NEWSLETTER

CPA TRAUMA Section

CANADIAN PSYCHOLOGICAL ASSOCIATION

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Dear members of the Traumatic Stress Section:

I invite you to read the new issue of our newsletter and reflect on the qualities of a therapist, vicarious traumatisation, protective factors, and a measurement of traumatic growth. You are welcome to give us your feedback and to advise us of any related news, upcoming events, job listings and recent publications you would like to be published in the next newsletter.

Please do not hesitate to contact the executive committee members of CPA TSS as we remain committed to serving your needs and interests.

Alain Brunet, Chair

In the middle of difficulty lies an opportunity.

Albert Einstein

Amidst the biggest 'storm' in our life and in its aftermath in its aftermath there lies an opportunity to grow and thrive, defying the strongest impact of destructive forces.

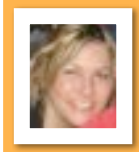
One of the brightest examples of such success is Warren Macdonald, an avid outdoor adventurer, whose fascinaing jorney is featured in this issue of the CPA Traumatic Section Newsletter. Inspired by his remarcable story, we dedicate this issue to the professionals on the front line of making changes in people's lives and to the concept of posttraumatic growth as a reflection of genuine change.

Team & Section News

By Anne Dietrich & Alain Brunet

Our Team

Alain Brunet, PhD
Chair

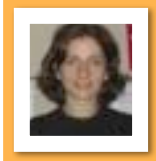


Anne Dietrich, PhD

Past Chair

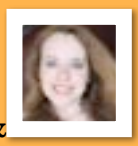
Colleen Hanley,

PhD, Treasurer par interim



Deniz Fikretoglu

PhD, Treasurer



Laura Armstrong &

Nick Carlton

PhD candidates, Student representatives

The executive committee has been actively involved in a number of activities in the recent months.

ISTSS Affiliation

In 2007, Dr. Danny Kaloupek of the International Society for Traumatic Stress Studies (ISTSS) contacted Dr. Dietrich regarding potential affiliation between the ISTSS and our TS section, and they had a meeting in November of 2007. Drs. Brunet and Dietrich met with Drs. Kaloupek and Schnyder (President of ISTSS) in 2008 and plans were made to submit an application for affiliate status. We have recently submitted a formal application for affiliate status with the ISTSS (www.istss.org) and it is currently being reviewed by the ISTSS Board of Directors.

The ISTSS is a large, non-profit professional organization devoted to advancement and exchange of knowledge about trauma and severe stress. Members of ISTSS include psychologists, psychiatrists, social workers, nurses, counsellors, administrators, researchers, advocates, journalists, clergy and others who are interested in the study and treatment of traumatic stress.

The society publishes the *Journal of Traumatic Stress,* its newsletter *Traumatic Stresspoints*, and has published PTSD Treatment Guidelines (Guilford Press). It is engaged in professional and public education and holds an annual conference each Fall.

There is a variety of organizations with affiliate status with the ISTSS, including trauma societies from Africa, Argentina, France, Australia, Germany, Europe and Japan. ISTSS and the affiliated organizations are partnered with the aim of advancing the field of traumatic stress worldwide. A representative of each affiliate may serve as an ex-officio member of the ISTSS Board of Directors and vice versa.

Benefits of Affiliation: Affiliate members receive reduced ISTSS membership dues, reduced conference registration fees and access to ISTSS publications (*Journal of Traumatic Stress*; *Stresspoints* newsletter, etc.). Dr. Dietrich arranged for one of the ISTSS board members, Bessel van der Kolk, to speak at one of our Annual Meetings. In the future, additional trauma experts from the ISTSS will be invited to speak on behalf of the Traumatic Stress section at future CPA conferences.

Conference

Dr. Brunet organized an International Conference on the Use of the Internet in the Field of Mental Health, and the Advanced Research workshop 'How the Internet can help individuals cope after a Traumatic Event' in May of 2009 at the Douglas Mental Health University Institute. There were 160 people from 17 countries who participated at the conference. The video recordings and Power Point slides of the presentations are available free of charge at http://www.douglas.qc.ca/teaching/internet/program.asp?l=e&

Participants learned about the development of projects using the Internet in mental health and particularly in the field of post-traumatic stress disorder. disseminate this knowledge, organizers decided to publish a book with the chapters written by key-

Section News Continues

note speakers (with IOS Press). The book is in preparation and will be published in December.

Website
The Traumatic Stress Section website (http://www.cpa.ca/sections/traumaticstress/) has been vastly improved and maintained. The following sections have been added: Basic Information on Traumatic Stress; Where to get help; Resources and Networks for Professionals; Web-sites and Online Networks for trauma survivors; Online videos on trauma; Newsletters and archives; Upcoming events; and Contact information. If you have not visited the website recently, please take a look.

Wine & Cheese
The CPA TS section held the Section Business Meeting with a Wine & Cheese event at the CPA conference in Montreal in June 2009. Members of the CPA Board of Directors were also present at the event. following the name change.

Current Membership
The number of current members is 259, approximately 80 of these are students.

Student Column

A brief student perspective on next-steps in trauma investigation

By Nick Carlton

The focus on negative sequelae following a trauma is pervasive for good reason. Traumatic events can precipitate maladaptive changes to cognitions and behaviours that cause distress and dysfunction throughout a person's life. Fortunately, relatively few people who experience traumatic events also endure such globally negative consequences. As such, explorations of positive or neutral traumatic sequelae may also be well warranted. Typically referred to as posttraumatic growth, significant positive changes can be motivated by traumatic stressors, therein resulting in an overall benefit to the individual. For example, the traumatizing accident or illness that motivates better lifestyle choices. In no way should this be taken as an endorsement for traumatic suffering; instead, posttraumatic growth provides potential avenues for facilitating recovery by granting people hope. Perhaps ironically, current and future trauma therapists may benefit personally from studies into posttraumatic growth as much as trauma survivors.

