on grief, and the mix of constant fear of something happening to loved ones with having the urge to move forward, affirm past loves, and benefit from opportunities to learn and to grow. Denham (2008) discusses the transition from being a victim to becoming a survivor by meaning making. It seems that PTG may be the concept that reflects this transition. PTG can be manifested in the ways that were indicated by therapists such as art, writing a book, becoming an advocate. This is the "survivor mission" that Herman (1997) discusses. One therapist indicated that with preexisting vulnerabilities, PTG is higher; this confirms the idea that PTG may require meaning making which may occur only in the presence of a more severe level of trauma. This confirms that notion in literature that although some level of resilience is needed for trauma recovery, high resilience may hinder PTG by preventing what appears to be the pain necessary for PTG to grow. Westphal & Bonanno (2007) argue that many if not most people have resilience in the face of trauma and that high levels of resilience typically provide little need or opportunity for PTG. Laufer & Solomon (2006) indicate that it is possible trauma needs to be severe enough to result in post-traumatic symptoms in order to activate processes of meaning making that appear to be central components of PTG. Therapists in this study indicated that PTG may be the result of a process that takes longer to occur than resilience. This is another indicator of the difference between the two phenomena. Other studies confirm that in contrast with resilience, PTG may be noticed only in the long run (Powell, Ekin-Wood & Collin, 2007).

Conceptualization of PTG as subjective and objective. Another important finding of this study is the conceptualization of PTG as subjective. Only one therapist indicated that she views it mostly objectively. It is interesting to note that this therapist holds this perspective even though she is an interpersonal cognitive behavioral therapist. Her over-arching model is one that relies heavily on objective phenomena,

which may have influenced her perceptions of PTG. However it is interesting that the other two self-identified cognitive behavioral therapists in this study did not view PTG as objective only. Most therapists viewed PTG as either subjective or both subjective and objective. Therapists in this study also indicated that PTG can be seen both as 'big' (changes can be seen externally) and 'small' (changes are internal, and cannot be seen externally). They indicated that internal changes may be realized as self enhancement or positive belief.

This notion of different aspects of PTG may be an important insight for understanding this phenomenon. These therapists may have unintentionally uncovered a response to the question of whether PTG is merely positive belief or a true change. These therapists tended to perceive it as a positive belief, either primarily subjectively felt by clients or having both internal and external expressions. A positive change in sense of self was ranked second among PTGI factors. This perception of the ways in which PTG affects trauma survivors may also be connected to the construct of self enhancement and to the importance of positive belief as aspects of PTG.

This particular set of finding is inconclusive as there was sufficient variability among the participants in this study as to preclude one clear theme from emerging. It seems that these study findings lean more towards positive belief than true change. For example, therapist 2 discussed different feeling with same behavior*: "still doing the same things, but feeling different-feeling more love and joy and grateful and appreciation…"* Hobfoll, Hall, Canetti-Nisim, Galea, Johnson &Palmieri's (2007) dismiss some forms of reported growth as illusory. In contrast, this study may demonstrate evidence for the adaptive value of self-enhancing or positive belief in coping with trauma similarly to evidence in other studies (Westphal & Bonanno, 2007). According to Luthar (2006), self enhancement can promote well-being even if it is a bias, which leads to a conclusion that even if PTG is based on positive belief it has value. An important question emerging from these findings is not whether it is, in fact, important to know whether PTG is "real" or "illusory," (positive belief) or rather, how it is experienced in the lives of survivors of trauma and their therapists. The objective/subjective question is, ultimately, one that requires

the imposition of categories that may not fit well into the experience of trauma that affects an individual on so many dimensions of functioning.

Other findings

Relationship seems to be important factor in PTG. It was ranked first in importance of the understanding of PTG by the therapists in this study. Although the ranking was done by a small sample and all therapists indicated that all factors are important, it seems that this finding confirms other studies that emphasize the importance of relationships including the therapeutic relationship. Herman (1997) describes the blossoming of friendships in the Nazi death camps. He says, "A loyal body… relationship of mutual sharing and protection, leading to the conclusion that the pair, rather than the individual, was the basic unit of survival" (p. 91-92). This emphasized the healing force of relationships.

Therapists indicated that culture and spirituality, both of which are relational phenomena, are important to PTG. Some therapists indicated that class and culture are preconditions to PTG and some indicated that these aspects change or develop when PTG occurs. In any case it seems that these may be important components of PTG. Denham (2008) discusses the 'rock culture', which is the values, customs, traditions and memories that guide a community (e.g. heritage, traditions of specific spirituality, religion or community). It seems that addressing the 'rock culture' of each client can be essential aspect of PTG.

