

Trauma, Recovery, and Growth

Positive Psychological Perspectives
on Posttraumatic Stress

Edited by
Stephen Joseph
P. Alex Linley



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Published by John Wiley & Sons, Inc., Hoboken, New Jersey.

Published simultaneously in Canada.

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ISBN 978-0-470-07502-9

Printed in the United States of America.

10 9 8 7 6 5 4 3 2 1

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Preface

POSITIVE PSYCHOLOGY IS a rapidly developing area of psychological research with exciting potential for applications in psychology, counseling, psychotherapy, and social work. In this book, we focus on what positive psychology has to offer in our work with survivors of stressful and traumatic events. Exposure to stressful and traumatic events can have severe and chronic psychological consequences. In adopting the positive psychology perspective, there is no denial of the suffering often caused by trauma. However, there is also a growing body of evidence testifying to the positive psychological changes that can result from people's struggle with stressful and traumatic experiences. These two sets of literatures have evolved somewhat independently, so that one group of researchers is largely concerned with posttraumatic stress and another is concerned with posttraumatic growth; and little work is going on that explicitly connects these two areas of research. Our aims have been to develop a synthesis between them and to explore the relevance of positive psychology to trauma practice. This book presents the efforts of researchers and practitioners to explore how positive psychology can inform our understanding of posttraumatic stress and posttraumatic growth, and especially to develop a more integrative understanding of the interplay between these outcomes following traumatic events. It is our firm belief that by conceptualizing traumatic reactions more holistically, we will be better qualified and informed in our efforts to help survivors of trauma facilitate their resilience, recovery, and growth. This book is our attempt to catalyze that process.

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PART I

TOWARD AN INTEGRATIVE
POSITIVE PSYCHOLOGY OF
POSTTRAUMATIC
EXPERIENCE

CHAPTER 1

Positive Psychological Perspectives on Posttraumatic Stress: An Integrative Psychosocial Framework

STEPHEN JOSEPH and P. ALEX LINLEY

IT IS WELL known that exposure to stressful and traumatic events can have severe and chronic psychological consequences. In adopting the positive psychology perspective, it must be made clear at the outset that there is no denial of the suffering often caused by trauma. There is, however, a growing body of evidence testifying to the positive psychological changes that can result from people's struggle with stressful and traumatic experiences. These two sets of literatures have evolved independently, with some researchers interested in posttraumatic stress, others in posttraumatic growth. In this chapter, we introduce the positive psychological perspective and begin developing a synthesis between these two areas of research and practice. Our goal is to show that posttraumatic stress and posttraumatic growth can be understood within an integrative psychosocial framework.

POSITIVE PSYCHOLOGY

The study of positive changes following stressful and traumatic events is part of the wider positive psychology agenda pursued by psychologists in recent years (e.g., Linley & Joseph, 2004b; Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2002). Positive psychology, as we know it, was launched by Martin E. P. Seligman's Presidential Address to the American Psychological Association's Annual Convention on August 21, 1999. Seligman argued that

since World War II, psychology had largely neglected its mission to make the lives of all people more productive and fulfilling, and to understand and nurture high talent (Seligman, 1999). Instead, psychology had largely become a medically oriented discipline interested in identifying and alleviating the increasing number of psychopathologies that came to be included in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994). In relation to posttraumatic stress disorder, this focus is hardly surprising. The establishment of the U.S. Veterans Administration (VA) in 1946 created many roles and funding streams for psychologists who wanted (and were needed) to work with people who had been in combat. Following the Vietnam War and the establishment of the diagnosis of posttraumatic stress disorder (PTSD) in the diagnostic nomenclature, this work expanded substantially to relieve the suffering and psychological problems experienced by Vietnam veterans. The myriad career paths and opportunities open to clinicians enabled them to help a great many people with psychological distress.