Evidence that even the most traumatized and distressed individual can recover - having learned from their experiences and found new ways to embrace their life thereafter - is likely to be a powerful motivator for those who choose to help others to work beyond trauma.

Accordingly, new investigations of models for posttraumatic offer promising and uplifting avenues for trauma research that should be explored.

A New Perspective

As the page was turned on the 21st century more and more researchers and practitioners aligned their efforts with the concept of recovery, wellbeing, integration and adaptation of mental health consumers opposed to the concept of cure from disease. The advent of positive psychology propelled a more positive outlook on the phenomenon of the therapeutic relationship. In an effort to help clients recover and realise their potential it is easy to forget that the practitioners themselves become affected in the process. The first article by Richard Harrison identifies the practices that protect practitioners from vicarious traumatisation and burnout, as well as delineates qualities of a successful therapist. The second article by Robert Fazio presents a concept and a model of 'Growth Consulting,' which involves perspectives of both therapist and client in illuminating a process of posttraumatic growth as well as 'core characteristics of successful growth consultant.' Finally, in the third article Patricia Frazier et al. challenge our knowledge by contrasting self-reported, perceived posttraumatic growth and actual posttraumatic growth.

The Tragedy and Triumph of Warren Macdonald

By Elena Saimon

Being a passionate adventurer Warren Macdonald has set and overcome many a breathtaking challenge. The toughest one, though, came unexpectedly in April 1997, when he found himself trapped under a one-tonne boulder for nearly two days in Australia, while climbing the Hinchinbrook Island's tallest pick. He was rescued, but the damage to his legs was irreversible.

"I sign the permission for the operation with tears coursing down my face. Lying there naked under all those lights, I retreat into myself: searching for strength, crying, feeling a sadness like I've never felt before... knowing I'm embarking on a journey into total darkness – and that, if I do come out of it, things can never be the same again."

Warren Macdonald in "A Test of Will"

Life was unfolding mercilessly: a few more operations, intense physiotherapy, learning anew how to do the simplest things… until his emotional state spiralled out of control and hit rock bottom. Then came a period of reflection and soul searching, of planning and of preparation. As a result, just ten months after losing his ability to walk, Macdonald climbed and reached the 1,545-metre summit of Cradle Mountain, in the heart of Tasmania's World Heritage Area. This achievement brought to the surface an overwhelming spectre of emotions and a sense of belonging and continuity. The goals that seemingly had fallen out of reach were seductive and appealing again and most importantly, Warren now believed that even the wildest of his dreams were attainable.

Now, 12 years since the accident Warren has under his belt, *Mount Kilimanjaro* (19,222 ft), Africa's tallest peak; *El Capitan,* America's tallest cliff face; Australian most challenging *Federation Peak*; and Canada's 600 ft *Weeping Wall* frozen waterfall in Alberta .

He reclaimed his power through embracing life and setting the goals most people would find unimaginable. He wrote a book; appeared in one of *The Discovery Channel* series*;* filmed a documentary; and appeared on numerous news and shows including *Larry King Live*, *The Oprah Winfrey Show* and *The Hour* with George Stroumboulopoulos. A successful motivational speaker and active environmentalist, he sends the message to the world that is as inspirational and enlightening as it is realistic and practical.

"It's not so much how different my life is, but how much fuller it is."

Warren Macdonald

Preventing Vicarious Traumatization of Mental Health Therapists: Identifying Protective Practices

Richard L. Harrison
University of British Columbia

An expanded version of this article was first published as: Harrison, R.L., & Westwood, M.J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training, 46* (2), 203-219.

This research was funded by the Social Sciences and Humanities Research Council of Canada and the Michael Smith Foundation for Health Research in partnership with WorkSafe BC.

Introduction

The risks of working with traumatized individuals on a regular basis are well documented. Mental health professionals may experience physical, emotional, and cognitive symptoms, similar to those of their traumatized clients (Buchanan, Anderson,

Uhlemann, & Horwitz, 2006; Figley, 1995). Although research and theory have begun to emerge about Vicarious Traumatization (VT), defined by McCann and Pearlman (1990) as the cumulative transformative effects upon therapists resulting from empathic engagement with traumatized clients, very little is known about the success and satisfaction of trauma therapists who are able to manage in the workplace despite the potentially noxious demands of their work. This qualitative study explored individual and organizational practices that mitigate the risk of VT. The sample included six peer-nominated, exemplary clinicians, trained at the masters or doctoral level, who self-identified as having managed well in their work with traumatized clients. Data was collected through in-depth interviews and analyzed based upon Lieblich, Tuval-Mashiach, and Zilber's (1998) typology of narrative analysis.

Results

Nine major themes emerged within and across clinicians' narratives of protective practices. They are described below:

Countering Isolation in Professional, Personal and Spiritual Domains of Life

Research participants rely on supervision, peer support, ongoing training, varied professional responsibilities, and organizational support to counter isolation in the professional realm. Peer group supervision helps enhance self-awareness, diminish shame about VT symptoms, and reinforce commitment to implement self-care practices, as needed. This helps therapists maintain healthy relationships and balance in their personal lives when "overloaded with my work or carrying too much". In turn, their personal relationships further sustain them in their professional efforts. Being involved in diverse professional roles (some combination of direct practice, teaching, supervising, and/or administration) put them into contact with a larger community, thus allowing them to feel a sense of interconnection and renewed hope.