It is possible that the theoretical orientation of the therapists impacted the view of the importance of class and culture. For example, therapist 5, who is working from a feminist therapy perspective, indicated the importance of culture and class:

> *"We have multiple and intersecting identities- aspects of how we define who we are ...our guiding culture and social class ...very much a part of construct of how your PTG looks like"*

However viewing these aspects as important was not limited to these lenses, as can be seen from the following example from therapist 1 that practices neurobiological, interpersonal therapies.

> *" more connection to healthy aspects of culture ...family culture, the country they live in and lived in, cultural identities, the person will have more understanding how the culture in their lives impacted what happened, broader understanding of the culture helps with self-blame, helps them*

have more compassion to themselves, helps them have connection to the healthy aspects of their

culture…say the family wasn't the nest culture for them, some of the growth will be: `I'm not

going to spend that much time in that aspect of culture, but I can develop a family with a broader

sense of culture- my town. My country, my people`"

PTG may be applicable in addressing 'isms'. Therapists indicated that PTG is also connected to "isms" (e.g. racism, sexism). For example one of the therapists indicated that going through micro-aggression and heterosexism informed her trauma practice and impacted her recognizing PTG in others after going through PTG on her own. This may show the relevance of PTG beyond the scope of trauma to broader "isms" and micro aggressions (Hays, 2010). Norcross, Beutler & Levant (2006) discuss not only the need for empirical validations or clinical expertise but also considerations of clients' values and preferences. (Berzoff, 2012; Segal; 2102, Mattei, 2012; Bennet & Rizzuto; 2012; Dasteel, 2012; Orzolek-Kronner & Desimone, 2012; Cohen, 2012) raise the significance of ethnic and cultural variations in addition to addressing issues such as discrimination against people with disabilities. In order to address trauma outcomes including PTG, it seems important to address cultural aspects as well as aspects of discrimination in future studies.

Well-Being. The therapists in this study indicated that well-being, both hedonic and eudemonic varieties, could emerge from PTG. This was consistent with Luthar's findings (2006).

PTGI. The interviewees indicated they found the requirement to rank the PTGI factors difficult, and that such ranking did not fit their way of thinking about PTG. At the same time they indicated that all of the PTGI factors were important. These may indicate that the organization of the PTGI is not part of their way of thinking, which would be consistent with the fact that it is used almost entirely as a research instruments and not integrated into the work of practicing psychotherapists, even those who are quite familiar with that body of research. Alternatively, it may indicate therapists' need for flexibility, and that their work does not organize around the factor structure of a research instrument.

LIMITATIONS

It is the nature of qualitative research to have limitations. It is not intended to generate objective, generalizable findings. Rather, the qualitative researcher is transparent about her/his identities and how those both inform the conduct of the research as well as the ways in which participants' responses are coded. Grounded Theory exists to assist researchers in moving from the qualitative to the quantitative realm (Auerbach & Silverstein, 2003). The entire construct of limitations is grounded in quantitative frames of reference. In this instance, the researcher is herself a person who has experienced trauma exposure, and who is the granddaughter of Holocaust survivors; she is a therapist with trauma survivors. A snowball sample was utilized, ensuring that most of the participants knew at least one other person in the study. These findings are thus exemplary of qualitative research; they provide a rich base of data from which theory can be developed and quantitative questions asked.

According to Patton (2002) snowball sampling gets bigger and bigger as the investigator accumulates new information. Although this is a small sample, rich information was collected. Some of the answers began to sound similar from one participant to another, indication of theoretical saturation. Without restrictions of time, the sample would have been bigger, possibly resulting in richer, more heterogeneous findings. Nonetheless, this is a standard sample size for a qualitative study (Auerbach & Silverstein, 2003) in which representativeness is not desirable. The data offer insights based on a wide variety of clinical experience, but several major therapy theories are not represented by this group. There is also a large gap between the least experienced therapist (13 years) and the most experienced one (40 years), which might contribute to some differences in how these women responded to the questions. There was also some important variability across the types of trauma that these therapists saw, e.g., health trauma versus childhood complex trauma.