These events, combined with the longer history of clinical psychology being broadly under the umbrella of psychiatrists in psychiatric hospitals (Albee, 2000; Maddux, Snyder, & Lopez, 2004), created an illness ideology that pervaded the science and practice of clinical psychology (of which the diagnosis and treatment of posttraumatic stress disorder was very much a part). Why was this? First, clinical psychology practitioner training typically occurred in psychiatric hospitals and clinics, where clinical psychologists worked primarily as psycho-diagnosticians under the direction of psychiatrists trained in medicine and psychoanalysis. Clinical psychologists tended to adopt, uncritically, the methods and assumptions of their psychiatrist counterparts, who were trained specifically in the medical model and the illness ideology. This might be entirely appropriate for physical disorders, but not, we would argue, for all psychological problems, including those of posttraumatic stress.

Second, as noted, the U.S. Veterans Administration, established shortly after World War II, developed training centers and standards for clinical psychologists primarily within psychiatric settings that were steeped in biological and psychoanalytic models. To reject the medical model and its attendant illness ideology would have been anathema to many clinical psychologists of this period, leading to a further acceptance and implicit osmosis of the illness ideology into the science and practice of clinical psychology.

Third, the U. S. National Institute of Mental Health (NIMH), founded in 1947, focused—despite its name—all its millions of research and practice dollars on treating mental illness, which irrevocably shaped the direction and practice of clinical psychologists. Again, rejecting the medical model

and the illness ideology would have meant rejecting the opportunity offered by this research and practice funding—a stiff test of theoretical values against pragmatic career choices.

Fourth, the assumptions of clinical psychology, grounded in the illness ideology, were enshrined in the standards for clinical psychology training at the American Psychological Association conference in Boulder, Colorado, in 1950. This led to “the uncritical acceptance of the medical model, the organic explanation of psychological problems, with psychiatric hegemony, medical concepts, and language,” and became the “fatal flaw” of the scientist-practitioner model that “has distorted and damaged the development of clinical psychology ever since” (Albee, 2000, p. 247).

Grounded in this medico-psychiatric historical context, the illness ideology has permeated the language of clinical psychology, leading it to become the language of medicine and psychopathology. Characterized thus, clinical psychology narrows our focus to what is weak and deficient rather than to what is strong and healthy. It emphasizes abnormality over normality, poor adjustment over healthy adjustment, and sickness over health. Inherently, therefore, it has emphasized posttraumatic *stress disorder* rather than posttraumatic *growth* as the outcome following traumatic events, despite consistent evidence that most people are at least resilient in the face of trauma and many report positive changes (Linley & Joseph, 2004a).

Further, this illness ideology prescribes a certain way of thinking about psychological problems that tells us what aspects of human behavior should receive our attention. Maddux et al. (2004) identified three primary ways in which the uncritical adoption of the illness ideology has determined the remit and scope of clinical psychology. First, it promotes dichotomies between normal and abnormal behaviors, between clinical and nonclinical problems, and between clinical populations and nonclinical populations. Second, it locates human maladjustment inside people, rather than in their interactions with the environment and their encounters with sociocultural values and social institutions. Third, it portrays people who seek help as victims of intrapsychic and biological forces beyond their control, and thus leaves them as passive recipients of an expert’s care.

The medical model and illness ideology of clinical psychology can be seen to be founded on four basic assumptions (Maddux et al., 2004):

1. Clinical psychology is concerned with *psychopathology*—deviant, abnormal, and maladaptive behavioral and emotional conditions. Thus the focus is not on facilitating mental health but on alleviating mental illness. This excludes the millions of people who might experience problems in everyday living for the benefit of the much smaller number of people experiencing severe conditions. Hence, the focus on posttraumatic stress

disorder and the medicalization of the condition have made it into something that is enduring and distinct from normal reactions of cognitive-emotional processing following trauma.