Therapists also described a sense of connection to a "spiritual" realm of larger meaning that helps counter isolation and despair. They are comforted by the belief that they are not alone in their efforts, and that these are not futile. Most described time spent in nature as an important aspect of this sense of spiritual connection.

Developing Mindful Awareness

The practice of mindfulness (present-focused attending to minute, ongoing shifts in mind, body, and the surrounding world), integrated into daily life, helps most of these therapists to develop enhanced patience, presence and compassion. Breathing consciously and redirecting attention to embodied experience of the here-and-now helps them stay calmly focused and grounded, engage with greater equanimity, and remain hopeful in the face of suffering. Mindfulness enhanced clinicans' ability to engage in many of the other protective practices identified below.

Consciously Expanding Perspective to Embrace Complexity

When caught up in despair, these therapists purposefully expand their perspective. They use self-talk, imagery, time in nature, humor, and interactions with people in other lines of work to challenge negative cognitions, embrace complexity, and counter-balance their "skewed perspective" on the world. Participants accept the inevitability of pain and suffering along with life's potential for beauty, joy and growth. They see a "gift" side of loss, which is to say that devastating experiences can also be generative; pain and positive transformation can coexist. Clinicians described their lives as having been "enriched," deepened, and "empowered" by their vicarious experiences of client *posttraumatic growth* (Tedeschi & Calhoun, 1995), as well as personal experiences of trauma and subsequent growth. Ultimately, this expanded perspective encompasses openness to the unknown and sustains hope.

Active Optimism

The belief that people can heal is central to a positive disposition, which envelops and underlies the phenomenon of clinicians who manage well in their work with clients who have experienced serious traumatic events. Research participants shared an over-arching positive orientation, conveyed in terms of an ability to maintain faith and trust in: a) self as good enough; b) the therapeutic change process; and c) the world as a place of beauty and potential (despite and in addition to pain and suffering). These three attributes parallel the core assumptions that Janoff-Bulman (1992) identified as being shattered by experiences of trauma. There is a circular quality to this positive orientation: the ability to sustain hope and maintain faith that things get better informs many of the protective practices engaged by these exemplary clinicians, which in turn serve to renew their enduring hope and trust. Several explicitly equated optimism with awareness.

These clinicians put their optimism into action. They approach problems as solvable. When the

scope of a problem is too large, they look at what small part they can address. They use heightened self-awareness to recognize how work is affecting them, and determine what to do about this. Most have consciously developed a plan or personalized set of strategies to counter VT and recommend that other therapists do so.

Holistic Self-Care

Participants take a holistic approach to self-care, which they consider crucial to their ability to maintain personal and professional wellbeing. They attend to physical, mental, emotional, spiritual, and aesthetic (e.g., purposefully "bringing beauty in") aspects of self-care. Self-care provides balance, and at times "closure". It is renewing and allows therapists to be more present when engaging in both personal and professional relationships. They recommend all clinicians who work with trauma engage in self-care practices, including some form of personal therapy. They recognize that there is an ethical component to self-care. If they do not take care of themselves, they are at risk of harming others. Consequently, they strongly believe that taking care of caregivers needs to become a higher priority in health care and related fields.

Maintaining Clear Boundaries and Honoring Limits

These clinicians maintain clear and consistent boundaries in multiple realms of interaction. They acknowledge their own limits, including personal vulnerability to VT. They have developed a range of strategies to help maintain boundaries (both psychological and physical) between work and personal life. These include keeping work-related books at the office, limiting time spent debriefing with partners, not working on one's birthday, and taking time off work to travel, among others. Moreover, they maintain clarity about the limits of their sphere of influence. They avoid dual relationships, and recognize that as therapists, they are not responsible for making change in clients' lives.

Furthermore, participants hold realistic expectations of self, other, and the world, and do not confuse the ideal with the actual or the likely. They recognize that change unfolds slowly, in small increments, and that larger scale change is a community rather than an individual responsibility. One said, "I do advocacy work, but only when I feel passionate about it. I'm really also very able to say 'NO. I give at the office,' so to speak."

Perhaps most importantly, they maintain clear boundaries with regard to the distinction between empathy and sympathy. While remaining highly attuned to clients, they do not engage in emotional fusion or otherwise confuse clients' feelings or experiences with their own. They maintain firm interpersonal boundaries that are sufficiently permeable to allow them to experience intimate connection within the context of a present-oriented professional relationship, without losing personal perspective. Participants are attentive to those times when clients' stories resonate more powerfully with the therapist's personal history, in which case they may seek supervision or personal therapy to help maintain clarity and manage what gets stirred up for them. This clarity around boundaries is helpful to clients and protective of therapists. One clinician explained that although he feels "connected" and is often deeply touched by clients' stories of prior traumatic events, he remains clear that "It's still their story. [It] doesn't get painted on my wall."

These exemplary clinicians employ visualizations and personal ritual to remain fully present yet differentiated when disturbing client material risks encroaching upon their personal perspective. This allows them to remain empathically engaged, highly "present and connected," yet protected and distinct in their role as attuned, caring witness to client stories of traumatic experience. A clinician described one such strategy:

> *I try to think of myself as a screen door, where the wind blows through and doesn't attach to the screen. It's an image that I find particularly helpful. I see their story as the wind and I'm the screen. They will have stories that could, if forceful like a gale wind, be dangerous and something to be contended with, but if my door is solid and my screen allows for air to move through it, then even a gale force wind can pass through my screen door.*

Exquisite Empathy

Many therapists described feeling invigorated rather than depleted by their intimate empathic engagement with clients. This was a novel and unexpected finding, because empathic engagement has previously been conceptualized as a risk factor rather than a protective practice. However, when clinicians maintain clarity about interpersonal boundaries, when they are able to get very close without fusing or

confusing the client's story, experiences, and perspective with their own, this exquisite kind of empathic attunement can be nourishing and sustaining for therapist and client alike, in part because the therapists recognize it is beneficial to the clients. Thus the ability to establish a deep, intimate, therapeutic alliance based upon presence, heartfelt concern, and love is an important aspect of wellbeing and professional satisfaction for many of these clinicians.