These findings might be enriched by initially including therapists from other geographic locations, and therapists who work with a wider diversity of ethnicities and cultures. For example, it might be intriguing for this researcher to conduct a similar study with therapists in her home country, where certain kinds of trauma exposure are ubiquitous, and contrast those with the findings of the current

research. While all participants contributed two names of other therapists, some repeated the same names that were already suggested. The use of 'snowball recruitment' may have the effect of generating participating who are already quite similar to one another in terms of common theories and practices, common culture, etc. Other methods of recruitment, intended to enlarge the spectrum of therapists' characteristics could be utilized if there were a longer time frame available in which to conduct the research. A demographic questionnaire including culture, race, ethnicity, religion, spirituality and class of the therapists would have facilitated understanding of the level of correlation between the interviewees; however such demographic questionnaire was not utilized, as this would have been inconsistent with the qualitative nature of the study.

There is potential subjectivity and bias in this qualitative study as only one person conducted and coded the interviews. The presence of a second coder is preferable, and would be useful were there more time available in which to do this work. The thesis chair was consulted in order to reduce these risks through providing assistance creating the interview guide, which was also reviewed by Division of Human Subjects (DHS) and the coding process was also monitored by thesis chair. Because the researcher was limited to DHS, she could not ask follow up questions beyond the scope of the interview guide, that would have enable deeper understanding. Also the researcher was limited to ask only about the general perception of the interviewees and not about specific clients

IMPLICATIONS FOR SOCIAL WORK PRACTICE AND RESEARCH

This study illustrates the widely varying conceptualizations of Post-Traumatic Growth as well as other concepts that affect and connect to it. Time restrictions limited the scope of the study findings to get a wider, richer picture of the notion of PTG. Further study is needed to focus attention on PTG and explore how therapists use it and how this concept can be used in therapy. The fact that the majority of therapists interviewed were not familiar with the term "PTG," even though they are all perceived by peers as expert in working with trauma survivors, demonstrates how much this construct needs to be actively introduced to practicing social work clinicians.

Only three of the therapists in this study knew the term- Post Traumatic Growth. However, all therapists in the study indicated that they had been able to observe positive changes that occur following trauma in their work. Although they were able to identify PTG without knowing of its formal existence, it is possible that naming it and knowing it in a formal way may cue therapists to look for it and their work, and introduce the construct to their clients. It seems that this is especially important in the training of new trauma therapists or therapists in general as well as social workers and other professionals who work with survivors of trauma.

The theme that emerged from this research of the tension between the "Objective and subjective view of PTG" suggests that helping therapists to think about clients in terms of positive belief versus 'true change' may be important in understanding PTG. It may also be helpful to clinicians to rethinking concepts of self- blame and attribution of responsibility and how to address them in trauma not simply as negative effects, but also as forms of coping with trauma. It would be beneficial for therapists to be more aware of what information about PTG would enrich the life of trauma survivors in a meaningful way.

The study included therapists using wide range of therapies and theories. The core of PTG as defined in this study was based on the PTGI. These research-derived factors were confirmed as important by all therapists. Therapists also added other factors such as creativity and having a healing model (e.g. therapy, art, spirituality. Therapists indicated the importance of listening for PTG in contradiction to "pushing it". This strengthens the notion that PTG may be connected to self enhancement and positive belief of the client, as the client needs to notice it on her or his own initiative and time frame. Therapists indicated the importance of being attuned to their clients and avoid coercing the therapist's view on them. It is up to the clients to acquire their own positive view of self and others, and that therapists, while serving as mirrors, cannot insist that clients adopt a more positive view of themselves until they experience the readiness to do so.

In recent years there has been a transition in the various mental health disciplines from looking for pathologies to viewing strengths and positive aspects, as the field of Positive Psychology has emerged and developed. Similarly, strength- and-competency based views of clients, such as feminist and narrative

therapies, have emphasized that not all responses to adverse life events are forms of pathology (Brown, 2007; White, 2007). The construct of PTG situates itself within these emerging models of human beings, even those in distress, as capable copers.

It is also important to be attuned to clients values, priorities and context and not force "looking at the bright side" when clients do not perceive that such a bright side exists. As the interviewees indicated, and according to the stages of change model, readiness can be crucial for certain kinds of movement in therapy to take place (Miller & Rollnick, 2013). Many of the therapists in this study indicated that it was their experience that it may take a long time for clients to notice and demonstrate PTG.