2. Psychopathology, clinical problems, and clinical populations differ in *kind*, not just in degree, from normal problems in living, nonclinical problems, and nonclinical populations: They are considered to be independent and distinct entities. This *categorical model* presents the remit of clinical psychology as being categorically different from normal problems, thus requiring different theories. With this implicit categorization, posttraumatic stress has been considered to be fundamentally different in kind from posttraumatic growth, leading to the evolution of disparate research groups and foci instead of a more appropriate integrative approach to understanding. We have started to develop this approach elsewhere (Joseph & Linley, 2005), and it is a primary focus of this book.
3. Psychological problems are analogous to biological or medical diseases in that they reflect conditions inside the individual (the illness analogy), rather than in the person's interactions with his or her environment. From this premise, it is easy to understand the search for biological markers of posttraumatic stress in isolation from wider social and psychological factors. Posttraumatic growth research has tended to focus on the social psychology of the growth experience; posttraumatic stress disorder research has often focused on the biology, physiology, and neurochemistry of disease.
4. Following from this illness analogy, the role of the clinical psychologist is to identify (diagnose) the so-called disorder inside the person (patient) and to prescribe an intervention (treatment) for eliminating (curing) the internal disorder (disease). These interventions are referred to as *treatment* unlike often equally successful attempts on the part of friends, family, teachers, and ministers. This approach persists even though many people following a traumatic event neither seek nor require a professional intervention. For many, the support of existing social networks are sufficient.

In sharp contrast, positive psychological approaches to clinical psychology reject these implicit assumptions, and instead present four assumptions of a positive clinical psychology (Maddux et al., 2004):

1. Positive clinical psychology is concerned with everyday problems in living to the same extent as it is with the more extreme variants of everyday functioning that we might refer to as *psychopathology*. Positive clinical psychology is also as much concerned with understanding and enhancing subjective and psychological well-being and effective functioning as it is with alleviating subjective distress and maladaptive functioning.
2. Psychopathology, clinical problems, and clinical populations, differ *only in degree*, not in kind, from normal problems in living, nonclinical problems,

and nonclinical populations: They are considered to be related entities falling somewhere on a *continuum* of human functioning. This *dimensional model* suggests a focus on health and fulfillment as much as on illness and distress, since they are related constructs that can be defined by the same psychological theories. Within this dimensional model, normality and abnormality, wellness and illness, and effective and ineffective psychological functioning lie along a *continuum* of human functioning. They are not separate and distinct entities, but are considered to be extreme variants of normal psychological phenomena.

3. Psychological disorders are *not* analogous to biological or medical diseases. Instead, they reflect problems in the person's interactions with his or her environment, and not only and simply of problems within the person. Further, these problems in living are not construed as being located within an individual, but rather as being located within the interactions between an individual, other people, and the larger culture. This demands a closer inspection of the much more complex interplay of psychological, social, and cultural factors that bear on an individual's psychological health.
4. Following from these three former assumptions, the role of the positive clinical psychologist is to identify human strengths and promote mental health. The people who seek this assistance are clients or students, not patients, and the professionals providing these approaches may be teachers, counselors, consultants, coaches, or even social activists, and not just clinicians or doctors. They use educational, relational, social, and political strategies and techniques, not medical interventions. Further, the facilities providing this assistance may be centers, schools, or resorts, not clinics or hospitals.

Hence, in the context of adaptation following trauma, the new approaches emerging from the positive psychology perspective contrast greatly with the traditional emphasis by psychologists on illness and psychopathology. At first glance, the new field of positive psychology might seem to offer little to those who study and work in the field of traumatic stress. But, as we have shown with the preceding assumptions, we can start to reconfigure our understanding of the evolution of clinical psychology and the forces that shaped it. We can also learn how this pervasive illness ideology has separated the study of posttraumatic stress from that of posttraumatic growth, instead of developing an integrative perspective for understanding these experiences in the same framework of human experience.

Many literatures and philosophies throughout human history have conveyed the idea that personal gain is to be found in suffering (see Linley, 2003), and this idea is central to the existential-humanistic tradition of psychology (Jaffe, 1985; Yalom & Lieberman, 1991). The motif of the value that can be found through suffering permeates many religions of both the East

(Buddhism) and West (Christianity); it is a recurrent theme in great European literature (Dante Alighieri's description of his search for his lost love Beatrice, taking him through Hell and Purgatory to reach Paradise in *The Divine Comedy*; Fyodor Dostoevsky's redemption of the murderer Raskolnikov when he embraces the suffering of the prison camps to atone for his actions in *Crime and Punishment*), and also in the continental existential philosophy tradition (e.g., Kierkegaard and Nietzsche), and the creativity and growth that followed World War II (Simonton, 1994; see Linley, 2003, for a fuller review).