Professional Satisfaction

All participants take satisfaction in being effective in their work, making a meaningful contribution through their professional efforts, and being highly skilled at what they do. Their lives have been "expanded and enriched" by their work. They consider it an extraordinary privilege to assist people who have experienced trauma, and this sustains them in their professional efforts. Clinicians suggested that organizational cultures and managerial styles that value therapist expertise and afford practitioners greater professional autonomy further contribute to professional satisfaction.

Creating Meaning

Finally, these therapists recognize the importance of their ability to create or perceive meaning, regardless whether this involved belief in an ultimate universal goodness; an elusive transcendent greater purpose; commitment to family, work, and/or community building; or a sense of interconnection with the efforts of others in continuity over time. This last finding relates back to the notion of countering isolation in the spiritual domain of life. Furthermore, it parallels the work of Briere and Jordan (2004) and van der Kolk and McFarlane (1996), who found that the process of making meaning beyond concrete events helps to contextualize and reduce the threat of trauma.

Implications for Practice

These findings underscore the ethical imperative shared by employers, educators, professional bodies, and individual clinicians to create time and space to address VT through: regular supervision (within the context of a supportive supervisory relationship); peer and social support networks; life-work balance; holistic self-care (including personal therapy); and mindful self-awareness within and beyond the workplace. The novel finding that empathic engagement can be a protective practice challenges prior assumptions about the etiology and inevitability of VT. Clinicians who engaged in what I have called "exquisite empathy" (discerning, highly present, sensitively attuned, well-boundaried, heartfelt empathic engagement) described having been invigorated rather than depleted by their intimate professional connections with traumatized clients. Previously, therapist empathy for traumatized clients had consistently been depicted as a key risk factor for VT.

Moreover, it appears that, for some clinicians, efforts to avoid or resist the intensity of clients' trauma stories may be counter-productive. This is in keeping with the literature on PTSD treatment, which suggests traumatized individuals must integrate traumatic experiences into their identity and self story, rather than splitting these off (Herman, 1992). If VT is indeed a form of trauma, in which clients' accounts of traumatic experiences become the traumatic stressor for clinicians, it follows that clinicians may benefit from embracing their professional relationship to clients' traumatic material rather than attempting to distance themselves from this aspect of their work. Exquisite empathy may facilitate this, because it involves a mutually healing connection, in which client and clinician alike benefit from the latter's caring, well-boundaried, ethical attunement to the client.

References

Briere, J., & Jordan, C.E. (2004). Violence against women: Outcome complexity and implications for treatment. *Journal of Interpersonal Violence*, 19, 1252-1276

Buchanan, M., Anderson, J.O., Uhlemann, M.R., & Horwitz, E. (2006). Secondary traumatic stress: An investigation of Canadian mental health workers. *Traumatology*, 12 (4), 1-10.

Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Levittown, PA: Brunner/Mazel.

Janoff-Bulman, R. (1992). *Shattered assumption: Towards a new psychology of trauma.*

Lieblich, A., Tuval-Mashiach, R, & Zilber, T. (1998) *Narrative research: Reading, analysis and interpretation*. Thousand Oaks, CA: Sage Publications.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A contextual model for understanding the effects of trauma on helpers. *Journal of Traumatic Stress, 3* (1), 131-149.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.

Van der Kolk, B.A., McFarlane, A.C. (1996). The black hole of trauma. In B.A. van der Kolk, A.C. McFarlane & L.Weisaeth (Eds.) *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: The Guilford Press.

Growth Consulting: Practical Methods of Facilitating Growth Through Loss and Adversity

Robert J. Fazio, PhD
Hold The Door For Others

This article is an abridged version of the following article: Fazio, R.J. (2009). Growth Consulting: Practical methods of facilitating growth trough loss and adversity. Journal of Clinical Psychology: In Session, Vol.65(5), 532-543.

Prior to the formal introduction of psychotherapy, people did learn and grow. Historically, people were able to heal through community, connections, and relationships. It is well known that human relationships are essential and possibly the most influential ingredient in healing emotional and mental distress.

I have personally learned the power of relationships and focus on growth, while not ignoring challenges, in the realm of crisis, loss, or adversity. My father perished in the 9/11 terrorist attack in New York. I learned from many of his colleagues that in the last moments of his life he was literally holding the door to help others leave the towers and return home to their loved ones. His actions fuel my passion – to help people help themselves grow through loss and adversity and to achieve their dreams.

I present Growth Through Loss and Adversity (GTLA), a framework for growth consulting (GC), a strength-and skills-based model that can be used in a variety of domains.

Growth Consulting

GC is based on the worldview that people have the ability to grow, especially in times of adversity and crisis. I use the term *GC* because the helper is a trusted advisor who helps the helpee gain insight and connects the person to resources that are useful and aligned with his or her goals. The interaction between a helper and helpee is just as important, if not more important, than the content or challenge. The essential characteristics of a GC are in Table 1.