The concept of PTG has importance for the work of clinicians, researchers and scholars. In addition, there is importance of identifying PTG at a systemic level, not only in individuals, rather also among families and communities and to consider ways that may assist enable the development of PTG in micro, mezzo and macro levels. Specifically, policy makers should be convinced to allocate enough resources for the therapy process, to enable PTG to set in and develop. They should also be convinced to allocate the kinds of resources to communities that allow them to recover fully from trauma, rather than re-traumatizing and betraying communities as has, for example, occurred in the aftermath of Hurricane Katrina.

<div align="center">NEXT STEPS</div>

Next steps should include further investigation of PTG and its application in trauma treatment, perhaps using samples of therapists from a variety of cultures, ethnicities and gender orientations. It is important to conduct a study investigating how trauma survivors themselves, both those who are therapy client and those who are not, perceive the concept PTG. It is also important to explore how to train future therapists in recognizing and identifying PTG, Finally, it will be useful to develop a quantitative study deriving from the conclusion of this study.

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APPENDIX A

PTGI and SF-PTGI

PTGI consists of 21 items. The SF-PTGI comprises a subset of these items. SF-PTGI was found to provide almost the same information. Following is a complete listing of PTGI items, each accompanied with an indication whether it was included in SF-PTGI or left out.

PTGI versus SF-PTGI:

PTGI:

1) Relating to others - knowing that I can count on people in times of trouble; A sense of closeness with others; A willingness to express my emotions; Having compassion for others; Putting effort into my relationships; I learned a great deal about how wonderful people are, I accept needing others.

2) New possibilities - I developed new interests; I established a new path for my life; I'm able to do better things with my life; New opportunities are available which wouldn't be otherwise; I'm more likely to try to change things which need changing

3) Personal strength - A feeling of self-reliance; Knowing I can handle difficulties; Being able to accept the way things work out; I discovered that I'm stronger than I thought I was

4) Spiritual change - A better understanding of spiritual matters; I have stronger religious faith

5) Appreciation for life - My priorities about what is important in life; An Appreciation for the value of my own life; Appreciating each day.

SF-PTGI:

1) Relating to others- I have a greater sense of closeness with others; I learned a great deal about how wonderful people are.

2) New possibilities - I established a new path for my life (same item as in PTGI); I am able to do better things with my life.

3) Personal strength - I know better that I can handle difficulties; I discovered that I'm stronger than I thought I was (same item as in PTGI).

4) <u>Spiritual change </u>- I have a better understanding of spiritual matters (same as PTGI); I have a stronger

religious faith (same as PTGI).

5) <u>Appreciation for life:</u> I changed my priorities about what is important in life; I have a greater

appreciation for the value of my own life (same as PTGI).

APPENDIX B

Table 1 - participants' theoretical orientation

Theory / Therapist →	1	2	3	4	5	6	7	8
inter-relational- neurobiological	*			*		*		
Psychodynamic		*						
interpersonal -cognitive behavioral			*				*	*
Strategic				*				
positive psychology							*	
feminist therapy					*			
family system				*				
Accelerated Experiential, Dynamic Therapy (AEDP)						*		
somatic theories				*		*		
Existential theory							*	

APPENDIX C

Table 2- Participants' years of clinical practice experience and kinds of trauma

Kinds of trauma/Therapist→ Years of experience→	1 23	2 20	3 14	4 33	5 40	6 31	7 13	8 16
Physical abuse	*	*		*	*	*		*
Sexual abuse (e.g. childhood sexual abuse, sex trade victims, military sexual trauma)	*	*		*	*	*		*
natural disasters	*					*		
Hate crimes/trauma -LGBTQ clients homophobia trans phobia/oppression trauma /workplace violence	*				*	*		*
Combat trauma	*	*		*	*	*		
Torture/prisoners of war	*			*				
Accidents	*	*		*	*	*		
Health related trauma (e.g. life threatening illness such as cancer, HIV in the past, mescal-skeleton injuries, brain injuries, spinal cord injury, cancer, mutation, amputation)	*		*				*	
Emotional abuse \neglect	*	*		*	*	*		*
International persecution trauma (e.g. refugees)				*				

RESEARCH INTERVIEW GUIDE AND CONSENT FORM

Overall question:

How do therapists who specialize in trauma treatment, understand (or define) PTG or positive changes?

Detailed Questions:

1. In your work as a therapist, do you take into account positive changes that result from trauma? If so, how?

2. In what aspects of functioning or living have you seen PTG or positive changes?

3. What would you see as PTG in each of the following areas of functioning?

> a. Emotions
>
> b. Behavior
>
> c. Cognitions

Please provide an example of each without disclosing confidential client information

4. Is there a difference between the concepts of resilience and PTG/positive changes? If yes, what is the difference? If no, what does the concept of PTG/positive changes add to your understanding of resilience?