It is only in the past decade that the topic of growth following adversity has become a focus for much empirical and theoretical work, attracting researchers from a variety of perspectives and clinical contexts (e.g., Affleck & Tennen, 1996; Aldwin & Levenson, 2004; Frazier, Conlon, & Glaser, 2001; Harvey, Barnett, & Overstreet, 2004; Linley, 2000; McMillen, Smith, & Fisher, 1997; Siegel & Schrimshaw, 2000; Tedeschi & Calhoun, 2004). In this book, we have brought together a collection of international authors and experts in the field of trauma and growth to write about their work and its implications for practice.

THEORETICAL INTEGRATION: THE PSYCHOSOCIAL FRAMEWORK

The study of growth following adversity has largely developed separately from the study of posttraumatic stress for the reasons previously explored. Although there have been early attempts to integrate the two, with at least an acknowledgment of the gains that may follow from trauma and how these relate to posttraumatic stress (Lyons, 1991; van der Kolk, 1996), our aim in this book is to begin developing a synthesis between these two largely distinct literatures. It is not possible to fully understand recovery from posttraumatic stress without awareness that for some people this involves positive changes beyond their previous levels of functioning and well-being; and vice versa, it is not possible to fully understand growth following adversity without knowledge of the traumatic distress that serves as the trigger for such change.

At a broad level, we propose that posttraumatic stress and posttraumatic growth can be integrated within a single framework. Joseph, Williams, and Yule (1995, 1997) presented a multifactorial psychosocial framework of posttraumatic adjustment that integrated social and cognitive perspectives (see Joseph & Williams, 2005 for a recent overview). The main components of the psychosocial framework are presented in Figure 1.1. The description starts with the occurrence of a traumatic event and continues in a clockwise direction through event cognitions, appraisals, emotional states, cop-