Table 1. Core Characteristics of Successful Growth Consultants (Fazio & Fazio, 2006)

We know that what a therapist brings into a relationship largely affects the outcome (e.g., Norcross, 2002). Self-awareness, as well as subtle shifts in attitude and philosophy, is necessary when working with clients experiencing loss. In the process of healing and growth, gaining insight and letting yourself feel the deep pain of loss is often necessary. The manner in which we invite clients to move into their loss is Connect, Care, and Challenge. The purpose is to help people self-connect, self-care, and self-challenge and develop resources to grow through their adversity.

Connect. The therapeutic relationship may account for up to 30% of client improvement (Lambert, 1992). The relationship we seek is characterized by comfortable professionalism, mutual respect, and attentive listening. I believe that therapy starts as soon as you greet your client. You have a better chance you of connecting quickly and deeply removing barriers.

Care. You cannot truly care about someone until you put effort into understanding his or her experience and worldview. Clients do not care what you know until they know that you care. During growth consulting I need to be certain that clients know that I care and that I am on their team.

Challenge. Support and challenge are essential to developing resilience (Neil & Dias, 2001). When my clients just get by or when their symptoms are reduced, I do not consider it a success. A successful interaction is when clients walk out of the room more resilient and more emotionally intelligent then when they walked in. Challenging clients is not about just confrontation, nor is it about telling clients what to do. It is about helping clients gain insight and inviting them in creative ways to challenge themselves. By the act of challenging clients, we send them a direct message that says as a professional "I believe in you, I am with you, and I know you can help yourself."

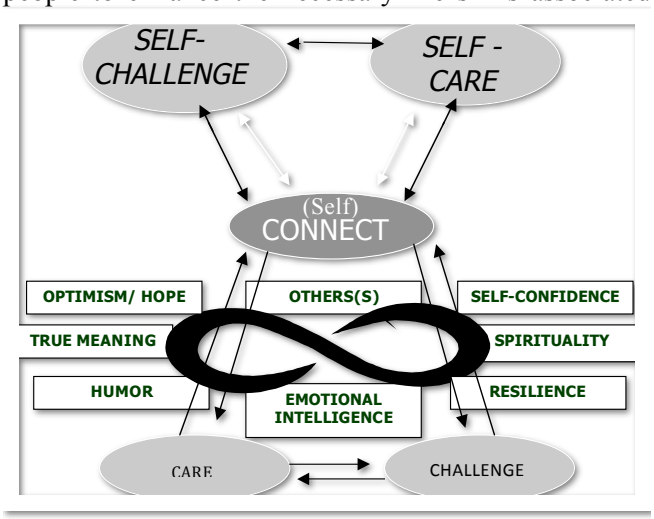
The OTHERS(S) Model

The OTHERS(S) model was designed to promote growth. We have used this model as a guide for personal, professional, and community interventions (Fazio & Fazio, 2006; Fazio et al., 2008). Please see Figure 1. Our team is in the process of updating a self-assessment tool for each component of the model.

Table 1. Core Characteristics of Successful Growth Consultants (Fazio & Fazio, 2006)

Components	Descriptors
Self-awareness	Understanding our reactions, values, and biases and when to self-care.
Common Sense	This should guide what to say, when to say it, how to say it, and when to be quiet.
Timing	Identify what resource fits when, where, and how.
Connecting Skills	A connection drives the will of a client so you can trust one another and healing and growth take place.
Ability to Normalize	It is the GC's job to identify what is healthy and at what point. I normalize as a way to deepen my connection with clients a give honest feedback about change if the reactions are unhealthy.
Confidence, Competence and Confidence in your Competence	Maximize your effectiveness by having not only confidence and strong therapeutic skills sets, but also confidence in what we are doing.
Passion	There may not be anything that helps a person more then when they can sense you have passion and are dedicated to helping them.
Multicultural Competency	Respect for the person in front of you, their worldview, and their ethnic background is absolutely essential. Grieving to one culture may be seen as weakness to another.

The OTHERS(S) model is an acronym for eight resources that promote growth following loss and adversity: Optimism, True meaning, Humour, Emotional intelligence (EI), Resilience, Spirituality, Self-confidence, and Others (relationships). The basis for the eight core resources is three foundational resources, connect, care, and challenge, that allow people to enhance the necessary life skills associated with the OTHERS(S) model. Clinicians can help clients to explore the benefits from adversity when possibilities of growth are as salient as attention to pain, grievance, and suffering. Therefore much of the work is focused on self-understanding and building relationships. The descriptions, key messages, and skills needed to foster these resources are presented in Table 2.



Clinical Issues

Clinicians may better recognize that someone's struggle related to adversity is not based solely in perceived deficits and losses but also in potential gains and growth.

I believe in living what you teach. I want to present a nontraditional, positive approach to helping people in times of their adversity, trauma, or loss. The skills are transferable into formal psychotherapy and widely applicable into community interventions, executive coaching, and everyday conversations. Above all people are the most powerful agents of growth.

Table 2. Foundational, Relational, and C

Foundational Resources (the ability to…)

Self-Connect	**Definition:** be self-aware, which includes an understanding your thoughts, feelings, motives, values, and triggers (emotional reactions). **Key Skill:** *Journal writing.* Become aware of your personal thoughts, feelings, and behaviors. **Key Probe:** Tell me something you have become more aware of lately?
Self-Care	**Definition:** appropriately respond to your emotional and physical needs. **Key Skill:** *Reflection*. Listen to and accommodate your physical and emotional needs, you can better equip yourself to not only maintain ground through difficult times, but also thrive despite challenging obstacles. **Key Probe:** What do you need to do in order to be healthier physically and emotionally?
Self-Challenge	**Definition:** the ability to find inner strength and push yourself to take action steps toward growth. Self-Challenge. Emphasize finding your inner strength, even in the most painful and a challenging time of your life. **Key Skill**: *Challenge affirmations.* Think about how you can achieve your personal goals, and providing specific reasons for your success. **Key Probe**: What is one thing you are going to do differently that will help you grow?