5. What is the relationship between symptom reduction and PTG/positive changes? How does this relationship affect your work with clients?

6. Do you view changes as subjective in the perception of the self and/ or in your own view? Please describe.

7. Which of the following factors/ elements/dimensions are included in your understanding of PTG or positive changes? How are they included?

> a. Culture
>
> b. Social class
>
> c. Spirituality and spiritual change
>
> d. Pre-existing vulnerabilities
>
> e. Perceived changes in self

      f.   A changed sense of relationships with others

      g.   A changed philosophy of life

      h.   New possibilities (e.g. new interests, opportunities)

      i.   Personal strength

      j.   Appreciation of life

      k.   Other

8.   Please rank each of these factors in terms of how important each is to understanding PTG. Rank 1 as most important, 2 as second most important, , 3 as third most important, etc.

9.   Do you define well-being in relation to factors external to the individual internal to the individual?

10.   What is your primary theoretical orientation for trauma therapy?

11.   How many years have you worked as a trauma therapist? Which kinds of trauma have you treated?

In your practice, what is the importance of the concept of post traumatic growth? Please describe.

INFORMED CONSENT

Researchers' statement

You are asked to participate in a research study examining trauma experts' thoughts regarding the nature of and relevance of the concept of Post Trauma Growth (PTG) or on the notion that positive changes may occur to individuals who seek therapy to deal with trauma. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not.
Please read the form carefully.

You may ask questions about the purpose of the research, the nature of the interview you will be given, the possible risks and benefits, your rights as a research subject , and anything else about the research or this form that is not clear prior to participating in the interview. When all your questions have been answered, you can decide if you want to be in the study. This process is called "informed consent." You

may request a copy of this form for your records. This research is voluntary and trauma therapists have the choice of to participate in the research or decline to participate

Purpose of the study

The study examines the concept of PTG or positive changes in trauma therapy clients as these are understood by experienced therapists. The research may reveal new unique and rich insights about the nature, relevance, and components of the concepts of post therapy traumatic growth and well-being.

Results should be useful to researchers, other scholars, and therapists in thinking about and using these relatively new concepts in the trauma field.

The research conductor

Michal Keidar an MSW second year student and is doing this research for her thesis in the University of Washington.

Study Procedures

This study is conducted by interviews. Trauma therapists are asked to answer a series of y open ended questions and to evaluate specific dimensions of PTG and client well-being. Questions seek to understand how therapists conceptualize PTG and well- being in their therapy with clients. Each therapist participant is interviewed alone with the researcher. Interviews are audio taped. No identifying information is included in the interview or attached to the audio tape. Consent forms are kept separate from the audiotapes and transcriptions. Once transcribed the audio tape is destroyed. Each tape and transcript is identified by the gender and years of experience of the therapist (e.g. female 15 years) Interviews will take 30-60 minutes with no further obligations.

Possible risks and discomforts

The interviews will be done by audio recording that will be destroyed after data are collected. Only the researcher will have access to the recording and confidentiality will be kept. The signed consent forms which are the only information collected which identifies subject participants will be kept in a locked cabinet separate from audiotapes and transcriptions. The research will not reveal any information about

clients or any identifying information about therapists. If therapists mistakenly reveal identifying

information about themselves, their location of practice, and make any reference about a specific client,

the tape would be stopped and reversed to a point in the interview before the revealing responses were

made. The interview will resume from that point in the interview. Revealing part will be erased and only

then the interview will continue. Low Stress and emotional discomfort might result from participating in

this study. If the participant feels distress during the interview, that participant is requested to inform the

interviewer immediately and the interview will be stopped.

Benefits from taking part in this study

By participating in this study, participants have the opportunity to provide 'inside' perspectives to their

unique experiences and points of view regarding the use of PTG and well-being. This potentially may

sharpen their own thinking.

Other information

You may refuse to participate and you are free to withdraw from this study at any time obligation. All of

the information you provide will remain confidential. Information will be aggregated across interviews.

Your identity and location of practice will never be identified. By willing to participate in this study, you

acknowledge that this study has been explained to you. You hereby volunteer to take part in this

research. If you later have questions about the research, you can ask the researcher. You will be given a

copy of this form from the researcher.