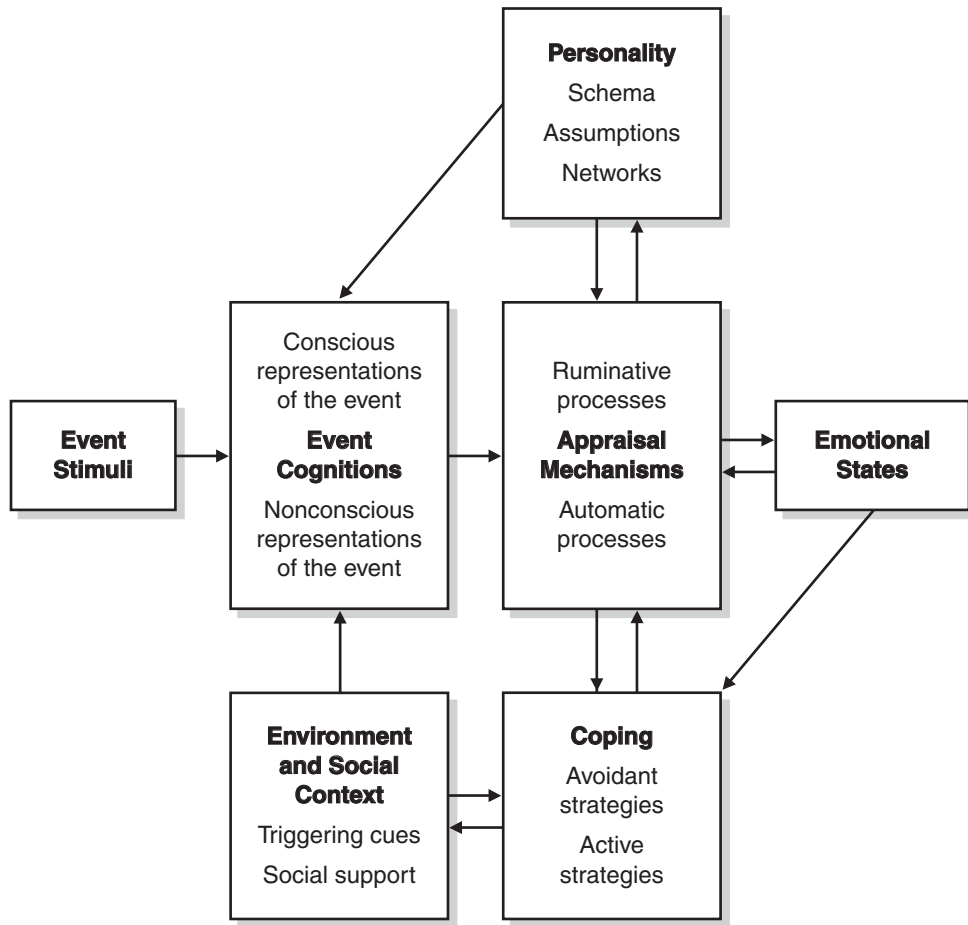


Figure 1.1 Psychosocial Framework of Posttraumatic Stress Reactions. *Source: Post-Traumatic Stress: Psychosocial Perspectives on PTSD and Treatment*, by S. Joseph, R. Williams, and W. Yule, Chichester, England: Wiley, 1997. Copyright John Wiley & Sons Limited. Reprinted with permission.

ing, appraisals with cognitions being influenced by both personality and memory representations and the social environment, culminating in either a circular flow through this cycle or in changes within the representational state that constitutes resolution.

In brief, event stimuli provide the basis for event cognitions, the conscious and nonconscious representations of the traumatic experience. Event cognitions, in turn provide the basis for appraisal processes. Appraisal can take the form of consciously controlled cognitive processes or automatic processes, indicative of an ongoing need for cognitive-emotional processing. The occurrence of cognitive appraisals and reappraisals may be associated with distressing emotional states, such as fear, anger, guilt, and

shame (or positive emotional states such as hope, joy, humor, gratitude, as discussed in Chapter 17). The occurrence of these cognitive and emotional states leads to various states of coping, as individuals try to manage their emotional states and make sense of their experience. These individual processes occur in a social context that influences event cognitions and coping. Because the level of affect involved in trauma is high, individuals may need the support of others, either professionals or those close to them, in allowing themselves to remember and talk about a trauma. Input from others can interact through appraisal processes to influence the individual's meaning attributions, emotional states, memory structures, and coping in a helpful or harmful manner. The significance of each set of factors may differ between individuals and explain individual variation as well as group similarities.

POSTTRAUMATIC STRESS

Thus, the psychosocial framework describes how the interaction between psychological and social factors operates to impede or promote cognitive-emotional processing. It is a psychosocial framework because although cognitive-emotional processing is an internal psychological experience, the speed and depth of cognitive-emotional processing are affected by personality and social psychological factors. Importantly, the psychosocial framework is not grounded in medical ideology and so does not explicitly refer to posttraumatic stress as a separate outcome but views posttraumatic stress as the process inherent in the interaction of these factors. Phenomena characteristic of posttraumatic stress—reexperiencing, avoidance, and arousal (American Psychiatric Association, 1994)—are understood within the psychosocial framework as experiences of event cognitions/appraisal, coping, and emotional states, respectively. Within the psychosocial framework, reexperiencing, avoidance, and arousal are viewed, not as pathology indicative of disorder, but as indicative of the need for cognitive-emotional processing of the new trauma-related information (see Joseph & Williams, 2005). Furthermore in the psychosocial framework, reexperiencing, avoidance, and arousal are viewed as continuous variables rather than as dichotomous states that are either present or absent.

POSTTRAUMATIC GROWTH

Relevant to this discussion is that the psychosocial framework recognizes that changes in personality/assumptive worlds can occur as part of the process of adjustment in relation to new appraisals. When these changes involve a positive reconfiguration of schema, this is what is referred to as

posttraumatic growth. Whereas much of the previous literature on the effects of traumatic events has focused on the relationship between appraisal mechanisms and distressing emotional states, understanding positive growth processes involves a shift of focus to the relation between appraisal mechanisms and personality/assumptive world (Joseph & Williams, 2005). Unlike the subjective psychological experiences of re-experiencing, avoidance, and hyperarousal following trauma (which are states indicative of the need for cognitive-emotional processing of the traumatic information), the experience of posttraumatic growth is more concerned with fundamental positive changes in personality schema and people's assumptive worlds.