Relational Recourses (when you are the helper) (the ability to…)

Connect	Establish and deepen the relationship with the person you are helping grow." **Key Probe:** I am dedicated to helping you help yourself. Tell me more about what is most challenging right now.
Care	Express empathy and let the person know that you are helping that you are genuinely interested in their healing and growth. **Key Probe:** I want to make sure I am seeing things from your perspective. Help me understand.
Challenge	*Connect*, *care*, and then motivate (Challenge) the person toward growth. **Key Probe:** I know this is very hard. I am going to push you a bit here. Let's talk about a couple strategies that will help you take somewhat of a break and focus on the your growth. How do you feel about learning some new skills?

Core Resources (OTHERS(S)) (the ability to…)

Optimism/Hope	**Definition:** to develop and maintain a positive attitude even during challenging times. **Key Skill*:*** *Find the positive and refocusing.* **Key Probe:** How have you become stronger since losing?
True Meaning	**Definition:** make meaning of adversity and finding purpose for the future. **Key Skill:** *Self-Questioning/ Growth Stories.* Ask yourself positive and purposeful questions. Write your story of loss and growth. **Key Probe:** What meaning and/or purpose have you found as a result of your loss or adversity?
Humor	***Definition:*** laugh and use humor to effectively deal with adversity. **Key Skill*:*** *Find the lighter side.* Strike a balance between taking things seriously enough and not taking them too seriously **Key Probe:** What is the dumbest thing someone has said to you since_____ has passed away?
Emotional Intelligence	**Definition:** read and regulate your feelings and thoughts and that of others to have successful social interactions **Key Skill:** *Emotion coaching.* Become aware of your emotions, understand them, and then channel them into positive responses to adversity. **Key Probe:** What are you feeling right now? When are your feelings most challenging? Why do you think that is?
Resilience	**Definition:** adapt, bounce back, and respond with strength to adversity. **Key Skill:** *Self-Talk.* Communicate with yourself and teaching yourself to be adaptive. **Key Probe:** What other difficult times have you been through before? What has helped you bounce back?

Spirituality	**Definition:** to connect with people, institutions, causes, or with the surrounding universe. **Key Skill:** *Leveraging your spirit*. Personally define the passion within you that encourages you to thrive. An example of this could be *the connectedness I share with others.* **Key Probe:** Share with me what spirituality means to you?
Self-confidence	**Definition:** believe in yourself and use your resources. **Key Skill:** *"Canning the T."* Think about how you "can" accomplish something. Instead of saying "I can't", think about a smaller step toward your goal and figure out what you "can" do in the present and grow from there. "Can't is can with a T. Therefore, you have to can the T." **Key Probe:** Can you rate your self-confidence on a scale of 1 to 10, 10 being the highest? Describe to me what a 10 looks like for you?
OTHERS(S)	**Definition:** integrate your resources to build and maintain relationships and heal through helping others **Key Skill:** *Hold the Door for Others.* By reaching out and connecting with others, people can often heal and grow through loss. Volunteer to help someone in any way you can. **Key Probe:** What can you teach others as a result of your loss?

Select References and Recommended Readings

Fazio, R.J., Fazio, L.M. (2006). Growth through loss: Promoting healing and growth in the face of trauma, crisis and loss. *Journal of Personaliy*, 64, 899-922.

Fazio, R.J., Strunk, D., & Danish, S. J. (2004). Resilience and Emotional Intelligence as predictors of posttraumatic growth in those who lost loved ones on septembre 11th. Unpublished Dissertation. Virginia Commonwealth University.

Lambert, M. J. (1992). Psychotherapy outcome research. In J. C. Norcoss & M. R. Goldfried (Eds.), *Handbook of Psychotherapy integration* (pp. 94-129). New York: Basic Books.

Neil, J., & Dias, K. (2001). Adventure education and resilience: The double edge sword. *Journal of Adventure Education and Outdoor Learning, 1*(2), 36-42.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs.* New York: Oxford University Press.

Does Self-Reported Posttraumatic Growth Reflect Genuine Positive Change?

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This article is an abridged version of the following article: Frazier, P., Tennen, H., Gavian, M., Park, C., Tomich, P., & Tashiro, T. (2009). Does self-reported post-traumatic growth reflect genuine positive change? *Psychological Science*, 20, 912-919.

Over the past decade, many studies have shown that most people report that they have grown psychologically in the aftermath of trauma, a phenomenon often referred to as posttraumatic growth (PTG). Two controversies have arisen about this line of research. One concerns whether growth following adversity represents genuine life changes. Evidence of significant change consists of numerous reports of PTG by trauma survivors (Tedeschi et al., 1998). However, McFarland and Alvaro (2000) presented compelling evidence that individuals who reported growth following a trauma did so not because they actually changed in positive ways following the trauma, but because they derogated their pre-event selves. Another study also suggested that reports of growth following adversity at least partly reflect self-protective strategies (Davis & McKearney, 2003).

The second controversy concerns the unique way that PTG typically is measured. Essentially, participants must (a) evaluate their current standing on a dimension (e.g., closeness to other people), (b) recall their previous standing on the same dimension, (c) compare their current and previous standings, (d) assess the degree of change, and (e) determine how much of that change can be attributed to the traumatic event. However, research in other domains suggests that perceived changes are weakly related to

prospective data documenting actual changes (e.g., Robins, Noftle, Trzesniewski, & Roberts, 2005).