Understood in this way, growth following adversity is not about emotional states and subjective well-being (SWB), it is about psychological well-being (PWB). The distress that arises from the subjective states of re-experiencing, avoidance, and hyperarousal can be understood as reflections of the person's subjective well-being. In contrast, psychological well-being is about engagement with the existential challenges of life. It comprises dimensions of self-acceptance, environmental mastery, personal growth, autonomy, positive relations with others, and having a purpose in life (Ryff, 1989; Ryff & Singer, 1996). These dimensions can be readily associated with the three broad dimensions of posttraumatic growth: changes in life philosophy (PWB: purpose in life, autonomy); changes in perceptions of self (PWB: environmental mastery, personal growth, self-acceptance); and changes in relationships with others (PWB: positive relations with others). Understood in relation to posttraumatic adaptation, it becomes clear that the positive shifts in personality schema and assumptive worlds that are characteristic of posttraumatic growth can be understood as reflections of one's psychological well-being. On a broad level, subjective well-being is about the hedonic perspective, whereas psychological well-being is about the eudemonistic perspective (Ryan & Deci, 2001), a distinction that we have drawn out elsewhere in mapping an integrative understanding of adaptation following traumatic events (Joseph & Linley, 2005).

Growth is not about changes in subjective well-being; it is about personality development—how people develop psychological well-being (understanding of one's place and significance in the world; engagement with the existential challenges of life, of which trauma is certainly one). In this way, the psychosocial framework provides a broad understanding of the relation between posttraumatic stress and posttraumatic growth: how personality influences the cycle of appraisal, emotional states, and coping (that constitute the posttraumatic stress reactions), which in turn influences personality (that constitutes posttraumatic growth).

ORGANISMIC VALUING THEORY

Moving to a more specific theoretical level, Joseph and Linley (2005) have begun to integrate the preceding ideas more explicitly into a positive psychology model, the organismic valuing theory of adaptation to threatening events. This new theory is (a) consistent with the psychosocial framework, (b) grounded in the person-centered meta-theoretical position that people are intrinsically motivated toward growth, and (c) builds on the new positive psychology literature to provide a more detailed theoretical account of the relationship between appraisal processes and personality/assumptive worlds. In particular, it specifies the different directions in which cognitive-emotional processing can proceed as the person moves through the cycles of appraisal, emotional states, and coping. Figure 1.2 shows a schematic representation of the organismic valuing theory of growth through adversity.

ASSIMILATION VERSUS ACCOMMODATION

It is proposed that as the person moves through the cycle of appraisals, emotional states, coping, and further appraisals, new trauma-related information can only be processed in one of two ways. Either the new trauma-related information must be *assimilated* within existing models of the world, or existing models of the world must *accommodate* the new trauma-related information.

To illustrate the idea of assimilation, victimizing events may have a shattering effect on just world beliefs, as discussed by Janoff-Bulman (1992). To assimilate experience so that just world beliefs are maintained requires complex cognitive strategies. Self-blame is one such strategy. If people are to blame for their own misfortune, then the world remains a just one in which they get what they deserve. In contrast, victims who accommodate their experience, by appraising and accepting that the new trauma-related information is incongruent with preexisting beliefs, must modify their perceptions of the world. These individuals no longer perceive the world as just, but as random or unjust, and they modify their existing models of the world to accommodate this new information. Accommodation requires people to change their worldviews, whether that change is in a positive or a negative direction.

POSITIVE VERSUS NEGATIVE ACCOMMODATION

By definition, cognitive accommodation processes can be in either a negative or a positive value direction. At the experiential level, a person can accommodate new trauma-related information (e.g., that random events happen in the world and that bad things can happen at any time), in one of two ways.

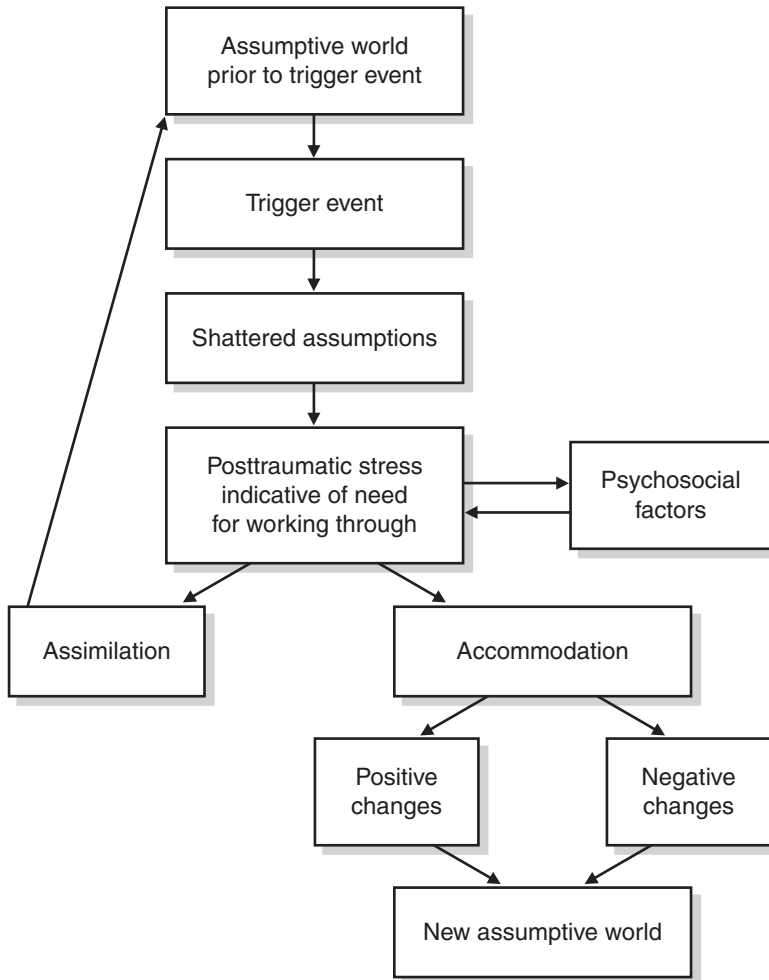


Figure 1.2 Organismic Valuing Theory of Growth through Adversity, Schematically Represented

Accommodation may be made in a negative direction (e.g., a depressogenic reaction of hopelessness and helplessness), or in a positive direction (e.g., that life is to be lived to the full in the here and now). Thus, cognitive accommodation can lead to negative changes in worldview and resultant psychopathology, or to positive changes in worldview and growth.

THREE COGNITIVE OUTCOMES

In the organismic valuing theory, three cognitive outcomes to the psychological resolution of trauma-related difficulties are posited. First, experiences are assimilated, leading to a return to the pretrauma baseline, but

also leaving the person vulnerable to future retraumatization. People who assimilate their experience maintain their pre-event assumptions despite the evidence to the contrary and would be expected to develop more rigid defenses, which in turn leave them at increased vulnerability for future development of posttraumatic stress. Second, experiences are accommodated in a negative direction, leading to psychopathology such as borderline personality problems, depression, and helplessness. Third, experiences are accommodated in a positive direction, leading to growth (e.g., living in the moment, valuing relationships, and appreciating life).

SOCIAL SUPPORT PROCESSES

Assimilation or accommodation is influenced by the extent to which people have a supportive social environment and a malleable personality schema that is open to revision. A rigid personality schema that does not permit any information contrary to that already held by the person would lead to assimilation, with the person fitting the new trauma information to the preexisting schema. This then leaves the person with increased vulnerability for future posttraumatic stress. Accommodating the new trauma information involves changes in personality schema, which will manifest either as some form of psychopathology or as posttraumatic growth, depending on whether the information is negatively accommodated or positively accommodated, respectively.

PROCESS VERSUS OUTCOME

Although we have referred to these as three cognitive outcomes, it is also appropriate to think of these as three broad directions of processing. Certainly, in research, we may employ measures to assess change as an outcome, but the processes described here are developmental and continuous across the life span, so that a person cannot be said to reach an endpoint at which processing of new event-related information ceases.