The purpose of this study was to determine whether self-reported growth following a traumatic event (perceived growth) was associated with actual change from pre- to posttrauma (actual growth). We also assessed whether perceived and actual growth were differentially related to distress and positive reinterpretation coping. If measures of perceived and actual growth are highly related to each other, we would expect them to have similar relations with distress and positive reinterpretation coping.

METHOD

Participants and Procedure

Participants were undergraduate students recruited from four large universities in the United States. They completed on-line surveys at Time 1 (T1; N = 1,528) and 8 weeks later, at Time 2 (T2; N = 1,281; 84%). The sample used in the present analyses consisted of 122 participants who reported a traumatic event between T1 and T2. Most participants in this subsample were between 18 and 21 (89%), female (85%), and Caucasian (77%).

Measures

All measures were completed with regard to the previous 2 weeks and had adequate reliability in this sample. More information is contained in the original article.

Traumatic Events

We used the Traumatic Life Events Questionnaire (TLEQ) to assess exposure to traumatic events (Kubany, 2004). Participants indicated whether they had experienced each of 17 nonchildhood events or any other traumatic event in the 8 weeks between T1 and T2. We included in our sample only the 122 individuals who said their recent event caused considerable to extreme distress. The most common "worst" traumatic events reported between T1 and T2 were a loved one experiencing a life-threatening accident, assault, or illness (28%) and the sudden and unexpected death of a close friend or loved one (27%).

Perceived Posttraumatic Growth on the PTGI

To assess perceived change from pre- to posttrauma, we asked participants to complete the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) at T2 with regard to the event they had experienced between T1 and T2. The PTGI is the most common measure of PTG and measures the extent to which individuals believe they have changed in positive ways as the result of a traumatic event.

Actual Posttraumatic Growth on the PTGI Items

To assess actual change from pre- to posttrauma on the same items used to assess perceived growth, we created a "current standing" version of the PTGI (C-PTGI) that participants completed at T1 and T2. The C-PTGI items were phrased to reflect participants' current experience rather than changes resulting from the trauma.

Actual Posttraumatic Growth on Measures of PTG Domains

To assess actual change from pre- to posttrauma, at T1 and T2 we administered five measures that corresponded to the domains of growth assessed by the PTGI and the general domains reported in the broader PTG literature. All measures were standard scales with good evidence of reliability and validity: the positive relationships subscale from Ryff's (1989) Psychological Well Being (PWB) scale, the Presence of Meaning subscale from the Meaning in Life Questionnaire (Steger, Frazier, Oishi, & Kaler, 2006), the Satisfaction With Life Scale (Diener, Emmons, Larsen, & Griffin, 1985), the Gratitude Questionnaire (McCullough, Emmons, & Tsang, 2002), and the Religious Commitment Inventory (Worthington et al., 2003). All five measures had moderate to large correlations (*r*'s = .38 to .63) with C-PTGI total scores.

Distress and Coping

Distress was assessed at T1 and T2 using the Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995). Positive reinterpretation coping with regard to the recent trauma was assessed at T2 using a subscale from the COPE (Carver, Scheier, & Weintraub, 1989).

RESULTS

Relations Between Measures of Perceived and Actual Growth

There were small positive correlations between perceived growth on the PTGI and actual growth from pre- to posttrauma on the C-PTGI and small to moderate positive correlations between perceived growth on the PTGI and change in religious commitment (Table 1). However, perceived growth was not related to pre- to posttrauma improvements in positive relationships, meaning in life, life satisfaction, or gratitude. Even the correlations between the specific PTGI subscales and the domain measures that most closely corresponded to them were nonsignificant.

TABLE 1
Correlations Between the PTGI at Time 2 and Change in C-PTGI and PTG-Domain Measures From Time 1 to Time2

	Change measure					
PTGI score	C-PTGI	Positive relationships	Meaning in life	Life satisfaction	Gratitude	Religious commitment
Total score	.22*	−.15	.03	.06	.03	.29***
Relating to Others	.21*	−.10	.04	.11	.09	.21*
Personal Strength	.29***	−.14	.05	.07	.04	.32***
New Possibilities	.10	−.24**	.07	.02	−.06	.20*
Appreciation of Life	.22*	−.04	.01	.09	.05	.34***
Spiritual Change	.03	−.09	−.13	−.10	−.06	.21*

Note. n = 119–121. PTGI = Post-Traumatic Growth Inventory; C-PTGI = "current standing" version of the PTGI. Change scores were created by subtracting T1 scores from T2 scores on the C-PTGI and the five PTG-domain measures.

*p < .05. **p < .01. ***p < .001.

Relations of Perceived and Actual Growth With Distress and Coping

Perceived growth was associated with increased distress, whereas actual growth generally was associated with decreased distress (Table 2). The primary exception was that increased religious commitment was associated with an increase in distress from pre- to posttrauma.

Perceived growth was also strongly related to positive reinterpretation coping, whereas actual growth generally was unassociated with coping. The one exception was that increased religious commitment was associated with more positive reinterpretation coping at T2.

DISCUSSION

Our results were similar to those of studies that have compared perceived and actual change in other domains (e.g., Robins et al., 2005) in that perceived posttraumatic growth as measured by the PTGI did not appear to measure actual growth from pre- to posttrauma. PTGI scores were unrelated to most measures of actual growth in PTG-related domains (positive relationships, meaning in life, life satisfaction, and gratitude), even though those measures appear to tap the same domains as the PTGI. Even when we used virtually the same items (PTGI and C-PTGI), the relation between perceived and actual growth was small. Moreover, perceived growth was associated with increases in distress from pre- to posttrauma, whereas actual growth was related to decreased distress, a pattern suggesting that perceived and actual growth reflect different processes. Finally, perceived growth (but not actual growth) was strongly related to positive reinterpretation coping. All of this suggests that retrospective reports of growth measure something different from actual pre- to posttrauma change.

The one exception to this general pattern of results involves religious commitment. Change in religious commitment was the only measure of actual change that was related to perceived change on the PTGI, and, like the PTGI, it was related to more rather than less distress and to greater use of positive reinterpretation coping. One explanation is that increased religious commitment in the face of trauma, like self-reported PTG, may be a way of coping with the trauma. In contrast, increases in life satisfaction or gratitude seem more likely to reflect actual growth (outcomes) than to reflect coping strategies (processes).

It would be inappropriate to conclude from our findings that people cannot change in positive ways following traumatic events. Indeed, a relatively small proportion of our participants demonstrated actual change, although we have no way of knowing if this change can be attributed to their traumatic experience. Nor do our findings challenge evidence that perceived positive change in the face of adversity can predict subsequent health and well-being. Rather, the message

we hope to convey is that existing approaches to the assessment of posttraumatic growth are not in keeping with current practice in all other areas of psychological research, and this significant flaw impedes progress in what we believe is a most promising area of inquiry.

TABLE 2

Correlations of Perceived and Actual Growth With Change in Distress and With Coping at Time 2

Measure of growth	Change in distress	Time 2 coping
Perceived growth		
PTGI	.26**	.52***
Actual growth		
Change in C-PTGI	−.10	.12
Change in positive relationships	−.43***	−.07
Change in meaning in life	−.24**	.08
Change in life satisfaction	−.22*	.02
Change in gratitude	−.28**	.11
Change in religious commitment	.28**	.18*

Note. n = 119–120. PTGI = Post-Traumatic Growth Inventory; C-PTGI = "current standing" version of the PTGI.
*p < .05. **p < .01. ***p < .001.

REFERENCES

Carver, C.S., Scheier, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically based approach. Journal of Personality and Social Psychology, 56, 267–283.

Davis, C.G., & McKearney, J.M. (2003). How do people grow from their experience with trauma or loss? Journal of Social and Clinical Psychology, 22, 477–492.

Diener, E., Emmons, R.A., Larsen, R.J., & Griffin, S. (1985). The Satisfaction With Life Scale. Journal of Personality Assessment, 49, 71–75.

Kubany, E. (2004). Traumatic Life Events Questionnaire and PTSD Screening and Diagnostic Scale. Los Angeles: Western Psychological Services.

Lovibond, P.F., & Lovibond, S.H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. Behaviour Research and Therapy, 33, 335–343.

McCullough, M.E., Emmons, R.A., & Tsang, J. (2002). The grateful disposition: A conceptual and empirical topography. Journal of Personality and Social Psychology, 82, 112–127McFarland, C., & Alvaro, C. (2000). The impact of motivation on temporal comparisons: Coping with traumatic events by perceiving personal growth. Journal of Personality and Social Psychology, 79, 327–343.

Robins, R.W., Noftle, E.E., Trzesniewski, K.H., & Roberts, B.W. (2005). Do people know how their personality has changed? Correlates of perceived and actual personality change in young adulthood. Journal of Personality, 73, 489–521.

Ryff, C.D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57, 1069–1081.

Steger, M.F., Frazier, P., Oishi, S., & Kaler, M. (2006). The Meaning in Life Questionnaire: Assessing presence of and search for meaning in life. Journal of Counseling Psychology, 53, 80–93.

Tedeschi, R., & Calhoun, L. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. Journal of Traumatic Stress, 9, 455–471.

Tedeschi, R., Park, C., & Calhoun, L. (1998). Posttraumatic growth: Conceptual issues. In R. Tedeschi, C. Park, & L. Calhoun (Eds.), Posttraumatic growth: Positive changes in the aftermath of crisis (pp. 1–23). Mahwah, NJ: Erlbaum.

Worthington, E.L., Wade, N.G., Hight, T.L., Ripley, J.S., McCullough, M.E., Berry, J.W., et al. (2003). The Religious Commitment Inventory—10: Development, refinement, and validation of a brief scale for researc and counseling. Journal of Counseling Psychology, 50, 84–96.

Upcoming Trauma Conferences & Events

6th Psychological Trauma Symposium (PTS)
'Traumas in Daily Life'
December 11-13, 2009
Istanbul, Turkey
http://www.ruhsaltravma2009.org/

National Summit on Interpersonal Violence and Abuse Across the Lifespan: *Forging a Shared Agenda*
February 24-26, 2010
Sheraton Dallas Hotel, Dallas, Texas, USA
www.npeiv.org

32nd Annual Conference, Association for Death Education and Counseling (ADEC)
April 7-10, 2010
Hyatt Regency Crown Center, Kansas City, Missouri, USA
www.adec.org/conf/index.cfm

ISTSS Psychotraumatology Meeting
April 19, 2010
Zürich World Trade Center, Zürich, Switzerland

6th World Congress of Behavioral and Cognitive Therapies (WCBCT)
June 2-5, 2010
Boston, Massachusetts, USA

CPA 71st Annual Convention
June 3-5, 2010
Winnipeg, Manitoba, Canada
http://www.cpa.ca/convention/

ISTSS 26th Annual Meeting
November 4-6, 2010
Le Centre Sheraton Montreal Hotel, Montréal, Québec, Canada
Pre-Meeting Institutes November 3, 2010.
http://www.istss.org/meetings/futureDates.cfm

ISTSS 27th Annual Meeting
November 3-5, 2011
with Pre-Meeting Institutes Nov. 2
Baltimore Marriott Waterfront
Baltimore, Maryland, USA
www.istss.org