MULTIFACTORIAL SELF-STRUCTURE

Furthermore, although these three directions of processing provide a useful conceptual framework, the self-structure is multifaceted. Thus, it might broadly be the case that a person emotionally processes experiences in one of these directions, but we would propose that different facets of the self-structure can be accommodated, some positively and some negatively, whereas other facets may be assimilated. Thus, we do not propose the three directions of processing as mutually exclusive categories. In the previous il-

lustration, self-blame maintains that facet of self-structure concerned with the perception of the world as just. The person has assimilated trauma-related information in such a way as to maintain just-world beliefs. But the very process of self-blame has implications for other facets of self-structure that must now accommodate the new information about the self that arises as a result of this appraisal process. To fully understand the processes of assimilation and accommodation, we need to conceptualize the self-structure as multifaceted.

GROWTH AS A UNIVERSAL HUMAN TENDENCY

The organismic valuing theory posits that people are intrinsically motivated toward positive accommodation, but circumstances and environments may restrict, impede, or distort this intrinsic motivation. A person's social environment may not be supportive of their newly developed world-views, or well-intentioned others may intervene in a way that distorts the natural directions of the person's recovery. But irrespective of the dispositional personality and social environment that shapes these possible outcomes, it is a fundamental premise of the organismic valuing theory that people are motivated to pursue positive accommodation following trauma, just as they are throughout life in general. In this way, the organismic valuing process is not seen as specific to posttraumatic adaptation, but rather as a universal human tendency. It may become especially noticed in the aftermath of trauma, but it is always present to a greater or lesser extent.

CLINICAL AND RESEARCH CONSIDERATIONS

The possibility of the three cognitive outcomes helps resolve the question of why it is that previously traumatized people often appear to be more vulnerable instead of more resistant to the effects of future stressful and traumatic events. This is what we would predict when people assimilate their experiences rather than accommodate them. However, we also would predict that people who accommodate their experiences would be more resilient to future similar traumatic experiences because their assumptive world has been revised to be more congruent with the trauma-related information.

The main clinical implication is the assertion that what we know about the alleviation of posttraumatic stress does not necessarily apply to facilitating growth, as hypothetically, the reduction of PTSD should occur through either assimilation or accommodation, but only positive accommodation can be considered to support growth. It is possible that existing therapies for trauma may sometimes thwart growth-related processes.

There is a need to understand how these three directions of processing are influenced by psychosocial factors. The psychosocial framework emphasizes the role of the social context, social support, and social capital in influencing how the person moves through the cycle of appraisals, emotional states, and coping. The organismic valuing theory of growth through adversity develops the social perspective further through its grounding in the person-centered psychology of Carl Rogers (Rogers, 1959) who emphasizes the importance of nonjudgmental, empathic, and genuine relationships. Nondirective relationship-based therapeutic approaches may be beneficial to the facilitation of growth (Joseph & Linley, 2006); and some more directive approaches, however well-intentioned, may actually distort clients from the pathways and directions that are right for them in their recovery and growth following trauma.

Our endeavor has been to develop an understanding of posttraumatic adjustment processes that can synthesize the literature in posttraumatic stress and posttraumatic growth. The psychosocial framework provides an understanding of the cycle of appraisal, emotional states, coping, followed by further appraisal, influenced by personality and social context. Organismic valuing theory adds to this an understanding of the three broad directions that this cognitive-emotional processing can take. Further theoretical and research work is needed to address the issues that arise out of the preceding framework. However, as a first step toward an integrative positive psychological theory, it offers several new research questions and a useful perspective for those working clinically.

AIM OF THIS BOOK

In editing this book, our aim has been to provide coverage of this new field of research, review theoretical models of growth, and to open discussion on the implications of growth for clinical practice. Much has been written about treatments for posttraumatic stress, but we cannot simply assume that what we know about the treatment of posttraumatic stress will generalize to the facilitation of posttraumatic growth. It is possible that some current treatments for posttraumatic stress may actually thwart people's growth following trauma.

SYNTHESIS OF THE POSITIVE AND THE NEGATIVE

The facilitation of posttraumatic growth includes the wider ambitions of the positive psychology movement toward developing ways of thinking and working that integrate the negative and positive aspects of human experience (Linley, Joseph, Harrington, & Wood, 2006). As therapies aimed at facilitating growth following adversity are developed, we need to research